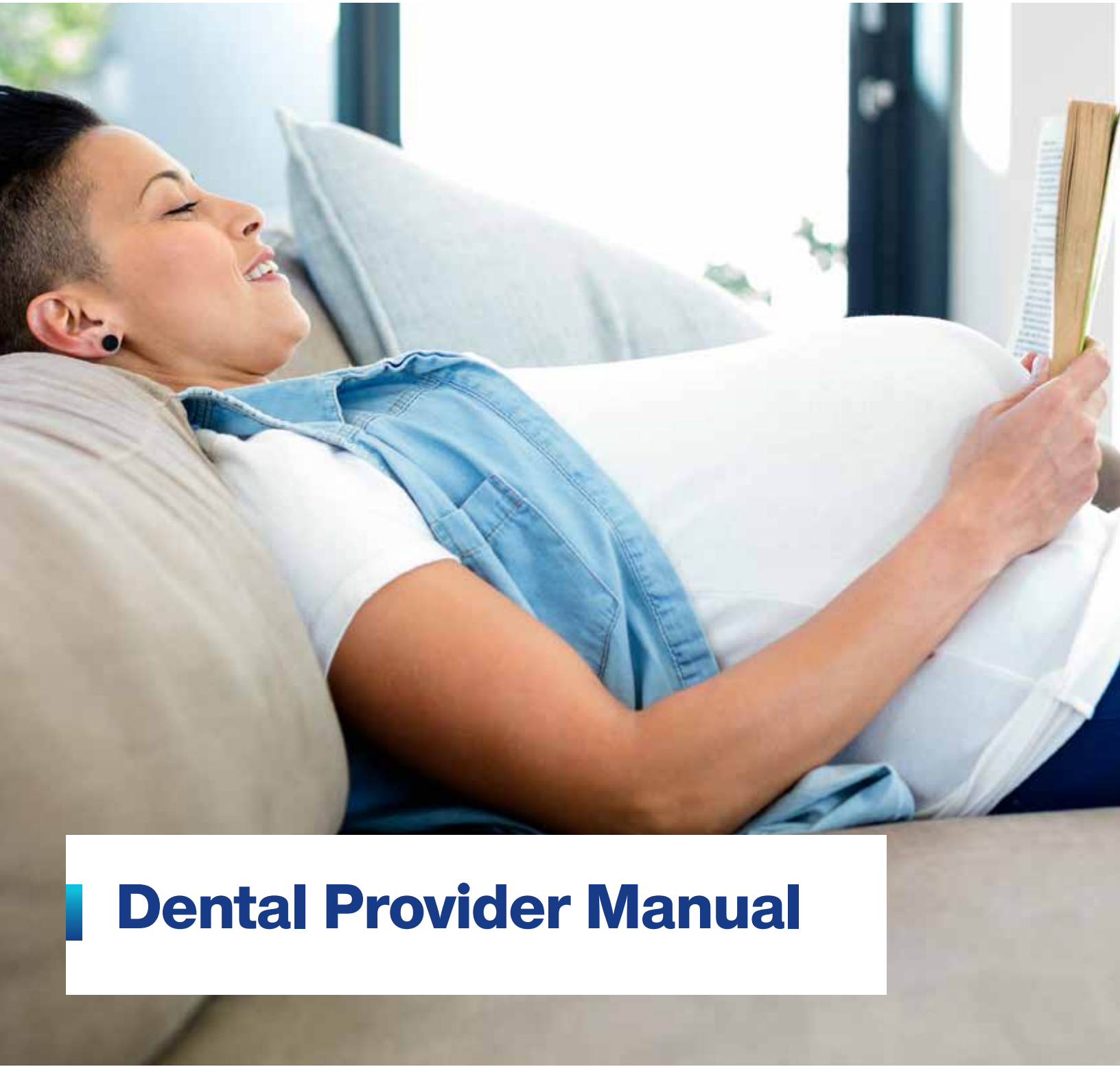


Dental Provider Manual

UnitedHealthcare
Healthy Michigan Plan & Pregnant Women

January 2020

UnitedHealthcare®

Contents

Section 1: **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 Dual Complete 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 Healthy Michigan Plan & Pregnant Women 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** (note: all other concerns should be directed to **1-855-918-2265.**)

If you have any questions or concerns about the information contained within this Manual, please contact the UnitedHealthcare Provider Services team at **1-855-918-2265.**

Unless otherwise specified herein, this Manual is effective on January 1, 2020 for dental providers currently participating in the UnitedHealthcare network, and effective immediately for newly contracted dental providers.

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 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 UnitedHealthcare Healthy Michigan Plan & Pregnant Women beneficiaries in your community.

Sincerely,

UnitedHealthcare Professional Networks

Section 2: **Resources and Services—Supporting Your Needs**

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 by knowledgeable specialists. They are trained to handle specific dental provider issues such as eligibility, claims, benefits information and contractual questions.

On the following page 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: 1-855-918-2265 Hours: 7 a.m. - 5 p.m. Monday –Friday, CST**	**Online uhcproviders.com**	**Interactive Voice Response (IVR) System Phone: 1-855-918-2265 Hours: 24 /7**
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, demographic updates, etc.)	✓	✓	
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	✓		

NEED:	RESOURCE: Address:	Phone Number:	Payer I.D.:	Submission Guidelines:	Form(s) Required:
Claim Submission (initial)	CLAIMS UnitedHealthcare P.O. Box 1317 Milwaukee, WI 53201	**1-855-918-2265**	GP133	Within 365 calendar days of the date of service	ADA Claim Form, 2012 version or later
Prior Authorization Requests	Prior Authorizations UnitedHealthcare P.O. Box 1484 Milwaukee, WI 53201	**1-855-918-2265**	GP133		ADA Claim Form – check the box titled: Request for Predetermination / Preauthorization section of the ADA Dental Claim Form
Provider Reprocessing or Adjustment Requests	Adjustments/Resubmissions UnitedHealthcare PO Box 341 Milwaukee, WI 53201	**1-855-918-2265**	GP133	Within 60 calendar days from receipt of payment	ADA Claim Form Provider narrative supporting appeal
UnitedHealthcare Member Complaints & Appeals	UnitedHealthcare Community Plan P.O. Box 30991 Salt Lake City, UT 84130	**1-800-903-5253**	n/a	Within 60 calendar days of the date of determniation Determination	n/a
UnitedHealthcare Provider Appeals	UnitedHealthcare P.O. Box 1337 Milwaukee, WI 53201	**1-855-918-2265**	n/a	Appeals must be submitted within 60 calendar days of receipt of the authorization decision.	n/a

2.2 Integrated Voice Response (IVR) System—1-855-918-2265

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, print remittance information, claim receipt acknowledgment and network specialist locations.**

To use the website, go to **uhcproviders.com** and register as a participating user. For assistance, call **1-855-918-2265**.

Section 3: **Patient Eligibility Verification Procedures**

3.1 Member Eligibility

Eligibility or dental benefits may be verified online or via phone for the UnitedHealthcare Community Plans for UnitedHealthcare Healthy Michigan Plan & Pregnant Women.

To verify eligibility, please call our Provider Services line at **1-855-918-2265** or go to **uhcproviders.com.**

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 the plan. The ID cards are issued to all recipients enrolled in benefits. The ID cards are customized with the UnitedHealthcare logo and include the toll-free customer service number for the health plan.

Medicaid ID cards issued by the state of Michigan do not guarantee payment under the UnitedHealthcare Community Plan for UnitedHealthcare Healthy Michigan Plan & Pregnant Women. It is the provider's responsibility to verify member eligibility with the UnitedHealthcare plan prior to rendering service; presentation of an ID card does not guarantee payment.

To verify a member's dental coverage, go to **uhcproviders.com** or contact the dental Provider Services line at **1-855-918-2265**.

3.3 Eligibility Verification

You can verify eligibility on our website at uhcproviders.com 24 hours a day, seven 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 **1-855-918-2265** during normal business hours for assistance with website issues.

UnitedHealthcare also offers an Interactive Voice Response (IVR) system; simply call **1-855-918-2265**. Through our IVR system, you may access real-time information, 24 hours a day, seven 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 **1-855-918-2265**.

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

4.1 UnitedHealthcare Healthy Michigan Plan & Pregnant Women Covered Services

CODE	DESCRIPTION	LIMITATIONS	AGE	AUTH	CLINICAL DOCUMENTATION
D0120	Periodic Oral Evaluation - Established Patient	1 per 6 months	19-64	NO	N/A
D0140	Limited Oral Evaluation -Problem Focused	2 per month	19-64	NO	N/A
D0150	Comprehensive Oral Evaluation - New Or Established Patient	1 per 6 months	19-64	NO	N/A
D0191	Assessment Of A Patient	1 per 6 months	19-64	NO	N/A
D0210	Intraoral - Complete Series of Radiographic Images	1 per 5 years	19-64	NO	N/A
D0220	Intraoral - Periapical First Radiographic Image	4 per month	19-64	NO	N/A
D0230	Intraoral - Periapical Each Additional Image	12 per year	19-64	NO	N/A
D0240	Intraoral - Occlusal Radiographic Image	2 per 3 years	19-64	NO	N/A
D0270	Bitewing - Single Radiographic Image	1 per 12 months	19-64	NO	N/A
D0272	Bitewings - Two Radiographic Images	1 per 12 months	19-64	NO	N/A
D0273	Bitewings - Three Radiographic Images	1 per 12 months	19-64	NO	N/A
D0274	Bitewings - Four Radiographic Images	1 per 12 months	19-64	NO	N/A
D0330	Panoramic Radiographic Image	1 per 5 years	19-64	NO	N/A
D0999	FQHC Encounter Payment		19-64	NO	N/A
D1110	Prophylaxis - Adult	1 per 6 months	19-64	NO	N/A
D1354	Interim Caries Arresting Medicament Application - per tooth	Once per date of service up to 5 teeth maximum; Twice per year	19-64	NO	N/A
D2140	Amalgam - One Surface, Primary Or Permanent	1 per 2 years	19-64	NO	N/A
D2150	Amalgam - Two Surfaces, Primary Or Permanent	1 per 2 years	19-64	NO	N/A
D2160	Amalgam - Three Surfaces, Primary Or Permanent	1 per 2 years	19-64	NO	N/A
D2161	Amalgam - Four Or More Surfaces, Primary Or Permanent	1 per 2 years	19-64	NO	N/A
D2330	Resin-Based Composite - One Surface, Anterior	1 per 2 years	19-64	NO	N/A
D2331	Resin-Based Composite - Two Surfaces, Anterior	1 per 2 years	19-64	NO	N/A
D2332	Resin-Based Composite - Three Surfaces, Anterior	1 per 2 years	19-64	NO	N/A
D2335	Resin-Based Composite - Four Or More Surfaces Or Involving Incisal Angle	1 per 2 years	19-64	NO	N/A
D2390	Resin-Based Composite Crown, Anterior	1 per 2 years	19-64	NO	N/A
D2391	Resin-Based Composite - One Surface, Posterior	1 per 2 years	19-64	NO	N/A
D2392	Resin-Based Composite - Two Surfaces, Posterior	1 per 2 years	19-64	NO	N/A
D2393	Resin-Based Composite - Three Surfaces, Posterior	1 per 2 years	19-64	NO	N/A
D2394	Resin-Based Composite - Four Or More Surfaces, Posterior	1 per 2 years	19-64	NO	N/A
D2710	Crown - Resin-Based Composite (Indirect)	1 per 5 years; permanent anterior teeth only	19-20	Yes	Pre-operative x-rays of adjacent teeth and opposing teeth
D2712	Crown - 3/4 Resin-Based Composite (Indirect)	1 per 5 years; permanent anterior teeth only	19-20	Yes	Pre-operative x-rays of adjacent teeth and opposing teeth
D2910	Re-Cement Or Re-Bond Inlay, Onlay, Veneer Or Partial Coverage Restoration	1 per 6 months	19-64	NO	N/A
D2915	Re-Cement or Re-Bond Cast Indirectly Fabricated Or Pre-Fabricated Post and Core	1 per 6 months	19-20	NO	N/A
D2930	Prefabricated Stainless Steel Crown - Primary Tooth	1 per 2 years	19-20	NO	N/A
D2931	Prefabricated Stainless Steel Crown - Permanent Tooth	1 per 2 years; permanent posterior teeth only	19-20	NO	N/A
D2933	Prefabricated Stainless Steel Crown With Resin Window	1 per 2 years; primary anterior teeth only	19-20	NO	N/A

CODE	DESCRIPTION	LIMITATIONS	AGE	AUTH	CLINICAL DOCUMENTATION
D2934	Prefabricated Esthetic Coated Stainless Steel Crown - Primary Tooth	1 per 2 years	19-20	NO	N/A
D2940	Protective Restoration	1 per 2 years	19-64	NO	N/A
D2950	Core Buildup, Including Any Pins When Required	1 per 2 years	19-20	NO	N/A
D2951	Pin Retention - Per Tooth, In Addition To Restoration	1 per 2 years	19-64	NO	N/A
D2952	Post And Core In Addition To Crown, Indirectly Fabricated	1 per 2 years	19-20	NO	N/A
D2954	Prefabricated Post And Core In Addition To Crown	1 per 2 years	19-20	NO	N/A
D2999	Unspecified Restorative Procedure, By Report	N/A	19-64	Yes	Description of procedure and narrative of medical necessity
D3110	Pulp Cap - Direct (Excluding Final Restoration)	1 per lifetime	19-20	No	N/A
D3222	Partial Pulpotomy For Apexogenesis - Permanent Tooth	1 per lifetime	19-20	No	N/A
D3310	Endodontic Therapy, Anterior Tooth (Excluding Final Restoration)	1 per lifetime	19-20	No	N/A
D3320	Endodontic Therapy Premolar Tooth (Excluding Final Restoration)	1 per lifetime	19-20	No	N/A
D3330	Endodontic Therapy, Molar tooth (Excluding Final Restoration)	1 per lifetime	19-20	No	N/A
D3346	Retreatment Of Previous Root Canal Therapy - Anterior	1 per lifetime	19-20	Yes	Pre-operative periapical x-ray and narrative of medical necessity
D3347	Retreatment Of Previous Root Canal Therapy - Premolar	1 per lifetime	19-20	Yes	Pre-operative periapical x-ray and narrative of medical necessity
D3348	Retreatment Of Previous Root Canal Therapy - Molar	1 per lifetime	19-20	Yes	Pre-operative periapical x-ray and narrative of medical necessity
D3410	Apicoectomy - Anterior	1 per lifetime	19-20	No	N/A
D3421	Apicoectomy - Premolar (First Root	1 per lifetime	19-20	No	N/A
D3425	Apicoectomy - Molar (First Root)	1 per lifetime	19-20	No	N/A
D3426	Apicoectomy - Each Additional Root)	1 per lifetime	19-20	No	N/A
D3430	Retrograde Filling - Per Root	1 per lifetime	19-20	No	N/A
D3999	Unspecified Endodontic Procedure, By Report	1 per lifetime	19-20	Yes	Description of procedure and narrative of medical necessity; Pre-operative periapical x-ray of the tooth/area; Completed 6 point perio charting
D4355	Full Mouth Debridement	1 per year	19-64	Yes	FMX or panoramic x-rays
D5110	Complete Denture - Maxillary	1 per 5 years	19-64	Yes	FMX or panoramic x-rays
D5120	Complete Denture - Mandibular	1 per 5 years	19-64	Yes	FMX or panoramic x-rays
D5130	Immediate Denture - Maxillary	1 per 5 years	19-64	Yes	FMX or panoramic x-rays
D5140	Immediate Denture - Mandibular	1 per 5 years	19-64	Yes	FMX or panoramic x-rays
D5211	Maxillary Partial Denture - Resin Base	1 per 5 years	19-64	Yes	FMX or panoramic x-rays
D5212	Mandibular Partial Denture - Resin Base	1 per 5 years	19-64	Yes	FMX or panoramic x-rays
D5213	maxillary partial denture - cast metal framework with resin denture bases	1 per 5 years	19-64	Yes	FMX or panoramic x-rays
D5214	mandibular partial denture - cast metal framework with resin denture bases	1 per 5 years	19-64	Yes	FMX or panoramic x-rays
D5225	Maxillary Partial Denture - Flexible Base	1 per 5 years	19-64	Yes	FMX or panoramic x-rays
D5226	Mandibular Partial Denture - Flexible Base	1 per 5 years	19-64	Yes	FMX or panoramic x-rays
D5410	Adjust Complete Denture - Maxillary	2 per year	19-64	No	N/A
D5411	Adjust Complete Denture - Mandibular	2 per year	19-64	No	N/A
D5421	Adjust Partial Denture - Maxillary	2 per year	19-64	No	N/A
D5422	Adjust Partial Denture - Mandibular	2 per year	19-64	No	N/A
D5511	Repair Broken Complete Denture Base - Mandibular	2 per year	19-64	No	N/A
D5512	Repair Broken Complete Denture Base - Maxillary	2 per year	19-64	No	N/A
D5520	Replace Missing Or Broken Teeth - Complete Denture (Each Tooth)	2 per year	19-64	No	N/A
D5611	Repair Resin Partial Denture Base - Mandibular	2 per year	19-64	No	N/A

CODE	DESCRIPTION	LIMITATIONS	AGE	AUTH	CLINICAL DOCUMENTATION
D5612	Repair Resin Partial Denture Base - Maxillary	2 per year	19-64	No	N/A
D5621	Repair Cast Partial Framework - Mandibular	2 per year	19-64	No	N/A
D5622	Repair Cast Partial Framework - Maxillary	2 per year	19-64	No	N/A
D5630	Repair Or Replace Broken Retentive / Clasping Materials - Per Tooth	2 per year	19-64	No	N/A
D5640	Replace Broken Teeth - Per Tooth	2 per year	19-64	No	N/A
D5650	Add Tooth To Existing Partial Denture	2 per year	19-64	No	N/A
D5660	Add Clasp To Existing Partial Denture - Per Tooth	2 per year	19-64	No	N/A
D5710	Rebase Complete Maxillary Denture	2 per year	19-64	No	N/A
D5711	Rebase Complete Mandibular Denture	2 per year	19-64	No	N/A
D5720	Rebase Maxillary Partial Denture	2 per year	19-64	No	N/A
D5721	Rebase Mandibular Partial Denture	2 per year	19-64	No	N/A
D5730	Reline Complete Maxillary Denture (Chairside)	1 per 2 years	19-64	No	N/A
D5731	Reline Complete Mandibular Denture (Chairside)	1 per 2 years	19-64	No	N/A
D5740	Reline Maxillary Partial Denture (Chairside)	1 per 2 years	19-64	No	N/A
D5741	Reline Mandibular Partial Denture (Chairside)	1 per 2 years	19-64	No	N/A
D5750	Reline Complete Maxillary Denture (Laboratory)	1 per 2 years	19-64	No	N/A
D5751	Reline Complete Mandibular Denture (Laboratory)	1 per 2 years	19-64	No	N/A
D5760	Reline Maxillary Partial Denture (Laboratory)	1 per 2 years	19-64	No	N/A
D5761	Reline Mandibular Partial Denture (Laboratory)	1 per 2 years	19-64	No	N/A
D5899	Unspecified Removable Prosthodontic Procedure, By Report	N/A	19-64	Yes	Description of procedure and narrative of medical necessity
D6930	Re-Cement Or Re-Bond Fixed Partial Denture	N/A	19-64	No	N/A
D7111	Extraction, Coronal Remnants – Primary Tooth	1 per lifetime	19-64	No	N/A
D7140	Extraction, Erupted Tooth Or Exposed Root	1 per lifetime	19-64	No	N/A
D7210	Extraction, Erupted Tooth	1 per lifetime	19-64	No	N/A
D7220	Removal Of Impacted Tooth - Soft Tissue	1 per lifetime	19-64	No	N/A
D7230	Removal Of Impacted Tooth - Partially Bony	1 per lifetime	19-64	No	N/A
D7240	Removal Of Impacted Tooth - Completely Bony	1 per lifetime	19-64	No	N/A
D7250	Removal Of Residual Tooth (Cutting Procedure)	1 per lifetime	19-64	No	N/A
D7260	Oroantral Fistula Closure	1 per lifetime	19-64	No	N/A
D7261	Primary Closure Of Sinus Perforation	1 per lifetime	19-64	No	N/A
D7270	Reimplantation And/Or Stabilization Of Accidentally Evulsed / Displaced Tooth	1 per lifetime; Permanent anterior teeth only	19-20	No	N/A
D7310	Alveoloplasty In Conjunction With Extractions - Four Or More Teeth	1 per lifetime	19-64	No	N/A
D7320	Alveoloplasty Not In Conjunction With Extractions - Four Or More Teeth	1 per 5 years	19-64	No	N/A
D7471	Removal Of Lateral Exostosis (Maxilla Or Mandible)	1 per lifetime	19-64	No	N/A
D7472	Removal Of Torus Palatinus	1 per lifetime	19-64	No	N/A
D7473	Removal Of Torus Mandibularis	1 per lifetime	19-64	No	N/A
D7485	Reduction Of Osseous Tuberosity	1 per lifetime	19-64	No	N/A
D7510	Incision And Drainage Of Abscess - Intraoral Soft Tissue	N/A	19-64	No	N/A
D7970	Excision Of Hyperplastic Tissue - Per Arch	1 per 2 years	19-64	No	N/A
D7971	Excision Of Pericoronal Gingiva	1 per 2 years	19-64	No	N/A
D7972	Surgical Reduction Of Fibrous Tuberosity	1 per 2 years	19-64	No	N/A
D7999	Unspecified Oral Surgery Procedure, By Report	N/A	19-64	Yes	Description of procedure and narrative of medical necessity
D9110	Palliative (Emergency) Treatment Of Dental Pain - Minor Procedure	1 per day	19-20	No	N/A
D9222	Deep Sedation/General Anesthesia - First 15 Minutes	N/A	19-64	Yes	Narrative of medical necessity

CODE	DESCRIPTION	LIMITATIONS	AGE	AUTH	CLINICAL DOCUMENTATION
D9223	Deep Sedation / General Anesthesia - Each subsequent 15 Minute Increment	N/A	19-64	Yes	Narrative of medical necessity
D9239	Intravenous Moderate (Conscious) Sedation/Analgesia - First 15 Minutes	N/A	19-64	Yes	Narrative of medical necessity
D9243	Intravenous Moderate (Conscious) Sedation/Analgesia - Each Subsequent 15 Minute	N/A	19-64	Yes	Narrative of medical necessity
D9310	Consultation - Diagnostic Service Provided By Dentist Or Physician	N/A	19-64	No	N/A
D9420	Hospital Or Ambulatory Surgical Center Call	1 per 6 months	19-64	No	N/A
D9930	Treatment Of Complications (Post-Surgical) - Unusual Circumstances, By Report	1 per day	19-64	Yes	Description of procedure and narrative of medical necessity
D9999	Unspecified Adjunctive Procedure, By Report	N/A	19-64	Yes	Description of procedure and narrative of medical necessity

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 **1-855-918-2265** if you have any questions regarding frequency limitations.

4.2.a Additional Exclusions

1. Dental services that are not necessary.
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 performed in a dental setting that has not been prior authorized.
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. Services 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 notice of cancellation. Please note that Medicaid members may not be billed for missed appointments.

4.3 Member Complaints and Appeals

Providers may come across members who want to file a grievance. Providers may assist or instruct members how to do so. For more information, this process is explained in the member handbook.

To submit a grievance in writing, members may send a letter to the address below:

UnitedHealthcare Community Plan
Grievance and Appeals Department
P.O. Box 30991
Salt Lake City, UT 84130-0991
1-800-903-5253

Members who call to file a grievance regarding a provider are encouraged to contact the provider first.

If the member is not satisfied with the answer given by the provider, the member is encouraged to call as noted in the paragraph above. A Service Coordinator may call a provider's office to clarify a situation and provide appropriate direction to the member. Once UnitedHealthcare Community Plan receives the grievance, the Grievance Coordinator will investigate the issue. The member will receive a written notice that the grievance has been received and the expected date of its resolution. A final resolution letter shall be sent to the member within 30 calendar days from receipt of the grievance.

If the member was denied a requested service or is not satisfied with UnitedHealthcare Community Plan's decision, the member may file an appeal. An appeal may be filed over the phone or in writing. An appeal filed over the phone requires that it is followed by a written appeal that is signed by the member within 10 calendar days. All letters of appeal must be sent to the address listed above. After UnitedHealthcare Community Plan has completed its review of the member's appeal, a written decision letter will be sent within 30 calendar days from the date the initial verbal or written appeal is received. The decision letter will explain how the decision was reached. Providers may file an appeal on behalf of the member if the member gives them that authority in writing and a copy of the authorization is sent to UnitedHealthcare Community Plan with the appeal. No punitive action will be taken against a provider who files an appeal on behalf of a member. A member shall have the right to request a fair hearing and may occur without first going through the grievance/appeal process. The member must request a State Fair Hearing within 90 calendar days of the date of the determination.

Please refer to the UnitedHealthcare website at **uhccommunityplan.com** for further information and instructions if needed.

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 a dispute. If there is any member liability outside of 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 billing, 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:

1-855-918-2265
UnitedHealthcare Dental
Attn: Appeals Department
PO Box 1337
Milwaukee, WI 53201

When a claim is reprocessed as a result of a reprocessing or adjustment request or dispute, providers will receive a new remittance advice within 30 days of receipt of the reprocessing/adjustment request or dispute. If the reprocessing or adjustment request or dispute does not result in the reprocessing of a claim, providers will receive written notification of the outcome within 30 days of receipt of the reprocessing or adjustment request or 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.

All providers must comply with the Utilization Management program requirements. Failure to follow such requirements may result in delay or denial of payment for services rendered.

5.1.a Prior Authorization Clinical Criteria

Crowns {D2710, D2712)

- Recurrent decay around margins of existing crown
- Documentation shows healthy bone/periodontium
- Minimum 50% bone support
- No periodontal furcation
- No subcrestal caries
- Clinically acceptable RCT
- Anterior - 50% incisal edge / 4+ surfaces involved
- Bicuspid -1 cusp/ 3+ surfaces involved
- Molar- 2 cusps/ 4+ surfaces involved

Root canal retreatment (D3346 - D3348)

- Minimum 50% bone support
- No periodontal furcation
- No subcrestal caries
- Evidence of apical pathology/fistula
- Pain from percussion/ temp

Full dentures (D5110, D5120)

- Existing denture greater than 5 years old
- Remaining teeth do not have adequate bone support or are not restorable
- Note: Complete and partial dentures are benefits for all beneficiaries. All dentures require prior authorization (PA). Providers must assess the beneficiary's general oral health and provide a five-year prognosis for the prosthesis requested. An upper partial denture PA request must also include the prognosis of six sound teeth.

Immediate dentures (D5130, D5140)

- Remaining anterior teeth do not have adequate bone support or are not restorable

Partial dentures (D5211 – D5214)

- Replacing one or more anterior teeth
- Less than eight posterior teeth in occlusion (excluding 3rd molars)
- Existing partial denture greater than 5 years old
- Remaining teeth have greater than 50% bone support and are restorable if needed

Deep Sedation, General Anesthesia and Intravenous Moderate Sedation

5.1.b Authorization Decisions – Turnaround Times & Filing Limits

UnitedHealthcare will render a decision (1) within 3 business days of receipt of an expedited authorization request or (2) in all other cases, within 3 business days of receipt of necessary information but no more than 14 days of the request.

Services must be performed within 365 days from the date that the approval notification is received by the practitioner.

Providers will receive a faxed notification of the decision within 2 days of of the determination made.

Retrospective Review is a process of reviewing medical services after the service has been provided, not inclusive of an appeal review. The process includes review of records to determine medical necessity and appropriateness of care and setting.

When an adverse determination is rendered without provider input, the provider has the right to reconsideration. The reconsideration shall occur within one business day of receipt of the request and shall be conducted by the enrollee's health care provider and the clinical peer reviewer making the initial determination.

All services that have not been appropriately authorized may be subject to retrospective review. Retrospective review decisions are rendered by the appropriate clinical staff and the authorization decision communicated to the provider within 30 days of receipt of necessary information. Notice will be mailed to both provider and member on the date of any payment denial, in whole or in part. A provider may file a UR Appeal or a Retrospective Denial.

5.1.c Payment for non-covered services:

When non-covered services are provided for UnitedHealthcare Healthy Michigan Plan & Pregnant Women 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.

Please note that it is recommended that benefits and eligibility be confirmed by the provider before treatment is rendered.

5.1.d After Hours Emergency

When a provider treats a patient outside of their normal business hours, providers should:

1. Confirm patient eligibility on the date of service through our website uhcproviders.com, or our Interactive Voice Response system **1-855-918-2265.**
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. Covered services that do not require prior authorization can be rendered.
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.

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.

5.1.e Missed Appointment Fees

Providers may not bill members for missed appointment fees, regardless of provider's standard office policy.

UnitedHealthcare Healthy Michigan Plan & Pregnant Women members are held harmless and cannot be billed for a missed appointment, whether or not the member gave prior notice to the provider office.

Section 6: **Radiology Requirements**

6.1 Radiographs

For some procedures, it is required that copies of radiographs are submitted prior to payment. Requirements for radiographs are listed in 5.1.a. Providers should refer to this section for documentation guidelines before performing a procedure.

Guidelines for providing radiographs are as follows:

- Send a duplicate radiograph instead of the original
- Radiograph must be diagnostic for the condition or site and contain all critical anatomical landmarks
- Radiographs should be labeled with the practice name, member 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

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 & Required Elements

7.1.a Dental Claim Form

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

7.1.b Claim Submission Options

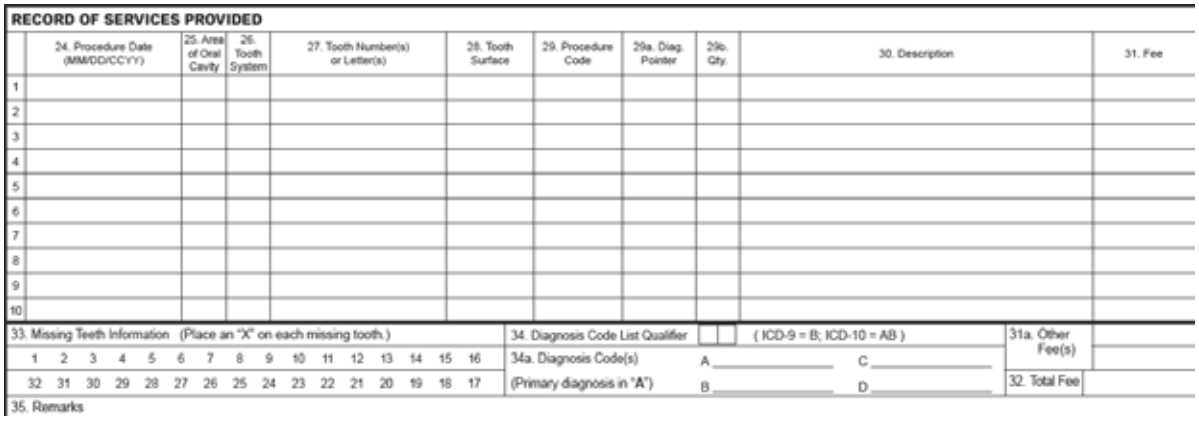
Electronic Claims

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 1-855-918-2265 for more information regarding electronic claims submission.

Payer ID GP133

ICD-10 Instructions

Effective Oct. 1, 2015, ICD-10 codes are required for oral surgery and anesthesia services.



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.)

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16

32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17

34. Diagnosis Code List Qualifier (ICD-9 = B; ICD-10 = AB)

34a. Diagnosis Code(s) (Primary diagnosis in "A") A B C D

31a. Other Fee(s)

32. Total Fee

35. Remarks

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.

7.1.c 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 below.

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, City, State, ZIP Code
- Date of birth
- Gender
- Subscriber ID number

Patient Information

- Name (Last, First and Middle Initial)
- Address, 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 Identification number
- Relationship to the Member

Billing Dentist or Dental Entity

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

- Name
- Address, City, State, ZIP Code
- License 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
- Address, City, State, ZIP Code
- Phone number
- National Provider Identifier (NPI)

Record of Services Provided

Most claim forms have 10 field rows 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 prosthodontic 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.

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**.

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 Claim Appeals

A provider appeal must be submitted within 90 calendar days after the receipt of the Provider Remittance Advice and/or decision. Instances where a provider is pursuing an appeal on behalf of a member are subject to the Member Appeal process in this Manual.

Refer to the Quick Reference Guide section for appeal submission addresses.

7.3 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 clearinghouses to support electronic claims submissions. While the payer ID may vary for some plans, the UnitedHealthcare number 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. If you do not currently work with a clearinghouse, you may either sign up with one to initiate this process or simply register with our preferred vendor.

7.4 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.

7.5 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 "Claims Submission Best Practices & Required Elements" 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.

7.6 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 state of New York 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 UnitedHealthcare of such on each impacted claim form.

Please note: When a member is covered under UnitedHealthcare for both UnitedHealthcare Healthy Michigan Plan & Pregnant Women and Medicare (Dual Complete), the provider should submit only one claim using the Member's primary insurance ID number (Medicare). UnitedHealthcare will coordinate benefits automatically for these two plans, when COB is applicable.

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 UnitedHealthcare 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 UnitedHealthcare for any additional payment along with primary payer's Explanation of Benefits (EOB).

7.7 Timely Submission

All UnitedHealthcare Healthy Michigan Plan & Pregnant Women claims should be submitted within 365 days of the date of service.

It is the responsibility of the provider to follow up on any unpaid claims in a timely manner. Providers should resubmit unpaid claims or call to check status of unpaid claims if a response to the claim is not received within 30 days of the original submission.

7.8 Claim Adjudication and Periodic Overview

95% of Clean Claims shall be adjudicated in 30 days

100% of all claims within 45 days

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.

If claims are submitted with missing information, incomplete or outdated claim forms, 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.

7.9 Explanation of Dental Plan Reimbursement

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 Advices be kept for future reference and reconciliation.

Below is a list and description of each field:

PROVIDER NAME AND ID NUMBER- Treating dentist's name and 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 - 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

CDT CODE

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

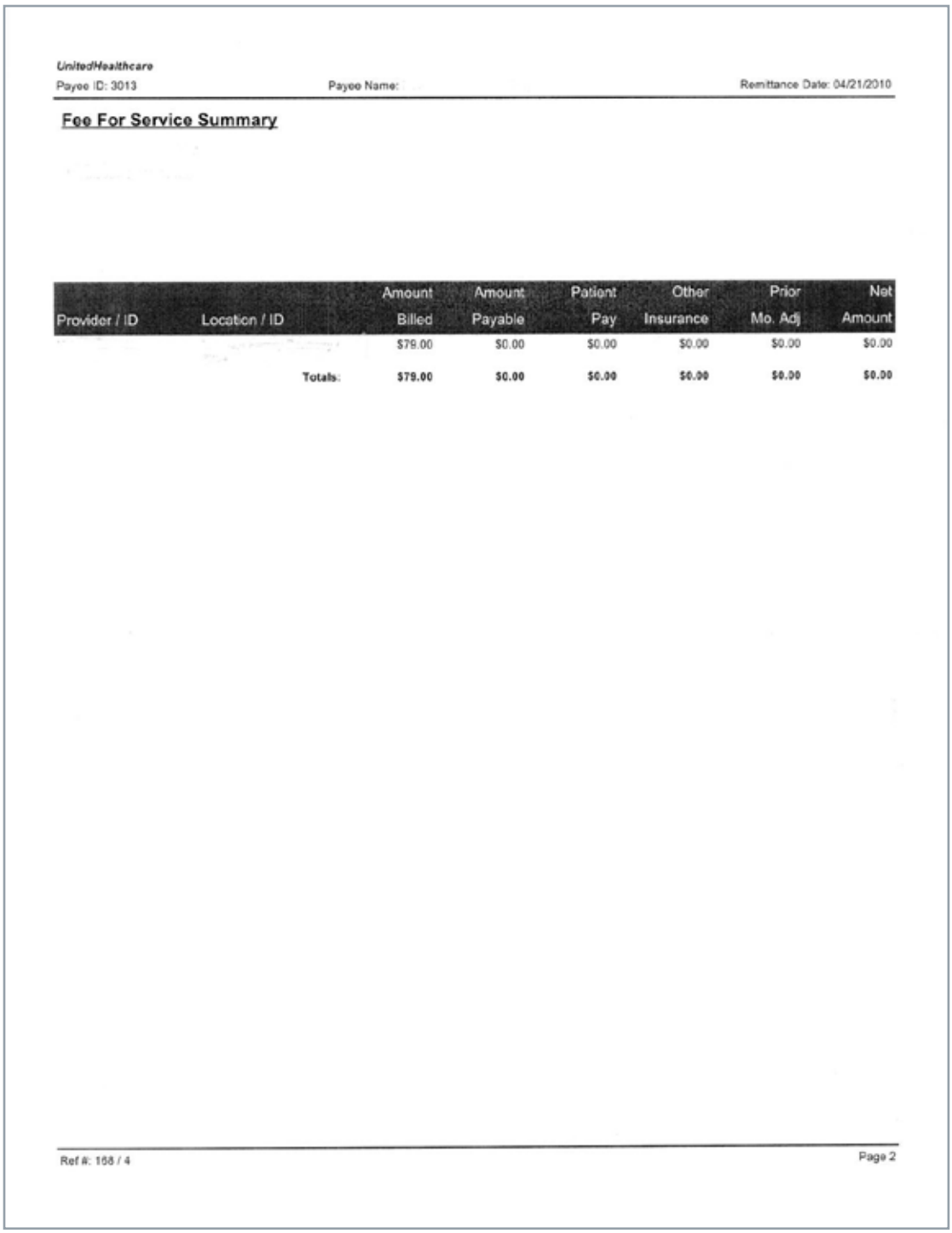
PATIENT PAY - Amount to be paid by the member

OTHER INSURANCE AMOUNT - Amount paid by other carriers

NET AMOUNT - Final amount to be paid

EXCEPTION CODES - Codes that explain how the claim was adjudicated

7.9.a Explanation of Benefits Sample (Front)



UnitedHealthcare

Payee ID: 3013 Payee Name: Remittance Date: 04/21/2010

Fee For Service Summary

Provider / ID	Location / ID	Amount Billed	Amount Payable	Patient Pay	Other Insurance	Prior Mo. Adj	Net Amount
		$79.00	$0.00	$0.00	$0.00	$0.00	$0.00
	Totals:	**$79.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**

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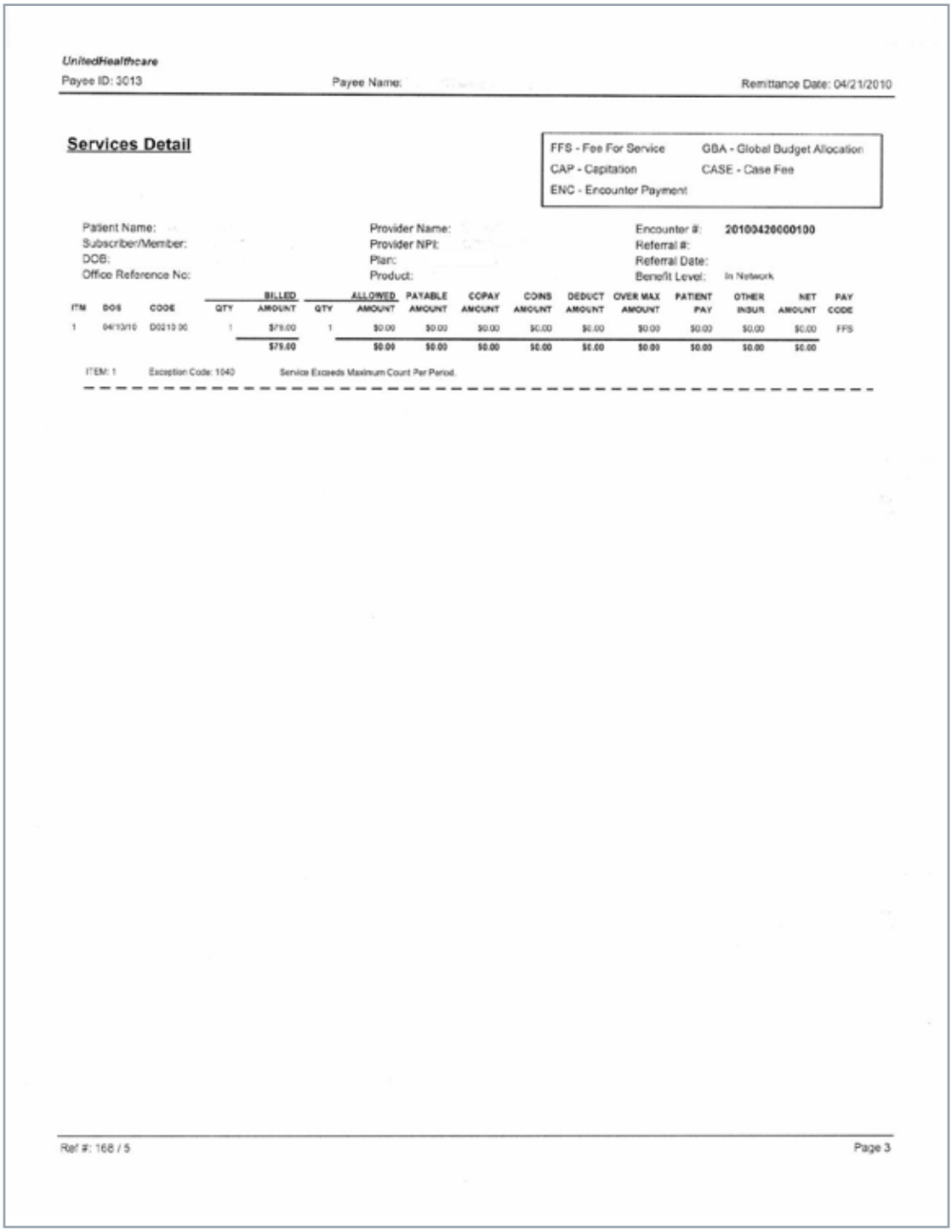
7.9.a Explanation of Benefits Sample (Back)



UnitedHealthcare

Payee ID: 3013 Payee Name: Remittance Date: 04/21/2010

Services Detail

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

Patient Name:
Subscriber/Member:
DOB:
Office Reference No:

Provider Name:
Provider NPI:
Plan:
Product:

Encounter #: 20100426000100
Referral #:
Referral Date:
Benefit Level: In Network

ITM	DOS	CODE	BILLED QTY	BILLED AMOUNT	ALLOWED QTY	ALLOWED AMOUNT	PAYABLE AMOUNT	COPAY AMOUNT	COINS AMOUNT	DEDUCT AMOUNT	OVER MAX AMOUNT	PATIENT PAY	OTHER INSUR	NET AMOUNT	PAY CODE
1	04/13/10	D0210 00	1	$79.00	1	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	FFS
				$79.00		$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	

ITEM: 1 Exception Code: 1040 Service Exceeds Maximum Count Per Period.

Ref #: 168 / 5 Page 3

Section 8: **Quality Management**

8.1 Quality Improvement Program (QIP) Description

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 decision regarding your participation made by UnitedHealthcare based on information received during the credentialing or recredentialing process. To initiate an appeal of a credentialing or 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):

8.2.a 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)

8.2.b 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 1-855-918-2265.

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.

8.2.c 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.

8.2.d 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.

8.3 Preventive Health Guidelines

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.

(See Section 6 for treatment codes that require clinical review and documentation requirements)

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 or Medicare, 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 1-888-233-4877.

Section 10: **Evidence-Based Dentistry and the Clinical Policy and Technology Committee**

According to the American Dental Association®, Evidence-Based Dentistry (EBD) is a patient centered approach to treatment decisions, providing personalized dental care based on the most current scientific evidence.

At UnitedHealthcare, we use evidence-based guidelines as the foundation of many of our clinical efforts, including:

- Practice guidelines, parameters and algorithms
- Comparing dentist quality and utilization data
- Chart auditing, site visits, credentialing

The "hierarchy of evidence" used by UnitedHealthcare is as follows:

- Statistically robust, well-designed randomized controlled trials;
- Statistically robust, well-designed cohort studies;
- Multi-site observational studies;
- Single-site observational studies;

In the absence of incontrovertible scientific evidence, policies may be based upon national consensus statements by recognized authorities. The following hierarchy is how United Healthcare applies such consensus statements:

- National guidelines and consensus statements
- Centers for Medicare and Medicaid Services (CMS) National Coverage Decisions (NCDs)
- Clinical position papers based upon rigorous review of scientific evidence or clinical registry data from professional specialty societies when their statements are based upon referenced clinical evidence.

We consult a variety of sources when reviewing evidence and these may include:

- Electronic indices —PubMed, Cochrane
- Reference listings in other articles
- Professional journals

At UnitedHealthcare, the Dental Clinical Policy and Technology Committee is responsible for evaluating evidence for the development and approval of dental policies, benefits (coverage guidelines), clinical programs, and business functions. Clinical policies and coverage guidelines are updated no less than annually, and communicated to providers monthly via online Dental Policy Update Bulletins.

The Committee 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. Non-Voting Members may include Legal Services, Medical Policy Development and Operations Teams, Guest dentist specialists, Medical Directors and business leaders, and Clinical content experts. The Committee convenes bimonthly and no less frequently than four times per year.

Section 11: **Governing Administrative Policies**

11.1 Appointment Scheduling Standards

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

- Emergency Care or Urgent Appointments: Immediately or within 24 hours
- Elective or Routine Care Appointments: Offered within 4 weeks 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.

- 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.

11.1.a Missed Appointments

Offices should inform patients of office policies relating to missed appointments. Providers may not bill members for any fees that may be incurred as a result of a missed appointment.

11.2 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, seven 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.

11.3 New Associates

As your practice expands and changes and new associates are added, you must contact us within 10 calendar days 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, please contact Provider Services at **1-855-918-2265**.

11.4 Change of Address, Phone Number, E-mail Address, Fax or Tax Identification Number

When there are demographic changes within your office, you must notify us at least 10 calendar days prior to the effective date of the change. 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 - RMO
ATTN: 224-Prov Misc Mail WPN
PO BOX 30567
SALT LAKE CITY, UT 84130

Credentialing updates should be sent to

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 that the changes apply.

UnitedHealthcare reserves the right to conduct an onsite 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 at 1-855-918-2265 for guidance.

11.5 Office Conditions

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

You must submit to us an attestation from each dental office location, that the physical office meets ADA standards or describes how accommodation for ADA standards are made, and that medical recordkeeping practices conform with our standards.

11.6 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.

11.7 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, e-mails and advance appointment scheduling.

11.8 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 cannot be held liable 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.

11.9 Nondiscrimination

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.

11.10 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.

The website listed below contains valuable materials that will assist dental providers and their staff to become culturally competent.

https://www.hrsa.gov/about/organization/bureaus/ohe/health-literacy/culture-language-and-health-literacy

Section 12: **Fraud Waste & 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

Section 13: **Appendix**

13.1 Practitioner Rights Bulletin

1. Providers applying for initial credentialing do not have appeal rights, unless required by State regulation.
2. Providers rejected for re-credentialing 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 one 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 ten 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.

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 or 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 15 business days of receipt of the information. You will have an additional 15 business days to submit your reply in writing; and within two 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 to us in writing (U.S. mail, e-mail, facsimile) or telephonically.

To appeal adverse Committee Decisions

In the event you are denied participation or continued participation, you have the right to appeal the decision in writing within 30 calendar days of the date of receipt of the rejection/denial letter. To appeal the decision, submit your request to the following address:

UnitedHealthcare Dental
Government Programs – Provider Operations
Fax: **1-866-829-1841**

13.2 Provider Terminations and Appeals

Providers who are found to be in breach of their Provider Agreement or have demonstrated quality-of-care issues are subject to review, corrective action, and/or termination in accordance with approved criteria.

13.3 Breach of Provider Agreement

A provider may be found in violation of their Provider Agreement for, but not limited to, the following reasons:

1. Failure to comply with DBP UnitedHealthcare's credentialing or recredentialing procedures
2. Violations of DBP UnitedHealthcare's Policies and Procedures or the provisions of the Provider Manual
3. Insufficient malpractice coverage with refusal to obtain such
4. Information supplied (such as licensure, dental school and training) is not supported by primary source verification

5. Failure to report prior, present or pending disciplinary action by any government agency
6. Any federal or state sanction that precludes participation in Government Programs (such providers will be excluded from participation in our Medicaid panel)
7. Failure to report fraud or malpractice claims

13.4 Quality-of-Care Issues.

A provider who has demonstrated behavior inconsistent with the provision of quality of care is subject to review, corrective action, and/or termination. Questions of quality-of-care may arise for, but are not limited to, the following reasons:

1. chart audit reveals clear and convincing evidence of under- or over utilization, fraud, upcoding, overcharging, or other inappropriate billing practices.
2. Multiple quality-of-care related complaints or complaints of an egregious nature for which investigation confirms quality concerns.
3. Malpractice or disciplinary history that elicits risk management concerns.

Note

A provider cannot be prohibited from the following actions, nor may a provider be refused a contract solely for the following:

1. Advocated on behalf of an enrollee
2. Filed a complaint against the MCO
3. Appealed a decision of the MCO
4. Provided information or filed a report pursuant to PHL4406-c regarding prohibition of plans
5. Requested a hearing or review

13.5 Review Process

We may not terminate a contract unless we provide the practitioner with a written explanation of the reasons for the proposed contract termination and an opportunity for a review or hearing as described below.

A. Cases which meet disciplinary or malpractice criteria are initially reviewed by the Credentialing Committee. Other quality-of-care cases are reviewed by the Peer Review Committee.

B. The Committees make very effort to obtain a provider narrative and appropriate documents prior to making any determination.

C. The Committees may elect to accept, suspend, unpublish, place a provider on probation, require corrective action or terminate the provider.

D. The provider will be allowed to continue to provide services to members for a period of up to sixty (60) days from the date of the provider's notice of termination.

E. The Hearing Committee will immediately remove from our network any provider who is unable to provide health care services due to a final disciplinary action. In such cases, the provider must cease treating members upon receipt of this determination.

13.6 Appeals Process

A. Providers are notified in writing of their appeal rights within fifteen (15) calendar days of the Committee's determination. The letter will include the reason for denial/termination; notice that the provider has the right to request a hearing or review, at the provider's discretion, before a panel appointed by UnitedHealthcare; notice of a thirty (30)-day time frame for the request; and, a time limit for the hearing date, which must be held within thirty (30) days after the receipt of a request for a hearing.

B. Providers must request an appeal in writing within ninety (90) calendar days of the date of notice of termination, and provide any applicable information and documentation to support the appeal.

C. The Hearing will be scheduled within thirty (30) days of the request for a hearing.

D. The appeal may be heard telephonically, unless the clinician requests an in-person hearing. In such cases, all additional costs relevant to the Hearing are the provider's responsibility.

E. The Hearing Committee includes at least three members appointed by UnitedHealthcare, who are not in direct economic competition with the provider, and who have not acted as accuser, investigator, fact-finder, or initial decision-maker in the matter. At least one

person on the panel will be the same discipline or same specialty as the person under review. The panel can consist of more than three members, provided the number of clinical peers constitute one-third or more of the total membership.

F. The Hearing Committee may uphold, overturn, or modify the original determination. Modifications may include, but are not limited to, placing the provider on probation, requiring completion of specific continuing education courses, requiring site or chart audits, or other corrective actions.

G. The decision of the Hearing Committee is sent to the provider by certified letter within thirty (30) calendar days.

H. Decisions of terminations shall be effective not less than thirty (30) days after the receipt by the provider of the Hearing Panel's decision.

I. In no event shall determination be effective earlier than sixty (60) days from receipt of the notice of termination.

Note

A provider terminated due to a case involving imminent harm to patient care, a determination of fraud, or a final disciplinary action by a state licensing board or other governmental agency that impairs the health care professional's ability to practice is not eligible for a hearing or review.