Dental Provider Manual

UnitedHealthcare Community Plan of Indiana
Hoosier Care Connect

Provider Services: 1-844-402-9118

UnitedHealthcare Community Plan

Contents

Section 1: Introduction— Who we are

Welcome to UnitedHealthcare Community Plan

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

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

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

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

Our Commercial program plan requirements are contained in a separate Provider Manual. If you support one of our Commercial plans and need that Manual, please contact Provider Services at **1-800-822-5353** (Please note: all other concerns should be directed to **1-844-402-9118**).

If you have any questions or concerns about the information contained within this Manual, please contact the UnitedHealthcare Community Plan Provider Services team at **1-844-402-9118**.

Unless otherwise specified herein, this Manual is effective on April 1, 2021 for dental providers currently participating in the UnitedHealthcare Community Plan of Indiana network, and effective immediately for newly contracted dental providers.

Please note: "Member" is used in this Manual to refer to a person eligible and enrolled to receive coverage for covered services in connection with your agreement with us. "You" or "your" refers to any provider subject to this Manual. "Us", "we" or "our" refers to UnitedHealthcare Community Plan on behalf of itself and its other affiliates for those products and services subject to this Manual.

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

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

Sincerely,

UnitedHealthcare Community Plan, Professional Networks

Section 2: Resources and services — How we help you

2.1 Quick Reference Guide

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

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

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

YOU WANT TO:	Provider Services Line— Dedicated Service Representatives Phone: 1-844-402-9118 Hours: 8 a.m.-8 p.m. (EST) Monday-Friday	Online uhcdentalproviders.com	Interactive Voice Response (IVR) System and Voicemail Phone: 1-844-402-9118 Hours: 24 hours a day, 7 days a week
Ask a Benefit/Plan Question (including prior authorization requirements)	✓	✓	
Ask a question about your contract	✓		
Changes to practice information (e.g., associate updates, address changes, adding or deleting addresses, Tax Identification Number change, specialty designation)	✓	✓	
Inquire about a claim	✓	✓	✓
Inquire about eligibility	✓	✓	✓
Inquire about the In-Network Practitioner Listing	✓	✓	✓
Nominate a provider for participation	✓	✓	
Request a copy of your contract	✓		
Request a Fee Schedule	✓	✓	
Request an EOB	✓	✓	
Request an office visit (e.g., staff training)	✓		
Request benefit information	✓	✓	
Request documents	✓	✓	
Request participation status change	✓		

2.2 Provider Web Portal

The UnitedHealthcare Community Plan website at **uhcdentalproviders.com** offers many time-saving features including **eligibility verification, benefits, claims submission and status, print remittance information, claim receipt acknowledgment and network specialist locations.** The portal is also a helpful content library for **standard forms, provider manuals, quick reference guides, training resources** and more.

To use the website, go to **uhcdentalproviders.com** and register as a participating user. Online access requires only an internet browser, a valid user ID, and a password. There is no need to download or purchase software.

To register on the site, you will need your Payee ID number. To receive your Payee ID and for other Provider Web Portal assistance, call **1-844-402-9118**.

2.3 Addresses and Phone Numbers

NEED:	Address:	Phone Number:	Payer I.D.:	Submission Guidelines:	Form(s) Required:
Claim Submission (initial)	Claims: P.O. Box 781 Milwaukee, WI 53201	**1-844-402-9118**	GP133	Within 90 calendar days from the date of service For out of network , within 180 days from the date of service	ADA* Claim Form, 2012 version or later
Corrected Claims	Corrected Claims: P.O. Box 481 Milwaukee, WI 53201	**1-844-402-9118**	N/A	Within 90 days from date of service.	ADA Claim Form Reason for requesting adjustment or resubmission
Claim Appeals (Appeal of a denied or reduced payment)	Claim Appeals: P.O. Box 1391 Milwaukee, WI 53201	**1-844-402-9118**	N/A	Within 30 days after the claim determination	Supporting documentation, including claim number is required for processing.
Prior Authorization Requests	Pre-authorizations: P.O. Box 1313 Milwaukee, WI 53201	**1-844-402-9118**	GP133	N/A	ADA Claim Form – check the box titled: Request for Predetermination / Preauthorization section of the ADA Dental Claim Form
Member Benefit Appeal for Service Authorization (Appeal of a denied or reduced service)	UnitedHealthcare Grievances and Appeals P.O. Box 31364 Salt Lake City, UT 84131-0364	**1-800-832-4643**	N/A	Within 60 calendar days from the date of the adverse benefit determination	N/A

2.4 Integrated Voice Response (IVR) System— 1-844-402-9118

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).

2.5 UHC On Air

UHC On Air is a source for 24/7 on demand video broadcasts created specifically for UHC Dental providers. UHC On Air provides instant access to content for providers, such as:

- Educational video resources,
- Interactive provider training materials,
- Onboarding content for new dentists,
- Up-to-date operational and clinical policy information,
- Market-specific programs, and
- Provider advocate profiles.

To access UHC On Air, log into **uhcdental.com** with your Optum ID.

Section 3: Patient eligibility verification procedures

3.1 Member Eligibility

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

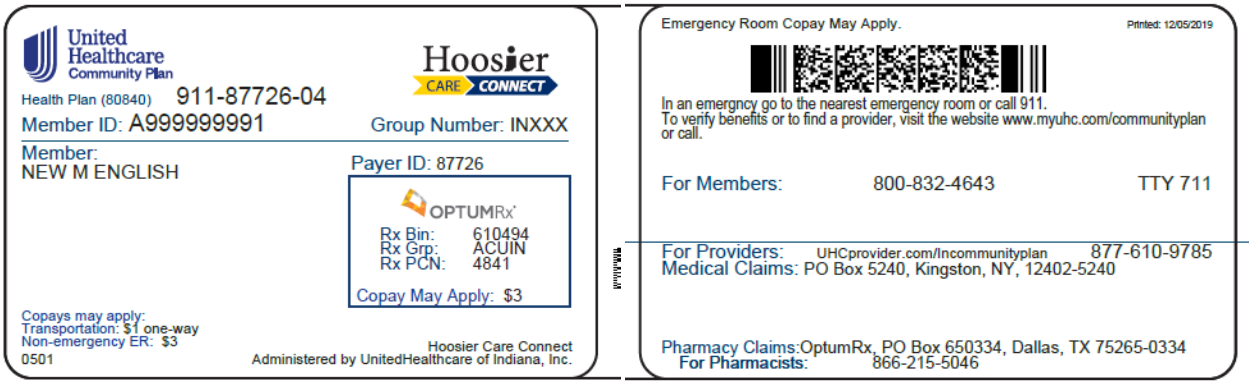
We receive daily updates on member eligibility and can provide the most up-to-date information available.

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

3.2 Identification Card

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

A member ID card is not a guarantee of payment. It is the responsibility of the provider to verify eligibility at the time of service. To verify a member's dental coverage, go to **uhcdentalproviders.com** or contact the dental Provider Services line at **1-844-402-9118**. A sample ID card is provided below. The member's actual ID card may look slightly different.



3.3 Eligibility Verification

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

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 **1-844-402-9118** from 8 a.m.–8 p.m. Monday–Friday EST for assistance with any technical website issues.

UnitedHealthcare Community Plan also offers an Interactive Voice Response (IVR) system for eligibility verification; simply call **1-844-402-9118** to access real-time information, 24 hours a day, 7 days a week.

Section 4: Patient access

4.1 Appointment scheduling standards

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

- **Urgent care appointments** . . . . . Within 5 calendar days of the request
- **Routine care appointments** . . . . . Offered within 30 calendar days of the request

We may 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. If necessary, the findings may be presented to UnitedHealthcare Community Plan'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, swelling or trauma.

Providers are encouraged to schedule members appropriately to avoid inconveniencing the members with long wait times. Members should be notified of anticipated wait times and given the option to reschedule their appointment.

4.2 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, 7 days a week through their practice or through other resources (such as another practice or a local emergency care facility). The out-of-office greeting must instruct callers what to do to obtain services after business hours and on weekends, particularly in the case of an emergency.

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

4.3 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 **uhcdentalproviders.com** or contact Provider Services at **1-844-402-9118**.

Additionally, members are permitted to see any IHCP approved provider. Out of Network providers will be reimbursed at 98% of the standard Medicaid Fee Schedule.

4.4 Missed appointments

Enrolled Participating Providers are not allowed to charge Members for missed appointments.

If your office mails letters to Members who miss appointments, the following language may be helpful to include:

- "We missed you when you did not come for your dental appointment on month/date. Regular check-ups are needed to keep your teeth healthy.
- "Please call to reschedule another appointment. Call us ahead of time if you cannot keep the appointment. Missed appointments are very costly to us. Thank you for your help."

Contacting the Member by phone or postcard prior to the appointment to remind the individual of the time and place of the appointment may help to decrease the number of missed appointments.

The Centers for Medicare and Medicaid Services (CMS) interpret federal law to prohibit a Provider from billing Medicaid and CHIP Members for missed appointments. In addition, your missed appointment policy for UnitedHealthcare members cannot be stricter than that of your private or commercial patients.

4.5 Nondiscrimination

The Practice shall accept members as new patients and provide Covered Services in the same manner as such services are provided to other patients of your practice. The Practice shall not discriminate against any member on the basis of source of payment or in any manner in regards to access to, and the provision of, Covered Services. The Practice shall not unlawfully discriminate against any member, employee or applicant for employment on the basis of race, ethnicity, religion, national origin, ancestry, disability, medical condition, claims experience, evidence of insurability, source of payment, marital status, age, sexual orientation or gender.

4.6 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 Community Plan recognizes that the diversity of American society has long been reflected in our member population. UnitedHealthcare Community Plan 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 Community Plan 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.

http://www.hrsa.gov/culturalcompetence/index.html

Section 5: Office administration

5.1 Office site quality

UnitedHealthcare Community Plan and affiliates monitor complaints for quality of services (QOS) concerning participating care providers and facilities. Complaints about you or your site are recorded and investigated. We conduct appropriate follow-up to assure that members receive care in a safe, clean and accessible environment. For this reason, UnitedHealthcare Community Plan has set Clinical Site Standards for all primary care provider office sites to help ensure facility quality.

UnitedHealthcare Community Plan requires you and your facilities meet the following site standards:

- Clean and orderly overall appearance.
- Available handicapped parking and handicapped accessible facilities.
- Available adequate waiting room space and dental operatories for providing member care.
- Privacy in the operatory.
- Clearly marked exits.
- Accessible fire extinguishers.

5.2 Office conditions

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

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

5.3 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.

5.4 Recall system

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

5.5 Transfer of dental records

Your office shall copy all requested member dental files to another participating dentist as designated by UnitedHealthcare Community Plan or as requested by the member. Providers must provide a copy of a member's medical record upon reasonable request by the member at no charge, and the provider must facilitate the transfer of the member's medical record to another provider at the member's request. If your office terminates from UnitedHealthcare Community Plan, dismisses the member from your practice or is terminated by UnitedHealthcare Community Plan, the cost of copying files shall be borne by your office. Your office shall cooperate with UnitedHealthcare Community Plan in maintaining the confidentiality of such member dental records at all times, in accordance with state and federal law.

5.6 Office hours

Provide the same office hours of operation to UnitedHealthcare Community Plan members as those offered to commercial members.

5.7 Protect confidentiality of member data

UnitedHealthcare Community Plan members have a right to privacy and confidentiality of all health care data. We only give confidential information to business associates and affiliates who need that information to improve our members' health care experience. We require our associates to protect privacy and abide by privacy law. If a member requests specific medical record information, we will refer the member to you. You agree to comply with the requirements of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and associated regulations. In addition, you will comply with applicable state laws and regulations.

UnitedHealthcare Community Plan uses member information for treatment, operations and payment. UnitedHealthcare Community Plan has safeguards to stop unintentional disclosure of protected health information (PHI). This includes passwords, screen savers, firewalls and other computer protection. It also includes shredding information with PHI and all confidential conversations. All staff is trained on HIPAA and confidentiality requirements.

5.8 Provide access to your records

You shall provide access to any medical, financial or administrative records related to services you provide to UnitedHealthcare Community Plan members within 14 calendar days of our request. We may request you respond sooner for cases involving alleged fraud and abuse, a member grievance/appeal, or a regulatory or accreditation agency requirement. Maintain these records for 7 years or longer if required by applicable statutes or regulations.

5.9 Inform members of advance directives

Members have the right to make their own health care decisions. This includes accepting or refusing treatment. They may execute an advance directive at any time. An advance directive is a document in which the member makes rules around their health care decisions if they later cannot make those decisions.

Several types of advance directives are available. You must comply with Indiana state law requirements about advance directives.

Members are not required to have an advance directive. You cannot provide care or otherwise discriminate against a member based on whether they have executed one. Document in a member's medical record whether they have executed or refused to have an advance directive.

If a member has one, keep a copy in their medical record. Or provide a copy to the member's PCP. Do not send a copy of a member's advance directive to UnitedHealthcare Community Plan.

If a member has a complaint about non-compliance with an advance directive requirement, they may file a complaint with the UnitedHealthcare Community Plan medical director, the physician reviewer, and/or the state survey and certification agency as well as with the ADHS Division of Licensing Services.

5.10 Participate in quality initiatives

You shall help our quality assessment and improvement activities. You shall also follow our clinical guidelines, member safety (risk reduction) efforts and data confidentiality procedures.

UnitedHealthcare Community Plan clinical quality initiatives are based on optimal delivery of health care for particular diseases and conditions. This is determined by United States government agencies and professional specialty societies. See Chapter 12 for more details on the initiatives.

5.11 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 imperative 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 **1-844-402-9118**.

5.12 Change of address, phone number, email 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 **1-844-402-9118** for guidance.

Section 6: Member benefits/exclusions and limitations

For the most updated member benefits, exclusions, and limitations please visit our website at **uhcdentalproviders.com**. We align benefit design to meet all regulatory requirements by Indiana Medicaid and the Indiana Legislature including the Indiana Health Coverage Program (IHCP) Dental Services Manual and Dental Provider Fee Schedule. IHCP covered services may be referenced by accessing the following link: http://provider.indianamedicaid.com/ihcp/Publications/providerCodes/Dental_Services_Codes.pdf.

6.1 Exclusions and limitations

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

With the exception of medically necessary EPSDT services for children under the age of 21, any service not listed as a covered service in the benefit grids (Section 6.2) is excluded.

Please call Provider Services at **1-844-402-9118** if you have any questions regarding frequency limitations.

General Exclusions

1. Unnecessary dental services.
2. Any dental procedure performed solely for cosmetic/aesthetic reasons.
3. 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.
4. Any dental procedure not directly associated with dental disease.
5. Any procedure not performed in a dental setting that has not had prior authorization.
6. 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.
7. Service for injuries or conditions covered by workers' compensation or employer liability laws, and services that are provided without cost to the covered persons by any municipality, county or other political subdivision. This exclusion does not apply to any services covered by Medicaid or Medicare.
8. Expenses for dental procedures begun prior to the covered person's eligibility with the plan. See section 7 for transferred orthodontic case exceptions.
9. 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.
10. 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.
11. Charges for failure to keep a scheduled appointment without giving the dental office proper notification.

6.2 Benefit grid

The following benefit grid contains all covered dental procedures and is intended to align to all State and Federal regulatory requirements; therefore, this Grid is subject to change. For the most updated member benefits, exclusions, and limitations please visit our website at **uhcdentalproviders.com**.

CODE	Procedure	Age Limits	Valid Subcodes	Frequency Limit	Auth Requirement
D0120	PERIODIC ORAL EVALUATION	0-999		1 PER 6 MONTH	NO
D0140	LIMIT ORAL EVAL PROBLM FOCUS	0-999			NO
D0145	ORAL EVALUATION, PT < 3YRS	0-2		1 PER 1 YEAR	NO
D0150	COMPREHENSVE ORAL EVALUATION	0-999		1 PER 1 LIFETIME PER PROVIDER (MAX 2 PER YEAR) | CODESET LIMITS: D0150; D0160: 2 PER 1 YEAR	NO
D0160	EXTENSV ORAL EVAL PROB FOCUS	0-999		1 PER 1 LIFETIME PER PROVIDER (MAX 2 PER YEAR) | CODESET LIMITS: D0150; D0160: 2 PER 1 YEAR	NO
D0170	RE-EVAL,EST PT,PROBLEM FOCUS	0-999			NO
D0210	INTRAOR COMPLETE FILM SERIES	0-999		1 PER 3 YEAR | CODESET LIMITS: D0210; D0330: 1 PER 3 YEAR	NO
D0220	INTRAORAL PERIAPICAL FIRST	0-999		1 PER 12 MONTH	NO
D0230	INTRAORAL PERIAPICAL EA ADD	0-999		7 PER 12 MONTH	NO
D0240	INTRAORAL OCCLUSAL FILM	0-999		2 PER 1 DAY	NO
D0250	EXTRAORAL 2D PROJECT IMAGE	0-999			NO
D0251	EXTRAORAL POSTERIOR IMAGE	0-999			NO
D0270	DENTAL BITEWING SINGLE IMAGE	0-999		4 PER 12 MONTH | CODESET LIMITS: Bitewings (D0270, D0272, D0273, D0274): 4 PER 12 MONTHS	NO
D0272	DENTAL BITEWINGS TWO IMAGES	0-999		2 PER 12 MONTH | CODESET LIMITS: Bitewings (D0270, D0272, D0273, D0274): 4 PER 12 MONTHS	NO
D0273	BITEWINGS - THREE IMAGES	0-999		1 PER 12 MONTH | CODESET LIMITS: Bitewings (D0270, D0272, D0273, D0274): 4 PER 12 MONTHS	NO
D0274	BITEWINGS FOUR IMAGES	0-999		1 PER 12 MONTH | CODESET LIMITS: Bitewings (D0270, D0272, D0273, D0274): 4 PER 12 MONTHS	NO
D0277	VERT BITEWINGS 7 TO 8 IMAGES	0-999		1 PER 12 MONTH	NO
D0310	DENTAL SALIOGRAPHY	0-999			NO
D0330	PANORAMIC IMAGE	0-999		1 PER 3 Years | CODESET LIMITS: D0210; D0330: 1 PER 3 YEAR	NO
D0340	2D CEPHALOMETRIC IMAGE	0-999			NO
D0411	HBA1C IN OFFICE TESTING	0-999			NO
D0486	ACCESS OF TRANSEP CYTOL SAMP	0-999			NO
D1110	DENTAL PROPHYLAXIS ADULT	21-999		1 PER 12 MONTHS	NO
D1110	DENTAL PROPHYLAXIS ADULT	13-999		1 PER 6 MONTHS	NO
D1120	DENTAL PROPHYLAXIS CHILD	1-11		1 PER 6 MONTHS	NO
D1120	DENTAL PROPHYLAXIS CHILD	0-12 Months			YES
D1206	TOPICAL FLUORIDE VARNISH	1-20		1 PER 6 MONTH	NO
D1208	TOPICAL APP FLUORID EX VRNSH	0-20		1 PER 6 MONTH	NO
D1351	DENTAL SEALANT PER TOOTH	0-20	Premolars; Molars	1 PER 1 LIFETIME	NO
D1352	PREV RESIN REST, PERM TOOTH	0-20			YES
D1354	INT CARIES MED APP PER TOOTH	0-20			YES
D1510	SPACE MAINTAINER FXD UNILAT	1-20			NO
D1516	FIXED BILAT SPACE MAINT, MAX	1-3			YES
D1516	FIXED BILAT SPACE MAINT, MAX	4-20			NO
D1517	FIXED BILAT SPACE MAINT, MAN	1-3			YES
D1517	FIXED BILAT SPACE MAINT, MAN	4-20			NO

CODE	Procedure	Age Limits	Valid Subcodes	Frequency Limit	Auth Requirement
D1520	REMOVE UNILAT SPACE MAINTAIN	4-20			NO
D1526	REMOVE BILAT SPACE MAIN, MAX	1-3			YES
D1526	REMOVE BILAT SPACE MAIN, MAX	4-20			NO
D1527	REMOVE BILAT SPACE MAIN, MAN	1-3			YES
D1527	REMOVE BILAT SPACE MAIN, MAN	4-20			NO
D1551	RECEMENT SPACE MAINT - MAX	1-20			NO
D1552	RECEMENT SPACE MAINT - MAN	1-20			NO
D1553	RECEMENT UNILAT SPACE MAINT	1-20			NO
D1556	REM FIXED UNILAT SPACE MAINT	0-999			NO
D1557	REMOVE FIXED BILAT MAINT MAX	0-999			NO
D1558	REMOVE FIXED BILAT MAN	0-999			NO
D1575	DIST SPACE MAINT, FIXED UNIL	0-20			NO
D1999	UNSPECIFIED PREVENTIVE PROC	0-999			YES
D2140	AMALGAM ONE SURFACE PERMANEN	0-999			NO
D2150	AMALGAM TWO SURFACES PERMANE	0-999			NO
D2160	AMALGAM THREE SURFACES PERMA	0-999			NO
D2161	AMALGAM 4 OR > SURFACES PERM	0-999			NO
D2330	RESIN ONE SURFACE-ANTERIOR	0-999			NO
D2331	RESIN TWO SURFACES-ANTERIOR	0-999			NO
D2332	RESIN THREE SURFACES-ANTERIO	0-999			NO
D2335	RESIN 4/> SURF OR W INCIS AN	0-999			NO
D2390	ANT RESIN-BASED CMPST CROWN	0-999			NO
D2391	POST 1 SRFC RESINBASED CMPST	0-999			NO
D2392	POST 2 SRFC RESINBASED CMPST	0-999			NO
D2393	POST 3 SRFC RESINBASED CMPST	0-999			NO
D2394	POST >=4SRFC RESINBASE CMPST	0-999			NO
D2910	RECEMENT INLAY ONLAY OR PART	0-999			NO
D2920	RE-CEMENT OR RE-BOND CROWN	0-999			NO
D2921	REATTACH TOOTH FRAGMENT	0-999			NO
D2930	PREFAB STNLSS STEEL CRWN PRI	0-999			NO
D2931	PREFAB STNLSS STEEL CROWN PE	0-999			NO
D2932	PREFABRICATED RESIN CROWN	0-20			NO
D2933	PREFAB STAINLESS STEEL CROWN	0-20			NO
D2934	PREFAB STEEL CROWN PRIMARY	0-999			NO
D2940	PROTECTIVE RESTORATION	0-999			NO
D2941	INT THERAPEUTIC RESTORATION	0-999			NO
D2949	RESTORATIVE FOUNDATION	0-999			NO
D2980	CROWN REPAIR	0-999			NO
D2990	RESIN INFILTRATION OF LESION	0-999			NO
D3220	THERAPEUTIC PULPOTOMY	0-999			NO
D3222	PART PULP FOR APEXOGENESIS	0-999			NO
D3230	PULPAL THERAPY ANTERIOR PRIM	0-999			NO
D3240	PULPAL THERAPY POSTERIOR PRI	0-999			NO
D3310	END THXPY, ANTERIOR TOOTH	1-20			YES
D3320	END THXPY, PREMOLAR TOOTH	1-20			YES
D3330	END THXPY, MOLAR TOOTH	1-20			YES

CODE	Procedure	Age Limits	Valid Subcodes	Frequency Limit	Auth Requirement
D3346	RETREAT ROOT CANAL ANTERIOR	1-20			YES
D3347	RETREAT ROOT CANAL PREMOLAR	1-20			YES
D3348	RETREAT ROOT CANAL MOLAR	1-20			YES
D3351	APEXIFICATION/RECALC INITIAL	1-20			YES
D3352	APEXIFICATION/RECALC INTERIM	1-20			YES
D3353	APEXIFICATION/RECALC FINAL	1-20			YES
D3410	APICOECTOMY - ANTERIOR	1-20			YES
D3421	ROOT SURGERY PREMOLAR	1-20			YES
D3425	ROOT SURGERY MOLAR	1-20			YES
D3426	ROOT SURGERY EA ADD ROOT	1-20			YES
D3430	RETROGRADE FILLING	1-20			YES
D4210	GINGIVECTOMY/PLASTY 4 OR MOR	0-999			YES
D4211	GINGIVECTOMY/PLASTY 1 TO 3	0-999			YES
D4212	GINGIVECTOMY/PLASTY REST	0-999			YES
D4240	GINGIVAL FLAP PROC W/ PLANIN	0-999			YES
D4241	GNGVL FLAP W ROOTPLAN 1-3 TH	0-999			YES
D4260	OSSEOUS SURGERY 4 OR MORE	0-999			YES
D4341	PERIODONTAL SCALING & ROOT	3-20	UL, UR, LL, LR	4 PER 2 YEARS | CODESET LIMITS: D4341; D4342: 4 PER 2 YEARS	YES
D4341	PERIODONTAL SCALING & ROOT	21-999	UL, UR, LL, LR	4 PER 1 LIFETIME | CODESET LIMITS: D4341; D4342: 4 PER 1 LIFETIME	NO
D4342	PERIODONTAL SCALING 1-3TEETH	3-20	UL, UR, LL, LR	4 PER 2 YEARS | CODESET LIMITS: D4341; D4342: 4 PER 2 YEARS	YES
D4342	PERIODONTAL SCALING 1-3TEETH	21-999	UL, UR, LL, LR	4 PER 1 LIFETIME | CODESET LIMITS: D4341; D4342: 4 PER 1 LIFETIME	NO
D4346	SCALING GINGIV INFLAMMATION	0-999			NO
D4355	FULL MOUTH DEBRIDEMENT	0-999		1 PER 3 YEAR | CODESET LIMITS: D4355 Daily Limit: 1 PER 1 DAY	NO
D4910	PERIODONTAL MAINT PROCEDURES	3-999		1 PER 6 MONTHS	NO
D4910	PERIODONTAL MAINT PROCEDURES	21-999		1 PER 12 MONTHS	NO
D5110	DENTURES COMPLETE MAXILLARY	0-20		1 PER 6 YEAR | CODESET LIMITS: Maxillary Dentures- D5110, D5130, D5211, D5213, D5225 : 1 PER 6 YEAR	NO
D5110	DENTURES COMPLETE MAXILLARY	21-999		1 PER 6 YEAR | CODESET LIMITS: Maxillary Dentures- D5110, D5130, D5211, D5213, D5225 : 1 PER 6 YEAR	YES
D5120	DENTURES COMPLETE MANDIBLE	0-20		1 PER 6 YEAR | CODESET LIMITS: Mandible Dentures - D5120, D5140, D5212, D5214, D5226: 1 PER 6 YEAR	NO
D5120	DENTURES COMPLETE MANDIBLE	21-999		1 PER 6 YEAR | CODESET LIMITS: Mandible Dentures - D5120, D5140, D5212, D5214, D5226: 1 PER 6 YEAR	YES
D5130	DENTURES IMMEDIAT MAXILLARY	21-999		1 PER 6 YEAR | CODESET LIMITS: Maxillary Dentures- D5110, D5130, D5211, D5213, D5225 : 1 PER 6 YEAR	YES
D5140	DENTURES IMMEDIAT MANDIBLE	21-999		1 PER 6 YEAR | CODESET LIMITS: Mandible Dentures - D5120, D5140, D5212, D5214, D5226: 1 PER 6 YEAR	YES
D5211	DENTURES MAXILL PART RESIN	0-20		1 PER 6 YEAR | CODESET LIMITS: Maxillary Dentures- D5110, D5130, D5211, D5213, D5225 : 1 PER 6 YEAR	NO
D5211	DENTURES MAXILL PART RESIN	21-999		1 PER 6 YEAR | CODESET LIMITS: Maxillary Dentures- D5110, D5130, D5211, D5213, D5225 : 1 PER 6 YEAR	YES
D5212	DENTURES MAND PART RESIN	0-20		1 PER 6 YEAR | CODESET LIMITS: Mandible Dentures - D5120, D5140, D5212, D5214, D5226: 1 PER 6 YEAR	NO
D5212	DENTURES MAND PART RESIN	21-999		1 PER 6 YEAR | CODESET LIMITS: Mandible Dentures - D5120, D5140, D5212, D5214, D5226: 1 PER 6 YEAR	YES
D5213	DENTURES MAXILL PART METAL	0-20		1 PER 6 YEAR | CODESET LIMITS: Maxillary Dentures- D5110, D5130, D5211, D5213, D5225 : 1 PER 6 YEAR	NO

CODE	Procedure	Age Limits	Valid Subcodes	Frequency Limit	Auth Requirement
D5213	DENTURES MAXILL PART METAL	21-999		1 PER 6 YEAR | CODESET LIMITS: Maxillary Dentures- D5110, D5130, D5211, D5213, D5225 : 1 PER 6 YEAR	YES
D5214	DENTURES MANDIBL PART METAL	0-20		1 PER 6 YEAR | CODESET LIMITS: Mandible Dentures - D5120, D5140, D5212, D5214, D5226: 1 PER 6 YEAR	NO
D5214	DENTURES MANDIBL PART METAL	21-999		1 PER 6 YEAR | CODESET LIMITS: Mandible Dentures - D5120, D5140, D5212, D5214, D5226: 1 PER 6 YEAR	YES
D5225	MAXILLARY PART DENTURE FLEX	0-999		1 PER 6 YEAR | CODESET LIMITS: Maxillary Dentures- D5110, D5130, D5211, D5213, D5225 : 1 PER 6 YEAR	YES
D5226	MANDIBULAR PART DENTURE FLEX	0-999		1 PER 6 YEAR | CODESET LIMITS: Mandible Dentures - D5120, D5140, D5212, D5214, D5226: 1 PER 6 YEAR	YES
D5282	REMOVE UNIL PART DENTURE,MAX	0-20			NO
D5282	REMOVE UNIL PART DENTURE,MAX	21-999			YES
D5283	REMOVE UNIL PART DENTURE,MAN	0-20			NO
D5283	REMOVE UNIL PART DENTURE,MAN	21-999			YES
D5284	REM UNILAT DENT FLEX BASE	1-999			YES
D5286	REM UNILAT DENT 1 PC RESIN	1-999			YES
D5511	REP BROKE COMP DENT BASE MAN	21-999			YES
D5512	REP BROKE COMP DENT BASE MAX	21-999			YES
D5511	REP BROKE COMP DENT BASE MAN	0-20			NO
D5512	REP BROKE COMP DENT BASE MAX	0-20			NO
D5520	REPLACE DENTURE TEETH COMPLT	0-999			NO
D5611	REP RESIN PART DENT BASE MAN	0-20			NO
D5612	REP RESIN PART DENT BASE MAX	0-20			NO
D5611	REP RESIN PART DENT BASE MAN	21-999			YES
D5612	REP RESIN PART DENT BASE MAX	21-999			YES
D5621	REP CAST PART FRAME MAN	0-20			NO
D5622	REP CAST PART FRAME MAX	0-20			NO
D5630	REP PARTIAL DENTURE CLASP	0-20			NO
D5640	REPLACE PART DENTURE TEETH	0-20			NO
D5650	ADD TOOTH TO PARTIAL DENTURE	0-20			NO
D5660	ADD CLASP TO PARTIAL DENTURE	0-20			NO
D5621	REP CAST PART FRAME MAN	21-999			YES
D5622	REP CAST PART FRAME MAX	21-999			YES
D5630	REP PARTIAL DENTURE CLASP	21-999			YES
D5640	REPLACE PART DENTURE TEETH	21-999			YES
D5650	ADD TOOTH TO PARTIAL DENTURE	21-999			YES
D5660	ADD CLASP TO PARTIAL DENTURE	21-999			YES
D5730	DENTURE RELN CMPLT MAXIL CH	1-999			NO
D5731	DENTURE RELN CMPLT MAND CHR	1-999			NO
D5740	DENTURE RELN PART MAXIL CHR	1-999			NO
D5741	DENTURE RELN PART MAND CHR	1-999			NO
D5750	DENTURE RELN CMPLT MAX LAB	21-999			YES
D5751	DENTURE RELN CMPLT MAND LAB	21-999			YES
D5760	DENTURE RELN PART MAXIL LAB	21-999			YES
D5761	DENTURE RELN PART MAND LAB	21-999			YES
D5750	DENTURE RELN CMPLT MAX LAB	0-20			NO
D5751	DENTURE RELN CMPLT MAND LAB	0-20			NO
D5760	DENTURE RELN PART MAXIL LAB	0-20			NO

CODE	Procedure	Age Limits	Valid Subcodes	Frequency Limit	Auth Requirement
D5761	DENTURE RELN PART MAND LAB	0-20			NO
D5876	ADD METAL SUB TO ACRYLC DENT	0-999			YES
D5951	FEEDING AID	0-20			NO
D5952	PEDIATRIC SPEECH AID	0-19			NO
D5993	MAIN/CLEAN MAX PROSTHESIS	0-20			NO
D5999	MAXILLOFACIAL PROSTHESIS	0-999			YES
D6081	SCALE & DEBRIDE, SINGLE IMP	0-999			NO
D6096	REMOVE BROKEN IMP RET SCREW	0-999			NO
D6930	RECEMENT/BOND PART DENTURE	1-20			NO
D6980	FIXED PARTIAL REPAIR	1-20			NO
D7111	EXTRACTION CORONAL REMNANTS	0-999			NO
D7140	EXTRACTION ERUPTED TOOTH/EXR	0-999			NO
D7210	REM IMP TOOTH W MUCOPER FLP	0-999			NO
D7220	IMPACT TOOTH REMOV SOFT TISS	0-999			YES
D7230	IMPACT TOOTH REMOV PART BONY	0-999			YES
D7240	IMPACT TOOTH REMOV COMP BONY	0-999			YES
D7241	IMPACT TOOTH REM BONY W/COMP	0-999			YES
D7250	TOOTH ROOT REMOVAL	0-999			NO
D7251	CORONECTOMY	0-999			YES
D7260	ORAL ANTRAL FISTULA CLOSURE	0-999			NO
D7261	PRIMARY CLOSURE SINUS PERF	0-999			NO
D7270	TOOTH REIMPLANTATION	0-999			NO
D7280	EXPOSURE OF UNERUPTED TOOTH	0-999			NO
D7282	MOBILIZE ERUPTED/MALPOS TOOT	0-999			NO
D7285	BIOPSY OF ORAL TISSUE HARD	0-999			NO
D7286	BIOPSY OF ORAL TISSUE SOFT	0-999			NO
D7288	BRUSH BIOPSY	0-999			NO
D7295	BONE HARVEST,AUTO GRAFT PROC	0-999			NO
D7296	CORTICOTOMY, 1-3 TEETH	0-20			YES
D7297	CORTICOTOMY, 4 OR MORE TEETH	0-20			YES
D7310	ALVEOPLASTY W/ EXTRACTION	0-999			NO
D7311	ALVEOLOPLASTY W/EXTRACT 1-3	0-999			NO
D7320	ALVEOPLASTY W/O EXTRACTION	0-999			NO
D7321	ALVEOLOPLASTY NOT W/EXTRACTS	0-999			NO
D7410	RAD EXC LESION UP TO 1.25 CM	0-999			NO
D7411	EXCISION BENIGN LESION>1.25C	0-999			NO
D7412	EXCISION BENIGN LESION COMPL	0-999			NO
D7413	EXCISION MALIG LESION<=1.25C	0-999			NO
D7414	EXCISION MALIG LESION>1.25CM	0-999			NO
D7415	EXCISION MALIG LES COMPLICAT	0-999			NO
D7440	MALIG TUMOR EXC TO 1.25 CM	0-999			NO
D7441	MALIG TUMOR > 1.25 CM	0-999			NO
D7450	REM ODONTOGEN CYST TO 1.25CM	0-999			NO
D7451	REM ODONTOGEN CYST > 1.25 CM	0-999			NO
D7460	REM NONODONTO CYST TO 1.25CM	0-999			NO
D7461	REM NONODONTO CYST > 1.25 CM	0-999			NO

CODE	Procedure	Age Limits	Valid Subcodes	Frequency Limit	Auth Requirement
D7471	REM EXOSTOSIS ANY SITE	0-999			NO
D7472	REMOVAL OF TORUS PALATINUS	0-999			NO
D7473	REMOVE TORUS MANDIBULARIS	0-999			NO
D7485	SURG REDUCT OSSEOUSTUBEROSIT	0-999			NO
D7510	I&D ABSC INTRAORAL SOFT TISS	0-999			NO
D7511	INCISION/DRAIN ABSCESS INTRA	0-999			NO
D7520	I&D ABSCESS EXTRAORAL	0-999			NO
D7521	INCISION/DRAIN ABSCESS EXTRA	0-999			NO
D7560	MAXILLARY SINUSOTOMY	0-999			NO
D7610	MAXILLA OPEN REDUCT SIMPLE	0-999			NO
D7620	CLSD REDUCT SIMPL MAXILLA FX	0-999			NO
D7630	OPEN RED SIMPL MANDIBLE FX	0-999			NO
D7640	CLSD RED SIMPL MANDIBLE FX	0-999			NO
D7650	OPEN RED SIMP MALAR/ZYGOM FX	0-999			NO
D7660	CLSD RED SIMP MALAR/ZYGOM FX	0-999			NO
D7670	CLOSD RDUCTN SPLINT ALVEOLUS	0-999			NO
D7671	ALVEOLUS OPEN REDUCTION	0-999			NO
D7680	REDUCT SIMPLE FACIAL BONE FX	0-999			NO
D7710	MAXILLA OPEN REDUCT COMPOUND	0-999			NO
D7720	CLSD REDUCT COMPD MAXILLA FX	0-999			NO
D7730	OPEN REDUCT COMPD MANDBLE FX	0-999			NO
D7740	CLSD REDUCT COMPD MANDBLE FX	0-999			NO
D7750	OPEN RED COMP MALAR/ZYGMA FX	0-999			NO
D7760	CLSD RED COMP MALAR/ZYGMA FX	0-999			NO
D7770	OPEN REDUC COMPD ALVEOLUS FX	0-999			NO
D7771	ALVEOLUS CLSD REDUC STBLZ TE	0-999			NO
D7780	REDUCT COMPND FACIAL BONE FX	0-999			NO
D7810	TMJ OPEN REDUCT-DISLOCATION	0-999			NO
D7820	CLOSED TMP MANIPULATION	0-999			NO
D7910	DENT SUTUR RECENT WND TO 5CM	0-999			NO
D7911	DENTAL SUTURE WOUND TO 5 CM	0-999			NO
D7912	SUTURE COMPLICATE WND > 5 CM	0-999			NO
D7961	buccal / labial frenectomy (frenulectomy)	0-999		| CODESET LIMITS: Frenectomy: D7961, D7962: 2 PER 1 DAY	YES
D7962	lingual frenectomy (frenulectomy)	0-999		| CODESET LIMITS: Frenectomy: D7961, D7962: 2 PER 1 DAY	YES
D7972	SURG REDCT FIBROUS TUBEROSIT	0-999			NO
D7979	NON-SURGICAL SIALOLITHOTOMY	0-999			NO
D7980	SURGICAL SIALOLITHOTOMY	0-999			NO
D7982	SIALODOCHOPLASTY	0-999			NO
D7983	CLOSURE OF SALIVARY FISTULA	0-999			NO
D7999	ORAL SURGERY PROCEDURE	0-999			YES
D8010	LIMITED DENTAL TX PRIMARY	1-20			YES
D8020	LIMITED DENTAL TX TRANSITION	1-20			YES
D8030	LIMITED DENTAL TX ADOLESCENT	1-20			YES
D8040	LIMITED DENTAL TX ADULT	1-20			YES
D8050	INTERCEP DENTAL TX PRIMARY	1-20			YES
D8060	INTERCEP DENTAL TX TRANSITN	1-20			YES

CODE	Procedure	Age Limits	Valid Subcodes	Frequency Limit	Auth Requirement
D8070	COMPRE DENTAL TX TRANSITION	1-20			YES
D8080	COMPRE DENTAL TX ADOLESCENT	1-20			YES
D8090	COMPRE DENTAL TX ADULT	1-20			YES
D8210	ORTHODONTIC REM APPLIANCE TX	1-20			YES
D8220	FIXED APPLIANCE THERAPY HABT	0-999			YES
D9120	FIX PARTIAL DENTURE SECTION	0-999			YES
D9222	DEEP ANEST, 1ST 15 MIN	0-20		1 PER 1 DAY	YES
D9223	GENERAL ANESTH EA ADDL 15 MI	0-20			YES
D9230	ANALGESIA	0-20		1 PER 1 DAY	NO
D9239	IV MOD SEDATION, 1ST 15 MIN	0-20		1 PER 1 DAY	YES
D9243	IV SEDATION EA ADDL 15M	0-20			YES
D9248	SEDATION (NON-IV)	0-20		1 PER 1 DAY	NO
D9920	BEHAVIOR MANAGEMENT	1-20		1 PER 1 DAY	NO

6.3 Payment for non-covered services

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

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

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

Please note: It is recommended that benefits and eligibility be confirmed by the provider before treatment is rendered. Members are held harmless and cannot be billed for services that are covered under the plan.

Section 7: Authorization for treatment

7.1 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.

Prior authorization means the practitioner must submit those procedures for approval with clinical documentation supporting necessity before initiating treatment.

For questions concerning prior authorization, dental claim procedures, or to request clinical criteria, please call the Provider Services Line at **1-844-402-9118**.

You can submit your authorization request electronically, by paper through mail, or online at **uhcdentalproviders.com**. All documentation submitted should be accompanied with ADA Claim Form and by checking the box titled: "Request for Predetermination/Preauthorization" section of the ADA Dental Claim Form.

Authorization Submission Mailing Address:

Prior Authorization
P.O. Box 1313
Milwaukee, WI 53201

7.2 Authorization timelines

The following timelines will apply to requests for authorization:

- We will make a determination and provide written notification on expedited authorizations within 72 hours of receipt of the request.
- We will make a determination and provide written notification on standard authorizations within 7 calendar days of receipt of the request.
- Authorization approvals will expire 180 days from the date of determination.

7.3 Evidence-based dentistry and the Dental Clinical Policy and Technology Committee (DCPTC)

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

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

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

- Systematic review and meta-analysis
- Randomized controlled trials (RCT)
- Retrospective studies
- Case series
- Case studies

Anecdotal/expert opinion (including professional society statements, white papers and practice guidelines) Evidence is found in a variety of sources including:

- Electronic database searches such as Medline®, PubMed®, and the Cochrane Library.
- Hand search of the scientific literature
- Recognized dental school textbooks
- Evidence based dentistry can be used clinically to guide treatment decisions, and aid health plans in the development of benefits. At UnitedHealthcare Community Plan, we use evidence as the foundation of our efforts, including:
- Practice guidelines, parameters and algorithms based on evidence and consensus.
- Comparing dentist quality and utilization data
- Conducting audits and site visits
- Development of dental policies and coverage guidelines

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

7.4 2020 Indiana Medicaid (Hoosier Care Connect) clinical criteria

When submitting for prior authorization / retrospective review of these procedures, please note the documentation requirements when sending in the information to Skygen Dental. Skygen Dental criteria utilized for medical necessity determination were developed from information collected from American Dental Association's Code Manuals, clinical articles and guidelines, as well as dental schools, practicing dentists, insurance companies, other dental related organizations, and local state or health plan requirements. The criteria Skygen Dental reviewers will look for in order to approve the request is listed below. Should the procedure need to be initiated under an emergency condition to relieve pain and suffering, you are to provide treatment to alleviate the patient's condition. However, to receive reimbursement for the treatment, Skygen Dental will require the same criteria / documentation be provided (with the claim for payment) and the same criteria be met to receive payment for the treatment.

When reviewing requests for services the following guidelines will be used: Treatment will not be routinely approved when functional replacement with less costly restorative materials, including prosthetic replacement, is possible. Dental work for cosmetic reasons or because of the personal preference of the member or provider is not within the scope of the Medicaid program.

Procedure	Procedure Codes	Required Documentation	Criteria for Approval	Prior or Post
Dental Prophylaxis Child (Age 0 – 1)	D1120	• Narrative of necessity	• Documentation supports why a dental cleaning is needed for a child under 1 year old	Prior
Preventative Restoration – Permanent Tooth (Age 0 – 20)	D1352	• Narrative of necessity • Caries Risk Assessment	• Documentation describes medical necessity for restoration of pit and fissures carious lesions contained within enamel for moderate to high caries risk individuals	Prior
Interim Caries Medicament Application per Tooth (Age 0 – 20)	D1354	• Narrative of necessity • Caries Risk Assessment	• Active, non-symptomatic carious lesions • Individuals with high caries risk • Individuals unable to tolerate standard restorative treatment. • Individuals with multiple lesions that cannot be treated in one office visit • Caries that are difficult to treat with traditional restorations • Individuals with limited or restricted access to dental care	Prior
Fixed/Removeable Bilateral Space Maintainer (Age 1 - 3)	D1516, D1517, D1526, D1527	• Current x-rays of tooth/area	• Documentation supports why a space maintainer is needed for a child under 1 year old	Prior

Procedure	Procedure Codes	Required Documentation	Criteria for Approval	Prior or Post
Complete Dentures and Immediate Complete Dentures (Age 21 and older)	D5110, D5120, D5130, D5140	• Panoramic x-ray or full series	• Fewer than eight posterior teeth are in occlusion • If the member has not worn an existing prosthesis for 3 or more years, providers must submit documentation explaining why they are submitting a request for dentures at this time. For replacement dentures, in addition to the above: • The existing prosthesis is 6 years old or older, beyond repair/ill fitting, and cannot be relined. • The prosthesis has been lost, destroyed, or stolen. (Providers must submit an explanation of the circumstances)	Prior
Partial Dentures/ Unilateral Partial Dentures Age (21 and older)	D5211, D5212, D5213, D5214, D5282, D5283, D5286	• Panoramic x-ray or full series	• Fewer than eight posterior teeth are in occlusion Not covered in the following scenarios: • Partial dentures that replace only anterior teeth. Replacement of anterior teeth only is considered purely an aesthetic or cosmetic concern and not medically necessary	Prior
Flexible Base Partial Dentures/Unilateral Partial Denture (All ages)	D5225, D5226, D5284	• Panoramic x-ray or full series	Covered only for members with fewer than eight posterior teeth in occlusion AND one of the following: • A documented allergic reaction to other denture materials • A facial deformity due to congenital, developmental, or acquired defects (such as cleft palate conditions) that require the use of a flexible-base partial instead of an acrylic or cast-metal partial. Not covered in the following scenarios: • Partial dentures that replace only anterior teeth. Replacement of anterior teeth only is considered purely an aesthetic or cosmetic concern and not medically necessary	Prior
Full / Partial Dentures – Repair/ Adjust/Replace/Add Teeth and Clasps (Age 21 and older)	D5511, D5512, D5621, D5612, D5621, D5622, D5630, D5640, D5650, D5660, D5750, D5751, D5760, D5761, D5876	• Panoramic x-ray or full series	• Documentation supports the reline or repair will extend the useful life of a medically necessary denture that is 6 or more years old.	Prior
Corticotomy (Age 0 – 20)	D7296, D7297	• Panoramic x-ray • Narrative of necessity	• Documentation describes why osteogenic orthodontics is necessary	Prior
Frenectomy/ Frenulectomy (All ages)	D7961, D7962	• Narrative of necessity	When the position attachment of the frenum is: • Causing a diastema, gingival recession or stripping • Interfering with proper oral hygiene • Causing a functional disturbance, including, but not limited to mastication, swallowing and speech • Causing interference with feeding in newborns • Needed prior to the construction of a removable denture replacing teeth in the area of aberrant frenal attachment	Prior
Limited, Interceptive and Comprehensive Orthodontics (Age 1 – 20)	D8010, D8020, D8030, D8040, D8050, D8060, D8070, D8080, D8090	• ADA 2012 or newer claim form with service codes noted • Cephalometric radiographic • Panoramic x-ray • Intra and extraoral photographs • Treatment plan	Members meet the criteria for medical necessity for orthodontic care when it is part of a case involving treatment of craniofacial anomalies, malocclusion caused as the result of trauma, or a severe malocclusion or craniofacial disharmony that includes, but is not limited to: • Overjet equal to or greater than 9 mm • Reverse overjet equal to or greater than 3.5 mm • Posterior crossbite with no functional occlusal contact • Lateral or anterior open bite equal to or greater than 4 mm • Impinging overbite with either palatal trauma or mandibular anterior gingival trauma • One or more impacted teeth with eruption that is impeded (excluding third molars) • Defects of cleft lip and palate or other craniofacial anomalies or trauma • Congenitally missing teeth (extensive hypodontia) of at least one tooth per quadrant (excluding third molars)	Prior
Fixed or Removeable Appliance Therapy (Age 1 – 20)	D8210, D8220	• Narrative of necessity	• Documentation of thumb sucking or tongue thrusting habit	
Fixed Partial Denture Section (All ages)	D9120	• Narrative of necessity	• Documentation describes need to section fixed partial denture	

7.5 Radiology requirements

Guidelines for providing radiographs are as follows:

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

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

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

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

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

7.6 Appealing a denied authorization

Members have the right to appeal any fully or partially denied authorization determination. Denied requests for authorization are also known as “adverse benefit determinations.” An appeal is a formal way to share dissatisfaction with an adverse benefit determination. For more information about appeals on behalf of a member, please visit the member handbook at **UHCcommunityplan.com**.

As a treating provider, you may advocate for your patient and assist with their appeal. If you wish to file an appeal on the member’s behalf, you will need their consent to do so.

You or the member may call or mail the information relevant to the appeal within 60 calendar days from the date of the adverse benefit determination.

Member Denied Authorization Appeal mailing address:

UnitedHealthcare
Grievances and Appeals
P.O. Box 31364
Salt Lake City, UT 84131-0364
Toll-free: 800-832-4643 (TTY 711)

For standard appeals, if you appeal by phone, you must follow up in writing, ask the member to sign the written appeal, and mail it to UnitedHealthcare Community Plan. Expedited appeals do not need to be in writing.

The member has the right to:

- Receive a copy of the rule used to make the decision.
- Ask someone (a family member, friend, lawyer, health care provider, etc.) to help. The member may present evidence, and allegations of fact or law, in person and in writing.
- Review the case file before and during the appeal process. The file includes medical records and any other documents.
- Send written comments or documents considered for the appeal.
- Ask for an expedited appeal if waiting for this health service could harm the member’s health.
- Ask for continuation of services during the appeal. However, the member may have to pay for the health service if it is continued or if the member should not have received the service. As the provider, you cannot ask for a continuation. Only the member may do so.

7.7 Appeal determination timeframe:

- We resolve a standard appeal 30 calendar days from the day we receive it.
- We resolve an expedited appeal 72 hours from when we receive it.

Section 8: Claim submission procedures

8.1 Claim submission options

8.1.a Electronic claims

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).

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. UnitedHealthcare Community Plan partners with electronic clearinghouses to support electronic claims submissions. If you wish to submit claims electronically, contact your clearinghouse to initiate this process.

While the payer ID may vary for some plans, the Payer ID for **Community Plan members is GP133**. Please refer to the Important Addresses and Phone Numbers section for additional information as needed.

Electronic submission is private as the information being sent is encrypted. Call **1–877-897-4941** for more information regarding electronic claims submission.

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.

8.1.b Paper claims

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

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. Refer to the Exclusions, Limitations and Benefits section of this Manual to find the recommendations for dental services.

Refer to Section 8.2 for more information on claims submission best practices and required information. Section 2.3 will provide you with the appropriate claims address information to ensure your claims are routed to the correct resource for payment.

8.2 Claim submission requirements and best practices

8.2.a Dental claim form required information

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

One claim form should be used for each patient and the claim should reflect only 1 treating dentist for services rendered. The claims must also have all necessary fields populated as outlined in the following:

Header information

Indicate the type of transaction by checking the appropriate box: Statement of Actual Services.

Subscriber information

- Name (last, first and middle initial)
- Address (street, city, state, ZIP code)

- Date of birth
- Gender
- Subscriber ID number

Patient information

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

Primary payer information

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

Other coverage

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

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

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

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

Billing dentist or dental entity

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

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

Treating dentist and treatment location

List the following information regarding the dentist that provided treatment:

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

Record of services provided

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

Missing teeth information

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

Remarks section

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

ICD-10 instructions

RECORD OF SERVICES PROVIDED

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

33. Missing Teeth Information (Place an "X" on each missing tooth.)

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 _____ C _____

B _____ 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.

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**.

Supernumerary teeth

UnitedHealthcare recognizes tooth letters "A" through "T" for primary teeth and tooth numbers "1" to "32" for permanent teeth. Supernumerary teeth should be designated by using codes AS through TS or 51 through 82. Designation of the tooth can be determined by using the nearest erupted tooth. If the tooth closest to the supernumerary tooth is # 1 then the supernumerary tooth should be charted as #51, likewise if the nearest tooth is A the supernumerary tooth should be charted as. These procedure codes must be referenced in the patient's file for record retention and review.

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.

Invalid or incomplete claims:

If claims are submitted with missing information, incomplete or outdated claim forms, the claim will be rejected or returned to the provider and a request for the missing information will be sent to the provider. For example, if the claim is missing a tooth number or surface, a letter will be generated to the provider requesting this information.

8.2.b Coordination of Benefits (COB)

Our benefits contracts are subject to coordination of benefits (COB) rules. We coordinate benefits based on the member's benefit contract and applicable regulations.

UnitedHealthcare Community Plan is the payer of last resort. Other coverage should be billed as the primary carrier. When billing UnitedHealthcare Community Plan as a secondary payer, submit the primary payer's Explanation of Benefits or remittance advice with the claim.

8.2.c Timely submission (Timely filing)

All claims, including secondary claims, should be submitted within 90 days from the date of service for participating providers or within 180 days from the date of service for non-contracted (Out of Network) providers.

Refer to the Quick Reference Guide for address and phone number information.

8.3 Timely payment

- 100% of all clean paper claims will be paid or denied within 30 calendar days of receipt.
- 100% of all clean electronic claims will be paid or denied within 21 calendar days of receipt.

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.

8.4 Provider remittance advice

8.4.a Explanation of dental plan reimbursement (Remittance advice)

The Provider Remittance Advice is a claim detail of each patient and each procedure considered for payment. Use these as a guide to reconcile member payments. As a best practice, it is recommended that remittance advice is kept for future reference and reconciliation.

Below is a list and description of each field:

PROVIDER NAME AND ID NUMBER- Provider Name and ID number – Treating dentists name, Practitioner ID number (NPI National Provider Identifier, TIN Tax Identification Number)

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

AMOUNT BILLED - Amount submitted by provider

AMOUNT PAYABLE - Amount payable after benefits have been applied

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

OTHER INSURANCE - Amount payable by another carrier

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

NET AMOUNT (Summary Page) - Total amount paid

PATIENT NAME - Patient full name, as identified on the member's ID card or eligibility verification

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

PATIENT DOB - Date of Birth (mm/dd/yyyy)

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 - Dates of Service (mm/dd/yyyy): Dates that services are rendered/performed

CDTCODE - Current Dental Terminology - Procedure code of service performed

TOOTH NO. - Tooth Number procedure code of service performed (if applicable)

SURFACE(S) - Tooth Surface of service performed (if applicable) PLACE OF SERVICE - Treating location (office, hospital, other) **QTY OR NO. OF UNITS**

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

PAYABLE AMOUNT - Contracted amount

COPAY AMOUNT - Member responsibility

COINSURANCE AMOUNT - Member responsibility of total payment amount

DEDUCTIBLE AMOUNT - Member responsibility before benefits begin

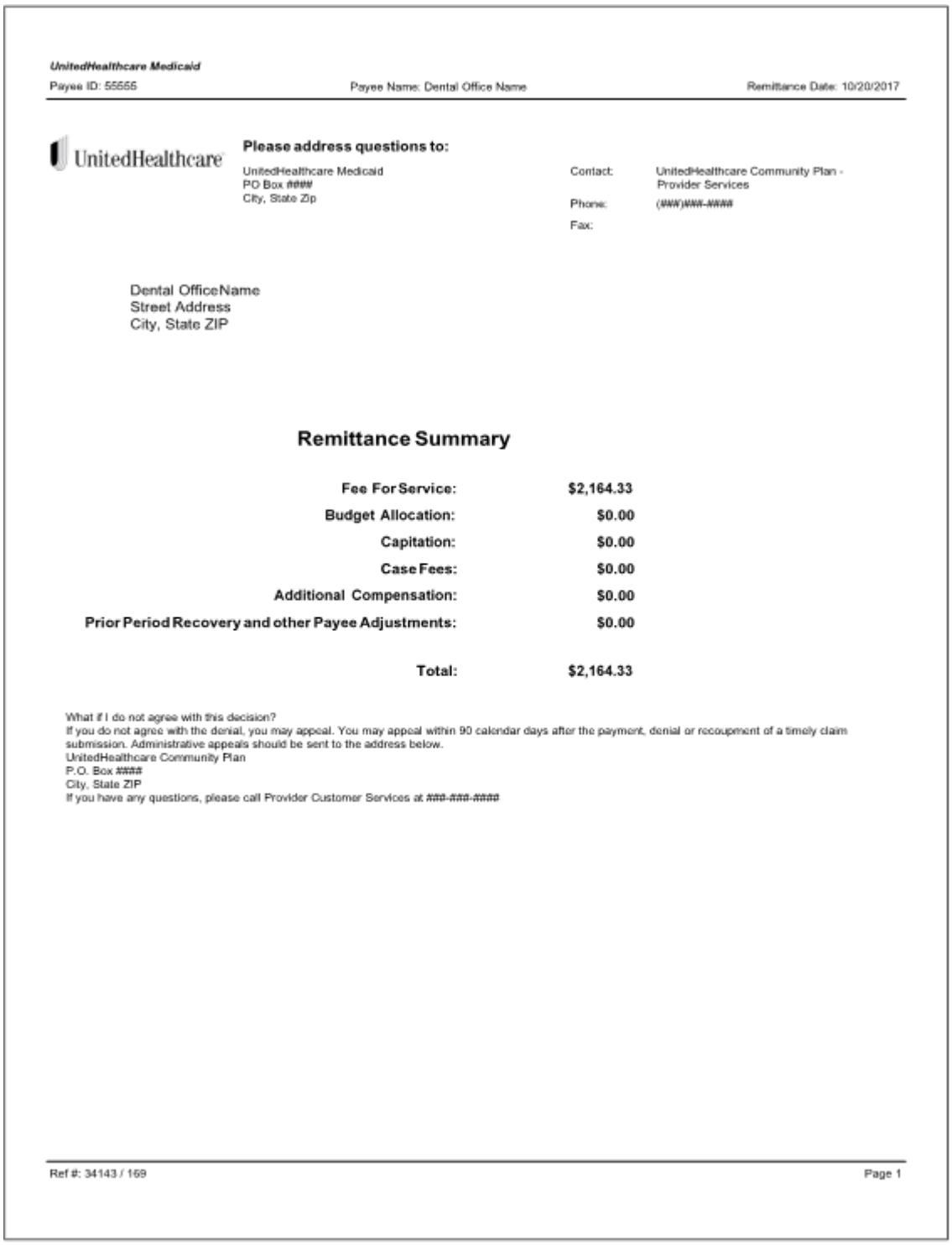
PATIENT PAY - Amount to be paid by the member

OTHER INSURANCE AMOUNT - Amount paid by other carriers

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

EXCEPTION CODES - Codes that explain how the claim was adjudicated

8.4.b Provider Remittance Advice Sample (Page 1)



UnitedHealthcare Medicaid

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

UnitedHealthcare

Please address questions to:

UnitedHealthcare Medicaid
PO Box ####
City, State Zip

Contact: UnitedHealthcare Community Plan - Provider Services
Phone: (###)###-####
Fax:

Dental OfficeName
Street Address
City, State ZIP

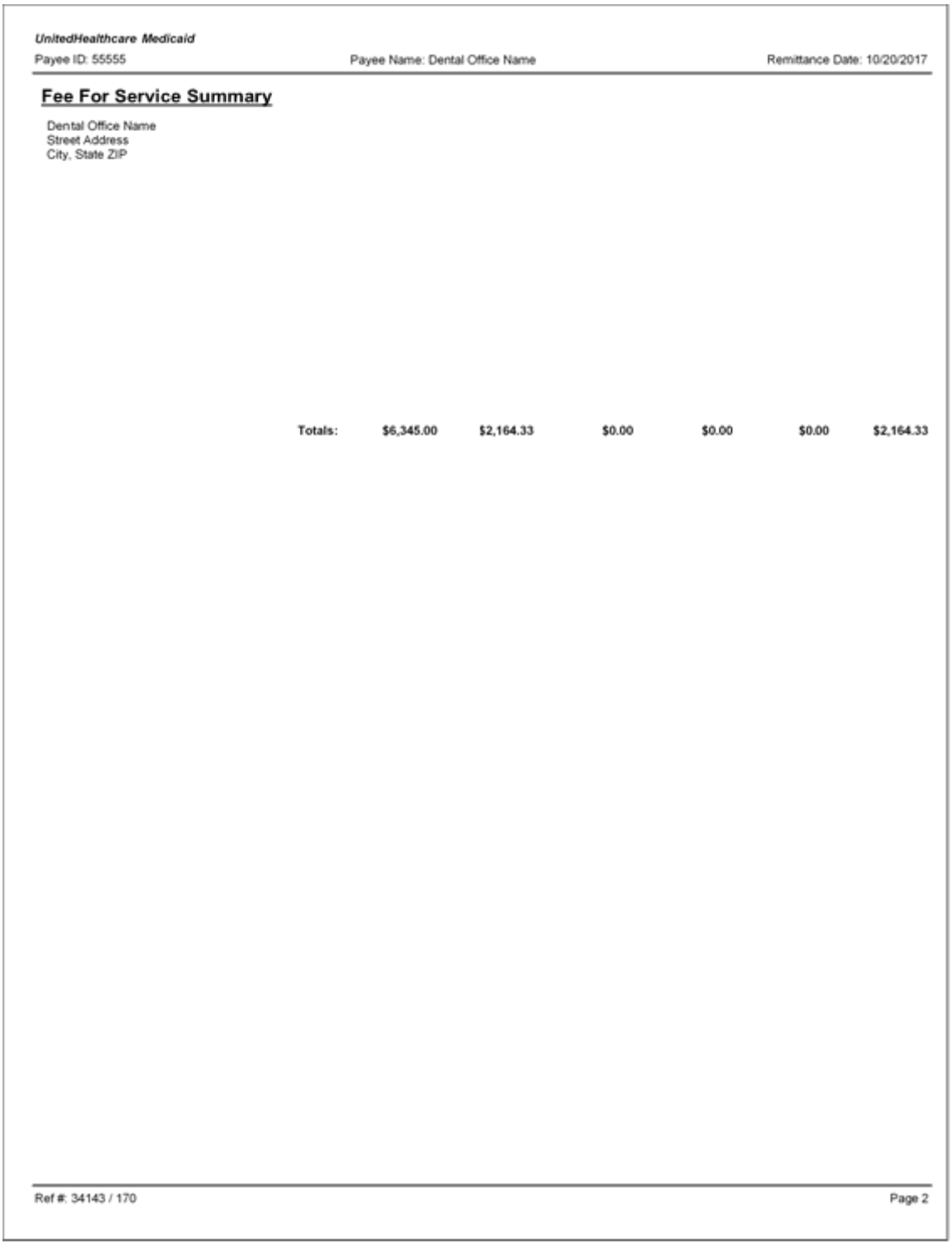
Remittance Summary

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

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

Ref #: 34143 / 169 Page 1

8.4.c Provider Remittance Advice Sample (Page 2)



UnitedHealthcare Medicaid

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

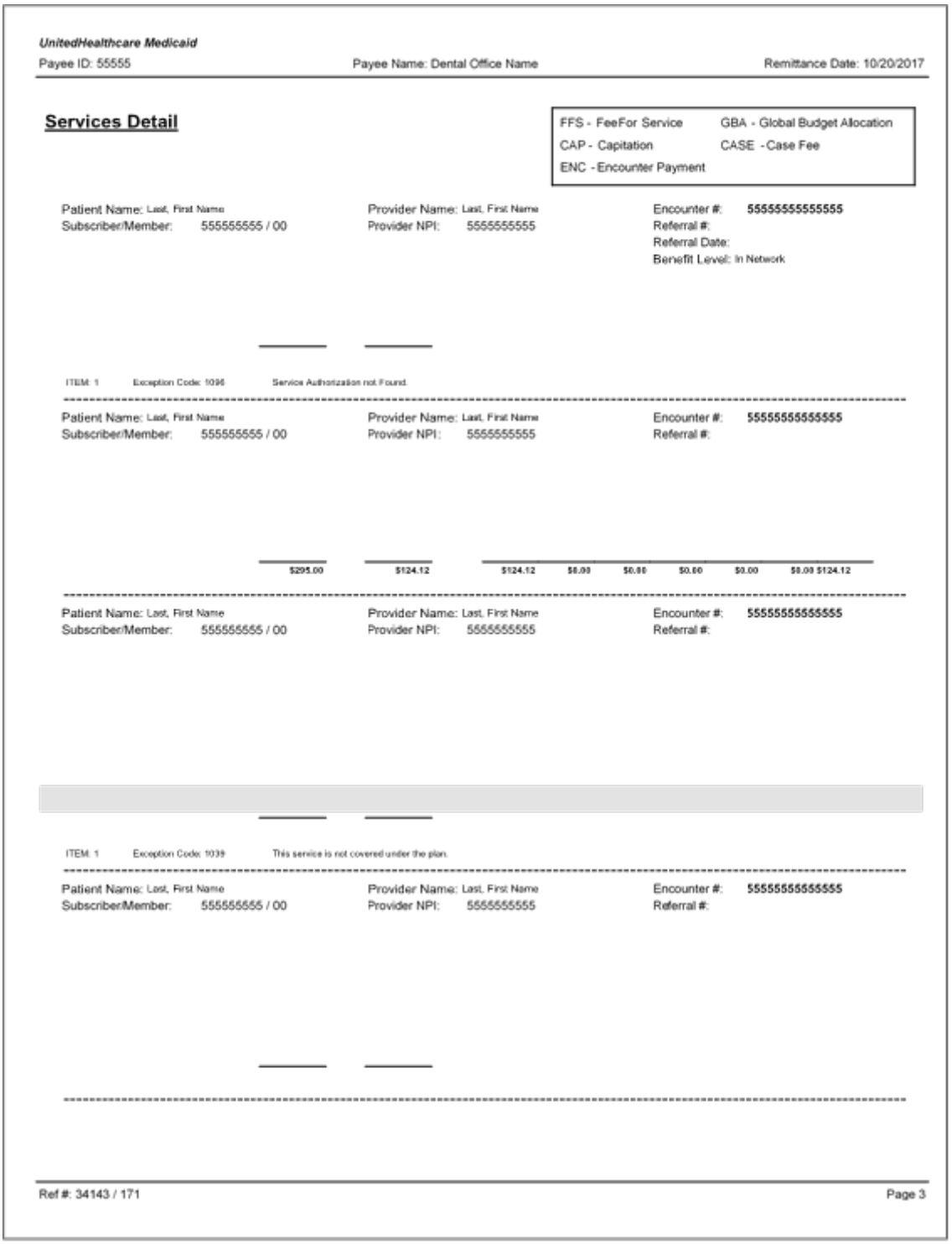
Fee For Service Summary

Dental Office Name
Street Address
City, State ZIP

Totals:	**$6,345.00**	**$2,164.33**	**$0.00**	**$0.00**	**$0.00**	**$2,164.33**

Ref #: 34143 / 170 Page 2

8.4.d Provider Remittance Advice Sample (Page 3)



UnitedHealthcare Medicaid

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

Services Detail

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

Patient Name: Last, First Name
Subscriber/Member: 555555555 / 00
Provider Name: Last, First Name
Provider NPI: 5555555555
Encounter #: 55555555555555
Referral #:
Referral Date:
Benefit Level: In Network

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

Patient Name: Last, First Name
Subscriber/Member: 555555555 / 00
Provider Name: Last, First Name
Provider NPI: 5555555555
Encounter #: 55555555555555
Referral #:

$295.00	$124.12	$124.12	$0.00	$0.00	$0.00	$0.00	$0.00 $124.12

Patient Name: Last, First Name
Subscriber/Member: 555555555 / 00
Provider Name: Last, First Name
Provider NPI: 5555555555
Encounter #: 55555555555555
Referral #:

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

Patient Name: Last, First Name
Subscriber/Member: 555555555 / 00
Provider Name: Last, First Name
Provider NPI: 5555555555
Encounter #: 55555555555555
Referral #:

Ref #: 34143 / 171 Page 3

8.5 Corrected claim process

Providers who receive a claim denial and need to submit a corrected claim should submit a corrected claim and appropriate documentation, if necessary, to:

Corrected Claims
P.O. Box 481
Milwaukee, WI 53201

You can submit a request for an additional claim review, if a claim was denied due to missing information, missing tooth number/ surface on the original submission or you have additional information you feel may change the claim payment decision. The determination of a corrected claim request will be provided a remittance statement within 30 days of receipt.

8.6 Appealing a denied claim payment

Providers have the right to appeal a claim payment that is fully or partially denied. UnitedHealthcare will follow state and Federal guidelines in the management of the appeals process, including 405 Indiana Administrative Code (IAC) 1-1.6.

Providers may submit an Informal Objection within 60 days of the adverse claim determination ("claim denial"). This Informal Objection must be submitted in writing at the address below. The Informal Objection will be reviewed and resolved within 30 days.

If providers are not satisfied with the resolution to the Informal Objection, providers may submit a Formal Appeal in writing within 60 days of the Informal Objection to the same address below. The Formal Appeal will be reviewed and resolved within 30 days.

Appeals for Denied Claims Payment
P.O. Box 1391
Milwaukee, WI 53201

For an Informal Objection or Formal Appeal to be considered, providers should include a narrative indicating the reason for the appeal along with any relevant attachments that may support the reason for reconsideration.

8.7 Overpayment

If you find an overpaid claim, notify us of the overpayment immediately. Send us the overpayment within the time specified in your Agreement. If your payment is not received by that time, we may apply the overpayment against future claim payments in accordance with our Agreement and applicable law.

If you prefer us to recoup the funds from your next payment, call Provider Services.

If you prefer to mail a refund, send an Overpayment Return Check or the Return Overpayment through the Adjustment Request form. Also send a letter with the check. Include the following:

- Name and contact information for the person authorized to sign checks or approve financial decisions.
- Member identification number (e.g., ACC, DD, ALTCS EPD).
- Date of service.
- Original claim number (if known).
- Date of payment.
- Amount paid.
- Amount of overpayment.
- Overpayment reason.
- Check number

8.8 Tips for successful claims resolution

- Do not let claim issues grow or go unresolved.
- Call Provider Services if you can't verify a claim is on file.
- Do not resubmit validated claims on file unless submitting a corrected claim with the required indicators.
- File adjustment requests and claims disputes within contractual time requirements.
- If you must exceed the maximum daily frequency for a procedure, submit the medical records justifying medical necessity. If you have questions, call Provider Services.
- UnitedHealthcare Community Plan is the payer of last resort. This means you must bill and get an EOB from other insurance or source of health care coverage before billing UnitedHealthcare Community Plan. Secondary claims must be received within 365 days from the date of service, even if the primary carrier has not made payment.
- When submitting appeal or reconsiderations requests, provide the same information required for a clean claim. Explain the discrepancy, what should have been paid and why.

Section 9: Quality management

9.1 Quality Improvement Program (QIP) description

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

The objective of the QIP is to make sure that quality of care is being assessed; that problems are being identified; and that follow up is completed where indicated. The QIP is directed by all state, federal and client requirements. The QIP addresses various service elements including accessibility, availability and continuity of care. It also monitors the provisions and utilization of services to make sure they meet professionally recognized standards of care.

The QIP description is reviewed and updated annually:

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

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

9.2 Credentialing

To become a participating provider, 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 Community Plan will review all current information relative to your license, sanctions, malpractice insurance coverage, etc. UnitedHealthcare Community Plan 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 some plans and/or markets. Please note that a site visit is required for each location. If a new location is added after initial contracting is completed, a site visit would be required for the new location before patients can be seen. Your Professional Networks Representative will inform you of any facility visits needed during the recruiting process. Offices must pass the facility review prior to activation.

The Dental Director and the Credentialing Committee review the information submitted in detail based on approved credentialing criteria. UnitedHealthcare Community Plan 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. Refer to the Appendix of this Manual for additional details regarding practitioner rights.

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 Community Plan 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.

UnitedHealthcare Community Plan 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 Community Plan. 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 Community Plan 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 Community Plan will also make an additional 3 attempts, at which time if there is no response, a termination letter will be sent to the provider as per their provider agreement.

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

Initial credentialing

- Completed application
- Signed and dated Attestation
- Current copy of their state license
- Current copy of their Drug Enforcement Agency (DEA) certificate
- Current copy of their Controlled Dangerous Substance (CDS) certificate, if applicable
- Current copy of their Sedation and/or General Anesthesia certificates, if applicable
- Copy of their Sedation and/or General Anesthesia training certificate/diploma, if applicable
- Signed and dated Sedation and/or General Anesthesia, 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)
- Disclosure of Ownership form (as required by the Federal Government)

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
- 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, 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 Provider Services.

9.3 Site visits

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

The site visit focuses primarily on: dental record keeping, 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.

UnitedHealthcare Dental, Dental Benefit Providers, reserves the right to conduct an on-site inspection prior to and any time during the effectuation of the contract of any Mobile Dental Facility or Portable Dental Operation bound by the "Mobile Dental Facilities Standard of Care Addendum."

9.4 Preventive health guideline

The UnitedHealthcare Community Plan approach to preventive health is a multi-focused strategy which includes several integrated areas. The following guidelines are for informational purposes for the dental provider, and will be referred to in a general way, in judging clinical appropriateness and competence.

UnitedHealthcare Community Plan's National Clinical Policy and Technology Committee reviews current professional guidelines and processes while consulting the latest literature, including, but not limited to, current ADA Current Dental Terminology (CDT), and specialty guidelines as suggested by organizations such as the American Academy of Pediatric Dentistry, American Academy of Periodontology, American Association of Endodontists, American Association of Oral and Maxillofacial Surgeons, and the American Association of Dental Consultants. Additional resources include publications such as the Journal of Evidence-Based Dental Practice, online resources obtained via the Library of Medicine, and evidence-based clearinghouses such as the Cochrane Oral Health Group and Centre for Evidence Based Dentistry as well as respected public health benchmarks such as Healthy People 2020 and the Surgeon General's Report on Oral Health in America. 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. 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 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 and based on age, results of a clinical assessment and risk, including application of prophylaxis, fluoride application, placement of sealants and adjunctive therapies where appropriate.

- Consideration should be given to conservative nonsurgical approaches to early caries, such as Caries Management by Risk Assessment (CAMBRA), where the lesion is non-cavitating, slowing progressing or restricted to the enamel or just the dentin; 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. UnitedHealthcare Community Plan may perform clinical studies and conduct interventions in the following target areas:

- Access
- Preventive services, including topical fluoride and sealant application
- Procedure utilization patterns

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 Community Plan to educate providers and members on maintaining oral health, specifically in the areas of prevention, caries, periodontal disease and oral cancer screening.

9.5 Addressing the opioid epidemic

Combating the opioid epidemic must include prevention, treatment, recovery and harm reduction. We engage in strategic community relationships and approaches for special populations with unique risks, such as pregnant women and infants. We use our robust data infrastructure to identify needs, drive targeted actions, and measure progress. Finally, we help ensure our approaches are trauma-informed and reduce harm where possible.

Brief summary of framework

- Prevention: Prevent Opioid-Use Disorders before they occur through pharmacy management, provider practices, and education.
- Treatment: Access and reduce barriers to evidence-based and integrated treatment.
- Recovery: Support care management and referral to person-centered recovery resources.
- Harm Reduction: Access to Naloxone and facilitating safe use, storage, and disposal of opioids.
- Strategic community relationships and approaches: Tailor solutions to local needs.
- Enhanced solutions for pregnant mom and child: Prevent neonatal abstinence syndrome and supporting moms in recovery.
- Enhanced data infrastructure and analytics: Identify needs early and measure progress.

Increasing education & awareness of opioids

It is critical you are up-to-date on the cutting edge research and evidence-based clinical practice guidelines. We keep Opioid Use Disorders (OUD) related trainings and resources available on our provider portal to help ensure you have the information you need, when you need it. For example, state-specific Behavioral Health Toolkits are developed to provide access to clinical practice guidelines, free substance use disorders/OUD assessments and screening resources, and other important state-specific resources. Additionally, Pain Management Toolkits are available and provide resources to help you identify our members who present with chronic physical pain and may also be in need of behavioral health services to address the psychological aspects of pain. Continuing education is available and includes webinars such as, "The Role of the Health Care Team in Solving the Opioid Epidemic," and "The Fight Against the Prescription Opioid Abuse Epidemic." While resources are available, we also workto help ensure you have the educational resources you need. For example, our Drug Utilization Review Provider Newsletter includes opioid trends, prescribing, and key resources.

Access these resources at UHCprovider.com. Then click "Drug Lists and Pharmacy". Click Resource Library to find a list of tools and education.

Prevention

We are invested in reducing the abuse of opioids, while facilitating the safe and effective treatment of pain. Preventing OUD before they occur through improved pharmacy management solutions, improved care provider prescribing patterns, and member and care provider education is central to our strategy.

UnitedHealthcare Community Plan has implemented a 90 MED supply limit for the long-acting opioid class. The prior authorization criteria coincide with the CDC's recommendations for the treatment of chronic non-cancer pain. Prior authorization applies to all long-acting opioids. The CDC guidelines on long-acting opioids are available online at cdc.gov > More CDC Topics > Injury, Violence & Safety > Prescription Drug Overdose > CDC Guideline for Prescribing Opioids for Chronic Pain.

Section 10: Member rights and responsibilities

For the most updated information regarding Member Rights and Responsibilities, please review the Member Handbook at the following link under the Member Information tab: UHCcommunityplan.com/IN.

10.1 Member rights

Be treated with respect and with due consideration for your dignity and privacy.

- Receive information about your treatment options and alternatives, in a way that you can understand them.
- Talk to your providers and the health plan about your medical care and treatment plan.
- Refuse treatment directly or through an advance directive.
- Be free from any action of being held against your will or cut off from others when these actions are intended to pressure you into doing something, punish you, or show revenge against you or make it easier for the medical staff.
- Review your medical records and request changes and/or additions to any area you feel is needed.
- Change your PMP at any time for any reason.
- Tell us if you are not satisfied with your treatment or with us; you can expect a prompt response.
- Know that you will not be treated poorly if you file a grievance or complaint about the health plan or the care provided.
- Make suggestions about our member rights and responsibilities policies.
- Talk to your Member Services Advocate or Care Manager to ask questions, get help or better understand your health care.
- Receive information:
  - In the format that you need, like braille, large print or audio
  - In the language you need

10.2 Member responsibilities

Use services

- Ask questions if you do not understand your rights or plan of treatment.
- Keep your appointments.
- Cancel appointments in advance when you cannot keep them.
- Contact your PMP first for non-emergency medical needs.
- Understand when you should and should not go to an emergency room.
- Know whom to call if you need a ride to the doctor or for other covered services.
- Treat providers and health plan staff with respect and dignity.
- Be in charge of your planning meeting.
- Ask anyone you want to come to your planning meetings.
- Choose your goals to work on and what is on your plan.
- Schedule your person-centered planning meeting at a time and place when the people who you want to attend are available.
- Agree to the services I want from the choice of services you can have.
- Pick an available provider you want to give you your services.
- Know that you may need help from your guardian, family and/or friends to make good choices.

Give information

- Tell your PMP and Member Services Advocate or Care Manager about your health and changes in your health.
- Tell your Member Services Advocate about changes in your private insurance. This includes adding or ending other insurance.

- Talk to your providers and your Care Manager about your health care. Ask questions about the ways your health problems can be treated.
- Notify your Care Manager and the Indiana FSSA if your family size changes, if you move or if your income changes.

"Healthier lives. Healthier you."

- Work as a team with your PMP and Care Manager to decide what care is best for you.
- Understand how what you do can affect your health.
- Do the best you can to stay healthy.
- Treat providers and staff with respect. This includes refraining from use of disparaging remarks, racial or ethnic slurs, profanity towards providers, caregivers and/or Care Managers.

Section 11: Fraud, waste and abuse training

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

- Provide detailed information about the Federal False Claims Act,
- Cite administrative remedies for false claims and statements,
- Reference state laws pertaining to civil or criminal penalties for false claims and statements, and
- 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 12: Appendix

12.1 Practitioner rights bulletin

- Providers applying for initial credentialing do not have appeal rights, unless required by State regulation.
- 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 Dental Benefit Providers (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.
- 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.
- 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.
- 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**

12.2 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.

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

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

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

12.3 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:

- Chart audit reveals clear and convincing evidence of under- or over utilization, fraud, upcoding, overcharging, or other inappropriate billing practices.
- Multiple quality-of-care related complaints or complaints of an egregious nature for which investigation confirms quality concerns.
- 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:

- Advocated on behalf of an enrollee
- Filed a complaint against the Managed Care Entity (MCE)
- Appealed a decision of the Managed Care Entity (MCE)
- Provided information or filed a report pursuant to PHL4406-c regarding prohibition of plans
- Requested a hearing or review

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.

- 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.
- The Committees make very effort to obtain a provider narrative and appropriate documents prior to making any determination.
- The Committees may elect to accept, suspend, unpublish, place a provider on probation, require corrective action or terminate the provider.
- 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.
- 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.

12.4 Appeals process

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

- 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.
- The decision of the Hearing Committee is sent to the provider by certified letter within thirty (30) calendar days.
- Decisions of terminations shall be effective not less than thirty (30) days after the receipt by the provider of the Hearing Panel's decision.
- 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.

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