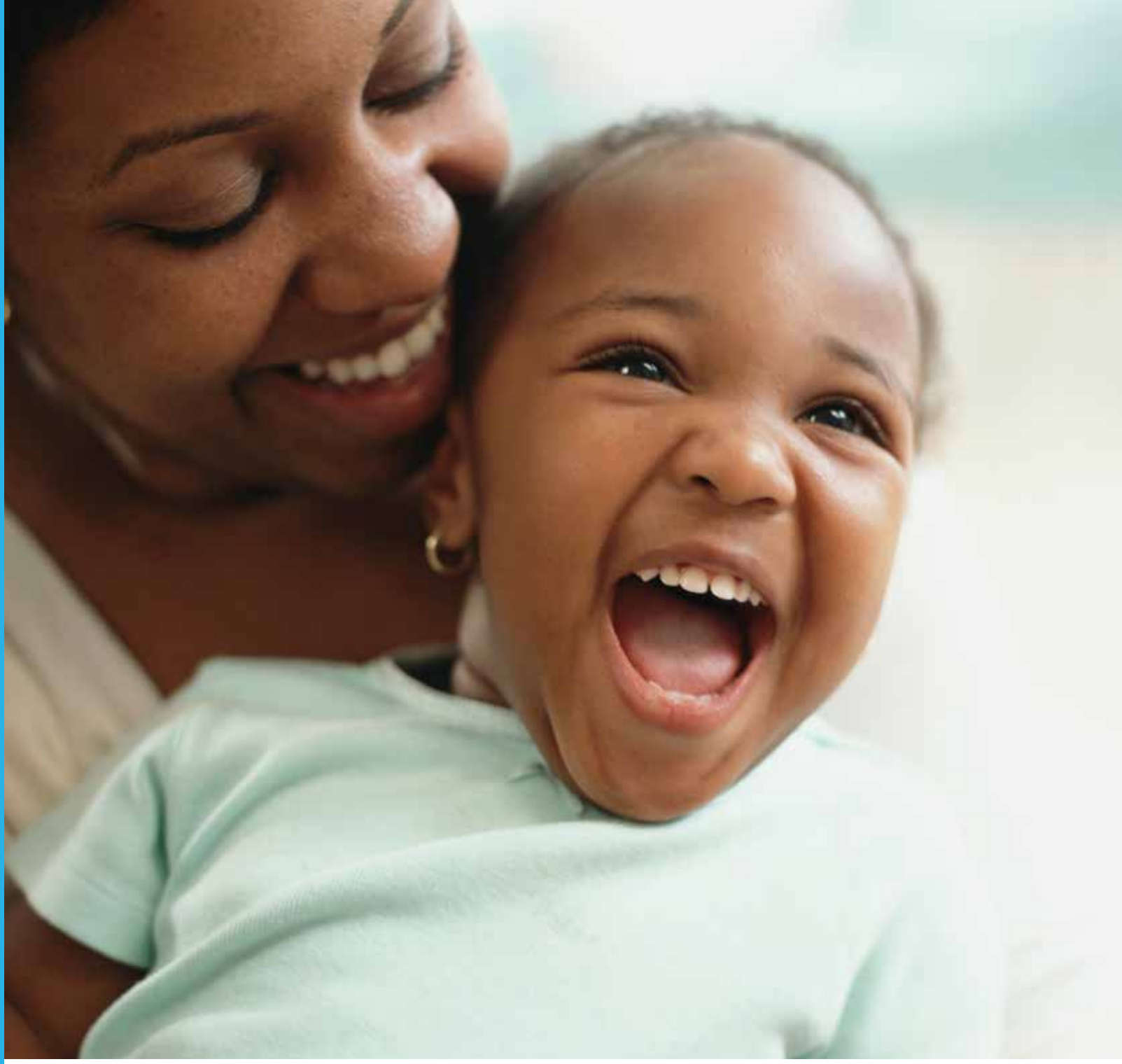


UnitedHealthcare KanCare

Dental Provider Manual

Effective 1/1/19

SKYGEN | KanCare | UnitedHealthcare®

Contents

Introduction—Who We Are

Section 1: **Welcome to UnitedHealthcare®**

UnitedHealthcare welcomes your participation with the UnitedHealthcare Community Plan KanCare dental provider network.

UnitedHealthcare is committed to providing accessible, quality, comprehensive dental care 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.

This Provider Manual is designed as a comprehensive reference guide for UnitedHealthcare KanCare plan. Here you will find the tools and information needed to successfully administer these plans. As changes and new information arise, we will send these updates to you. Please store these updates with this Provider Manual for future reference.

If you have any questions or concerns about the information contained within this Provider Manual, please contact the provider call center at **1-855-878-5372**.

Thank you for your continued support as we serve the Government Program beneficiaries in your community.

Sincerely,

UnitedHealthcare Professional Network

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

2.1 **Quick Reference**

UnitedHealthcare provides access to a Web Portal containing the full complement of online Provider resources. The Web Portal features an online Provider inquiry tool for real-time eligibility, claims, and authorization status. Visit the Web Portal at **uhcproviders.com** for helpful resources including:

- Standard forms
- Provider Manual
- Provider newsletter
- Claims status
- Electronic remittance advice
- Electronic funds transfer information
- Submit Claims
- Submit Authorization Requests

QUICK REFERENCE INFORMATION	
Member Eligibility	Participating Providers may access eligibility information through: • Logging in to Provider Web Portal via **uhcproviders.com** • Utilizing the Interactive Voice Response system (IVR) eligibility hotline at **1-855-878-5372** • Contacting Provider Services at **1-855-878-5372**
National Provider Identifier (NPI)	The Health Insurance Portability and Accountability Act (HIPAA) of 1996 requires the adoption of a standard unique Provider identifier for health care Providers. All participating Providers must have an NPI number. An NPI is a 10-digit, intelligence-free numeric identifier. *Intelligence-free* means that the numbers do not carry information concerning health care Providers, for instance the states in which they practice or their specialties. Providers can apply for an NPI by: • Completing the application online at **nppes.cms.hhs.gov** • Completing a paper copy by downloading it at **nppes.cms.hhs.gov** • Calling **1-800-465-3203** and requesting an application - Estimated time to complete the NPI application is 20 minutes.
Authorization Information	Prior authorization determinations must be made within fourteen (14) days from the date UnitedHealthcare receives this request, provided all information is complete. Prior authorizations will be honored for 180 days from the date they are determined. Authorization submissions can be received in the following formats: • Electronic authorizations via the dental provider website at **uhcproviders.com** • Electronic submission via a clearinghouse • HIPAA Compliant 837D file • Paper authorization via ADA 2012 Claim Form Mailed authorizations should be sent to the following address: **UnitedHealthcare Authorizations** **PO Box 2135** **Milwaukee, WI 53201**

QUICK REFERENCE INFORMATION	
Claims Information	The timely filing requirement is 180 calendar days for all claims and all services, and a 365 calendar day limit for any correction or rebilling of a timely filed claim. Claims submissions can be received in the following formats: • Electronic claims via the website at **uhcproviders.com** • Electronic submission via clearinghouse • HIPAA Compliant 837D file • Paper claims on 2012 ADA forms should be mailed to: **UnitedHealthcare KS Claims** **PO Box 1158** **Milwaukee, WI 53201**
Retro-Review Claims	Retro-Review claim submissions requires participating providers to submit documentation associated with certain dental services rendered as outlined in the benefit description at the end of this manual. • Retro-Review claims can be received in the following formats: • Electronic submission via Skygen USA's website at **uhcproviders.com** • Electronic submission via clearinghouse • Mailed via 2012 ADA claim form with the "Statement of Actual Services" box indicated on the claim form to: **UnitedHealthcare KS Claims** **PO Box 1158** **Milwaukee, WI 53201**
Inquiries, Complaints, and Grievances	To make an inquiry or complaint, contact Provider Services toll-free at **1-855-878-5372**. To file a written complaint, send complaint to the following address: **Complaints** **PO Box 1244** **Milwaukee, WI 53201**
Appeals Information	Appeals must be filed within 60 plus 3 calendar days calendar days of the date the denial letter was mailed or the date on the Provider Remittance. Pre Service UM Appeals need to include the member's written consent to appeal and must be submitted to the following address: **UnitedHealthcare Appeals** **PO Box 31364** **Salt Lake City, UT 84131** Post Service Provider Administrative appeals may be submitted in writing to the following address: **UnitedHealthcare Appeals** **PO Box 1244** **Milwaukee, WI 53201**
Additional Provider Resources	For information regarding additional Provider resources, please contact: • The Provider Services Call Center at 1-855-878- 5372 • Access the Dental Provider Web Portal at uhcproviders.com • UnitedHealthcare Community Plan Member Services at **1-877-542-9238** (TTY: **711**)

Section 3: **Provider Web Portal Registration & Introduction**

The Dental Provider Web Portal services allow us to maintain our commitment to help Providers keep office costs low, access information efficiently, receive payments quicker, and submit claims and authorizations electronically.

3.1 **Provider Web Portal**

The Provider Web Portal allows participating Providers direct access to the Enterprise System benefits administration software. Taking advantage of the online services offered through the Provider Web Portal lowers program administration and participation costs.

Online access requires only an internet browser, a valid user ID, and a password. From an internet browser, Providers and authorized office staff can log in for secured access to the system anytime from anywhere to handle a variety of day-to-day tasks, including:

- Verifying Member eligibility.
- Checking patient treatment history for specific services.
- Submitting claims for services rendered by simply entering procedure codes, tooth numbers, etc.
- Submitting authorization requests, using interactive clinical algorithms when appropriate.
- Sending electronic attachments, such as digital x-rays, EOBs, and treatment plans.
- Checking the status of submitted claims and authorizations.
- Accessing and reviewing remittance information.
- Downloading and printing Provider Manuals, Clinical Criteria, Provider Newsletters and Fee Schedules.
- Setting up office appointment schedules, which can automatically verify eligibility and pre-populate claim forms for online submission.
- Reviewing Provider clinical profiling data relative to peers. Uploading and downloading documents using a secure encryption protocol.
- Participating in surveys to rate provider satisfaction

3.2 **Registration**

To register for our Provider Web Portal visit www.uhcproviders.com, click on the Providers login tab, and follow the “Register Now” link.

There is no need to download or purchase software.

To access the Provider Web Portal, enter a unique user name and password.

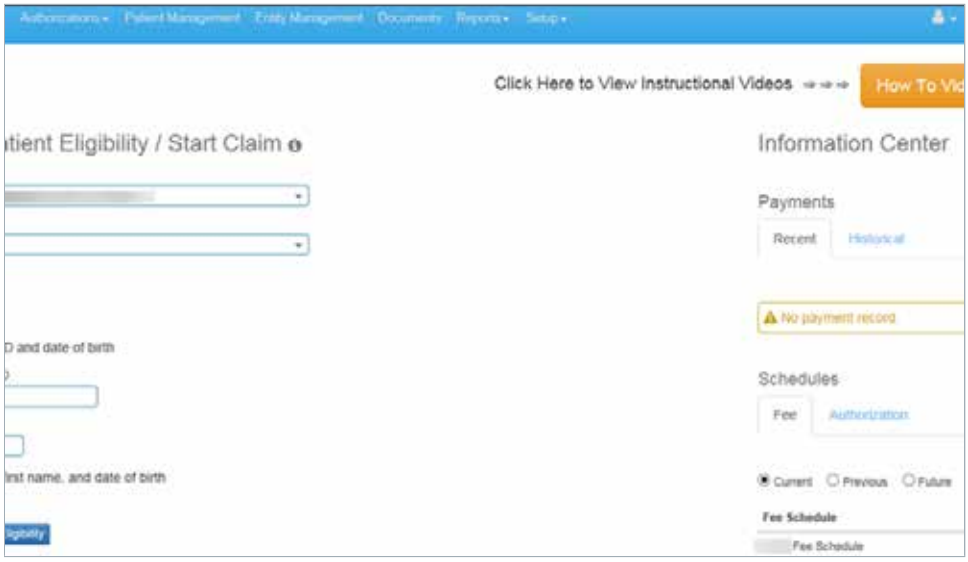
- Select “As a payee” for the option to view remittances.
- Contact Provider Services at 1-855- 878-5372 to obtain your Payee ID number.

3.3 **Introduction**

Once registered, you are now ready to navigate through the web portal and use the available resources and features to help streamline data entry.

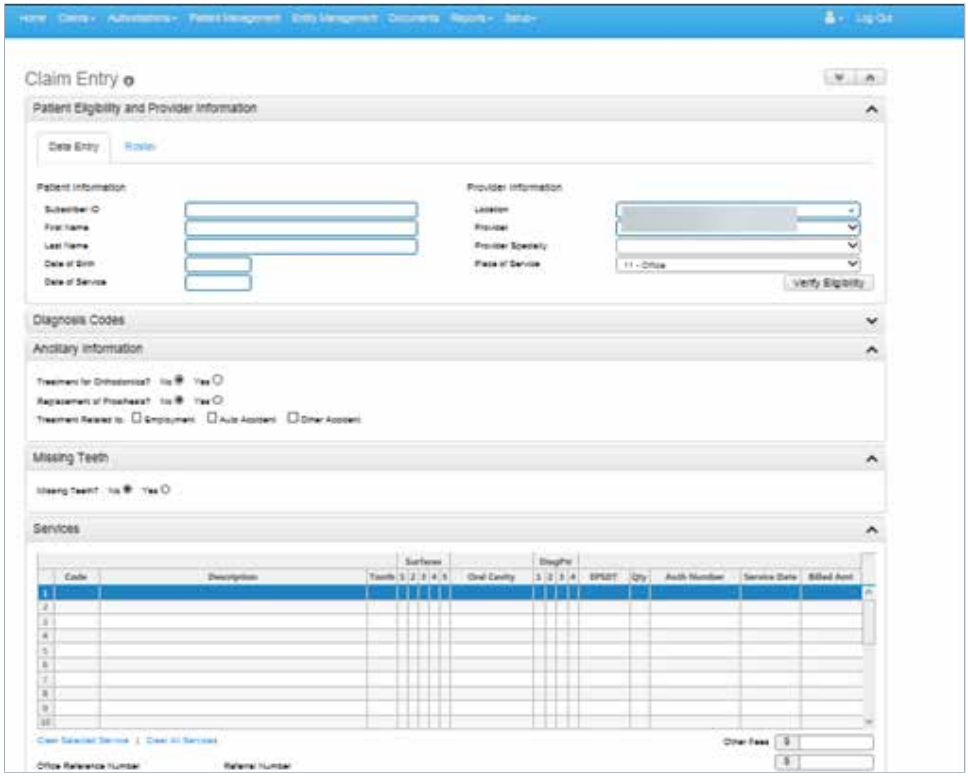
Verify Member Eligibility

- One-step Member eligibility verification
- Verify up to 250 Members at one time



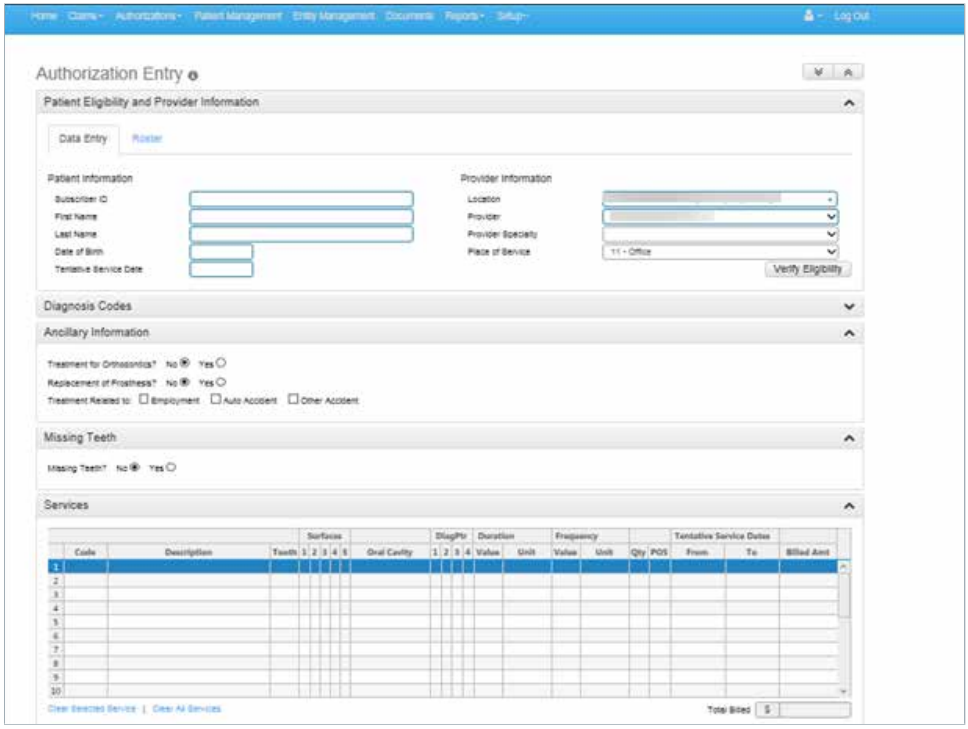
Manage claims

- Submit claims for services performed
- Review and print or save a list of claims submitted today for your records, before they are sent on for processing
- Check the status of previously submitted claims
- Enter additional information such as NEA# under the 'Notes' tab



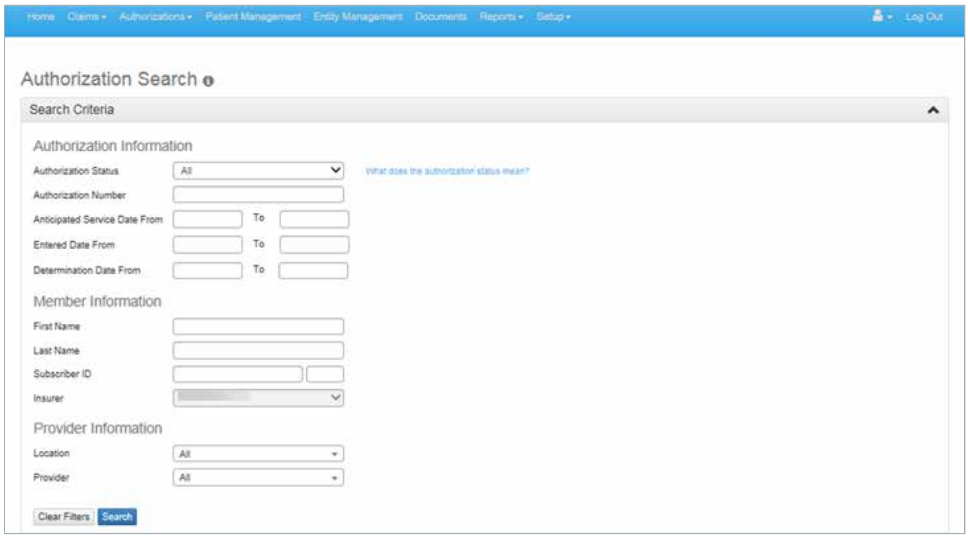
Authorizations

- Submit authorizations before performing services to obtain approval.
- Attach electronic files, including x-rays and review authorizations submitted today, before they are sent on for processing.
- Check the status of previously submitted authorizations.



From an Authorization Summary, you can:

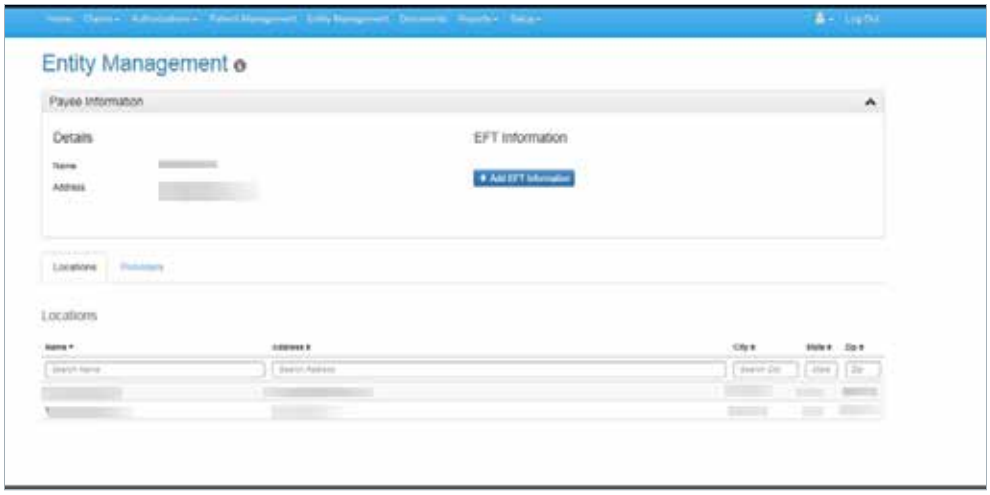
- Run any applicable authorization guidelines.
- Review a list of documentation required for each procedure code.
- Attach electronic files to the authorization record.
- Attach clearing house reference information to the authorization record.
- Print a copy of the Authorization Summary for your records.



Electronic Funds Transfer

The Dental Provider Web Portal services allow us to give you quicker payments by electronic funds transfers (EFT's). The electronic payment offers a direct deposit into your account and allows you to obtain remits quicker on your online account.

To obtain your online remittances, navigate to the My Documents page from the documents tab on the toolbar or by the link on the main page.



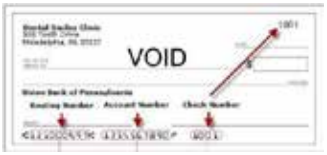
To enroll in EFT payment, please complete the following page and return to Provider Services via:

- Fax: **1-262-721-0722**
- Email: providerservices@skygenusa.com

UnitedHealthcare Community Plan

Electronic Funds Transfer (EFT) Authorization Agreement

*Get your reimbursement faster and easier with EFT! To receive your payments by EFT, please complete this form and **return it with a scanned or faxed copy of a** voided check. **(This Authorization Agreement will not be valid without a** voided check.**)***

Submission Options			
Send this completed form and voided check to SKYGEN USA via:	**Fax:** 262-721-0722 *or* **Email:** providerservices@skygenusa.com		
Submission Reason			
Select one checkbox.	❑ New EFT Authorization | ❑ Account or bank change to existing EFT Authorization		
Provider Information			
Provider Name *(Include d/b/a, if any.)*	Taxpayer Identification Number	*Select one checkbox.* ❑ SSN | ❑ EIN	
Street Address			
City	State	Zip Code	
Phone Number	Email Address		
Financial Institution Information			
Financial Institution Name	Financial Institution Routing Number *(Include 9 digits with any leading zeros.)*		
Account Number *(Include up to 10 digits with any leading zeros.)*	*To indicate account type, select one checkbox.* ❑ Checking Account | ❑ Savings Account		
Note: Please return this form with a *voided check* or the Authorization Agreement will not be valid.			
Authorization			
I hereby authorize SKYGEN USA, on behalf of itself and its affiliates, to initiate credit entries, and if necessary, debit entries and adjustments to my Checking Account/Savings Account indicated above at the financial institution listed. I agree that transactions authorized herein shall comply with all applicable U.S. laws. I accept responsibility for any resulting loss of payment and release Company from any liability for or arising from my failure to submit accurate or updated information to Company.			
Printed Name	Title		
Authorized Signature	Date		

Instructions for the

Electronic Funds Transfer (EFT) Authorization Agreement

RECEIVE ELECTRONIC CLAIMS PAYMENTS FASTER THAN MAILING PAPER CHECKS—FOR FREE!

Three Easy Steps for EFT Enrollment

1. Fill in the attached **EFT Authorization Agreement** form.
2. Return the completed form with a scanned or faxed copy of a *voided check* from your financial institution.
3. Send the form and *voided check* to Provider Services via email or fax. (Please see the form for the email address and fax number.)

Why enroll in EFT?

Direct Checking and Savings Account Payments

Prompt payments for services rendered is always a concern. Electronic Funds Transfer (EFT)—a secure and free online procedure—replaces paper checks for services rendered. This access enables you to:

- Receive claims payments in established bank accounts up to a week faster than paper checks.
- Decrease incoming mail, eliminating delays or mistakes due to hardcopy procedures.
- Lower administrative costs, save paper, and take advantage of a convenient audit trail.
- Review and verify remittances easily and conveniently on the Provider Web Portal—at no charge to your office.

Why use the web portal?

Online Resources for Enrolled Providers

Secure login access to the system—from anywhere at any time—allows you and your authorized office staff to handle a variety of routine tasks, such as the following.

- Verify member eligibility.
- Set up office appointment schedules, which automatically verify eligibility and fill in claim forms for online submission.
- Submit claims and verify claims status for services rendered.
- Submit authorization requests and send digital attachments, such as Explanation of Benefits (EOBs) and treatment plans.
- Check patient treatment history for specific services.

Section 4: **Provider Enrollment and Contracting**

In compliance with the Centers for Medicare & Medicaid Services (CMS) Medicaid Managed Care Final Rule 2390F and 42 CFR 438.602(b)(1), all participating providers who receive payment for KanCare members are required to be screened and enrolled in the Kansas Medical Assistance Program (KMAP).

This federal requirement applies to all provider types and specialties and is inclusive of all network billing, rendering, ordering, prescribing, referring, sponsoring, and attending providers. All MCO network providers must be enrolled with KMAP and screened prior to receiving payments from an MCO.

Providers may access the Provider Enrollment Portal at: https://portal.kmap-state-ks.us/providerenrollment/enrollmentcreate, or they may visit the KMAP main site, at **https://www.kmap-state-ks.us**.

Once providers have been enrolled as a KMAP provider, Skygen will retrieve all credentialing documents from KMAP, and will proceed with the credentialing and contracting process.

Section 5: **Provider Responsibilities**

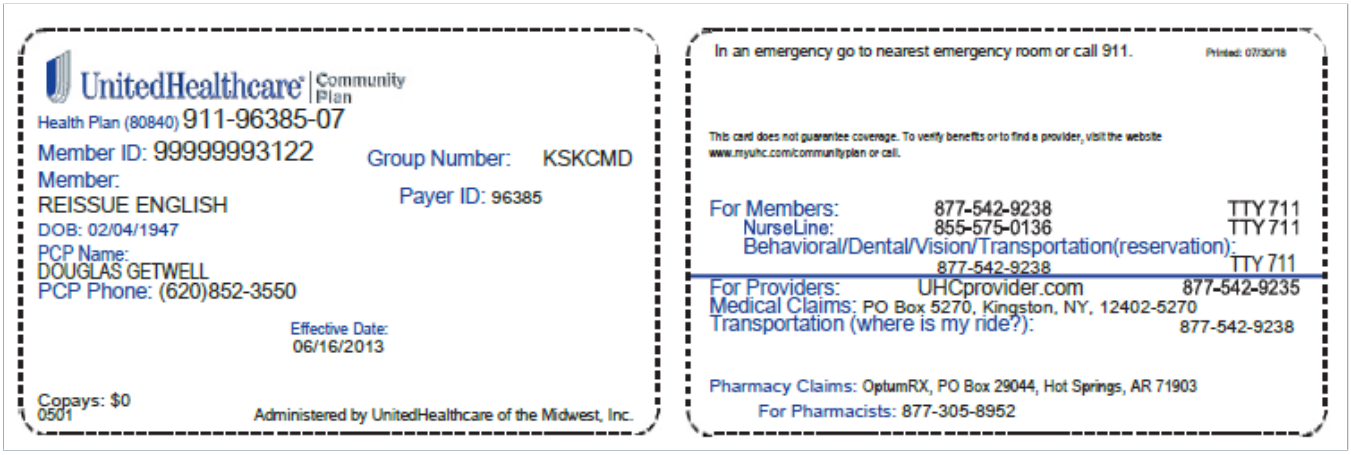
Enrolled Participating Providers have the following responsibilities:

- If a recommended treatment plan is not covered, the participating dentist, if intending to charge the Member for the non-covered services, must notify the Member in writing that the service will not be covered. The notice must contain language explaining that the member will be liable for the services if rendered and must be signed by the member.
- A Provider wishing to terminate from participation with the UnitedHealthcare KanCare provider network due to retirement, relocation, or voluntary termination must supply written notification of termination at least 60 days prior to expected final date of participation. All patients should be referred to the toll-free Member number 1-877-542-9238 (TTY: 711) to find another dentist in their area.
- A Provider may not bill both medical and dental codes for the same procedure.

Section 6: **Member Eligibility Verification Procedures and Services to Members**

6.1 **Member Identification Card**

The ID card below is a sample and is subject to change. Please note that members do not have a separate dental ID card for this plan.



Providers are responsible for verifying that Members are eligible at the time services are rendered and to determine if Members have other health insurance.

It is recommended that each dental office make a photocopy of the Member's identification card each time treatment is provided. It is important to note that the identification card does not need to be returned should a Member lose eligibility.

For additional information concerning Member Identification Cards, please contact the Provider Relations Department at **1-855-878-5372**.

6.2 **Eligibility Systems**

Enrolled Participating Providers may access Member eligibility information through:

- The Provider Web Portal at www.uhcproviders.com
- The Interactive Voice Response (IVR) system eligibility line at 1-855-878-5372.
- The Provider Services Department at 1-855-878-5372.

The eligibility information received from any of the above sources will be the same information you would receive by calling The Provider Services Department; however, by utilizing the IVR or the website, you can get information 24 hours a day, 7 days a week, without having to wait for an available Provider Services Representative.

6.2.a. **Access to eligibility information via www.uhcproviders.com**

The Dental website currently allows Enrolled Participating Providers to verify a Member's eligibility as well as submit claims. To access the eligibility information via the Provider Web Portal, simply log on to the website at www.uhcproviders.com.

Once you have entered the website, click on 'Providers.' You will then be able to log in using your password and ID. First time users will have to self-register by utilizing their Payee ID, office name and office address. Please refer to your payment remittance or contact Provider Services at 1-855-878-5372 to obtain your Payee ID.

Once logged in, select "eligibility look up" and enter the applicable information for each Member you are inquiring about. Verify the Member's eligibility by entering the Member's date of birth, the expected date of service and the Member's identification

number or last name and first initial. You are able to check on an unlimited number of patients and can print off the summary of eligibility given by the system for your records.

6.2.b. **Access to eligibility information via the IVR line**

To access the IVR, simply call the Provider Services Department at 1-855-878-5372 for eligibility and service history. The IVR system will be able to answer all of your eligibility questions for as many Members as you wish to check. Once you have completed your eligibility checks or history inquiries, you will have the option to transfer to a Provider Services Representative to answer any additional questions during normal business hours.

Callers will need to enter the appropriate Tax ID or NPI number, the Member's recipient identification number, and date of birth. Specific directions for utilizing the IVR to check eligibility are listed below. After our system analyzes the information, the patient's eligibility for coverage of dental services will be verified. If the system is unable to verify the Member information you entered, you will be transferred to a Providers Service Representative.

6.2.c. **Directions for using the IVR to verify eligibility:**

1. Call Provider Services at **1-855-878-5372**.
2. When prompted, enter your Provider NPI or Tax ID number.
3. Follow the additional prompts and enter Member Information using the ID number or SSN.
4. When prompted, enter the Members ID, less any alpha characters that may be part of the ID, or the SSN.
5. When prompted, enter the Member's date of birth in MMDDYYYY format.
6. Upon system verification of the Member's eligibility, you will be prompted to verify the eligibility of another Member, inquire about service history, or choose to speak to a Provider Service representative.

Please note that due to possible eligibility status changes, the information provided by either system does not guarantee payment. If you are having difficulty accessing either the IVR or website, please contact Provider Services at **1-855-878-5372**.

6.3 **Appointment Availability Standards**

The state of Kansas has established appointment time requirements for all situations to ensure that Members receive dental services in a time period that is appropriate to their health condition. Providers are required to adhere to the appointment standards are adhered to in an effort to ensure accessibility of needed services, maintain Member satisfaction and reduce unnecessary use of alternative services such as an emergency room.

- Routine dental care must be scheduled within 21 calendar days*
- Urgent care must be scheduled within 48 hours.
- Emergent care must be scheduled immediately.

Appointment standards will be monitored and corrective action will be taken if required.*

* UnitedHealthcare understands that there may be extenuating circumstances such as limited provider availability in a county which could prohibit a practitioner from meeting the 21 day period for routine appointments. Corrective action will not be taken when extenuating circumstances exist.

Section 7: **Covered Benefits**

Benefits are subject to change.

UHC KanCare CHIP (Ages 0-18) and Medicaid (Ages 0-20)

Code	Code Description	Teeth or Area Covered	Review Required	CHIP Age Range	Medicaid Age Range	Benefit Limitations
D0120	Periodic Oral Evaluation - Established Patient		No	0-18	0-20	Only one exam every 6 months per provider or provider billing group. Only one exam (D0120, D0140, D0145, Do150, D0170) per date of service, per beneficiary, per provider or provider billing group.
D0140	Limited Oral Evaluation - Problem Focused		No	0-18	0-20	Only one exam (D0120, D0140, D0145, Do150, D0170) per date of service, per beneficiary, per provider or provider billing group. Limited oral evaluation is only covered when performed in conjunction with treatment to address an emergency situation. An emergency is defined as treatment medically necessary to treat pain, infection, swelling, uncontrolled bleeding, or traumatic injury.
D0145	Oral Evaluation, Patient Under Three		No	0-2	0-2	Only one exam (D0120, D0140, D0145, Do150, D0170) per date of service, per beneficiary, per provider or provider billing group.
D0150	Comprehensive Oral Evaluation - New or Established Patient		No	0-18	0-20	One comprehensive exam per beneficiary, per provider or provider billing group per lifetime. Only one exam (D0120, D0140, D0145, or D0150) every six months per beneficiary, per provider or provider billing group.
D0170	Reevaluation - limited, problem focused		No	0-18	0-20	One per 12 months. Established beneficiary to assess the status of a previously existing condition (not post-operative visit). Not covered with any other procedure other than radiographs.
D0210	Intraoral - Complete Series (Including Bitewings)		No	0-18	0-20	One per 36 months. The following are also considered an Intraoral Complete Series (D0210) D0330 and D0272 D0330 and D0273 D0330 and D0274 D0330 and D0277
D0220	Intraoral - Periapical First Film		No	0-18	0-20	One per day. Any additional films (D0220 - D0340) performed on the same date of service as a complete intraoral series, or its equivalent, are considered content of service of the complete series and will not be reimbursed.
D0230	Intraoral - Periapical Each Additional Film		No	0-18	0-20	Any additional films (D0220 - D0340) performed on the same date of service as a complete intraoral series, or its equivalent, are considered content of service of the complete series and will not be reimbursed.

UHC KanCare CHIP (Ages 0-18) and Medicaid (Ages 0-20)

Code	Code Description	Teeth or Area Covered	Review Required	CHIP Age Range	Medicaid Age Range	Benefit Limitations
D0240	Intraoral - Occlusal Film		No	0-18	0-20	Any additional films (D0220 - D0340) performed on the same date of service as a complete intraoral series, or its equivalent, are considered content of service of the complete series and are not reimbursed.
D0250	Extraoral – 2d projection radiographic image created using a stationary radiation source, and detector		No	0-18	0-20	Any additional films (D0220 - D0340) performed on the same date of service as a complete intraoral series, or its equivalent, are considered content of service of the complete series and are not reimbursed.
D0251	Extraoral – First Radiographic Image		No	0-18	0-20	Any additional films (D0220 - D0340) performed on the same date of service as a complete intraoral series, or its equivalent, are considered content of service of the complete series and are not reimbursed.
D0270	Bitewing - Single Film		No	0-18	0-20	Any additional films (D0220 - D0340) performed on the same date of service as a complete intraoral series, or its equivalent, are considered content of service of the complete series and are not reimbursed. Only one bitewing code (D0270, D0272, D0273, D0274, D0277) per date of service, per beneficiary, per provider or provider billing group.
D0272	Bitewings - Two Films		No	0-18	0-20	Any additional films (D0220 - D0340) performed on the same date of service as a complete intraoral series, or its equivalent, are considered content of service of the complete series and are not reimbursed. Only one bitewing code (D0270, D0272, D0273, D0274, D0277) per date of service, per beneficiary, per provider or provider billing group.
D0273	Bitewings - Three Films		No	0-18	0-20	Any additional films (D0220 - D0340) performed on the same date of service as a complete intraoral series, or its equivalent, are considered content of service of the complete series and are not reimbursed. Only one bitewing code (D0270, D0272, D0273, D0274, D0277) per date of service, per beneficiary, per provider or provider billing group.
D0274	Bitewings - Four Films		No	0-18	0-20	Any additional films (D0220 - D0340) performed on the same date of service as a complete intraoral series, or its equivalent, are considered content of service of the complete series and are not reimbursed. Only one bitewing code (D0270, D0272, D0273, D0274, D0277) per date of service, per beneficiary, per provider or provider billing group.

UHC KanCare CHIP (Ages 0-18) and Medicaid (Ages 0-20)

Code	Code Description	Teeth or Area Covered	Review Required	CHIP Age Range	Medicaid Age Range	Benefit Limitations
D0277	Vertical Bitewings - 7-8 Films		No	0-18	0-20	Any additional films (D0220 - D0340) performed on the same date of service as a complete intraoral series, or its equivalent, are considered content of service of the complete series and are not reimbursed. Only one bitewing code (D0270, D0272, D0273, D0274, D0277) per date of service, per beneficiary, per provider or provider billing group.
D0321	Other Temporomandibular Joint Films, By Report		No	0-18	0-20	Any additional films (D0220 - D0340) performed on the same date of service as a complete intraoral series, or its equivalent, are considered content of service of the complete series and are not reimbursed.
D0322	Tomographic Survey		No	0-18	0-20	Any additional films (D0220 - D0340) performed on the same date of service as a complete intraoral series, or its equivalent, are considered content of service of the complete series and are not reimbursed.
D0330	Panoramic Film		No	0-18	0-20	One per 36 months. The following are also considered an Intraoral Complete Series (D0210) D0330 and D0272 D0330 and D0273 D0330 and D0274 D0330 and D0277
D0460	Pulp Vitality Test	1 - 32 51 - 82 (SN) A - T AS - TS (SN)	No	0-18	0-20	Maximum of three teeth per visit.
D0999	Unspecified Diagnostic Procedures, By Report		Yes	0-18	0-20	
D1110	Prophylaxis - Adult		No	13-18	13-20	One per 6 months. Title 21 Children Ages 13-18 Title 19 Children Ages 13-20 Includes scaling and polishing procedures to remove coronal plaque, calculus, and stains.
D1120	Prophylaxis - Child		No	12 and Under	12 and Under	One per 6 months. Title 21 Children Ages 0-12 Title 19 Children Ages 0-12 Includes scaling and polishing procedures to remove coronal plaque, calculus, and stains.
D1206	Topical Application Of Fluoride -		No	0-18	0-20	3 times per 12 months. Title 21
D1208	Topical Application Of Fluoride Varnish		No	0-18	0-20	3 times per 12 months. Title 21
D1351	Sealant - Per Tooth		No	0-18	0-20	Once per 12 months. Occlusal surfaces only. Teeth must be caries free. Sealant is not covered when placed over restorations.

UHC KanCare CHIP (Ages 0-18) and Medicaid (Ages 0-20)

Code	Code Description	Teeth or Area Covered	Review Required	CHIP Age Range	Medicaid Age Range	Benefit Limitations
D1510	Space Maintainer - Fixed - Unilateral per quadrant/arch	Per quadrant 10 (UR) 20 (UL) 30 (LL) 40 (LR)	No	0-18	0-20	Once per 12 months per quadrant.
D1516	Space maintainer - fixed - bilateral, maxillary	01 (UA) 02 (LA)	No	0-18	0-20	One per 12 months per arch.
D1517	Space maintainer - fixed - bilateral, mandibular	01 (UA) 02 (LA)	No	0-18	0-20	One per 12 months per arch.
D1526	Space maintainer - removable - bilateral, maxillary	01 (UA) 02 (LA)	No	0-18	0-20	One per 12 months per arch.
D1527	Space maintainer - removable - bilateral, mandibular	01 (UA) 02 (LA)	No	0-18	0-20	One per 12 months per arch.
D1550	Re-Cementation Of Space Maintainer	01 (UA) 02 (UA) 10 (UR) 20 (UL) 30 (LL) 40 (LR)	No	0-18	0-20	Not covered within 6 months of initial placement.
D1575	Distal shoe space maintainer- fixed, unilateral	Per quadrant 10 (UR), 20 (UL), 30 (LL), 40 (LR)	No	0-18	0-20	Once per 12 months per quadrant
D2140	Amalgam - One Surface, Primary Or Permanent	1 - 32 51 - 82 (SN) A - T AS - TS (SN)	No	0-18	0-20	1 in 12 months
D2150	Amalgam - Two Surfaces, Primary Or Permanent	1 - 32 51 - 82 (SN) A - T AS - TS (SN)	No	0-18	0-20	1 in 12 months
D2160	Amalgam - Three Surfaces, Primary Or Permanent	1 - 32 51 - 82 (SN) A - T AS - TS (SN)	No	0-18	0-20	1 in 12 months
D2161	Amalgam - Four Or More Surfaces, Primary Or Permanent	1 - 32 51 - 82 (SN) A - T AS - TS (SN)	No	0-18	0-20	1 in 12 months
D2330	Resin-Based Composite - One Surface, Anterior	6 - 11, 22 - 27 56 - 61 (SN) 72 - 77 (SN) C - H, M - R CS - HS (SN) MS - RS (SN)	No	0-18	0-20	1 in 12 months
D2331	Resin-Based Composite - Two Surfaces, Anterior	6 - 11, 22 - 27 56 - 61 (SN) 72 - 77 (SN) C - H, M - R CS - HS (SN) MS - RS (SN)	No	0-18	0-20	1 in 12 months

UHC KanCare CHIP (Ages 0-18) and Medicaid (Ages 0-20)

Code	Code Description	Teeth or Area Covered	Review Required	CHIP Age Range	Medicaid Age Range	Benefit Limitations
D2332	Resin-Based Composite - Three Surfaces, Anterior	6 - 11, 22 - 27 56 - 61 (SN) 72 - 77 (SN) C - H, M - R CS - HS (SN) MS - RS (SN)	No	0-18	0-20	1 in 12 months
D2335	Resin-Based Composite - Four Or More Surfaces Or Involving Incisal Angle	6 - 11, 22 - 27 56 - 61 (SN) 72 - 77 (SN) C - H, M - R CS - HS (SN) MS - RS (SN)	No	0-18	0-20	1 in 12 months
D2390	Resin-Based Composite Crown, Anterior	6 - 11, 22 - 27 56 - 61 (SN) 72 - 77 (SN) C - H, M - R CS - HS (SN) MS - RS (SN)	No	0-18	0-20	1 in 12 months
D2391	Resin-Based Composite - One Surface, Posterior	1 - 5, 12 - 21, 28 - 32 51 - 55 (SN) 62 - 71 (SN) 78 - 82 (SN) A, B, I - L, S, T, AS (SN), BS (SN) IS - LS (SN), SS (SN),TS (SN)	No	0-18	0-20	1 in 12 months
D2392	Resin-Based Composite - Two Surfaces, Posterior	1 - 5, 12 - 21, 28 - 32 51 - 55 (SN) 62 - 71 (SN) 78 - 82 (SN) A, B, I - L, S, T, AS (SN), BS (SN) IS - LS (SN), SS (SN),TS (SN)	No	0-18	0-20	1 in 12 months
D2393	Resin-Based Composite - Three Surfaces, Posterior	1 - 5, 12 - 21, 28 - 32 51 - 55 (SN) 62 - 71 (SN) 78 - 82 (SN) A, B, I - L, S, T, AS (SN), BS (SN) IS - LS (SN), SS (SN),TS (SN)	No	0-18	0-20	1 in 12 months
D2394	Resin-Based Composite - Four Or More Surfaces, Posterior	1 - 5, 12 - 21, 28 - 32 51 - 55 (SN) 62 - 71 (SN) 78 - 82 (SN) A, B, I - L, S, T, AS (SN), BS (SN) IS - LS (SN), SS (SN),TS (SN)	No	0-18	0-20	1 in 12 months

UHC KanCare CHIP (Ages 0-18) and Medicaid (Ages 0-20)

Code	Code Description	Teeth or Area Covered	Review Required	CHIP Age Range	Medicaid Age Range	Benefit Limitations
D2710	Crown - Resin-Based Composite (Indirect)	6 - 11 22 - 27 56 - 61 (SN) 72 - 77 (SN)	Yes	0-18	0-20	Once per 60 months
D2740	Crown - Porcelain/Ceramic Substrate	1 - 32 51 - 82 (SN)	Yes	0-18	0-20	Once per 60 months
D2751	Crown - Porcelain Fused To Predominantly Base Metal	1 - 32 51 - 82 (SN)	Yes	0-18	0-20	Once per 60 months
D2752	Crown - Porcelain Fused To Noble Metal	1 - 32 51 - 82 (SN)	Yes	0-18	0-20	Once per 60 months
D2783	Crown - Full Cast High Noble Metal	1 - 32 51 - 82 (SN)	Yes	0-18	0-20	Once per 60 months
D2791	Crown - 3/4 porcelain/ceramic	1 - 32 51 - 82 (SN)	Yes	0-18	0-20	Once per 60 months
D2792	Crown - Full Cast Noble Metal	1 - 32 51 - 82 (SN)	Yes	0-18	0-20	Once per 60 months
D2910	Recement Inlay, Onlay, Or Partial Coverage Restoration	1 - 32 51 - 82 (SN)	No	0-18	0-20	
D2920	Recement Crown	1 - 32, 51-82 (SN)	No	0-18	0-20	
D2921	Reattachment of tooth fragment, incisal edge or cusp	1 - 32 51 - 82 (SN)	No	0-18	0-20	Not allowed same tooth, same surface(s), same DOS as D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394
D2930	Prefabricated Stainless Steel Crown - Primary Tooth	A - T AS - TS (SN)	No	0-18	0-20	Once per 24 months.D2930 and D2934 cannot be placed on the same tooth during a 24-month period.
D2931	Prefabricated Stainless Steel Crown - Permanent Tooth	1 - 32 51 - 82 (SN)	No	0-18	0-20	Once per 24 months.
D2934	Prefabricated Esthetic coated Stainless Steel Crown - Primary Tooth	C - H, M - R CS - HS (SN) MS - RS (SN)	No	0-18	0-20	Once per 24 months. D2930 and D2934 cannot be placed on the same tooth during a 24-month period.
D2940	Sedative Filling	1 - 32 51 - 82 (SN)	No	0-18	0-20	Temporary restoration intended to relieve pain. Not to be used as a base or liner under a restoration.
D2951	Pin Retention - Per Tooth, In Addition To Restoration	1 - 32 51 - 82 (SN)	No	0-18	0-20	
D2954	Prefabricated Post And Core In Addition To Crown	1 - 32 51 - 82 (SN)	Yes	0-18	0-20	Once per 60 months
D2957	Each additional Prefabricated post - same tooth	1 - 3, 14 - 19, 30 - 32 51- 53 (SN) 64 - 69 (SN) 80 - 82 (SN)	No	0-18	0-20	Once per 60 months
D3110	Pulp Cap Indirect (excluding restoration)	1 - 32 51 - 82(SN)	No	0-18	0-20	
D3220	Therapeutic Pulpotomy	1 - 32 51 - 82(SN) A - T AS - TS	No	0-18	0-20	One per tooth, per lifetime. Not covered within 30 days of D3310 - D3331 on same tooth.

UHC KanCare CHIP (Ages 0-18) and Medicaid (Ages 0-20)

Code	Code Description	Teeth or Area Covered	Review Required	CHIP Age Range	Medicaid Age Range	Benefit Limitations
D3221	Pulpal Debridement	1 - 32 51 - 82(SN) A - T AS - TS	No	0-18	0-20	One per tooth, per lifetime. Not covered within 30 days ofD3310 - D3331 on same tooth.
D3222	Partial Pulpotomy For Apexogenesis - Permanent Tooth	1 - 32 51 - 82(SN)	Yes	0-18	0-20	One per tooth, per lifetime. Should only be performed as preparation for endodontic treatment.
D3310	Endodontic Therapy, Anterior Tooth (Excluding Final Restoration)	6 - 11 22 - 27 56 - 61(SN) 72 - 77(SN)	No	0-18	0-20	One per tooth, per lifetime.
D3320	Endodontic Therapy, Bicuspid Tooth (Excluding Final Restoration)	4, 5, 12, 13, 20, 21, 28, 29, 54(SN), 55(SN), 62(SN), 63(SN), 70(SN), 71(SN), 78(SN), 79(SN)	No	0-18	0-20	One per tooth, per lifetime.
D3330	Endodontic Therapy, Molar (Excluding Final Restoration)	1 - 3, 14 - 19 30 - 32 51 - 53(SN) 64 - 69(SN) 80 - 82(SN)	No	0-18	0-20	One per tooth, per lifetime.
D3331	Treatment of root canal obstruction - non surgical	1 - 32 51 - 82 (SN)	Yes	0-18	0-20	
D3351	Apexification / Recalcification / Pulpal Regeneration - Initial Visit	1 - 32 51 - 82 (SN)	No	0-18	0-20	
D3352	Apexification / Recalcification / Pulpal Regeneration - Interim	1 - 32 51 - 82 (SN)	No	0-18	0-20	
D3353	Apexification / Recalcification / Pulpal Regeneration - Final Visit	1 - 32 51 - 82 (SN)	No	0-18	0-20	
D3410	Apicoectomy / Periradicular Surgery - Anterior	6 - 11, 22 - 27 56 - 61(SN) 72 - 77(SN)	No	0-18	0-20	
D3421	Apicoectomy / Periradicular Surgery - Bicuspid (First Root)	4, 5, 12, 13, 20, 21, 28, 29, 54(SN), 55(SN), 62(SN), 63(SN), 70(SN), 71(SN), 78(SN), 79(SN)	No	0-18	0-20	
D3425	Apicoectomy / Periradicular Surgery - Molar (First Root)	1 - 3, 14 - 19 30 - 32 51 - 53(SN) 64-69(SN) 80 - 82(SN)	No	0-18	0-20	
D3426	Apicoectomy / Periradicular Surgery - Each Additional Root)	1 - 5, 12 - 21 28 - 32 51 - 55(SN) 62 - 71(SN) 78 - 82(SN)	No	0-18	0-20	
D3427	Periradicular surgery without apicoectomy	1 - 32 51 - 82 (SN)	No	0-18	0-20	Not allowed same tooth, same DOS as D3410, D3421, D3425, D3426

UHC KanCare CHIP (Ages 0-18) and Medicaid (Ages 0-20)

Code	Code Description	Teeth or Area Covered	Review Required	CHIP Age Range	Medicaid Age Range	Benefit Limitations
D3430	Retrograde Filling, per root	1 - 32 51 - 82 (SN)	No	0-18	0-20	
D4210	Gingivectomy Or Gingivoplasty - Four Or More Contiguous Teeth	Per quadrant - 10 (UR) 20 (UL) 30 (LL) 40 (LR)	Yes	0-18	0-20	A minimum of four affected teeth in the quadrant.
D4211	Gingivectomy Or Gingivoplasty - One To Three Contiguous Teeth	Per quadrant - 10 (UR) 20 (UL) 30 (LL) 40 (LR)	Yes	0-18	0-20	One to three affected teeth in the quadrant.
D4230	Anatomical Crown Exposure - 4 or more contiguous teeth per quadrant	Per quadrant - 10 (UR) 20 (UL) 30 (LL) 40 (LR)	Yes	0-18	0-20	Must be billed same date same tooth in conjunction with the restorative codes (D2140 - D2957).
D4231	Anatomical Crown Exposure - 1- 3 contiguous teeth per quadrant	Per quadrant - 10 (UR) 20 (UL) 30 (LL) 40 (LR)	Yes	0-18	0-20	Same date and same tooth in conjunction with the restorative code.
D4268	Surgical Revision Procedure per tooth	1 - 32 51 - 82 (SN)	Yes	0-18	0-20	Only covered after D4210.
D4341	Periodontal Scaling And Root Planing - Four Or More Teeth Per Quadrant	Per quadrant - 10 (UR) 20 (UL) 30 (LL) 40 (LR)	Yes	0-18	0-20	Four per 12 months. A minimum of four affected teeth in the quadrant.
D4342	Periodontal Scaling And Root Planing - One To Three Teeth Per Quadrant	Per quadrant - 10 (UR) 20 (UL) 30 (LL) 40 (LR)	Yes	0-18	0-20	Four per 12 months. One to three affected teeth in the quadrant.
D4346	Scaling in presence of generalized moderate or severe gingival inflammation- full mouth, after oral evaluation		Yes	0-18	0-20	Once per 12 months. Not covered on the same DOS as D1110, D1120, D4341, D4342, D4355, or D4910
D4355	Full Mouth Debridement		No	0-18	0-20	One per 12 months.
D5110	Complete Denture - Maxillary		Yes	0-18	0-20	One per 60 months.
D5120	Complete Denture - Mandibular		Yes	0-18	0-20	One per 60 months.
D5211	Maxillary Partial Denture - Resin Base		Yes	0-18	0-20	One per 60 months.
D5212	Mandibular Partial Denture - Resin Base		Yes	0-18	0-20	One per 60 months.
D5213	Maxillary Partial Denture - Cast Metal Framework With Resin Denture Bases		Yes	0-18	0-20	One per 60 months.
D5214	Mandibular Partial Denture - Cast Metal Framework With Resin Denture Bases		Yes	0-18	0-20	One per 60 months.

UHC KanCare CHIP (Ages 0-18) and Medicaid (Ages 0-20)

Code	Code Description	Teeth or Area Covered	Review Required	CHIP Age Range	Medicaid Age Range	Benefit Limitations
D5225	Maxillary Partial Denture - Flexible Base		Yes	0-18	0-20	One per 60 months.
D5226	Mandibular Partial Denture - Flexible Base		Yes	0-18	0-20	One per 60 months.
D5282	Removable unilateral partial denture - one piece cast metal (including clasps and teeth), maxillary	Per quadrant - 10 (UR) 20 (UL) 30 (LL) 40 (LR)	Yes	0-18	0-20	One per 60 months
D5283	Removable unilateral partial denture - one piece cast metal (including clasps and teeth), mandibular	Per quadrant - 10 (UR) 20 (UL) 30 (LL) 40 (LR)	Yes	0-18	0-20	One per 60 months
D5410	Adjust Complete Denture - Maxillary		No	0-18	0-20	Not covered within 6 months of placement
D5411	Adjust Complete Denture - Mandibular		No	0-18	0-20	Not covered within 6 months of placement
D5421	Adjust Partial Denture - Maxillary		No	0-18	0-20	Not covered within 6 months of placement
D5422	Adjust Partial Denture - Mandibular		No	0-18	0-20	Not covered within 6 months of placement
D5511	Repair broken complete denture base, mandibular		No	0-18	0-20	
D5512	Repair broken complete denture base, maxillary		No	0-18	0-20	
D5520	Replace Missing Or Broken Teeth - Complete Denture (Each Tooth)	1 - 32	No	0-18	0-20	
D5611	Repair resin partial denture base, mandibular	02 (LA) 30 (LL) 40 (LR)	No	0-18	0-20	
D5612	Repair resin partial denture base, maxillary	01 (UA) 10 (UR) 20 (UL)	No	0-18	0-20	
D5621	Repair cast partial framework, mandibular	02 (LA) 30 (LL) 40 (LR)	No	0-18	0-20	
D5622	Repair cast partial framework, maxillary	01 (UA) 10 (UR) 20 (UL)	No	0-18	0-20	
D5630	Repair Or Replace Broken Clasp	1 (UA) 2 (LA) 10 (UR) 20 (UL) 30 (LL) 40 (LR)	No	0-18	0-20	
D5640	Replace Broken Teeth - Per Tooth	1 - 32	No	0-18	0-20	
D5650	Add Tooth To Existing Partial Denture	1 - 32	No	0-18	0-20	

UHC KanCare CHIP (Ages 0-18) and Medicaid (Ages 0-20)

Code	Code Description	Teeth or Area Covered	Review Required	CHIP Age Range	Medicaid Age Range	Benefit Limitations
D5660	Add Clasp To Existing Partial Denture	1 (UA) 2 (LA) 10 (UR) 20 (UL) 30 (LL) 40 (LR)	No	0-18	0-20	
D5670	Replace all teeth and acrylic on cast metal framework (maxillary)		No	0-18	0-20	
D5671	Replace all teeth and acrylic on cast metal framework (maxillary)		No	0-18	0-20	
D5750	Reline Complete Maxillary Denture (Laboratory)		No	0-18	0-20	One per 24 months. Not covered within 24 months of placement.
D5751	Reline Complete Mandibular Denture (Laboratory)		No	0-18	0-20	One per 24 months. Not covered within 24 months of placement.
D5760	Reline Maxillary Partial Denture (Laboratory)		No	0-18	0-20	One per 24 months. Not covered within 24 months of placement.
D5761	Reline Mandibular Partial Denture (Laboratory)		No	0-18	0-20	One per 24 months. Not covered within 24 months of placement.
D5850	Tissue Conditioning, Maxillary		No	0-18	0-20	
D5851	Tissue Conditioning, Mandibular		No	0-18	0-20	
D6081	Scaling and debridement in the presence of inflammation or mucositis of a single implant, including cleaning of the implant surfaces, without flap entry and closure		Yes	0-18	0-20	Once per 12 months
D6100	Implant Removal by report	1-32 51-82 (SN)	Yes	15-18	15-20	
D6930	Recement Fixed Partial Denture	1 (UA) 2 (LA) 10 (UR) 20 (UL) 30 (LL) 40 (LR)	No	0-18	0-20	
D7140	Extraction, Erupted Tooth Or Exposed Root	1 - 32 51- 82 (SN) A - T AS - TS (SN)	No	0-18	0-20	
D7210	Surgical Removal Or Erupted Tooth	1 - 32 51- 82 (SN) A - T AS - TS (SN)	No	0-18	0-20	Includes cutting of gingiva and bone, removal of tooth structure, and closure.
D7220	Removal Of Impacted Tooth - Soft Tissue	1-32 51-82 (SN)	Yes	0-18	0-20	Includes cutting of gingiva and bone, removal of tooth structure, and closure.
D7230	Removal Of Impacted Tooth - Partially Bony	1-32 51-82 (SN)	Yes	0-18	0-20	Includes cutting of gingiva and bone, removal of tooth structure, and closure.
D7240	Removal Of Impacted Tooth - Completely Bony	1-32 51-82 (SN)	Yes	0-18	0-20	Includes cutting of gingiva and bone, removal of tooth structure, and closure.
D7241	Removal Of Impacted Tooth - Completely Bony, Unusual Surgical Complications	1-32 51-82 (SN)	Yes	0-18	0-20	Includes cutting of gingiva and bone, removal of tooth structure, and closure. Unusual complications such as nerve dissection, separate closure of the maxillary sinus, or aberrant tooth position.

UHC KanCare CHIP (Ages 0-18) and Medicaid (Ages 0-20)

Code	Code Description	Teeth or Area Covered	Review Required	CHIP Age Range	Medicaid Age Range	Benefit Limitations
D7250	Surgical Removal Of Residual Tooth (Cutting Procedure)	1 - 32 51- 82 (SN) A - T AS - TS (SN)	No	0-18	0-20	Includes cutting of gingiva and bone, removal of tooth structure, and closure. Will not be paid to the providers or group that originally removed the tooth.
D7260	Oroantral Fistula Closure		No	0-18	0-20	
D7270	Reimplantation And/Or Stabilization Of Accidentally Evulsed / Displaced Tooth	1 - 32 51- 82 (SN) A - T AS - TS (SN)	No	0-18	0-20	Includes splinting and/or stabilization.
D7280	Surgical Access Of An Unerupted Tooth	1-32 51-82 (SN)	Yes	0-18	0-20	Will not be payable unless the orthodontic treatment has been authorized as a covered benefit.
D7285	Biopsy of Oral Tissue, Hard		No	0-18	0-20	
D7286	Biopsy of Oral Tissue, Soft		No	0-18	0-20	
D7320	Alveoloplasty Not In Conjunction With Extractions - Four Or More Teeth	Per quadrant - 10 (UR) 20 (UL) 30 (LL) 40 (LR)	Yes	0-18	0-20	No extractions performed in an edentulous area.
D7350	Vesibuloplasty - Ridge Extension (Including Soft Tissue Grafts)	Per quadrant - 10 (UR) 20 (UL) 30 (LL) 40 (LR)	Yes	0-18	0-20	
D7410	Excision Of Pericoronal Gingiva		No	0-18	0-20	
D7411	Excision Of Benign Lesion Greater Than 1.25 Cm		No	0-18	0-20	
D7412	Excision Of Benign Lesion, Complicated		No	0-18	0-20	
D7413	Excision Of Malignant Lesion Up To 1.25 Cm		No	0-18	0-20	
D7414	Excision Of Malignant Lesion Greater Than 1.25 Cm		No	0-18	0-20	
D7415	Excision Of Malignant Lesion, Complicated		No	0-18	0-20	
D7440	Excision Of Malignant Tumor - Lesion Diameter Up To 1.25 Cm		No	0-18	0-20	
D7441	Excision Of Malignant Tumor - Lesion Diameter Greater Than 1.25 Cm		No	0-18	0-20	
D7450	Removal Of Benign Odontogenic Cyst Or Tumor - Dia Up To 1.25 Cm		No	0-18	0-20	
D7451	Removal Of Benign Odontogenic Cyst Or Tumor - Dia Greater Than 1.25 Cm		No	0-18	0-20	
D7460	Removal Of Benign Nonodontogenic Cyst Or Tumor - Dia Up To 1.25 Cm		No	0-18	0-20	

UHC KanCare CHIP (Ages 0-18) and Medicaid (Ages 0-20)

Code	Code Description	Teeth or Area Covered	Review Required	CHIP Age Range	Medicaid Age Range	Benefit Limitations
D7461	Removal Of Benign Nonodontogenic Cyst Or Tumor - Dia Greater Than 1.25 Cm		No	0-18	0-20	
D7471	Removal Of Lateral Exostosis (Maxilla Or Mandible)	1 (UA) 2 (LA)	Yes	0-18	0-20	Once per lifetime.
D7472	Removal Of Torus Palatinus		Yes	0-18	0-20	Once per lifetime.
D7473	Removal Of Torus Mandibularis		Yes	0-18	0-20	Once per lifetime.
D7490	Radical Resection Of Maxilla Or Mandible	1 (UA) 2 (LA)	No	0-18	0-20	
D7510	Incision And Drainage Of Abscess - Intraoral Soft Tissue		No	0-18	0-20	Not covered same date of service as D7511.
D7511	Incision And Drainage Of Abscess - Intraoral Soft Tissue - Complicated		No	0-18	0-20	
D7520	Incision And Drainage Of Abscess - Extraoral Soft Tissue		No	0-18	0-20	Not covered same date of service as D7521.
D7521	Incision And Drainage Of Abscess - Extraoral Soft Tissue - Complicated		No	0-18	0-20	
D7530	Removal Of Foreign Body From Mucosa		No	0-18	0-20	
D7540	Removal Of Reaction Producing Foreign Bodies		No	0-18	0-20	
D7550	partial ostectomy/sequestrectomy for removal of non-vital bone		No	0-18	0-20	
D7560	maxillary sinusotomy for removal of tooth fragment or foreign body		No	0-18	0-20	
D7610	maxilla - open reduction (teeth immobilized, if present)		No	0-18	0-20	
D7620	maxilla - closed reduction (teeth immobilized, if present)		No	0-18	0-20	
D7630	mandible - open reduction (teeth immobilized, if present)		No	0-18	0-20	
D7640	mandible - closed reduction (teeth immobilized, if present)		No	0-18	0-20	
D7650	malar and/or zygomatic arch - open reduction		No	0-18	0-20	
D7660	malar and/or zygomatic arch - closed reduction		No	0-18	0-20	
D7670	alveolus - closed reduction, may include stabilization of teeth	1 - 32	No	0-18	0-20	May include stabilization.
D7680	facial bones - complicated reduction with fixation and multiple surgical approaches		Yes	0-18	0-20	
D7710	maxilla - open reduction		No	0-18	0-20	
D7720	maxilla - closed reduction		No	0-18	0-20	
D7730	mandible - open reduction		No	0-18	0-20	
D7740	mandible - closed reduction		No	0-18	0-20	
D7750	malar and/or zygomatic arch - open reduction		No	0-18	0-20	

UHC KanCare CHIP (Ages 0-18) and Medicaid (Ages 0-20)

Code	Code Description	Teeth or Area Covered	Review Required	CHIP Age Range	Medicaid Age Range	Benefit Limitations
D7760	malar and/or zygomatic arch - closed reduction		No	0-18	0-20	
D7770	alveolus, open reduction stabilization of teeth		No	0-18	0-20	
D7780	facial bones - complicated reduction with fixation and multiple surgical approaches		No	0-18	0-20	
D7820	Closed Reduction Of Dislocation		No	0-18	0-20	
D7860	Arthrotomy		Yes	0-18	0-20	
D7865	Arthroplasty		Yes	0-18	0-20	
D7910	Suture Of Recent Small Wounds Up To 5 Cm		No	0-18	0-20	Not covered on same day as D7140, D7210, D7220, D7230, D7240, D7241, or D7250.
D7911	Complicated Suture - Up To 5 Cm		No	0-18	0-20	Not covered on same day as D7140, D7210, D7220, D7230, D7240, D7241, or D7250.
D7912	Complicated Suture - Greater Than 5 Cm		No	0-18	0-20	Not covered on same day as D7140, D7210, D7220, D7230, D7240, D7241, or D7250.
D7920	Skin Graft	1 (UA) 2 (LA) 10 (UR) 20 (UL) 30 (LL) 40 (LR)	Yes	0-18	0-20	
D7955	Repair of Maxillofacial soft or hard tissue		Yes	0-18	0-20	
D7960	Frenulectomy	1 (UA) 2 (LA)	No	0-18	0-20	Once per lifetime. Per location Lingual, Buccal or Labial. Not covered same date of service as D7963.The frenum may be excised when the tongue has limited mobility; for large diastemas between teeth, or when the frenum interferes with a prosthetic appliance; or when it is the etiology of periodontal tissue disease.
D7963	Frenuloplasty		No	0-18	0-20	Excision of frenum with excision or repositioning of abervant muscle and z-plasty or other local flap closure.
D7971	Excision Of Pericoronal Gingiva	1 - 32	No	0-18	0-20	
D7979	Non-surgical sialolithotomy		No	0-18	0-20	
D7980	Sialolithotomy		No	0-18	0-20	
D7981	excision of salivary gland, by report		No	0-18	0-20	
D7982	Sialodochoplasty		No	0-18	0-20	
D7983	Closure of Salivary Fistula		No	0-18	0-20	
D7990	Emergency Tracheotomy		No	0-18	0-20	
D8010	Limited Orthodontic Treatment Of The Primary Dentition		Yes – Prior Auth required	0-18	0-20	Limited to one replacement. Limited orthodontic treatment requires prior authorization and is only covered for eligible children with documented medical necessity.

UHC KanCare CHIP (Ages 0-18) and Medicaid (Ages 0-20)

Code	Code Description	Teeth or Area Covered	Review Required	CHIP Age Range	Medicaid Age Range	Benefit Limitations
D8020	Limited Orthodontic Treatment Of The Transitional Dentition		Yes – Prior Auth required	0-18	0-20	Limited to one replacement. Limited orthodontic treatment requires prior authorization and is only covered for eligible children with documented medical necessity.
D8050	Interceptive Orthodontic Treatment Of The Primary Dentition		Yes – Prior Auth required	0-18	0-20	Interceptive orthodontic treatment requires prior authorization and is only covered for eligible children with documented medical necessity.
D8060	Interceptive Orthodontic Treatment Of The Transitional Dentition		Yes – Prior Auth required	0-18	0-20	Interceptive orthodontic treatment requires prior authorization and is only covered for eligible children with documented medical necessity.
D8070	Comprehensive Orthodontic Treatment Of The Transitional Dentition		Yes – Prior Auth required	0-18	0-20	Comprehensive orthodontic treatment requires prior authorization and is only covered for eligible children with documented medical necessity.
D8080	Comprehensive Orthodontic Treatment Of The Adolescent Dentition		Yes – Prior Auth required	0-18	0-20	Comprehensive orthodontic treatment requires prior authorization and is only covered for eligible children with documented medical necessity.
D8210	Removable Appliance Therapy		Yes – Prior Auth required	0-18	0-20	Limited to one replacement. Removable appliance therapy requires prior authorization and is only covered for eligible children with documented medical necessity.
D8220	Fixed Appliance Therapy		Yes – Prior Auth required	0-18	0-20	Limited to one replacement. Removable appliance therapy requires prior authorization and is only covered for eligible children with documented medical necessity.
D8999	Unspecified Orthodontic Procedure, By Report		Yes – Prior Auth required	0-18	0-20	All orthodontic treatment requires prior authorization and is only covered for eligible children with documented medical necessity.
D9130	Temporomandibular joint dysfunction - non-invasive physical therapies		Yes	0-18	0-20	
D9212	Trigeminal Division Block		Yes	0-18	0-20	
D9219	Evaluation for deep sedation or general anesthesia		No	0-18	0-20	1 per patient per 12 months and limited to 1 per patient per provider in a lifetime.
D9222	Deep sedation/general anesthesia - first 15 minutes		Yes	0-18	0-20	
D9223	Deep sedation/general anesthesia - each subsequent 15 minute increment		Yes	0-18	0-20	
D9230	Inhalation Of Nitrous/Analgesia, Anxiolysis		No	0-18	0-20	Not covered when billed with only diagnostic and/or preventative services (D0120 through D1203, D1515 through D1550, D9410, D9420).

UHC KanCare CHIP (Ages 0-18) and Medicaid (Ages 0-20)

Code	Code Description	Teeth or Area Covered	Review Required	CHIP Age Range	Medicaid Age Range	Benefit Limitations
D9239	Intravenous moderate (conscious) sedation/ analgesia - first 15 minutes		Yes	0-18	0-20	Narrative of medical necessity/treatment plan must be submitted with claim.
D9243	Intravenous moderate (conscious) sedation/anesthesia – each 15 minute increment		Yes	0-18	0-20	
D9310	Consultation - Diagnostic Service Provided By Dentist Or Physician		No	0-18	0-20	One per 12 months by same provider. One inpatient follow-up per beneficiary within a 10 day period by same provider. Not covered on same date of service as D0120 -D0170, D9410, D9420.
D9311	Consultation with a medical health care professional		No	0-18	0-20	Once per 12 months by same provider. One inpatient follow- up per beneficiary within a 10 day period by same provider. Not covered on same DOS as D0120, D0170, D9410, or D9420
D9410	House/Extended Care Facility Call		No	0-18	0-20	Extended Care Facilities only.
D9420	Hospital Or Ambulatory Surgical Center Call		No	0-18	0-20	Hospital Facilities only
D9610	Therapeutic Drug Injection, By report		Yes	0-18	0-20	
D9613	Infiltration of sustained release therapeutic drug - single or multiple sites		No	0-18	0-20	
D9920	Behavior Management, By Report		Yes	0-18	0-20	
D9999	Unspecified Adjunctive Procedure, By Report		Yes	0-18	0-20	

UHC KanCare Medicaid/Title 19 Adults 21 and Over

Effective 1/1/19, limited preventative and restorative services for members age 21 and over are covered under this plan with an annual maximum of $500.00

Code	Code Description	Teeth or Area Covered	Review Required	Age Range	Benefit Limitations
D0120	Periodic Oral Evaluation - Established Patient		No	21+	Only one exam every 6 months per provider or provider billing group. Only one exam (D0120, D0140, D0150, D0170) per date of service, per beneficiary, per provider or provider billing group
D0140	Limited Oral Evaluation - Problem Focused		No	21+	Only one exam (D0120, D0140, D0150, D0170) per date of service, per beneficiary, per provider or provider billing group. Limited oral evaluation is only covered when performed in conjunction with treatment to address an emergency situation. An emergency is defined as treatment medically necessary to treat pain, infection, swelling, uncontrolled bleeding, or traumatic injury.
D0150	Comprehensive Oral Evaluation - New Or Established Patient		No	21+	One comprehensive exam per beneficiary, per provider or provider billing group per lifetime. Only one exam (D0120 or D0150) every six months per beneficiary, per provider or provider billing group.

UHC KanCare Medicaid/Title 19 Adults 21 and Over

Effective 1/1/19, limited preventative and restorative services for members age 21 and over are covered under this plan with an annual maximum of $500.00

Code	Code Description	Teeth or Area Covered	Review Required	Age Range	Benefit Limitations
D0170	Reevaluation - limited, problem focused		No	21+	One per 12 months. Established beneficiary to assess the status of a previously existing condition (not post-operative visit). Not covered with any other procedure other than radiographs.
D0210	Intraoral - Complete Series (Including Bitewings)		No	21+	One per 36 months. The following are also considered an Intraoral Complete Series (D0210) D0330 and D0272 D0330 and D0273 D0330 and D0274 D0330 and D0277
D0220	Intraoral - Periapical First Film		No	21+	One per day. Any additional films (D0220 - D0340) performed on the same date of service as a complete intraoral series, or its equivalent, are considered content of service of the complete series and will not be reimbursed.
D0230	Intraoral - Periapical Each Additional Film		No	21+	Any additional films (D0220 - D0340) performed on the same date of service as a complete intraoral series, or its equivalent, are considered content of service of the complete series and will not be reimbursed.
D0240	Intraoral - Occlusal Film		No	21+	Any additional films (D0220 - D0340) performed on the same date of service as a complete intraoral series, or its equivalent, are considered content of service of the complete series and are not reimbursed.
D0250	Extraoral – 2d projection radiographic image created using a stationary radiation source, and detector		No	21+	Any additional films (D0220 - D0340) performed on the same date of service as a complete intraoral series, or its equivalent, are considered content of service of the complete series and are not reimbursed.
D0251	Extraoral – First Radiographic Image		No	21+	Any additional films (D0220 - D0340) performed on the same date of service as a complete intraoral series, or its equivalent, are considered content of service of the complete series and are not reimbursed.
D0270	Bitewing - Single Film		No	21+	Any additional films (D0220 - D0340) performed on the same date of service as a complete intraoral series, or its equivalent, are considered content of service of the complete series and are not reimbursed. Only one bitewing code (D0270, D0272, D0273, D0274, D0277) per date of service, per beneficiary, per provider or provider billing group.
D0272	Bitewings - Two Films		No	21+	Any additional films (D0220 - D0340) performed on the same date of service as a complete intraoral series, or its equivalent, are considered content of service of the complete series and are not reimbursed. Only one bitewing code (D0270, D0272, D0273, D0274, D0277) per date of service, per beneficiary, per provider or provider billing group.
D0273	Bitewings - Three Films		No	21+	Any additional films (D0220 - D0340) performed on the same date of service as a complete intraoral series, or its equivalent, are considered content of service of the complete series and are not reimbursed. Only one bitewing code (D0270, D0272, D0273, D0274, D0277) per date of service, per beneficiary, per provider or provider billing group.

UHC KanCare Medicaid/Title 19 Adults 21 and Over

Effective 1/1/19, limited preventative and restorative services for members age 21 and over are covered under this plan with an annual maximum of $500.00

Code	Code Description	Teeth or Area Covered	Review Required	Age Range	Benefit Limitations
D0274	Bitewings - Four Films		No	21+	Any additional films (D0220 - D0340) performed on the same date of service as a complete intraoral series, or its equivalent, are considered content of service of the complete series and are not reimbursed. Only one bitewing code (D0270, D0272, D0273, D0274, D0277) per date of service, per beneficiary, per provider or provider billing group.
D0330	Panoramic Film		No	21+	One per 36 months. The following are also considered an Intraoral Complete Series (D0210) D0330 and D0272 D0330 and D0273 D0330 and D0274 D0330 and D0277
D1110	Prophylaxis - Adult		No	21+	One per 12 months. Includes scaling and polishing procedures to remove coronal plaque, calculus, and stains. Note: UnitedHealthcare's value added benefit may differ from other health plans.
D2140	Amalgam - One Surface, Primary Or Permanent	All Teeth (Teeth 1 through 32, A through T)	No	21+	One per 12 months. Note: UnitedHealthcare's value added benefit may differ from other health plans.
D2150	Amalgam - Two Surfaces, Primary Or Permanent	All Teeth (Teeth 1 through 32, A through T)	No	21+	One per 12 months. Note: UnitedHealthcare's value added benefit may differ from other health plans.
D2160	Amalgam - Three Surfaces, Primary Or Permanent	All Teeth (Teeth 1 through 32, A through T)	No	21+	One per 12 months. Note: UnitedHealthcare's value added benefit may differ from other health plans.
D2161	Amalgam - Four Or More Surfaces, Primary Or Permanent	All Teeth (Teeth 1 through 32, A through T)	No	21+	One per 12 months. Note: UnitedHealthcare's value added benefit may differ from other health plans.
D2330	Resin-Based Composite - One Surface, Anterior	Anterior Teeth (Teeth 6 - 11, 22 - 27, C - H, M - R)	No	21+	One per 12 months. Note: UnitedHealthcare's value added benefit may differ from other health plans.
D2331	Resin-Based Composite - Two Surfaces, Anterior	Anterior Teeth (Teeth 6 - 11, 22 - 27, C - H, M - R)	No	21+	One per 12 months. Note: UnitedHealthcare's value added benefit may differ from other health plans.
D2332	Resin-Based Composite - Three Surfaces, Anterior	Anterior Teeth (Teeth 6 - 11, 22 - 27, C - H, M - R)	No	21+	One per 12 months. Note: UnitedHealthcare's value added benefit may differ from other health plans.
D2335	Resin-Based Composite - Four Or More Surfaces Or Involving Incisal Angle	Anterior Teeth (Teeth 6 - 11, 22 - 27, C - H, M - R)	No	21+	One per 12 months. Note: UnitedHealthcare's value added benefit may differ from other health plans.
D2391	Resin-Based Composite - One Surface, Posterior	Posterior Teeth (1-5, 12-21, 28-32, A, B, I, J, K, L, S, T)	No	21+	One per 12 months. Note: UnitedHealthcare's value added benefit may differ from other health plans.

UHC KanCare Medicaid/Title 19 Adults 21 and Over

Effective 1/1/19, limited preventative and restorative services for members age 21 and over are covered under this plan with an annual maximum of $500.00

Code	Code Description	Teeth or Area Covered	Review Required	Age Range	Benefit Limitations
D2392	Resin-Based Composite - Two Surfaces, Posterior	Posterior Teeth (1-5, 12-21, 28-32, A, B, I, J, K, L, S, T)	No	21+	One per 12 months. Note: UnitedHealthcare's value added benefit may differ from other health plans.
D2393	Resin-Based Composite - Three Surfaces, Posterior	Posterior Teeth (1-5, 12-21, 28-32, A, B, I, J, K, L, S, T)	No	21+	One per 12 months. Note: UnitedHealthcare's value added benefit may differ from other health plans.
D2394	Resin-Based Composite - Four Or More Surfaces, Posterior	Posterior Teeth (1-5, 12-21, 28-32, A, B, I, J, K, L, S, T)	No	21+	One per 12 months. Note: UnitedHealthcare's value added benefit may differ from other health plans.
D6100	Implant Removal – by Report	1-32 51-82 (SN)	Yes	21+	
D7140	Extraction, Erupted Tooth Or Exposed Root	1 - 32 51- 82 (SN) A - T AS - TS (SN)	No	21+	
D7210	Surgical Removal Or Erupted Tooth	1 - 32 51- 82 (SN) A - T AS - TS (SN)	No	21+	Includes cutting of gingiva and bone, removal of tooth structure, and closure.
D7220	Removal Of Impacted Tooth - Soft Tissue	1-32 51-82 (SN)	Yes	21+	Includes cutting of gingiva and bone, removal of tooth structure, and closure.
D7230	Removal Of Impacted Tooth - Partially Bony	1-32 51-82 (SN)	Yes	21+	Includes cutting of gingiva and bone, removal of tooth structure, and closure.
D7240	Removal Of Impacted Tooth - Completely Bony	1-32 51-82 (SN)	Yes	21+	Includes cutting of gingiva and bone, removal of tooth structure, and closure.
D7241	Removal Of Impacted Tooth - Completely Bony, Unusual Surgical Complications	1-32 51-82 (SN)	Yes	21+	Includes cutting of gingiva and bone, removal of tooth structure, and closure. Unusual complications such as nerve dissection, separate closure of the maxillary sinus, or aberrant tooth position.
D7250	Surgical Removal Of Residual Tooth (Cutting Procedure)	1 - 32 51- 82 (SN) A - T AS - TS (SN)	No	21+	Includes cutting of gingiva and bone, removal of tooth structure, and closure. Will not be paid to the providers or group that originally removed the tooth.
D7260	Oroantral Fistula Closure		No	21+	
D7285	Biopsy of Oral Tissue, Hard		No	21+	
D7286	Biopsy of Oral Tissue, Soft		No	21+	
D7410	Excision Of Pericoronal Gingiva		No	21+	
D7411	Excision Of Benign Lesion Greater Than 1.25 Cm		No	21+	
D7412	Excision Of Benign Lesion, Complicated		No	21+	
D7413	Excision Of Malignant Lesion Up To 1.25 Cm		No	21+	
D7414	Excision Of Malignant Lesion Greater Than 1.25 Cm		No	21+	

UHC KanCare Medicaid/Title 19 Adults 21 and Over

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Code	Code Description	Teeth or Area Covered	Review Required	Age Range	Benefit Limitations
D7415	Excision Of Malignant Lesion, Complicated		No	21+	
D7440	Excision Of Malignant Tumor - Lesion Diameter Up To 1.25 Cm		No	21+	
D7441	Excision Of Malignant Tumor - Lesion Diameter Greater Than 1.25 Cm		No	21+	
D7450	Removal Of Benign Odontogenic Cyst Or Tumor - Dia Up To 1.25 Cm		No	21+	
D7451	Removal Of Benign Odontogenic Cyst Or Tumor - Dia Greater Than 1.25 Cm		No	21+	
D7460	Removal Of Benign Nonodontogenic Cyst Or Tumor - Dia Up To 1.25 Cm		No	21+	
D7461	Removal Of Benign Nonodontogenic Cyst Or Tumor - Dia Greater Than 1.25 Cm		No	21+	
D7471	Removal Of Lateral Exostosis (Maxilla Or Mandible)	1 (UA) 2 (LA)	Yes	21+	Once per lifetime.
D7472	Removal Of Torus Palatinus		Yes	21+	Once per lifetime.
D7473	Removal Of Torus Mandibularis		Yes	21+	Once per lifetime.
D7490	Radical Resection Of Maxilla Or Mandible	1 (UA) 2 (LA)	No	21+	
D7510	Incision And Drainage Of Abscess - Intraoral Soft Tissue		No	21+	Not covered same date of service as D7511.
D7511	Incision And Drainage Of Abscess - Intraoral Soft Tissue - Complicated		No	21+	
D7520	Incision And Drainage Of Abscess - Extraoral Soft Tissue		No	21+	Not covered same date of service as D7521.
D7521	Incision And Drainage Of Abscess - Extraoral Soft Tissue - Complicated		No	21+	
D7530	Removal Of Foreign Body From Mucosa		No	21+	
D7540	Removal Of Reaction Producing Foreign Bodies		No	21+	
D7550	partial ostectomy/ sequestrectomy for removal of non-vital bone		No	21+	
D7560	maxillary sinusotomy for removal of tooth fragment or foreign body		No	21+	

UHC KanCare Medicaid/Title 19 Adults 21 and Over

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Code	Code Description	Teeth or Area Covered	Review Required	Age Range	Benefit Limitations
D7610	maxilla - open reduction (teeth immobilized, if present)		No	21+	
D7620	maxilla - closed reduction (teeth immobilized, if present)		No	21+	
D7630	mandible - open reduction (teeth immobilized, if present)		No	21+	
D7640	mandible - closed reduction (teeth immobilized, if present)		No	21+	
D7650	malar and/or zygomatic arch - open reduction		No	21+	
D7660	malar and/or zygomatic arch - closed reduction		No	21+	
D7670	alveolus - closed reduction, may include stabilization of teeth	1 - 32	No	21+	May include stabilization.
D7680	facial bones - complicated reduction with fixation and multiple surgical approaches		Yes	21+	
D7710	maxilla - open reduction		No	21+	
D7720	maxilla - closed reduction		No	21+	
D7730	mandible - open reduction		No	21+	
D7740	mandible - closed reduction		No	21+	
D7750	malar and/or zygomatic arch - open reduction		No	21+	
D7760	malar and/or zygomatic arch - closed reduction		No	21+	
D7770	alveolus, open reduction stabilization of teeth		No	21+	
D7780	facial bones - complicated reduction with fixation and multiple surgical approaches		No	21+	
D7820	Closed Reduction Of Dislocation		No	21+	
D7860	Arthrotomy		Yes	21+	
D7910	Suture Of Recent Small Wounds Up To 5 Cm		No	21+	Not covered on same day as D7140, D7210, D7220, D7230, D7240, D7241, or D7250.
D7911	Complicated Suture - Up To 5 Cm		No	21+	Not covered on same day as D7140, D7210, D7220, D7230, D7240, D7241, or D7250.
D7912	Complicated Suture - Greater Than 5 Cm		No	21+	Not covered on same day as D7140, D7210, D7220, D7230, D7240, D7241, or D7250.

UHC KanCare Medicaid/Title 19 Adults 21 and Over

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Code	Code Description	Teeth or Area Covered	Review Required	Age Range	Benefit Limitations
D7920	Skin Graft	1 (UA) 2 (LA) 10 (UR) 20 (UL) 30 (LL) 40 (LR)	Yes	21+	
D7955	Repair of Maxillofacial soft or hard tissue		Yes	21+	
D7960	Frenulectomy	1 (UA) 2 (LA)	No	21+	Once per lifetime. Per location Lingual, Buccal or Labial. Not covered same date of service as D7963. The frenum may be excised when the tongue has limited mobility; for large diastemas between teeth, or when the frenum interferes with a prosthetic appliance; or when it is the etiology of periodontal tissue disease.
D7963	Frenuloplasty		No	21+	Excision of frenum with excision or repositioning of abervant muscle and z- plasty or other local flap closure.
D7971	Excision Of Pericoronal Gingiva	1 - 32	No	21+	
D7980	Sialolithotomy		No	21+	
D7981	excision of salivary gland, by report		No	21+	
D7982	Sialodochoplasty		No	21+	
D7983	Closure of Salivary Fistula		No	21+	
D7990	Emergency Tracheotomy		No	21+	
D9212	Trigeminal Division Block		Yes	21+	
D9219	Evaluation for deep sedation or general anesthesia		No	21+	1 per patient per 12 months and limited to 1 per patient per provider in a lifetime.
D9222	Deep sedation/general anesthesia - first 15 minutes		Yes	21+	
D9223	Deep sedation/general anesthesia - each subsequent 15 minute increment		Yes	21+	
D9230	Inhalation Of Nitrous/ Analgesia, Anxiolysis		No	21+	Not covered when billed with only diagnostic and/or preventative services (D0120 through D1203, D1515 through D1550, D9410, D9420).
D9243	Intravenous moderate (conscious) sedation/ anesthesia – each 15 minute increment		Yes	21+	
D9310	Consultation - Diagnostic Service Provided By Dentist Or Physician		No	21+	One per 12 months by same provider. One inpatient follow up per beneficiary within a 10 day period by same provider. Not covered on same date of service as D0120 -D0170, D9410, D9420.
D9311	Consultation with a medical health care professional		No	21+	Once per 12 months by same provider. One inpatient follow- up per beneficiary within a 10 day period by same provider. Not covered on same DOS as D0120, D0170, D9410, or D9420

UHC KanCare Medicaid/Title 19 Adults 21 and Over

Effective 1/1/19, limited preventative and restorative services for members age 21 and over are covered under this plan with an annual maximum of $500.00

Code	Code Description	Teeth or Area Covered	Review Required	Age Range	Benefit Limitations
D9410	House/Extended Care Facility Call		No	21+	Extended Care Facilities only.
D9420	Hospital Or Ambulatory Surgical Center Call		No	21+	Hospital Facilities only
D9610	Therapeutic Drug Injection, By report		Yes	21+	
D9613	Infiltration of sustained release therapueutic drug - single or multiple sites		No	21+	

UHC KanCare Medicaid/Title 19 - Frail and Elderly

Effective 1/1/19, limited preventative and restorative services for members age 21 and over are covered under this plan with an annual maximum of $500.00

Code	Code Description	Teeth or Area Covered	Review Required	Age Range	Benefit Limitations
D0120	Periodic Oral Evaluation - Established Patient		No	65+	Only one exam every 6 months per provider or provider billing group. Only one exam (D0120, D0140, D0150, D0170) per date of service, per beneficiary, per provider or provider billing group
D0140	Limited Oral Evaluation - Problem Focused		No	65+	Only one exam (D0120, D0140, D0150, D0170) per date of service, per beneficiary, per provider or provider billing group. Limited oral evaluation is only covered when performed in conjunction with treatment to address an emergency situation. An emergency is defined as treatment medically necessary to treat pain, infection, swelling, uncontrolled bleeding, or traumatic injury.
D0150	Comprehensive Oral Evaluation - New Or Established Patient		No	65+	One comprehensive exam per beneficiary, per provider or provider billing group per lifetime. Only one exam (D0120 or D0150) every six months per beneficiary, per provider or provider billing group.
D0170	Reevaluation - limited, problem focused		No	65+	One per 12 months. Established beneficiary to assess the status of a previously existing condition (not post-operative visit). Not covered with any other procedure other than radiographs.
D0210	Intraoral - Complete Series (Including Bitewings)		No	65+	One per 36 months. The following are also considered an Intraoral Complete Series (D0210) D0330 and D0272 D0330 and D0273 D0330 and D0274 D0330 and D0277
D0220	Intraoral - Periapical First Film		No	65+	One per day. Any additional films (D0220 - D0340) performed on the same date of service as a complete intraoral series, or its equivalent, are considered content of service of the complete series and will not be reimbursed.
D0230	Intraoral - Periapical Each Additional Film		No	65+	Any additional films (D0220 - D0340) performed on the same date of service as a complete intraoral series, or its equivalent, are considered content of service of the complete series and will not be reimbursed.
D0240	Intraoral - Occlusal Film		No	65+	Any additional films (D0220 - D0340) performed on the same date of service as a complete intraoral series, or its equivalent, are considered content of service of the complete series and are not reimbursed.

UHC KanCare Medicaid/Title 19 - Frail and Elderly

Effective 1/1/19, limited preventative and restorative services for members age 21 and over are covered under this plan with an annual maximum of $500.00

Code	Code Description	Teeth or Area Covered	Review Required	Age Range	Benefit Limitations
D0250	Extraoral – 2d projection radiographic image created using a stationary radiation source, and detector		No	65+	Any additional films (D0220 - D0340) performed on the same date of service as a complete intraoral series, or its equivalent, are considered content of service of the complete series and are not reimbursed.
D0251	Extraoral – First Radiographic Image		No	65+	Any additional films (D0220 - D0340) performed on the same date of service as a complete intraoral series, or its equivalent, are considered content of service of the complete series and are not reimbursed.
D0270	Bitewing - Single Film		No	65+	Any additional films (D0220 - D0340) performed on the same date of service as a complete intraoral series, or its equivalent, are considered content of service of the complete series and are not reimbursed. Only one bitewing code (D0270, D0272, D0273, D0274, D0277) per date of service, per beneficiary, per provider or provider billing group.
D0272	Bitewings - Two Films		No	65+	Any additional films (D0220 - D0340) performed on the same date of service as a complete intraoral series, or its equivalent, are considered content of service of the complete series and are not reimbursed. Only one bitewing code (D0270, D0272, D0273, D0274, D0277) per date of service, per beneficiary, per provider or provider billing group.
D0273	Bitewings - Three Films		No	65+	Any additional films (D0220 - D0340) performed on the same date of service as a complete intraoral series, or its equivalent, are considered content of service of the complete series and are not reimbursed. Only one bitewing code (D0270, D0272, D0273, D0274, D0277) per date of service, per beneficiary, per provider or provider billing group.
D0274	Bitewings - Four Films		No	65+	Any additional films (D0220 - D0340) performed on the same date of service as a complete intraoral series, or its equivalent, are considered content of service of the complete series and are not reimbursed. Only one bitewing code (D0270, D0272, D0273, D0274, D0277) per date of service, per beneficiary, per provider or provider billing group.
D0330	Panoramic Film		No	65+	One per 36 months. The following are also considered an Intraoral Complete Series (D0210) D0330 and D0272 D0330 and D0273 D0330 and D0274 D0330 and D0277
D1110	Prophylaxis - Adult		No	65+	One per 12 months. Includes scaling and polishing procedures to remove coronal plaque, calculus, and stains. Note: UnitedHealthcare's value added benefit may differ from other health plans.
D2140	Amalgam - One Surface, Primary Or Permanent	All Teeth (Teeth 1 through 32, A through T)	No	65+	One per 12 months. Note: UnitedHealthcare's value added benefit may differ from other health plans.
D2150	Amalgam - Two Surfaces, Primary Or Permanent	All Teeth (Teeth 1 through 32, A through T)	No	65+	One per 12 months. Note: UnitedHealthcare's value added benefit may differ from other health plans.

UHC KanCare Medicaid/Title 19 - Frail and Elderly

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Code	Code Description	Teeth or Area Covered	Review Required	Age Range	Benefit Limitations
D2160	Amalgam - Three Surfaces, Primary Or Permanent	All Teeth (Teeth 1 through 32, A through T)	No	65+	One per 12 months. Note: UnitedHealthcare's value added benefit may differ from other health plans.
D2161	Amalgam - Four Or More Surfaces, Primary Or Permanent	All Teeth (Teeth 1 through 32, A through T)	No	65+	One per 12 months. Note: UnitedHealthcare's value added benefit may differ from other health plans.
D2330	Resin-Based Composite - One Surface, Anterior	Anterior Teeth (Teeth 6 - 11, 22 - 27, C - H, M - R)	No	65+	One per 12 months. Note: UnitedHealthcare's value added benefit may differ from other health plans.
D2331	Resin-Based Composite - Two Surfaces, Anterior	Anterior Teeth (Teeth 6 - 11, 22 - 27, C - H, M - R)	No	65+	One per 12 months. Note: UnitedHealthcare's value added benefit may differ from other health plans.
D2332	Resin-Based Composite - Three Surfaces, Anterior	Anterior Teeth (Teeth 6 - 11, 22 - 27, C - H, M - R)	No	65+	One per 12 months. Note: UnitedHealthcare's value added benefit may differ from other health plans.
D2335	Resin-Based Composite - Four Or More Surfaces Or Involving Incisal Angle	Anterior Teeth (Teeth 6 - 11, 22 - 27, C - H, M - R)	No	65+	One per 12 months. Note: UnitedHealthcare's value added benefit may differ from other health plans.
D2391	Resin-Based Composite - One Surface, Posterior	Posterior Teeth (1-5, 12-21, 28-32, A, B, I, J, K, L, S, T)	No	65+	One per 12 months. Note: UnitedHealthcare's value added benefit may differ from other health plans.
D2392	Resin-Based Composite - Two Surfaces, Posterior	Posterior Teeth (1-5, 12-21, 28-32, A, B, I, J, K, L, S, T)	No	65+	One per 12 months. Note: UnitedHealthcare's value added benefit may differ from other health plans.
D2393	Resin-Based Composite - Three Surfaces, Posterior	Posterior Teeth (1-5, 12-21, 28-32, A, B, I, J, K, L, S, T)	No	65+	One per 12 months. Note: UnitedHealthcare's value added benefit may differ from other health plans.
D2394	Resin-Based Composite - Four Or More Surfaces, Posterior	Posterior Teeth (1-5, 12-21, 28-32, A, B, I, J, K, L, S, T)	No	65+	One per 12 months. Note: UnitedHealthcare's value added benefit may differ from other health plans.
D5110	Complete Denture - Maxillary		Yes	65+	One per 60 months.
D5120	Complete Denture - Mandibular		Yes	65+	One per 60 months.
D5211	Maxillary Partial Denture - Resin Base		Yes	65+	One per 60 months.
D5212	Mandibular Partial Denture - Resin Base		Yes	65+	One per 60 months.
D5213	Maxillary Partial Denture - Cast Metal Framework With Resin Denture Bases		Yes	65+	One per 60 months.

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Effective 1/1/19, limited preventative and restorative services for members age 21 and over are covered under this plan with an annual maximum of $500.00

Code	Code Description	Teeth or Area Covered	Review Required	Age Range	Benefit Limitations
D5214	Mandibular Partial Denture - Cast Metal Framework With Resin Denture Bases		Yes	65+	One per 60 months.
D5225	Maxillary Partial Denture - Flexible Base		Yes	65+	One per 60 months.
D5226	Mandibular Partial Denture - Flexible Base		Yes	65+	One per 60 months.
D5282	Removable unilateral partial denture - one piece cast metal (including clasps and teeth), maxillary	Per quadrant – 10 (UR) 20 (UL) 30 (LL) 40 (LR)	Yes	65+	One per 60 months
D5283	Removable unilateral partial denture - one piece cast metal (including clasps and teeth), mandibular	Per quadrant – 10 (UR) 20 (UL) 30 (LL) 40 (LR)	Yes	65+	One per 60 months
D5410	Adjust Complete Denture - Maxillary		No	65+	Not covered within 6 months of placement
D5411	Adjust Complete Denture - Mandibular		No	65+	Not covered within 6 months of placement
D5421	Adjust Partial Denture - Maxillary		No	65+	Not covered within 6 months of placement
D5422	Adjust Partial Denture - Mandibular		No	65+	Not covered within 6 months of placement
D5510	Repair Broken Complete Denture Base	1 (UA) 2 (LA)	No	65+	
D5520	Replace Missing Or Broken Teeth - Complete Denture (Each Tooth)	1 - 32	No	65+	
D5610	Repair Resin Denture Base	1 (UA) 2 (LA) 10 (UR) 20 (UL) 30 (LL) 40 (LR)	No	65+	
D5620	Repair Cast Framework	1 (UA) 2 (LA) 10 (UR) 20 (UL) 30 (LL) 40 (LR)	No	65+	
D5630	Repair Or Replace Broken Clasp	1 (UA) 2 (LA) 10 (UR) 20 (UL) 30 (LL) 40 (LR)	No	65+	
D5640	Replace Broken Teeth - Per Tooth	1 - 32	No	65+	

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Code	Code Description	Teeth or Area Covered	Review Required	Age Range	Benefit Limitations
D5650	Add Tooth To Existing Partial Denture	1 - 32	No	65+	
D5660	Add Clasp To Existing Partial Denture	1 (UA) 2 (LA) 10 (UR) 20 (UL) 30 (LL) 40 (LR)	No	65+	
D5670	Replace all teeth and acrylic on cast metal framework (maxillary)		No	65+	
D5671	Replace all teeth and acrylic on cast metal framework (maxillary)		No	65+	
D5750	Reline Complete Maxillary Denture (Laboratory)		No	65+	One per 24 months. Not covered within 24 months of placement.
D5751	Reline Complete Mandibular Denture (Laboratory)		No	65+	One per 24 months. Not covered within 24 months of placement.
D5760	Reline Maxillary Partial Denture (Laboratory)		No	65+	One per 24 months. Not covered within 24 months of placement.
D5761	Reline Mandibular Partial Denture (Laboratory)		No	65+	One per 24 months. Not covered within 24 months of placement.
D5850	Tissue Conditioning, Maxillary		No	65+	
D5851	Tissue Conditioning, Mandibular		No	65+	
D7210	Surgical Removal Or Erupted Tooth	1 - 32 51- 82 (SN) A - T AS - TS (SN)	No	65+	Includes cutting of gingiva and bone, removal of tooth structure, and closure.
D7220	Removal Of Impacted Tooth - Soft Tissue	1-32 51-82 (SN)	Yes	65+	Includes cutting of gingiva and bone, removal of tooth structure, and closure.
D7230	Removal Of Impacted Tooth - Partially Bony	1-32 51-82 (SN)	Yes	65+	Includes cutting of gingiva and bone, removal of tooth structure, and closure.
D7240	Removal Of Impacted Tooth - Completely Bony	1-32 51-82 (SN)	Yes	65+	Includes cutting of gingiva and bone, removal of tooth structure, and closure.
D7241	Removal Of Impacted Tooth - Completely Bony, Unusual Surgical Complications	1-32 51-82 (SN)	Yes	65+	Includes cutting of gingiva and bone, removal of tooth structure, and closure. Unusual complications such as nerve dissection, separate closure of the maxillary sinus, or aberrant tooth position.
D7250	Surgical Removal Of Residual Tooth (Cutting Procedure)	1 - 32 51- 82 (SN) A - T AS - TS (SN)	No	65+	Includes cutting of gingiva and bone, removal of tooth structure, and closure. Will not be paid to the providers or group that originally removed the tooth.
D7260	Oroantral Fistula Closure		No	65+	
D7285	Biopsy of Oral Tissue, Hard		No	65+	
D7286	Biopsy of Oral Tissue, Soft		No	65+	
D7410	Excision Of Pericoronal Gingiva		No	65+	

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Code	Code Description	Teeth or Area Covered	Review Required	Age Range	Benefit Limitations
D7411	Excision Of Benign Lesion Greater Than 1.25 Cm		No	65+	
D7412	Excision Of Benign Lesion, Complicated		No	65+	
D7413	Excision Of Malignant Lesion Up To 1.25 Cm		No	65+	
D7414	Excision Of Malignant Lesion Greater Than 1.25 Cm		No	65+	
D7415	Excision Of Malignant Lesion, Complicated		No	65+	
D7440	Excision Of Malignant Tumor - Lesion Diameter Up To 1.25 Cm		No	65+	
D7441	Excision Of Malignant Tumor - Lesion Diameter Greater Than 1.25 Cm		No	65+	
D7450	Removal Of Benign Odontogenic Cyst Or Tumor - Dia Up To 1.25 Cm		No	65+	
D7451	Removal Of Benign Odontogenic Cyst Or Tumor - Dia Greater Than 1.25 Cm		No	65+	
D7460	Removal Of Benign Nonodontogenic Cyst Or Tumor - Dia Up To 1.25 Cm		No	65+	
D7461	Removal Of Benign Nonodontogenic Cyst Or Tumor - Dia Greater Than 1.25 Cm		No	65+	
D7471	Removal Of Lateral Exostosis (Maxilla Or Mandible)	1 (UA) 2 (LA)	Yes	65+	Once per lifetime.
D7472	Removal Of Torus Palatinus		Yes	65+	Once per lifetime.
D7473	Removal Of Torus Mandibularis		Yes	65+	Once per lifetime.
D7490	Radical Resection Of Maxilla Or Mandible	1 (UA) 2 (LA)	No	65+	
D7510	Incision And Drainage Of Abscess - Intraoral Soft Tissue		No	65+	Not covered same date of service as D7511.
D7511	Incision And Drainage Of Abscess - Intraoral Soft Tissue - Complicated		No	65+	
D7520	Incision And Drainage Of Abscess - Extraoral Soft Tissue		No	65+	Not covered same date of service as D7521.
D7521	Incision And Drainage Of Abscess - Extraoral Soft Tissue - Complicated		No	65+	

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Code	Code Description	Teeth or Area Covered	Review Required	Age Range	Benefit Limitations
D7530	Removal Of Foreign Body From Mucosa		No	65+	
D7540	Removal Of Reaction Producing Foreign Bodies		No	65+	
D7550	partial ostectomy/ sequestrectomy for removal of non-vital bone		No	65+	
D7560	maxillary sinusotomy for removal of tooth fragment or foreign body		No	65+	
D7610	maxilla - open reduction (teeth immobilized, if present)		No	65+	
D7620	maxilla - closed reduction (teeth immobilized, if present)		No	65+	
D7630	mandible - open reduction (teeth immobilized, if present)		No	65+	
D7640	mandible - closed reduction (teeth immobilized, if present)		No	65+	
D7650	malar and/or zygomatic arch - open reduction		No	65+	
D7660	malar and/or zygomatic arch - closed reduction		No	65+	
D7670	alveolus - closed reduction, may include stabilization of teeth	1 - 32	No	65+	May include stabilization.
D7680	facial bones - complicated reduction with fixation and multiple surgical approaches		Yes	65+	
D7710	maxilla - open reduction		No	65+	
D7720	maxilla - closed reduction		No	65+	
D7730	mandible - open reduction		No	65+	
D7740	mandible - closed reduction		No	65+	
D7750	malar and/or zygomatic arch - open reduction		No	65+	
D7760	malar and/or zygomatic arch - closed reduction		No	65+	
D7770	alveolus, open reduction stabilization of teeth		No	65+	
D7780	facial bones - complicated reduction with fixation and multiple surgical approaches		No	65+	
D7820	Closed Reduction Of Dislocation		No	65+	
D7860	Arthrotomy		Yes	65+	

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Code	Code Description	Teeth or Area Covered	Review Required	Age Range	Benefit Limitations
D7910	Suture Of Recent Small Wounds Up To 5 Cm		No	65+	Not covered on same day as D7140, D7210, D7220, D7230, D7240, D7241, or D7250.
D7911	Complicated Suture - Up To 5 Cm		No	65+	Not covered on same day as D7140, D7210, D7220, D7230, D7240, D7241, or D7250.
D7912	Complicated Suture - Greater Than 5 Cm		No	65+	Not covered on same day as D7140, D7210, D7220, D7230, D7240, D7241, or D7250.
D7920	Skin Graft	1 (UA) 2 (LA) 10 (UR) 20 (UL) 30 (LL) 40 (LR)	Yes	65+	
D7955	Repair of Maxillofacial soft or hard tissue		Yes	65+	
D7960	Frenulectomy	1 (UA) 2 (LA)	No	65+	Once per lifetime. Per location Lingual, Buccal or Labial. Not covered same date of service as D7963. The frenum may be excised when the tongue has limited mobility; for large diastemas between teeth, or when the frenum interferes with a prosthetic appliance; or when it is the etiology of periodontal tissue disease.
D7963	Frenuloplasty		No	65+	Excision of frenum with excision or repositioning of abervant muscle and z- plasty or other local flap closure.
D7971	Excision Of Pericoronal Gingiva	1 - 32	No	65+	
D7980	Sialolithotomy		No	65+	
D7981	excision of salivary gland, by report		No	65+	
D7982	Sialodochoplasty		No	65+	
D7983	Closure of Salivary Fistula		No	65+	
D7990	Emergency Tracheotomy		No	65+	
D9212	Trigeminal Division Block		Yes	65+	
D9219	Evaluation for deep sedation or general anesthesia		No	65+	1 per patient per 12 months and limited to 1 per patient per provider in a lifetime.
D9222	Deep sedation/general anesthesia - first 15 minutes		Yes	65+	
D9223	Deep sedation/general anesthesia - each subsequent 15 minute increment		Yes	65+	

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Code	Code Description	Teeth or Area Covered	Review Required	Age Range	Benefit Limitations
D9230	Inhalation Of Nitrous/ Analgesia, Anxiolysis		No	65+	Not covered when billed with only diagnostic and/or preventative services (D0120 through D1203, D1515 through D1550, D9410, D9420).
D9243	Intravenous moderate (conscious) sedation/ anesthesia – each 15 minute increment		Yes	65+	
D9310	Consultation - Diagnostic Service Provided By Dentist Or Physician		No	65+	One per 12 months by same provider. One inpatient follow up per beneficiary within a 10 day period by same provider. Not covered on same date of service as D0120 -D0170, D9410, D9420.
D9311	Consultation with a medical health care professional		No	65+	Once per 12 months by same provider. One inpatient follow- up per beneficiary within a 10 day period by same provider. Not covered on same DOS as D0120, D0170, D9410, or D9420
D9410	House/Extended Care Facility Call		No	65+	Extended Care Facilities only.
D9420	Hospital Or Ambulatory Surgical Center Call		No	65+	Hospital Facilities only
D9610	Therapeutic Drug Injection, By report		Yes	65+	
D9613	Infiltration of sustained release therapeutic drug - single or multiple sites		No	65+	

For children receiving EPSDT services, any limits on services may be exceeded when medically necessary.

7.1 Referrals

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 shall 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 network specialists, contact the Provider Services line at 1-855-878-5372 or go to our website at **uhcproviders.com**.

7.2 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."

The following suggestions are offered to decrease the number of missed appointments:

- Contact the Member by phone or postcard prior to the appointment to remind the individual of the time and place of the appointment.

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.

If a UnitedHealthcare Member exceeds your office policy for missed appointments and you choose to discontinue seeing the patient, please inform them to contact Member Services for assistance in finding a new dentist. Providers with benefit questions should contact Provider Service directly at 1-855-878-5372.

All dental services performed must be recorded in the patient record, which must be available as required by your Provider Services Agreement.

7.3 **Payment for Non-Covered Services**

Enrolled Participating Providers shall hold Members and UnitedHealthcare harmless for the payment of Non-Covered Services except as provided in this paragraph. Providers may bill a Member for Non-Covered Services if the Provider obtains an agreement in writing from the Member prior to rendering such service that indicates:

- The services to be provided;
- UnitedHealthcare will not pay for or be liable for said Services; and
- Member will be financially liable for such services.

Enrolled Participating Providers must obtain this agreement in writing, and on the date the service(s) is/are rendered, when possible.

7.4 **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.
- Any service not listed as a covered service in the benefit grid is excluded.
- Please call our Provider Services line if you have any questions regarding frequency limitations.

7.4.a. **Additional Exclusions**

1. Dental services that are not necessary.
2. Hospitalization or other facility charges.
3. Any dental procedure performed solely for cosmetic/aesthetic reasons.
4. Reconstructive surgery regardless of whether or not the surgery which is incidental to a dental disease, injury, or congenital anomaly when the primary purpose is to improve physiological functioning of the involved part of the body.
5. Any dental procedure not directly associated with dental disease.
6. Any procedure not performed in a dental setting that has not been prior authorized.
7. Procedures that are considered experimental, investigational or unproven. This includes pharmacological regimens not accepted by the American Dental Association Council on Dental Therapeutics. The fact that an experimental, investigational or unproven service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in coverage if the procedure is considered to be experimental, investigational or unproven in the treatment of that particular condition.
8. Service for injuries or conditions covered by workmen's compensation or employer liability laws, and services that are provided without cost to the covered persons by any municipality, county or other political subdivision. This exclusion does not apply to any services covered by Medicaid or Medicare.
9. Expenses for dental procedures begun prior to the covered person's eligibility with the plan.
10. Dental services otherwise covered under the policy, but rendered after the date that an individual's coverage under the policy terminates, including dental services for dental conditions arising prior to the date that an individual's coverage under the policy terminates.
11. Services rendered by a provider with the same legal residence as a covered person or who is a member of a covered person's family, including spouse, brother, sister, parent or child.

12.Charges for failure to keep a scheduled appointment without giving the dental office proper notification.

7.5 Electronic Attachments

FastAttach™ - UnitedHealthcare accepts dental radiographs electronically via FastAttach™ for authorization requests and claims submissions. UnitedHealthcare in conjunction with National Electronic Attachment, Inc. (NEA), allows Enrolled Participating Providers the opportunity to submit all claims electronically, even those that require attachments. This program allows secure transmissions via the Internet lines for radiographs, periodontal charts, intraoral pictures, narratives and EOBs.

FastAttach™ is the SIMPLE way to:

- Eliminate Lost or Damaged Attachments
- Improve Your Payment Cycle
- Save on Postage and Printing Costs
- Reduce Your Follow Up With Payors
- Stop Sending Unnecessary Attachments With Claims

FastAttach™ is inexpensive and easy to use, reduces administrative costs, eliminates lost or damaged attachments and accelerates claims and prior authorization processing. It is compatible with most claims clearinghouse or practice management systems.

For more information, or to sign up for FastAttach, go to http://www.nea-fast.com or call NEA at 1-800-782-5150.

7.6 Spenddown Members-Medically Needy

In some cases, the income of a family or individual exceeds the income standard to receive public assistance monies. However, their income is not sufficient to meet all medical expenses. The family group/individual are considered Medically Needy (MN) must then incur a specified amount of medical expenses before they are eligible for Medicaid benefits. This process is referred to as spenddown.

Please refer to the KMAP website that identifies those beneficiaries with spenddown obligation. https://www.kmap-state-ks.us/

7.7 Claims Processed Against the Spenddown

The spenddown amount will be reduced by expenses for medically necessary services of eligible beneficiaries but not allowed for in the state Medicaid plan in one of two ways. Providers will bill Skygen USA for these services and Skygen USA will deduct appropriately billed amounts from the appropriate spenddown.

The spenddown amount will be handled like a “deductible.” Skygen USA will automatically credit the spenddown amount when participating providers bill claims for necessary services. Billed charges apply to spenddown in date-processed order. Providers should bill all services regardless of whether they believe they are Medicaid-covered services so that all charges can apply toward spenddown.

Providers will be reimbursed for claims submitted for Qualified Medicare Beneficiary (QMB)-covered services rendered to QMB/Medically Needy dual eligible members. These services are not affected by unmet spenddown.

7.8 Beneficiaries Responsibility

Each time a provider-billed or beneficiary-billed claim is used to reduce the spenddown, the members’ managed care organization will identify the need for a notice to be sent to the beneficiary explaining which service(s) were used to credit the spenddown and what the new remaining spenddown amount is. These notices will be mailed to beneficiaries weekly. The beneficiary is responsible for the payment of all bills used to reduce their spenddown amount.

7.9 Providers Reimbursement Maximized

Each claim used to reduce a beneficiary’s spenddown amount will be flagged to identify whether the claim would have paid if spenddown had been met. In the event a claim is submitted which exceeds the amount of spenddown remaining, all claims for the beneficiary will be reviewed.

Claims that are for non-covered services or for services that would not otherwise have been paid by Medicaid will be applied to spenddown first. Processed claims that would have paid if spenddown were met will be applied to spenddown in reverse date order. Once the spenddown amount is met, the fiscal agent will adjust any remaining payable claims so that the provider may receive reimbursement from Skygen USA for the services rendered.

7.10 **Frail and Elderly "In Crisis" Determination**

Frail and Elderly Waiver Program members have access to an expanded dental benefit for "crisis" situations based on the medical necessity of physical health issues. Examples of conditions qualifying for the "crisis" benefit determination include but are not limited to: Chemotherapy/cancer treatments, life-threatening infection, malnourishment, failure to thrive, etc.

Frail and Elderly members requesting an expanded benefit should contact their UnitedHealthcare Care Coordinator to facilitate the request.

The Care Coordinator will obtain a clinical summary from the member's physician and will forward the summary to the Chief Medical Officer for a medical necessity review. The Chief Medical Officer will approve or deny the request. Approvals will include the length of time that the member is considered eligible for the expanded benefit.

If approved, the member will be moved into the expanded benefit for a predetermined length of time.

Dental benefits under the Frail and Elderly In Crisis Benefit plan are administered the same as the other benefit plans. Codes that require a medical necessity review should be submitted with the appropriate documentation from the treating dentist. Providers may submit codes that require review as either a prior authorization request or as a retro review request.

Services that do not require a medical necessity review may be submitted without clinical documentation.

As with other benefit plans, it is the provider's responsibility to confirm eligibility and benefits on the date of service.

Section 8: **Retrospective Review, Prior Authorization* and Documentation Requirements**

***Prior Authorization is only required for orthodontic and non-participating provider requests**

8.1 **Retrospective Review**

Services that require retrospective review are outlined in the exhibit section at the end of this manual.

Claims that require retrospective review need to be submitted with the appropriate documentation, below are examples of documentation that maybe required:

- Radiographs (Pre-op, post-op or opposing arch x-rays as indicated in the exhibits)
- Narrative of Medical Necessity
- Perio Charting

Any claim for retrospective review submitted without the required documents will be denied and must be resubmitted for reimbursement.

The Dental Consultant reviews the documentation to ensure the services rendered meet the clinical criteria requirements as outlined in this manual. Once the clinical review is completed, the claim is either paid or denied within 20 calendar days for clean claim and notification will be sent to the provider via the provider remittance statement.

8.2 **Procedures Requiring Prior Authorization**

Orthodontic Services and Out of network services require Prior Approval. Prior authorizations will be honored for 180 days from the date they are issued. An approval does not guarantee payment. The Member must be eligible at the time the services are provided. The Provider should verify eligibility at the time of service.

With the exception of orthodontic services, participating providers have the option of submitting authorization requests for either Pre or Post review. Providers are encouraged to seek prior authorization in order to reduce the possibility of liability for their practice.

Requests for prior authorization should be sent with the appropriate documentation on a standard ADA 2012 approved form to

UnitedHealthcare Community Plan – KS
PO Box 2135
Milwaukee, WI 53201

Prior Authorization decisions are made within fourteen (14) calendar days from the date the prior authorization request is received provided all information is complete. If UnitedHealthcare denies the approval for some or all of the services requested, a written notice of the reasons for the denial(s) will be sent to the member. The notice will tell the Member that he or she may appeal the decision and provide instructions for filing an appeal. Prior Authorization requests submitted without the required documentation will be denied and must be resubmitted for review. The basis for granting or denying approval shall be whether the item or service is medically necessary, whether a less expensive service would adequately meet the Member's needs, and whether the proposed item or service conforms to commonly accepted standards in the dental community. If you have questions regarding a prior authorization decision, you can contact a dental reviewer by calling 1-855-878-5372.

8.3 **Orthodontic Models**

UnitedHealthcare does not currently accept orthodontic models as supporting documentation for authorization or claim submissions. If an orthodontic model is received, UnitedHealthcare will create a copy of all accompanying paperwork, process the authorization and return the orthodontic model to the dentist per plan guidelines.

Section 9: **Kansas Clinical Criteria for Retro-Review and Prior Authorization of Treatment and Emergency Treatment**

Some procedures require retrospective review or prior authorization before initiating treatment. When requesting these procedures, please note the documentation requirements when sending in the information to Skygen USA. The criteria that the Dental reviewers will look for in order to approve the request is listed below.

United Healthcare criteria utilized for this 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.

If there is any question that a procedure that is subject to retro review may not meet criteria and may not be paid, you have the option of submitting the procedure for prior authorization first.

Code	Description	Submission Criteria	Approval Criteria
D0999	Diagnostics	Narrative of medical necessity with pre authorization	
D2710 **D2740** **D2751** **D2752** **D2783** **D2791** **D2792**	Crowns	Periapical X-ray(s) that includes views of adjacent and opposing teeth, pre and post op X-rays required for teeth that have had root canal treatment.	• In general, criteria for crowns will be met only for permanent teeth needing multisurface restorations where other restorative materials have a poor prognosis. • Permanent molar teeth must have pathologic destruction to the tooth by caries or trauma and should involve four or more surfaces and two or more cusps. • Permanent bicuspid teeth must have pathologic destruction to the tooth by caries or trauma and should involve three or more surfaces and at least one cusp. • Permanent anterior teeth must have pathologic destruction to the tooth by caries or trauma and must involve four or more surfaces and at least 50 percent of the incisal edge. • To meet criteria, a crown must be opposed by a tooth or denture in the opposite arch or be an abutment for a partial denture. • The patient must be free from active and advanced periodontal disease. • The fee for crowns includes the temporary crown that is placed on the prepared tooth and worn while the permanent crown is being fabricated for permanent anterior teeth. • Cast crowns on permanent teeth are expected to last, at a minimum, five years. • A request for a crown following root canal therapy must meet the following criteria. • Request should include a dated postendodontic radiograph. • Tooth should be filled sufficiently close to the radiological apex to ensure that an apical seal is achieved, unless there is a curvature or calcification of the canal that limits the ability to fill the canal to the apex. • The filling must be properly condensed/obturated. Filling material does not extend excessively beyond the apex. Medical review for crowns will not meet criteria if a lesser means or restoration is possible Tooth has subosseous and/or furcation caries. • Tooth has advanced periodontal disease. • Tooth is a primary tooth. • Crowns are being planned to alter vertical dimension.

Code	Description	Submission Criteria	Approval Criteria
D2954	Prefabricated Post and Core	Pre-operative x-rays of adjacent teeth and opposing teeth.	Root canal fill should be sufficiently close to the radiological apex to ensure that an apical seal is achieved, unless there is a curvature or calcification of the canal that limits the dentist's ability to fill the canal to the apex.
D3222 **D3310** **D3320** **D3330** **D3331** **D3426**	Endodontics	Sufficient and appropriate preoperative radiographs showing clearly the adjacent and opposing teeth and a preoperative radiograph of the tooth to be treated; bitewings, periapicals or panorex. A dated postoperative radiograph must be submitted for review for payment showing the apex of each treated root	• Root canal therapy is performed in order to maintain teeth that have been damaged through trauma or carious exposure. Root canal therapy must meet the following criteria: • Fill should be sufficiently close to the radiological apex to ensure that an apical seal is achieved, unless there is a curvature or calcification of the canal that limits the dentist's ability to fill the canal to the apex. • Fill must be properly condensed/obturated. Filling material does not extend excessively beyond the apex. Medical review for root canal therapy will not meet criteria if: • Gross periapical or periodontal pathosis is demonstrated radiographically (caries subcrestal or to the furcation, deeming the tooth nonrestorable). • The general oral condition does not justify root canal therapy due to loss of arch integrity. • Root canal therapy is for third molars, unless they are an abutment for a partial denture. • Tooth does not demonstrate 50 percent bone support • Root canal therapy is in anticipation of placement of an overdenture. • A filling material not accepted by the Federal Food and Drug Administration (e.g. Sargenti filling material) is used.
D4210 **D4211**	Periodontics	Radiographs –pre-op periapicals or bitewings preferred. Narrative documenting medical necessity, photo (optional) • Complete periodontal charting with American Academy of Periodontology (AAP) Case Type • Treatment plan	• Shallow to moderate suprabony pockets after initial preparation • Suprabony pockets that require access after restorative therapy • Moderate gingival enlargements. • Not for infrabony pockets
D4230 **D4231**	Periodontics	Radiographs –pre-op periapicals or bitewings preferred. Narrative documenting medical necessity.	>75% crown coverage
D4268	Periodontics	Radiographs – periapicals or bitewings preferred. Narrative documenting medical necessity.	Narrative documenting medical necessity and past periodontal surgery.
D4341 **D4342**	Periodontics	Radiographs – periapicals or bitewings preferred • Complete periodontal charting with American Academy of Periodontology (AAP) Case Type • Treatment plan	• A minimum of three teeth affected in the quadrant • Periodontal charting indicating abnormal pocket depths in multiple sites • Additionally at least one of the following must be present: Radiographic evidence of root surface calculus • Radiographic evidence of noticeable loss of bone support
D5110 **D5120**	Complete Dentures	• Treatment plan. Appropriate radiographs showing clearly the adjacent and opposing teeth must be submitted for medical review: bitewings, periapicals or panorex.	If there is a pre-existing prosthesis, it must be at least five years old and unserviceable to qualify for replacement.
D5211 **D5212** **D5213** **D5214** **D5225**	Partial Dentures	• Appropriate radiographs showing clearly the adjacent and opposing teeth must be submitted for medical review: bitewings, periapicals or panorex.	• Partial dentures are covered only for recipients with good oral health and hygiene, good periodontal health (AAP Type I or II), and a favorable prognosis where continuous deterioration is not expected.

Code	Description	Submission Criteria	Approval Criteria
D5226			• Radiographs must show no untreated cavities or active periodontal disease in the abutment teeth, and abutments must be at least 50 percent supported in bone. • In general, if there is a pre-existing removable prosthesis (includes partial and full dentures), it must be at least five years old and unserviceable to qualify for replacement. • In general, a partial denture will be approved for benefits if it replaces one or more anterior teeth, or replaces two or more posterior teeth unilaterally or replaces three or more posterior teeth bilaterally, excluding third molars, and it can be demonstrated that masticatory function has been severely impaired. The replacement teeth should be anatomically full-sized teeth.
D6100	Implant Removal by report	Preoperative radiographs and narrative of medical necessity submitted with claim.	Failure of implant
D7220 **D7230** **D7240** **D7241**	Oral Surgery	Preoperative radiographs and narrative of medical necessity submitted with claim.	Reimbursement for Oral and Maxillofacial Surgery Services includes local anesthesia, sutures, and routine postoperative care. The extraction of asymptomatic impacted teeth is not a covered benefit. Symptomatic conditions would include pain and/or infection or demonstrated malocclusion causing a shifting of existing dentition. Removal of impacted teeth (such as third molars) are reviewed by the dental consultant. If these impacted teeth are asymptomatic, the root of the tooth should be adequately developed to determine that the impacted tooth is so positioned that it cannot fully erupt into function and could also and medical consequences. Contribute to pathology with dental The radiographs and/or narrative submitted with the claim must support the CDT code submitted.
D7260	Oral Surgery	Pre- and postoperative radiographs and narrative of medical necessity submitted with claim.	Narrative of medical necessity submitted with claim.
D7280	Oral Surgery	Preoperative radiographs and narrative of medical necessity submitted with claim.	Will not be payable unless the orthodontic treatment has been authorized as a covered benefit.
D7320	Oral Surgery	Preoperative radiographs and narrative of medical necessity submitted with claim.	No extractions performed in an edentulous area.
D7350	Oral Surgery	Preoperative radiographs and narrative of medical necessity submitted with claim.	Narrative of medical necessity submitted with claim.
D7471 **D7472** **D7473**	Oral Surgery	Appropriate radiographs and/or intraoral photographs/bone scans which clearly identify the exostosis must be submitted for medical review; bitewings, periapicals or panorex. • Treatment plan – includes prosthetic plan. • Narrative of medical necessity, if appropriate. Photo(s) clearly identifying exostosis(es) to be removed	Medical Necessity. Once per lifetime.
D7490 **D7680**	Oral Surgery	Preoperative radiographs and narrative of medical necessity submitted with claim.	Postoperative radiographs must be available in the beneficiary records.
D7860 **D7865** **D7920** **D7955**	Oral Surgery	Preoperative radiographs, if appropriate and narrative of medical necessity submitted with claim.	Postoperative radiographs if appropriate must be available in the beneficiary records.

Code	Description	Submission Criteria	Approval Criteria
D8010 **D8020** **D8030** **D8050** **D8060** **D8080** **D8210** **D8220**	Orthodontics	Traced cephalometric radiograph. • Mounted full mouth radiograph (14 films) or panoramic view. • External face photographs (lateral and frontal). o Intraoral photographs or slides (upper and lower occlusal views: right, left, and anterior centric occlusion views). • Diagnosis for which treatment is requested • Treatment plan including type of treatment, type of retention, and estimate of treatment time. A case may be submitted only twice; once as an original submission and once as a resubmission for consideration of a denial.	Orthodontic services require prior authorization and are only covered for eligible children with cases of severe orthodontic abnormality caused by genetic deformity (such as cleft lip or cleft palate) or traumatic facial injury resulting in serious health impairment to the beneficiary at the present time. Limited orthodontic treatment is treatment with a limited objective, not involving the entire dentition. It may be directed at the only existing problem or at only one aspect of a larger problem in which a decision is made to defer or forego more comprehensive therapy. Limited orthodontic treatment requires prior authorization and is only covered for eligible children with documented medical necessity
D8999	Orthodontics	Narrative of medical necessity, panorex of full mouth x-rays, photos	All orthodontic treatment requires prior authorization and is only covered for eligible children with documented medical necessity.
D9130		Narrative of medical necessity shall be submitted with claim	Medical necessity
D9223 **D9243**	Anesthesia	Narrative documenting: Medical condition(s) which require monitoring (e.g. cardiac problems, severe hypertension) Underlying hazardous medical condition (cerebral palsy, epilepsy, mental retardation, including Down's syndrome) which would render patient noncompliant • Documented failed sedation or a condition where severe periapical infection would render local anesthesia ineffective • Patients nine years of age and younger with extensive procedures to be accomplished. Procedures must be approved before anesthesia will be considered.	• Extensive or complex procedures for a member under the age of 9. Extensive or complex oral surgical procedures such as: • Impacted wisdom teeth • Surgical root recovery from maxillary antrum • Surgical exposure of impacted or unerupted cuspids • Radical excision of lesions in excess of 1.25 cm
D9999		Narrative of medical necessity shall be submitted with claim.	Medical necessity

The list of codes requiring medical review in the above grid applies to these benefit plans:

- UHC KanCare Medicaid Children (Ages 0-20)
- UHC KanCare CHIP (Ages 0-18)
- UHC KanCare Medicaid/Title 19 Adults 21 and Over

While submission and approval criteria is the same for all codes, please note that the following benefit plans have fewer codes requiring medical review. See below for a complete list of codes requiring medical review for each plan.

Section 10: **Claim Submission Procedures**

Claims may be submitted in four possible formats. These formats include:

1. Electronic claims via the Provider Web Portal (www.uhcproviders.com)
2. Electronic submission via clearinghouses
3. HIPAA Compliant 837D File
4. Paper claims via 2012 ADA claim form

10.1 **Electronic Claim Submission Utilizing the Provider Web Portal**

Enrolled Participating Providers may submit claims directly to by utilizing the "Provider" section of our website. Submitting claims via the website is very quick and easy and is at no additional cost to Providers!

It is especially easy if you have already accessed the site to check a Member's eligibility prior to providing the service.

To submit claims via the website, simply log on to www.uhcproviders.com.

If you have questions on submitting claims or accessing the website, please contact our Systems Operations Department at **1- 855-878-5372** or via e-mail at: providerservices@skygenusa.com

10.2 **Electronic Claim Submission via State of KS**

Dentists may continue to submit their claims via the State of KS

10.3 **Electronic Claim Submission via Clearinghouse**

Dentists may submit their claims via a clearinghouse.

You can contact your software vendor and make certain that UnitedHealthcare is listed as a payer. Your software vendor will be able to provide you with any information you may need to ensure that submitted claims are forwarded correctly.

The Payer ID is "GP133".

10.4 **HIPAA Compliant 837D File**

For Providers who are unable to submit electronically via the Internet or a clearinghouse, UnitedHealthcare may, on a case by case basis, work with the Provider to receive their claims electronically via a HIPAA Compliant 837D file from the Provider's practice management system. Please contact Customer Care at 1-855-878-5372 -or via email at providerservices@skygenusa.com to inquire about this option for electronic claim submission.

10.5 **Claim Submission**

Claims must be submitted on 2012 ADA approved claim forms. Please reference the ADA website for the most current claim form and completion instructions. Forms are available through the American Dental Association at:

American Dental Association
211 E. Chicago Ave.
Chicago, IL 60611
1-800-947-4746

Member name, identification number, and date of birth must be listed on all claims submitted. If the Member identification number is missing or miscoded on the claim form, the patient cannot be identified. This could result in the claim being returned to the submitting Provider office, causing a delay in payment.

The Provider and office location information must be clearly identified on the claim. Frequently, if only the dentist signature is used for identification, the dentist's name cannot be clearly identified. To ensure proper claim processing, the claim form must include the following:

- The treating Provider's name;

- The location in which the treatment occurred;
- The billing (business office) location; and
- The treating Provider's Kansas Medicaid ID #, NPI, or tax identification number (TIN).

The date of service must be provided on the claim form for each service line submitted.

Approved ADA dental codes as published in the current CDT book or as defined in this manual must be used to define all services.

Provider must list all quadrants, tooth numbers, and surfaces for dental codes that necessitate identification (extractions, root canals, amalgams and resin fillings). Missing tooth and surface identification codes can result in the delay or denial of claim payment.

Affix the proper postage when mailing bulk documentation. Postage due mail will not be accepted. This mail will be returned to the sender and will result in delay of payment.

Claims should be mailed to the following address:

UHC Community Plan of KS
PO Box 1158
Milwaukee, WI 53201

10.6 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

United Healthcare of Kansas
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.

10.7 Facilities with Encounter Payments (FQHC's, etc.)

All dental services performed by facilities that are reimbursed through encounter payments need to submit an encounter claim for each unique member visit. The encounter claim is processed to track utilization of HEDIS/EPSDT services. It is mandatory to submit encounter data per state and federal guidelines. Claims should be submitted with each individual service rendered. The services will be entered into Skygen USA's claims payment system for utilization tracking. The actual encounter (PPS) rate will be paid for the claim.

10.8 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. Patient records must be kept for a minimum of 7 years.

ADA American Dental Association® Dental Claim Form

HEADER INFORMATION

1. Type of Transaction (Mark all applicable boxes)
☐ Statement of Actual Services ☐ Request for Predetermination/Preauthorization
☐ EPSDT / Title XIX

2. Predetermination/Preauthorization Number

INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION

3. Company/Plan Name, Address, City, State, Zip Code

OTHER COVERAGE (Mark applicable box and complete items 5-11. If none, leave blank.)

4. Dental? ☐ Medical? ☐ (If both, complete 5-11 for dental only.)

5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)

6. Date of Birth (MM/DD/CCYY) | 7. Gender ☐ M ☐ F | 8. Policyholder/Subscriber ID (SSN or ID#)

9. Plan/Group Number | 10. Patient's Relationship to Person named in #5 ☐ Self ☐ Spouse ☐ Dependent ☐ Other

11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code

POLICYHOLDER/SUBSCRIBER INFORMATION (For Insurance Company Named in #3)

12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code

13. Date of Birth (MM/DD/CCYY) | 14. Gender ☐ M ☐ F | 15. Policyholder/Subscriber ID (SSN or ID#)

16. Plan/Group Number | 17. Employer Name

PATIENT INFORMATION

18. Relationship to Policyholder/Subscriber in #12 Above ☐ Self ☐ Spouse ☐ Dependent Child ☐ Other | 19. Reserved For Future Use

20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code

21. Date of Birth (MM/DD/CCYY) | 22. Gender ☐ M ☐ F | 23. Patient ID/Account # (Assigned by Dentist)

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) A _____ C _____
(Primary diagnosis in "A") B _____ D _____

31a. Other Fee(s)
32. Total Fee

35. Remarks

AUTHORIZATIONS

36. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.

X _____
Patient/Guardian Signature Date

37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.

X _____
Subscriber Signature Date

BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber.)

48. Name, Address, City, State, Zip Code

49. NPI | 50. License Number | 51. SSN or TIN

52. Phone Number ( ) - | 52a. Additional Provider ID

ANCILLARY CLAIM/TREATMENT INFORMATION

38. Place of Treatment (e.g. 11=office; 22=O/P Hospital) (Use "Place of Service Codes for Professional Claims") | 39. Enclosures (Y or N) ☐

40. Is Treatment for Orthodontics? ☐ No (Skip 41-42) ☐ Yes (Complete 41-42) | 41. Date Appliance Placed (MM/DD/CCYY)

42. Months of Treatment | 43. Replacement of Prosthesis ☐ No ☐ Yes (Complete 44) | 44. Date of Prior Placement (MM/DD/CCYY)

45. Treatment Resulting from ☐ Occupational Illness/Injury ☐ Auto accident ☐ Other accident

46. Date of Accident (MM/DD/CCYY) | 47. Auto Accident State

TREATING DENTIST AND TREATMENT LOCATION INFORMATION

53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed.

X _____
Signed (Treating Dentist) Date

54. NPI | 55. License Number

56. Address, City, State, Zip Code | 56a. Provider Specialty Code

57. Phone Number ( ) - | 58. Additional Provider ID

J430D (Same as ADA Dental Claim Form – J430, J431, J432, J433, J434)

To reorder call 800.947.4746
or go online at adacatalog.org

ADA American Dental Association®
America's leading advocate for oral health

The following information highlights certain form completion instructions. Comprehensive ADA Dental Claim Form completion instructions are printed in the CDT manual. Any updates to these instructions will be posted on the ADA's web site (ADA.org).

GENERAL INSTRUCTIONS

A. The form is designed so that the name and address (Item 3) of the third-party payer receiving the claim (insurance company/dental benefit plan) is visible in a standard #9 window envelope (window to the left). Please fold the form using the 'tick-marks' printed in the margin.

B. Complete all items unless noted otherwise on the form or in the CDT manual's instructions.

C. Enter the full name of an individual or a full business name, address and zip code when a name and address field is required.

D. All dates must include the four-digit year.

E. If the number of procedures reported exceeds the number of lines available on one claim form, list the remaining procedures on a separate, fully completed claim form.

COORDINATION OF BENEFITS (COB)

When a claim is being submitted to the secondary payer, complete the entire form and attach the primary payer's Explanation of Benefits (EOB) showing the amount paid by the primary payer. You may also note the primary carrier paid amount in the "Remarks" field (Item 35). There are additional detailed completion instructions in the CDT manual.

DIAGNOSIS CODING

The form supports reporting up to four diagnosis codes per dental procedure. This information is required when the diagnosis may affect claim adjudication when specific dental procedures may minimize the risks associated with the connection between the patient's oral and systemic health conditions. Diagnosis codes are linked to procedures using the following fields:

Item 29a – Diagnosis Code Pointer ("A" through "D" as applicable from Item 34a)

Item 34 – Diagnosis Code List Qualifier (B for ICD-9-CM; AB for ICD-10-CM)

Item 34a – Diagnosis Code(s) / A, B, C, D (up to four, with the primary adjacent to the letter "A")

PLACE OF TREATMENT

Enter the 2-digit Place of Service Code for Professional Claims, a HIPAA standard maintained by the Centers for Medicare and Medicaid Services. Frequently used codes are:

11 = Office; 12 = Home; 21 = Inpatient Hospital; 22 = Outpatient Hospital; 31 = Skilled Nursing Facility; 32 = Nursing Facility

The full list is available online at "www.cms.gov/PhysicianFeeSched/Downloads/Website_POS_database.pdf"

PROVIDER SPECIALTY

This code is entered in Item 56a and indicates the type of dental professional who delivered the treatment. The general code listed as "Dentist" may be used instead of any of the other codes.

Category / Description Code	Code
Dentist A dentist is a person qualified by a doctorate in dental surgery (D.D.S.) or dental medicine (D.M.D.) licensed by the state to practice dentistry, and practicing within the scope of that license.	122300000X
General Practice	1223G0001X
Dental Specialty (see following list)	Various
Dental Public Health	1223D0001X
Endodontics	1223E0200X
Orthodontics	1223X0400X
Pediatric Dentistry	1223P0221X
Periodontics	1223P0300X
Prosthodontics	1223P0700X
Oral & Maxillofacial Pathology	1223P0106X
Oral & Maxillofacial Radiology	1223D0008X
Oral & Maxillofacial Surgery	1223S0112X

Provider taxonomy codes listed above are a subset of the full code set that is posted at "www.wpc-edi.com/codes/taxonomy"

10.9 Coordination of Benefits (COB)

When UnitedHealthcare Community Plan is the secondary insurance carrier, a copy of the primary carrier's Explanation of Benefits (EOB) must be submitted with the claim. For electronic claim submissions, the payment made by the primary carrier must be indicated in the appropriate COB field. When a primary carrier's payment meets or exceeds a Provider's contracted rate or fee schedule, UnitedHealthcare Community Plan will consider the claim paid in full and no further payment will be made on the claim.

NOTE: UnitedHealthcare follows KMAP TPL policy. All KMAP TPL billing requirements still apply. Please refer to KMAP General TPL Payment provider manual. Clarification to this provider manual will be added at a later date.

10.10 Filing Limits

The timely filing requirement for the UnitedHealthcare KS is 180 calendar days for all services, and a 365 calendar day limit for any correction or rebilling of a timely filed claim. UnitedHealthcare determines whether a claim has been filed timely by comparing the date of service to the receipt date applied to the claim when the claim is received. If the span between these two dates exceeds the time limitation, the claim is considered to have not been filed timely.

10.11 Receipt and Audit of Claims

In order to ensure timely, accurate remittances to each dentist, an edit of all claims is performed upon receipt. This edit validates Member eligibility, procedure codes, and Provider identifying information. A Dental Reimbursement Analyst dedicated to Kansas dental offices analyzes any claim conditions that would result in non-payment. When potential problems are identified, your office may be contacted and asked to assist in resolving this problem. Please feel free to contact Provider Services at 1-855-878-5372 with any questions you may have regarding claim submission or your remittance.

Each Enrolled Participating Provider office receives an "explanation of benefit" report with their remittance. This report includes Member information and an allowable fee by date of service for each service rendered during the period.

If a dentist wishes to appeal any reimbursement decision, they need to submit an appeal in writing, along with any necessary additional documentation within 60 calendar days of the date on the provider remittance to:

UnitedHealthcare of Kansas – Corrected Claims
P.O. Box 481
Milwaukee, WI 53201

Provider will receive a response to the appeal within 30 BUSINESS days,

Section 11: **Grievance Reconsideration and Appeal Process**

11.1 **Member Grievance, Appeal, and State Fair Hearing Process**

Grievance Process

A grievance is any expression of dissatisfaction about any matter other than an adverse benefit determination. You can file a grievance if you are not happy with the way you were treated, the quality of care or services you received or if you have problems getting culturally competent care. If you need help filing a grievance, UnitedHealthcare will provide designated Member advocates to assist you in understanding and using our grievance system. UnitedHealthcare has Member Advocates that will help you in writing or filing a grievance and help you through the grievance process until your issue is resolved. Call **1-877-542-9238**, or if you have a machine for telephone calls because you do not hear well, please call **TDD/TTY: 711**.

To file a grievance:

In writing:

UnitedHealthcare Community Plan - Kansas
Attention: Appeals and Grievance
P.O. Box 31364
Salt Lake City, UT 84131-0364

By telephone (toll-free):

1-877-542-9238
(During business hours 8 a.m. – 6 p.m. CST)

Electronically:

https://www.personalhealthmessagecenter.com/public/forms/KS-Grievance

or In Person:

10895 Grandview Drive, Suite 200
Overland Park, KS 66210
(During business hours 8 a.m. – 5 p.m. CST)

You may file a grievance at any time. UnitedHealthcare Community Plan will keep your grievance private. We will let you know we received your grievance within ten (10) calendar days. We will try to take care of your grievance right away. We will resolve your grievance within thirty (30) calendar days and tell you in writing how it was resolved.

Appeal Process

An appeal is a request for a review of an action. You can appeal our decision if a service was denied, reduced, or ended early. You have sixty (60) calendar days from the date of the notice of adverse benefit determination (plus three (3) calendar days will be allowed for mailing time) to file an appeal. Below are your rights to proceed with the appeal process:

To file an appeal:

In writing:

UnitedHealthcare Community Plan - Kansas
Attention: Appeals and Grievance
P.O. Box 31364
Salt Lake City, UT 84131-0364

1-877-542-9238
(During business hours 8 a.m. – 6 p.m. CST)

Electronically:

https://www.personalhealthmessagecenter.com/public/forms/KS-Appeal

or In Person:

10895 Grandview Drive, Suite 200
Overland Park, KS 66210
(During business hours 8 a.m. – 5 p.m. CST)

You may also provide supporting appeal documents in person. If you need help filing an appeal, call Member Services at **1-877-542-9238**. Within five (5) calendar days, we will let you know in writing that we got your appeal. You may choose someone, including an attorney or provider, to represent you and act on your behalf. You must sign a consent form allowing this person to represent you. If you are a person with disabilities you may call Member Services at **1-877-542-9238 (TTY: 711)** to file the appeal. UnitedHealthcare Community Plan does not cover any fees or payments to your representatives. That is your responsibility.

If you want copies of your case file or the guidelines we used to make our decision, we can give them to you, free of charge. We will keep your appeal private. We will send you our decision in writing within thirty (30) calendar days.

Expedited (faster) Decisions

If you or your doctor wants a fast decision because your health is at risk, call Member Services at 1-877-542-9238 for an expedited appeal. UnitedHealthcare Community Plan will call you with our decision within 72 hours of getting your request for an expedited appeal. This timeframe may be extended up to 14 calendar days if you ask for the extension or we show that there is need for additional information and the delay is in your best interest. If we ask for an extension, we will send you a letter to let you know the reason for the delay. If we decide your health is not at risk, we will send you a letter telling you we will follow the regular appeal process time to make our decision.

Continuation of Services During the Appeal Process

If you want to keep getting previously approved services while we review your appeal, you must tell us within 10 calendar days from the date your notice is sent. If the final decision of the appeal review agrees with United Healthcare's action, you may need to pay for non-waiver services or benefits you received during the appeal process.

HCBS Appeals

If you are a member receiving HCBS waiver services and benefits, the previously authorized waiver services and benefits will continue for sixty (60) calendar days from the date of the notice of adverse benefit determination that terminates, suspends or reduces the previously authorized waiver services and benefits (plus three (3) calendar days will be allowed for mailing time). If an appeal is requested within sixty (60) calendar days (plus three (3) calendar days will be allowed for mailing time) calendar days from the date of the notice of adverse benefit determination, your current waiver services and benefits will continue while the appeal is being reviewed.

Benefits that are continued pending the outcome of the appeal will be continued for 120 calendar days from the date the notice of appeal resolution concerning the termination, suspension or reduction of previously authorized services (plus three (3) calendar days will be allowed for mailing). The notice of appeal resolution will advise you that the appeal decision may be reviewed through a request for a state fair hearing. If a State Fair Hearing request is submitted within one hundred twenty (120) calendar days (plus three (3) calendar days will be allowed for mailing time) from the date of appeal resolution notice, services and benefits will be continued through the date of the decision in the state fair hearing.

Deemed Exhaustion

Failure of United Healthcare to adhere to the notice and timing requirements listed above, means that the Member is deemed to have exhausted the appeals process and the Member may initiate a State Fair Hearing. In these situations, the Member will be notified in writing of the deemed exhaustion and next steps. Receipt of this notice is not required before a member can submit a request for a State Fair Hearing.

State Fair Hearing:

If you disagree with the outcome of your appeal by UnitedHealthcare Community Plan, you or someone acting for you (provider, family member, etc.) can request a State Fair Hearing. You may only file for a State Fair Hearing after you have completed the formal appeal process with UnitedHealthcare Community Plan.

You must file for a State Fair Hearing within one hundred twenty (120) calendar days from the date of the appeal resolution notice (plus three (3) calendar days will be allowed for mailing time).

To file a State Fair Hearing:

In writing:

Office of Administrative Hearings
1020 S. Kansas Avenue
Topeka, KS 66612

By telephone (toll-free):

1-877-542-9238
(During business hours 8 a.m. – 6 p.m. CST)

Electronically via Office of Administrative Hearings fax:

(785) 296-4848

or In Person:

10895 Grandview Drive, Suite 200
Overland Park, KS 66210
(During business hours 8 a.m. – 5 p.m. CST)

Reconsideration Process

Reconsideration is defined as a request by a provider for an MCO to review a claim decision. Reconsideration is an optional process available to providers prior to submitted an appeal.

Requests must be submitted within 120 calendar days from the remittance date, plus 3 calendar days from the date of the notice.

Reconsideration requests can be submitted through various means.

By Phone:

1-855-878-5372

By Mail:

UnitedHealthcare Community Plan - KS
Attention: Appeals and Grievances
P.O Box 1244
Milwaukee, WI 53201

Providers may terminate the reconsideration process and submit a formal appeal request within 60 calendar days of the original remittance notice of action, plus 3 calendar days from the date of the notice.

If you disagree with a claim reconsideration decision, you have the right to file a formal claim appeal within 60 calendar days of the reconsideration notice of action.

Providers have the right to represent him/herself or be represented by legal counsel or another spokesperson when requesting reconsideration or an appeal.

11.2 Provider Grievance, Reconsideration, Appeal, and State Fair Hearing Process

Grievance Process

A grievance is any expression of dissatisfaction about any matter other than an Action. If you need help filing a grievance, call Provider Services at **1-877-542-9238 (TDD/TTY: 711)**.

To file a grievance:

In writing:

UnitedHealthcare Community Plan - Kansas
Attention: Appeals and Grievance
P.O Box 1244
Milwaukee, WI 53201

By telephone (toll-free):

1-855-878-5372
(During business hours 8 a.m. – 5 p.m. CST)

Electronically (fax):

For electronic submission of appeals and grievance, please contact provider services at **1-855-878-5372**.

Providers have one hundred eighty (180) calendar days from the date of the incident being grieved, to file a grievance. UnitedHealthcare Community Plan will keep your grievance private. We will let you know we received your grievance within ten (10) calendar days. We will resolve your grievance within thirty (30) calendar days and tell you in writing how it was resolved.

Reconsideration Process

The provider reconsideration process allows a provider to dispute a claim payment determination prior to requesting an appeal, but is not required prior to the submission of an appeal. If you need help filing a reconsideration, call Provider Services at **1-877-542-9238 (TDD/TTY: 711)**.

To file a reconsideration:

In writing:

UnitedHealthcare Community Plan - Kansas
Attention: Appeals and Grievance
P.O Box 1244
Milwaukee, WI 53201

By telephone (toll-free):

1-855-878-5372
(During business hours 8 a.m. – 5 p.m. CST)

Electronically (fax):

For electronic submission of appeals and grievance, please contact provider services at **1-855-878-5372**.

Reconsideration requests must be submitted within one hundred twenty (120) calendar days from the remittance date (plus three (3) calendar days is allowed for mailing time). You should submit a fully completed claims reconsideration request form and all supporting documentation. Please do not send a claim or claim copy with your reconsideration request. If you send a claim or claim copy with the reconsideration, the reconsiderations team cannot accept it and will return it to you. If you disagree with a claim adjustment or our decision not to make a claim adjustment, you can file a formal appeal.

Appeal Process

An appeal is a request for a review of an action. You have sixty (60) calendar days from the date of the notice of action (plus three (3) calendar days is allowed for mailing time) to file an appeal.

To file an appeal:

In writing:

UnitedHealthcare Community Plan - Kansas
Attention: Appeals and Grievance
P.O Box 1244
Milwaukee, WI 53201

By telephone (toll-free):

1-855-878-5372
(During business hours 8 a.m. – 5 p.m. CST)

Electronically (fax):

For electronic submission of appeals and grievance, please contact provider services at **1-855-878-5372.**

You may also provide supporting appeal documents in person. If you need help filing an appeal, call Provider Services at **1-877-542-9238 (TTY: 711)**. Within ten (10) calendar days, we will let you know in writing that we got your appeal. You may choose someone, including an attorney or provider, to represent you and act on your behalf. UnitedHealthcare Community Plan does not cover any fees or payments to your representatives. We will keep your appeal private and will send you our appeal decision in writing within thirty (30) calendar days.

State Fair Hearing

If you disagree with the outcome of your appeal by UnitedHealthcare Community Plan, you can request a State Fair Hearing. You may only file for a State Fair Hearing after you have completed the formal appeal process with UnitedHealthcare Community Plan.

You must file for a State Fair Hearing within one hundred twenty (120) calendar days from the date of the appeal resolution notice (plus three (3) calendar days is allowed for mailing time).

To file a State Fair Hearing:

In writing:

Office of Administrative Hearings
1020 S. Kansas Avenue
Topeka, KS 66612

By telephone (toll-free):

1-877-542-9238
(During business hours 8 a.m. – 5 p.m. CST)

Electronically via Office of Administrative Hearings fax:

(785) 296-4848

or In Person:

10895 Grandview Drive, Suite 200
Overland Park, KS 66210
(During business hours 8 a.m. – 5 p.m. CST)

Section 12: **Health Insurance Portability and Accountability Act (HIPAA)**

As a healthcare Provider, if you transmit any health information electronically your office is required to comply with all aspects of the HIPAA regulations that have gone/will go into effect as indicated in the final publications of the various rules covered by HIPAA.

UnitedHealthcare has implemented various operational policies and procedures to ensure that it is compliant with the Privacy Standards as well. UnitedHealthcare also intends to comply with all Administrative Simplification and Security Standards by their compliance dates. One aspect of our compliance plan will be working cooperatively with Providers to comply with the HIPAA regulations.

The Provider, UnitedHealthcare, and Skygen USA agree to conduct their respective activities in accordance with the applicable provisions of HIPAA and such implementing regulations.

When contacting Provider Services, Providers will be asked to provide their TAX ID or NPI number. When calling regarding Member inquiries, Providers will be asked to provide specific Member identification such as Member ID/SSN, date of birth, name, and/or address.

In regulation to the Administrative Simplification Standards, you will note that the benefit tables included in this Provider manual reflect the most current coding standards (CDT-2010) recognized by the ADA. Effective the date of this manual, UnitedHealthcare will require Providers to submit all claims with the proper CDT codes listed in this manual. In addition, all paper claims must be submitted on the current approved ADA 2012 claim form.

Note: Copies of the HIPAA policies are available upon request by contacting Provider Services at **1-855-878-5372** or via e-mail at Providerservices@skygenusa.com.

Section 13: **Quality Improvement Program (QIP)**

UnitedHealthcare has established and continues to maintain an on-going 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 reviewed; that problems are being identified; and that follow-up is planned where indicated. The Program is directed by all state, federal and client requirements. The Program addresses various service elements including accessibility, availability and continuity of care. It also monitors the provisions and utilization of services to make sure they meet professionally recognized standards of care. The Program is reviewed and updated annually.

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

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

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

A complete copy of our QIP policy and procedure is available upon request by contacting our Provider Services Line.

Section 14: **Credentialing**

As required by law, any DDS or DMD who is interested in participation with Skygen USA is invited to apply and submit a credentialing application form for review by the Skygen USA's Credentialing Committee. Skygen USA, in conjunction with the Plan, has the sole right to determine which dentists it shall accept and continue as Participating Providers.

Providers who seek participation in any Skygen USA Managed Care network must be credentialed prior to participation in the network. Skygen USA will not differentiate or discriminate in the treatment of Providers seeking credentialing on the basis of race, ethnicity, sex, age, national origin or religion.

All applications reviewed by Skygen USA must satisfy NCQA and/or URAC standards of credentialing, as they apply to Dental services.

The Credentialing Committee has the discretion and authority to accept an application without restrictions. If the Credentialing Committee determines that an application should be accepted with restriction or declined, it shall recommend the appropriate action to the Executive Subcommittee for approval.

In reviewing an application, the Credentialing Committee may request further information from the applicant. The Credentialing Committee may table an application pending the outcome of an investigation of the applicant by a hospital, licensing board, government agency or any other organization or institution; or recommend any other action it deems appropriate.

Adverse credentialing recommendations of the Credentialing Committee can be forwarded to the Executive Subcommittee for final approval, subject to any appeal following such approval offered to and accepted by the applicant. If the applicant accepts the opportunity for a reconsideration review, the Credentialing Committee will review all original documents, as well as, any additional information submitted for the reconsideration review. If an applicant accepts the opportunity to appeal the Credentialing Committee's recommendation, the Peer Review Committee will complete the review.

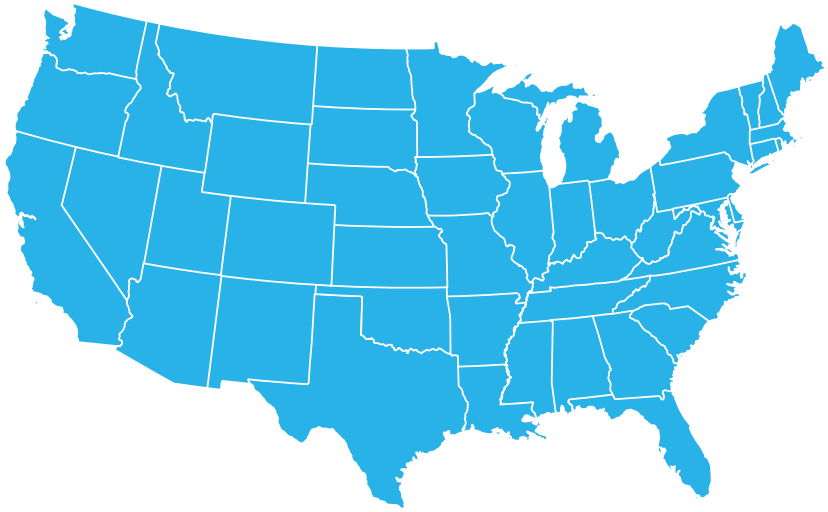
Any acceptance of an applicant is conditioned upon the applicant's execution of a participation agreement with Skygen USA.

The Plan retains the ultimate responsibility for Skygen USA's credentialing process and final credentialing decisions. The Plan is notified of any terminations or disciplinary actions.

To begin credentialing Providers go to credentialingportal.com and choose the appropriate state the application will be effective for.

SKYGEN USA
POWERING HEALTHCARE FOR THE DIGITAL AGE

Please choose the state you are applying to be credentialed in:



Section 15: **Important Notice for Submitting Paper Authorizations and Claims**

In order to maintain HIPAA compliance only ADA 2012 Dental Claim forms will be accepted when submitting preauthorizations.

All other forms, including ADA forms dated prior to 2012, will not be accepted and will result in a rejection of the preauthorization request.

Additionally, when making a correction to a previously submitted claim, please send it clearly marked "Corrected Claims" on ADA 2012 forms to:

United Healthcare of Kansas – Corrected Claims
P.O. Box 481
Milwaukee, WI 53201

Please contact the Provider service toll free number if you have questions. If you are in need of the current forms, please visit the ADA website at www.ada.org for ordering information.

Clean claims include the following:

- Member name
- Member date of birth
- Member ID number
- Treating Provider
- Payee (Billing Provider)
- Tax ID number
- Date of service
- Location of service
- Procedure code

Claims with missing or invalid information may be rejected and returned to the Provider.

Clean authorizations include the following:

- Member name
- Member date of birth
- Member ID number
- Treating Provider
- Payee and location
- Procedure code

Authorizations with missing or invalid information may be rejected and returned to the Provider.

Section 16: **Dental Services in a Hospital Setting – Authorization Process**

Dentists do not need to obtain prior approval for dental procedures performed in a hospital outpatient setting or an Ambulatory Surgical Treatment Center (ASTC) for children. All dental procedures performed in these outpatient settings may be subject to post payment review.

16.1 **Dental Billing Procedures**

Dentists must record a narrative of the dental procedure performed and the corresponding CDT/HCPCS dental codes in the patient's medical record at the outpatient setting. If the specific dental code is unknown, the code D9999 may be used.

Claims must be submitted for the covered professional services in the same format and manner as all standard dental procedures on a standard 2012 ADA claim form to the following:

Online: www.uhcproviders.com

EDI: **GP133**

Paper: **KanCare**
PO Box 3571
Topeka, KS 66601-3571

16.2 **Hospital/ASTC Billing Procedures**

The hospital or ASTC will bill UnitedHealthcare Community Plan on a UB-92 form for the all-inclusive rate for facility services using the assigned CDT/HCPCS dental code. The hospital must have this code in order to be paid for the facility services. The applicable dental codes will result in payment to hospital/ASTC for the Ambulatory Procedures Listing (APL) Group 1d – Surgical Procedures/Very Low Intensity.

16.3 **Participating Hospitals/ASCs**

Dentists must administer the services at a hospital or ASC that is enrolled in the UnitedHealthcare medical benefits program.

Please Note: Participating Hospitals may change. Please contact plan for current listing.

Section 17: **Health Guidelines – Ages 0-18 Years**

Recommendations for Pediatric Oral Health Assessment, Preventive Services, and Anticipatory Guidance/Counseling

Since each child is unique, these recommendations are designed for the care of children who have no contributing medical conditions and are developing normally. These recommendations will need to be modified for children with special health care needs or if disease or trauma manifests variations from normal. The American Academy of Pediatric Dentistry (AAPD) emphasizes the importance of very early professional intervention and the continuity of care based on the individualized needs of the child.

Refer to the text of guideline on the following page for supporting information and references.

American Academy of Pediatric Dentistry	AGE				
	6 TO 12 MONTHS	12 TO 24 MONTHS	2 TO 6 YEARS	6 TO 12 YEARS	12 YEARS AND OLDER
Clinical oral examination [1]	•	•	•	•	•
Assess oral growth and development [2]	•	•	•	•	•
Caries-risk assessment [3]	•	•	•	•	•
Radiographic assessment [4]	•	•	•	•	•
Prophylaxis and topical fluoride [3,4]	•	•	•	•	•
Fluoride supplementation [5]	•	•	•	•	•
Anticipatory guidance/counseling [6]	•	•	•	•	•
Oral hygiene counseling [7]	Parent	Parent	Patient/parent	Patient/parent	Patient
Dietary counseling [8]	•	•	•	•	•
Injury prevention counseling [9]	•	•	•	•	•
Counseling for nonnutritive habits [10]	•	•	•	•	•
Counseling for speech/language development	•	•	•		
Substance abuse counseling				•	•
Counseling for intraoral/perioral piercing				•	•
Assessment and treatment of developing malocclusion			•	•	•
Assessment for pit and fissure sealants [11]			•	•	•
Assessment and/or removal of third molars					•
Transition to adult dental care					•

1 First examination at the eruption of the first tooth and no later than 12 months. Repeat every 6 months or as indicated by child's risk status/susceptibility to disease. Includes assessment of pathology and injuries.

2 By clinical examination.

3 Must be repeated regularly and frequently to maximize effectiveness.

4 Timing, selection, and frequency determined by child's history, clinical findings, and susceptibility to oral disease.

5 Consider when systemic fluoride exposure is suboptimal. Up to at least 16 years.

6 Appropriate discussion and counseling should be an integral part of each visit for care.

7 Initially, responsibility of parent; as child matures, jointly with parent; then, when indicated, only child.

8 At every appointment; initially discuss appropriate feeding practices, then the role of refined carbohydrates and frequency of snacking in caries development and childhood obesity.

9 Initially play objects, pacifiers, car seats; when learning to walk; then with sports and routine playing, including the importance of mouthguards.

10 At first, discuss the need for additional sucking: digits vs pacifiers; then the need to wean from the habit before malocclusion or skeletal dysplasia occurs. For school-aged children and adolescent patients, counsel regarding any existing habits such as fingernail biting, clenching, or bruxism.

11 For caries-susceptible primary molars, permanent molars, premolars, and anterior teeth with deep pits and fissures; placed as soon as possible after eruption.

Section 18: **Fraud and Abuse**

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

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

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

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

All Network Providers and third-party contractors are expected to promptly report any perceived or alleged instances of fraud. Reporting may be made directly to the compliance helpline at 1-888-233-4877.