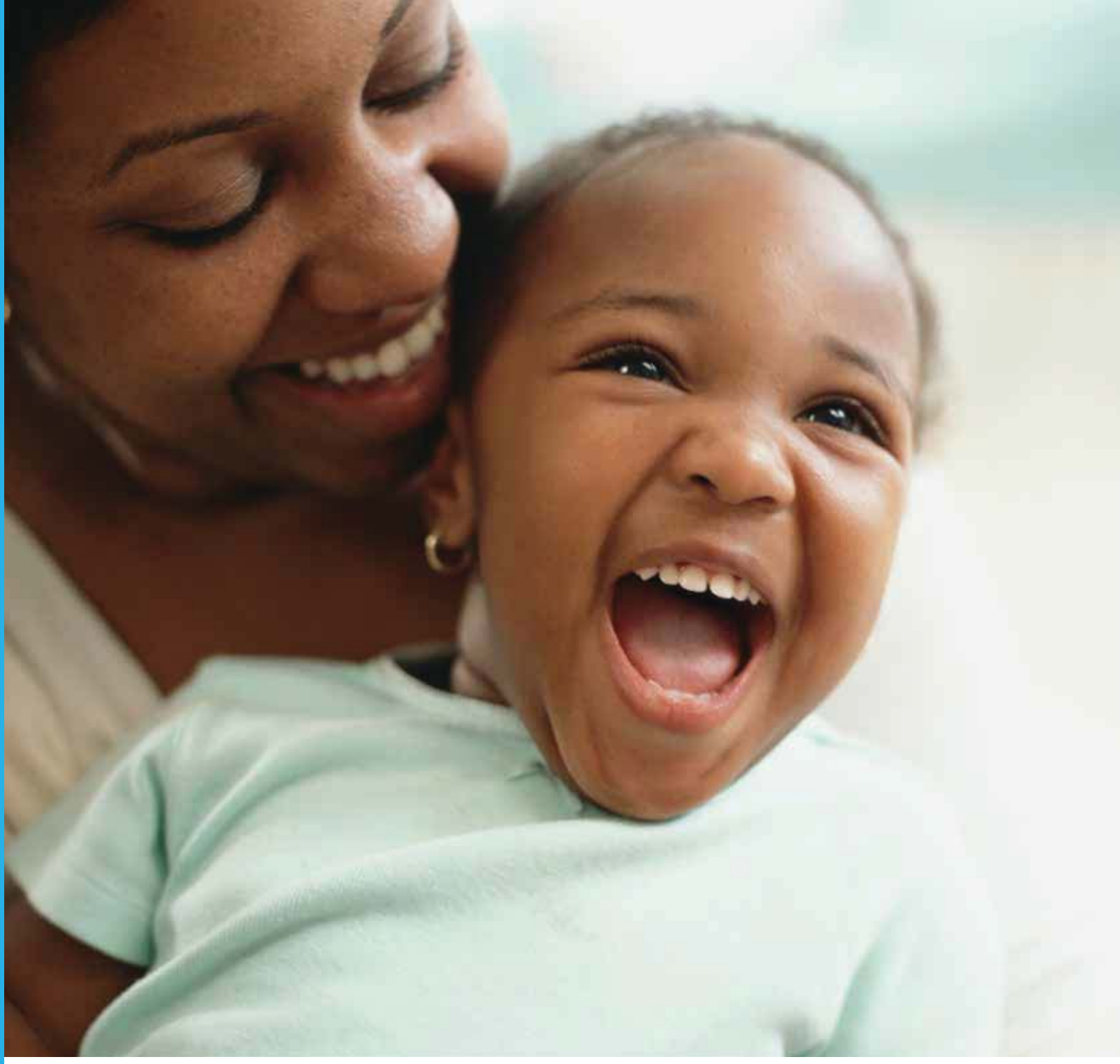


UnitedHealthcare Community Plan
New York Medicaid and Medicare
Dental Provider Manual

UnitedHealthcare®

Contents

Introduction—Who We Are

Section 1: **Welcome to UnitedHealthcare®**

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

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

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

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

Our Commercial program plan requirements are contained in a separate Provider Manual. If you support one of our Commercial plans and need that Manual, please contact Provider Services at 1-800-822-5353 (note: all other concerns should be directed to**1-800-304-0634**.

If you have any questions or concerns about the information contained within this Manual, please contact the UnitedHealthcare Provider Services team at**1-800-304-0634**.

Unless otherwise specified herein, this Manual is effective on November 12, 2018 for dental providers currently participating in the UnitedHealthcare network, and effective immediately for newly contracted dental providers.

Note: "Member" is used in this Manual to refer to a person eligible and enrolled to receive coverage for covered services in connection with your agreement with us. "Manual" refers to this 2018 Provider Manual. "You" or "your" refers to any provider subject to this Manual. "Us", "we" or "our" refers to UnitedHealthcare on behalf of itself and its other affiliates for those products and services subject to this Manual. The Medicare benefits in this Manual are effective January 1, 2019.

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

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

Sincerely,

UnitedHealthcare Professional Networks

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

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

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

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

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

	RESOURCE:		
YOU WANT TO:	**Provider Services Line – Dedicated Service Representatives Phone: 1-800-304-0634 Hours: 9 a.m.–6 p.m. Monday – Friday, EST**	**Online uhcproviders.com**	**Interactive Voice Response (IVR) System Phone: 1-800-304-0634 Hours: 24 /7**
Ask a benefit / plan question (including prior authorization requirements)	✓	✓	
Ask a question about your contract	✓		
Changes to practice information (e.g., associate updates, address changes, adding or deleting addresses, Tax Identification Number change, specialty designation, demographic updates,etc.)	✓	✓	
Inquire about a claim	✓	✓	✓
Inquire about eligibility	✓	✓	✓
Inquire about the In- Network Practitioner Listing	✓	✓	✓
Nominate a provider for participation	✓	✓	
Request a copy of your contract	✓		
Request a Fee Schedule	✓	✓	
Request an EOB	✓	✓	
Request an office visit (e.g., staff training)	✓		
Request benefit information	✓	✓	
Request documents	✓	✓	
Request participation status change	✓		

	RESOURCE:				
NEED:	**Address:**	**Phone Number**	**Payor I.D.**	**Submission Guidelines**	**Form(s) Required**
Claim Submission (initial)	Medicaid, CHP, MLTC, Medicaid Advantage and HARP: PO Box 2061 Milwaukee, WI 53201 Medicare: PO Box 2176 Milwaukee, WI 53201	Medicaid, CHP, MLTC, Medicaid Advantage and HARP: **1-800-304-0634** Medicare: **1-844-275-8750**	GP133	Medicaid, CHP, MLTC, Medicaid Advantage and HARP: within 120 calendar days from the date of service. Medicare: within 365 days from the date of service	ADA Claim Form, 2012 version or later
Prior Authorization Requests	Medicaid, CHP, MLTC, Medicaid Advantage and HARP: PO Box 2067 Milwaukee, WI 53201 Medicare: PO Box 361 Milwaukee, WI 53201	Medicaid, CHP, MLTC, Medicaid Advantage and HARP: **1-800-304-0634** Medicare: **1-844-275-8750**	GP133		ADA Claim Form – check the box titled: Request for Prior Authorization
Non- Emergency Transportation for Members		1-800-493-4647			
Provider Reprocessing or Adjustment Requests	Medicaid, CHP, MLTC, Medicaid Advantage and HARP: PO Box 1267 Milwaukee, WI 53201 Medicare: PO Box 2053 Milwaukee, WI 53201	Medicaid, CHP, MLTC, Medicaid Advantage and HARP: **1-800-304-0634** Medicare: **1-844-275-8750**	GP133	Within 60 calendar days from receipt of payment	ADA Claim Form Provider narrative supporting appeal
UnitedHealthcare Member Complaints & Appeals	UnitedHealthcare Community Plan P.O. Box 31364 Salt Lake City, UT 84131	Medicaid: **1-800-493-4647** Medicare: **1-800-514-4912**	N/A	N/A	N/A
UnitedHealthcare Provider Appeals	UnitedHealthcare P.O. Box 31364 Salt Lake City,UT 84131Community Plan.	**1-888-456-0218**	N/A	Appeals must be submitted within 60 calendar days of receipt of the authorization decision.	N/A

2.2 Integrated Voice Response (IVR) System –1-800-304-0634

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

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

2.3 Website

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

To use the website, please go to **uhcproviders.com** and register as a participating user. For assistance, please call **1-800-304-0634**.

Section 3: **Patient Eligibility Verification Procedures**

3.1 **Member Eligibility**

Eligibility or dental benefits may be verified online or via phone for the UnitedHealthcare Community Plans for Families, Kids and Adults; Medicaid, CHP, MLTC, Medicaid Advantage, HARP and Dual Complete.

To verify eligibility, please call our Provider Services line at **1-800-304-0634** or go to **uhcproviders.com**.

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

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

3.2 **Member Identification Card**

Members are issued an identification (ID) card by the plan. The ID cards are issued to all recipients enrolled in benefits; there will not be a separate ID card for UnitedHealthcare Medicaid and Medicare dental plans. The ID cards are customized with the UnitedHealthcare logo and include the toll-free customer service number for the health plan.

Medicaid ID cards issued by the state of NY do not guarantee payment under the UnitedHealthcare Community Plans for Families, Kids or Adults; Medicaid, CHP, MLTC, Medicaid Advantage, HARP and Dual Complete. It is the provider's responsibility to verify member eligibility with the UnitedHealthcare plan prior to rendering service; presentation of an ID card does not guarantee payment.

To verify a member's dental coverage, go to **uhcproviders.com** or contact the dental Provider Services line at **1-800-304-0634**.

3.3 **Eligibility Verification**

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

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

- Payee ID number from a remittance advice

The username and password that are established during the registration process will be used to access the website. One username and password are granted for each payee ID number. Please call **1-800-304- 0634** during normal business hours for assistance with website issues.

UnitedHealthcare also offers an Interactive Voice Response (IVR) system; simply call **1-800-304-0634**. Through our IVR system, you may access real-time information, 24 hours a day, seven days a week. The UnitedHealthcare IVR system enables you to do the following:

- Verify eligibility
- Obtain claim status

3.4 **Specialist Referral Process**

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

To obtain a list of participating network specialists, go to our website at **uhcproviders.com** or contact Provider Services at **1-800-304-0634**.

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

4.1.a **Medicaid, CHP, MLTC, Medicaid Advantage and HARP**

Code	Description of Service	Frequency Limits	Prior Authorization Required
D0120	Periodic oral evaluation	1 in 6 months	No
D0140	Limited oral exam		No
D0145	Oral evaluation, patient under three, counseling with primary caregiver	1 in 6 months	No
D0150	Comp oral exam	1 in 12 months	No
D0160	Extensive oral exam	2 in 12 months	No
D0170	Re-evaluation		No
D0180	Comp periodontal eval	2 in 12 months	No
D0210	Complete series	1 in 36 months	No
D0220	1st periapical		No
D0230	Add'l periapical		No
D0240	Occlusal	2 in 36 months	No
D0250	Extraoral - 2D Projection Radiographic image		No
D0251	Extra-Oral Posterior	2 in 12 months	No
D0270	Single bitewing	2 in 12 months	No
D0272	Two bitewings	2 in 12 months	No
D0273	Three bitewings	2 in 12 months	No
D0274	Four bitewings	2 in 12 months	No
D0310	Sialography		No
D0320	TMJ arthrogram		No
D0321	Other TMJ films, by report		No
D0330	Panoramic film	1 in 36 months	No
D0340	Cephalometric film	1 in 12 months	No
D0350	Oral/facial images	1 in 12 months	No
D0367	Cone beam CT capture and interpretation with field of view of both jaws; with or without cranium nterpretation with field of view of both jaws; with or without cranium	1 in 5 years	Yes
D0470	Diagnostic casts	1 in 24 months	No
D0474	Accession of tissue, gross and microscopic exam		No
D0485	Consultation, including preparation of slides from biopsy material supplied by referring source		

Code	Description of Service	Frequency Limits	Prior Authorization Required
D0502	Other Pathology Procedures, By Report	2 in 12 months	No
D0999	FQHC Encounter-Unspecified		Yes
D1110	Prophy-adult	2 in 12 months	No
D1120	Prophy-child	2 in 12 months	No
D1206	Topical fluoride varnish; moderate to high caries risk patients	2 in 12 months-age 6 and under 4 1in 12months	No
D1208	Topical fluoride varnish; moderate to high caries risk Patients-Excludes varnish	2 in 12 months-age 6 and under 4 1in 12months	No
D1320	Tobacco Counseling	2 in 12 months	No
D1351	Sealant - per tooth	1 in 36 months	No
D1510	Space maintainer-fixed-uni		No
D1516	Space Maintainer - Fixed Bilateral, Maxilliary		No
D1517	Space Maintainter-Fixed Bilateral, Mandibular		No
D1550	Recementation space maintainer		No
D2140	Amalgam - one surface, primary or permanent		No
D2150	Amalgam - two surfaces, primary or permanent		No
D2160	Amalgam - three surface, primary or permanent		No
D2161	Amalgam - four surfaces, primary or permanent		No
D2330	Resin-1 surface, anterior		No
D2331	Resin-2 surfaces, anterior		No
D2332	Resin-3 surfaces, anterior		No
D2335	Resin-4+ surfaces or anterior		No
D2390	Comp resin crown, anterior		No
D2391	Composite - 1 surf posterior		No
D2392	Composite - 2 surf posterior		No
D2393	Composite - 3 surf posterior		No
D2394	Resin-4+ surf, posterior		No
D2710	Crown - resin (laboratory)	1 in 5 years (per tooth)	Yes
D2720	Crown-resin w high noble metal	1 in 5 years (per tooth)	Yes
D2721	Crown-resin with base metal	1 in 5 years (per tooth)	Yes

Code	Description of Service	Frequency Limits	Prior Authorization Required
D2722	Crown - resin with noble metal	1 in 5 years (per tooth)	Yes
D2740	Crown-porcen/ceramic substrate	1 in 5 years (per tooth)	Yes
D2750	Crown-porc fused to high noble	1 in 5 years (per tooth)	Yes
D2751	Crown-porcelain fused to metal	1 in 5 years (per tooth)	Yes
D2752	Crown-porce fused noble metal	1 in 5 years (per tooth)	Yes
D2780	Crown - ¾ cast high noble metal	1 in 5 years (per tooth)	Yes
D2781	Crown - ¾ cast predominantly base metal	1 in 5 years (per tooth)	Yes
D2782	Crown - ¾ cast noble metal	1 in 5 years (per tooth)	Yes
D2790	Crown-full cast high noble	1 in 5 years (per tooth)	Yes
D2791	Crown - full cast base metal	1 in 5 years (per tooth)	Yes
D2792	Crown - full cast noble metal	1 in 5 years (per tooth)	Yes
D2794	Crown - Titanium	1 in 5 years (per tooth)	No
D2920	Re-cement crown		No
D2930	Prefab steel crown-prime tooth		No
D2931	Prefab steel crown-perm tooth		No
D2932	Prefabricated resin crown	1 in 24 months (per tooth)	No
D2933	Prefab steel crown w resin win		No
D2934	Prefab Esthetic coated stainless steel crown - primary tooth	1 in 5 years (per tooth)	No
D2951	Pin retention - per tooth	1 in 12 months (per tooth)	No
D2952	Cast post and core plus crown	1 in 5 years (per tooth)	Yes
D2954	Prefabr post/core	1 in 5 years (per tooth)	Yes
D2955	Post removal (not endodontic)		No
D2980	Crown repair, by report		Yes
D2999	Unspecified restorative proc		Yes
D3220	Therapeutic pulpotomy	1 lifetime (per tooth)	No
D3230	Pulpal therapy - anterior, primary	1 lifetime (per tooth)	No
D3240	Pulpal therapy- posterior, primary	1 lifetime (per tooth)	No
D3310	Endodontic therapy, anterior (exc final rest)	1 lifetime (per tooth)	Yes
D3320	Endodontic therapy, bicuspid (exc final rest)	1 lifetime (per tooth)	Yes
D3330	Endodontic therapy, molar (exc final rest)	1 lifetime (per tooth)	Yes
D3346	Retreat prior root canal-anter	1 lifetime (per tooth)	Yes
D3347	Retreat prior root canal-bicus	1 lifetime (per tooth)	Yes
D3348	Retreatment root canal-molar	1 lifetime (per tooth)	Yes
D3351	Apexification/recalcification/ pulpal regeneration - initial visit	1 lifetime (per tooth)	No
D3352	Apexification/recalcification/ pulpal regeneration - interim replacement	1 lifetime (per tooth)	No
D3353	Apexification/recalcification	1 lifetime (per tooth)	No
D3410	Apicoectomy/periradicular-ant	1 lifetime (per tooth)	No
D3421	Apicoectomy/periradicular- bicuspid	1 lifetime (per tooth)	No
D3425	Apicoectomy/periradicular-molar	1 lifetime (per tooth)	No
D3426	Apicoectomy/periradicular-each root	1 lifetime (per tooth)	No
D3430	Retrograde filling - per root	1 lifetime (per tooth)	No
D3999	Unspecified endodontic proc		Yes
D4210	Gingivectomy-gingivoplast/quad	1 in 24 months	Yes
D4211	Gingevectomy or gingivoplasty, 1 to 3 contiguous teeth or tooth	1 in 24 months	Yes
***D4245**	Apically positioned flap		Yes
***D4266**	Guided tissue regeneration - resorbable barrier, per site		Yes
***D4267**	Guided tissue regeneration - non-resorbable barrier, per site (includes membrane removal)		Yes
***D4273**	Autogenous connective tissue graft procedure (including donor and recipient surgical sites) first tooth, implant or edentulous tooth position in graft		Yes
***D4275**	Non-autogenous connective tissue graft (including recipient site and donor material) - first tooth, implant, or edentulous tooth position in graft		Yes
***D4277**	Free soft tissue graft procedure (including recipient and donor surgical sites) first tooth, implant, or edentulous tooth position in graft		Yes
***D4278**	Free soft tissue graft procedure (including recipient and donor surgical sites) each additional contiguous tooth, implant, or edentulous tooth position in same graft site		Yes
***D4283**	Autogenous connective tissue graft procedure (including donor and recipient surgical sites) - each additional contiguous tooth, implant or edentulous tooth position in same graft site		Yes
***D4285**	Non-autogenous connective tissue graft procedure (including recipient surgical site and donor material) - each additional contiguous tooth, implant or edentulous tooth position in same graft site.		Yes
D4341	Perio scaling & root plan/quad	1 in 24 months	Yes

Code	Description of Service	Frequency Limits	Prior Authorization Required
D4342	Periodontal scaling and root planing - 1 to 3 teeth per quadrant	1 in 24 months	Yes
D4910	Periodontal maintenance proc	2 in 12 months	Yes
D4999	Unspecified periodontal proc		Yes
D5110	Complete denture - maxillary	1 in 48 months	Yes
D5120	Complete denture - mandibular	1 in 48 months	Yes
D5211	Maxillary part denture-resin	1 in 48 months	Yes
D5212	Mandibular part denture-resin	1 in 48 months	Yes
D5213	Maxillary part denture-cst mtl	1 in 48 months	Yes
D5214	Mandibular part denture- cst metal	1 in 48 months	Yes
D5225	Maxillary Partial Denture Flexible Base	1 in 48 months	Yes
D5226	Mandibular Partial Denture - Flexible Base	1 in 48 months	Yes
D5410	Adjust Complete Denture - Maxillary	1 in 6 months	No
D5411	Adjust Complete Denture - Mandibular	1 in 6 months	No
D5421	Adjust Partial Denture - Maxillary	1 in 6 months	No
D5422	Adjust Partial Denture - Mandibular	1 in 6 months	No
D5511	Repair Broken Complete Denture Base, Mandibular		No
D5512	Repair Broken Complete Denture Base, Maxillary		No
D5520	Replace Teeth-Dent/Per Tooth		No
D5611	‘Repair Resin Partial Denture Base, Mandibular		No
D5612	‘Repair Resin Partial Denture Base, Maxillary		No
D5621	‘Repair Cast Partial Framework, Mandibular		No
D5622	Repair Cast Partial Framework, Maxillary		No
D5630	Repair or replace broken clasp	1 in 6 months	No
D5640	Replace broken teeth-per tooth	1 in 6 months	No
D5650	Add tooth to partial denture		No
D5660	Add clasp to partial denture		No
D5710	Rebase comp maxillary denture	1 in 12 months	No
D5711	Rebase comp mandibular denture	1 in 12 months	No
D5720	Rebase maxillary partial dent	1 in 12 months	No
D5721	Rebase mandibular partial dent	1 in 12 months	No
D5730	Reline comp max dent (chair)	1 in 12 months	No

Code	Description of Service	Frequency Limits	Prior Authorization Required
D5731	Reline mandibular dent (chair)	1 in 12 months	No
D5740	Reline max part denture(chair)	1 in 12 months	No
D5741	Reline partial dent (chair)	1 in 12 months	No
D5750	Reline comp maxillary denture	1 in 12 months	No
D5751	Reline comp mandibular denture	1 in 12 months	No
D5760	Reline maxillary partial dent	1 in 12 months	No
D5761	Reline mandibular partial dent	1 in 12 months	No
D5820	Interim part dent, maxillary	1 in 12 months	No
D5821	Interim part dent-mandibular	1 in 12 months	No
D5850	Tissue conditioning, maxillary	1 in 12 months	No
D5851	Tissue conditioning, mandibular	1 in 12 months	No
D5899	Unspec removable prostho proc, by report		Yes
D5911	Facial moulage (sectional)		No
D5912	Facial moulage (complete)		No
D5913	Nasal prosthesis		No
D5914	Auricular prosthesis		No
D5915	Orbital prosthesis		No
D5916	Ocular prosthesis		No
D5919	Facial prosthesis		No
D5922	Nasal septal prosthesis		No
D5923	Ocular prosthesis, interim		No
D5924	Cranial prosthesis		No
D5925	Facial augment implant prosthe		No
D5926	Nasal prosthesis, replacement		No
D5927	Auricular prosthesis, replace		No
D5928	Orbital prosthesis, replace		No
D5929	Facial prosthesis, replacement		No
D5931	Obturator prosthesis, surgical		No
D5932	Obturator prosthesis, defin		No
D5933	Obturator prosthesis, modify		No
D5934	Mandibular resect prosthesis		No
D5935	Mandib resection prosthesis		No
D5936	Obturator prosthesis, interim		No
D5937	Trismus appliance (not TMD)		No
D5951	Feeding aid		No
D5952	Speech aid prosthesis, ped		No
D5953	Speech aid prosthesis, adult		No
D5954	Palatal augment prosthesis		No
D5955	Palatal lift prosthesis, defin		No

Code	Description of Service	Frequency Limits	Prior Authorization Required
D5958	Palatal lift prosthesis, inter		No
D5959	Palatal lift prosthesis, mod		No
D5960	Speech aid prosthesis, mod		No
D5982	Surgical stent		No
D5983	Radiation carrier		No
D5984	Radiation shield		No
D5985	Radiation cone locator		No
D5986	Fluoride gel carrier		No
D5987	Commissure splint		No
D5988	Surgical splint		No
D5999	Maxillofacial prosthesis		Yes
*D6010	Surgical placement of implant body	1 per lifetime (per tooth)	Yes
*D6013	Surgical placement of mini implant	1 per lifetime (per tooth)	Yes
*D6052	Semi-precision attachment abutment	1 per 8 years (per tooth)	Yes
*D6055	Connecting bar - implant supported or abutment supported	1 per 8 years (per tooth)	Yes
*D6056	Prefabricated abutment - includes modification and placement	1 per 8 years (per tooth)	Yes
*D6057	Custom fabricated abutment - includes placement	1 per 8 years (per tooth)	Yes
*D6058	Abutment supported porcelain/ ceramic crown	1 per 8 years (per tooth)	Yes
*D6059	Abutment supported porcelain fused to metal crown (high noble metal)	1 per 8 years (per tooth)	Yes
*D6060	Abutment supported porcelain fused to metal crown (predominantly base metal)	1 per 8 years (per tooth)	Yes
*D6061	Abutment supported porcelain fused to metal crown (noble metal)	1 per 8 years (per tooth)	Yes
*D6062	Abutment supported cast metal crown (high noble metal)	1 per 8 years (per tooth)	Yes
*D6063	Abutment supported cast metal crown (predominately base metal)	1 per 8 years (per tooth)	Yes
*D6064	Abutment supported cast metal crown (noble metal)	1 per 8 years (per tooth)	Yes
*D6065	Implant supported porcelain/ceramic crown	1 per 8 years (per tooth)	Yes
*D6066	implant supported porcelain fused to metal crown (titanium, titanium alloy, high noble metal	1 per 8 years (per tooth)	Yes
*D6067	Implant supported metal crown (titanium, titanium alloy, high noble metal)	1 per 8 years (per tooth)	Yes

Code	Description of Service	Frequency Limits	Prior Authorization Required
*D6081	Scaling and debridement in the presence of inflammation or mucositis of a single implant, including cleaning on the implant surfaces, without flap entry and closure	1 per 12 months	Yes
*D6090	Repair implant supported prosthesis	1 per 12 months	Yes
*D6091	Replacement of semi-precision or precision attachment (male or female component) of implant/abutment supported posthesis, per attachment	1 per 24 months (per tooth)	Yes
*D6092	Re-cement or re-bond implant/ abutment supported fixed partial denture		Yes
*D6093	Re-cement or re-bond implant/ abutment supported crown	1 per 24 months (per tooth)	Yes
*D6094	Abutment supported crown (titanium)	1 per 8 years (per tooth)	Yes
*D6095	Repair implant abutment	1 per 12 months	Yes
*D6096	Remove broken implant retaining screw	1 per 12 months	Yes
*D6100	Implant removal		Yes
*D6101	Debridement of a peri-implant defect or defects surrounding a single implant, and surface cleaning of the exposed implant surfaces, including flap entry and closure	1 per 24 months	Yes
*D6102	Debridement and osseous contouring of a peri-implant defect or defects surrounding a single implant and includes surface cleaning of the exposed implant surfaces, including flap entry and closure	1 per 24 months	Yes
*D6103	Bone graft for repair of peri-implant defect - does not include flap entry and closure	1 per 24 months	Yes
*D6104	Bone graft at time of implant placement	1 per lifetime (per tooth)	Yes
*D6110	Implant/abutment supported removable denture for edentulous arch - maxillary	1 per 8 years (per tooth)	Yes
*D6111	Implant/abutment supported removable denture for edentulous arch - mandibular	1 per 8 years (per tooth)	Yes
*D6112	Implant/abutment supported removable denture for partially edentulous arch - maxillary	1 per 8 years (per tooth)	Yes
*D6113	Implant/abutment supported removable denture for partially edentulous arch - mandibular	1 per 8 years (per tooth)	Yes
*D6190	Radiographic/surgical implant index, by report	1 per 12 months	No
*D6199	Unspecified implant procedure, by report		Yes
D6210	Pontic - cast high noble metal	1 in 5 years (per tooth)	Yes
D6211	Pontic-cast base metal	1 in 5 years (per tooth)	Yes
D6212	Pontic - cast noble metal	1 in 5 years (per tooth)	Yes

Code	Description of Service	Frequency Limits	Prior Authorization Required
D6214	Pontic - Titanium	1 in 5 years (per tooth)	No
D6240	Pontic-porc fused-high noble	1 in 5 years (per tooth)	Yes
D6241	Pontic-porcelain fused metal	1 in 5 years (per tooth)	Yes
D6242	Pontic-porce fused-noble metal	1 in 5 years (per tooth)	Yes
D6245	Pontic - Porcelain/Ceramic	1 in 5 years (per tooth)	No
D6250	Pontic-resin w high noble met	1 in 5 years (per tooth)	Yes
D6251	Pontic-resin with base metal	1 in 5 years (per tooth)	Yes
D6252	Pontic-resin with noble metal	1 in 5 years (per tooth)	Yes
D6545	Retainer - cast metal fixed	1 in 5 years (per tooth)	Yes
D6720	Crown-resin w/high noble metal	1 in 5 years (per tooth)	Yes
D6721	Crown-resin w/base metal	1 in 5 years (per tooth)	Yes
D6722	Crown-resin w/noble metal	1 in 5 years (per tooth)	Yes
D6740	Retainer Crown - Porcelain/Ceramic	1 in 5 years (per tooth)	No
D6750	Crown-porc fused high noble	1 in 5 years (per tooth)	Yes
D6751	Crown-porc fused to metal	1 in 5 years (per tooth)	Yes
D6752	Crown-porc fused noble metal	1 in 5 years (per tooth)	Yes
D6780	Crown-3/4 cst high noble metal	1 in 5 years (per tooth)	Yes
D6781	Retainer Crown - 3/4 Cast Predominantly Base Metal	1 in 5 years (per tooth)	No
D6782	Retainer Crown - 3/4 Cast Noble Metal	1 in 5 years (per tooth)	No
D6783	Retainer Crown - 3/4 Porcelain/ Ceramic	1 in 5 years (per tooth)	No
D6790	Crown-full cast high noble	1 in 5 years (per tooth)	Yes
D6791	Crown - full cast base metal	1 in 5 years (per tooth)	Yes
D6792	Crown - full cast noble metal	1 in 5 years (per tooth)	Yes
D6794	Retainer Crown - Titanium	1 in 5 years (per tooth)	No
D6930	Re-cement fixed partial denture		No
D6980	Fixed partial denture repair		Yes
D6999	Fixed prosthodontic procedure		Yes
D7111	Coronal remnants	1 in lifetime (per tooth)	No
D7140	Extraction - erupted or exposed root	1 in lifetime (per tooth)	No
D7210	Surgical removal erupted tooth	1 in lifetime	No
D7220	Removal impacted tooth-soft	1 in lifetime	No

Code	Description of Service	Frequency Limits	Prior Authorization Required
D7230	Remove impact tooth-part bony	1 in lifetime	No
D7240	Remove impact tooth-comp bony	1 in lifetime	No
D7241	Removal of impacted tooth-bony	1 in lifetime	No
D7250	Surg remove residual roots	1 in lifetime	No
D7260	Oroantral fistula closure	1 in lifetime (per tooth)	No
D7261	Closure of sinus perforation	1 in lifetime (per tooth)	No
D7270	Tooth reimplantation-accident	1 in lifetime (per tooth)	No
D7272	Tooth transplantation		No
D7280	Surg exp impacted tooth-ortho	1 in lifetime (per tooth)	No
D7283	Placement of device to facilitate eruption of impacted tooth	1 in lifetime (per tooth)	No
D7285	Biopsy of oral tissue - hard		No
D7286	Biopsy of oral tissue - soft		No
D7287	Cytology sample		No
D7290	Surgical reposition of teeth	1 in lifetime (per tooth)	No
D7296	Corticotomy - One To Three Teeth Or Tooth Spaces, Per Quadrant		No
D7297	Corticotomy - Four Or More Teeth Or Tooth Spaces, Per Quadrant		No
D7310	Alveoloplasty w extract/quad	1 in lifetime (per tooth)	No
D7311	Alveoloplasty w/ extractions - 1-3 teeth/spaces per quad	1 in lifetime (per tooth)	No
D7320	Alveoloplasty - per quad	1 in lifetime (per tooth)	No
D7321	Alveloplasty w/o extractions - 1-3 teeth/spaces per quad	1 in lifetime (per tooth)	No
D7340	Vestibuloplasty - ridge extent		No
D7350	Vestibuloplasty - ridge extent		No
D7410	Radical excise lesion<=1.25cm		No
D7411	Excise benign lesion>=1.25 cm		No
D7412	Excise benign lesion, complicated		No
D7413	Excise malignant lesion <=1.25 cm		No
D7414	Excise benign lesion>=1.25 cm		No
D7415	Excise malignant lesion, complicated		No
D7440	Excis malignant tumor<=1.25cm		No
D7441	Excis malignant tumor>1.25cm		No
D7450	Rem cyst/tumor-lesion <=1.25cm		No
D7451	Rem cyst/tumor-lesion >1.25cm		No
D7460	Rem cyst/tumor-lesion <=1.25cm		No
D7461	Rem cyst/tumor-lesion >1.25cm		No
D7465	Destruction of lesion(s)		No
D7471	Removal of exostosis - per site		No
D7472	Removal of torus palatinus		No

Code	Description of Service	Frequency Limits	Prior Authorization Required
D7473	Removal of torus madibularis		No
D7485	Surg reduc of osseous tuberosity		No
D7490	Radical resection w bone graft		No
D7510	Incision/drain abscess-intraor		No
D7511	I&D of abscess - intraoral soft tissue-complicated		No
D7520	Incision/drain abscess-extraor		No
D7521	Incision and drainage - extraoral - complicated		No
D7530	Removal of foreign body		No
D7540	Removal of foreign bodies		No
D7550	Sequestrectomy-osteomyelitis		No
D7560	Maxillary sinusotomy		No
D7610	Maxilla - open reduction		No
D7620	Maxilla - closed reduction		No
D7630	Mandible-open reduction		No
D7640	Mandible - closed reduction		No
D7650	Malar/zygomatic arch-open red		No
D7660	Malar/zygomatic arch-closed		No
D7670	Alveolus stabilization teeth		No
D7671	Alveolus - open reduction		No
D7680	Facial bones - complex reduce		No
D7710	Maxilla - open reduction		No
D7720	Maxilla - closed reduction		No
D7730	Mandible - open reduction		No
D7740	Mandible - closed reduction		No
D7750	Malar/ zygomatic arch-open		No
D7760	Malar/zygomatic arch-closed		No
D7770	Alveolus-stabilization teeth		No
D7771	Alveolus - closed reduction, stabilization		No
D7780	Facial bones - complex reduce		No
D7810	Open reduction of dislocation		No
D7820	Closed reduction dislocation		No
D7830	Manipulation under anesthesia		No
D7840	Condylectomy		No
D7850	Surgical discectomy		No
D7852	Disc repair		No
D7854	Synovectomy		No
D7856	Myotomy		No
D7858	Joint reconstruction		No
D7860	Arthrotomy		No
D7865	Arthroplasty		No
D7870	Arthrocentesis		No
D7872	Arthroscopy - diagnosis		No
D7873	Arthroscopy-surg: lavage/lysis		No
D7874	Arthroscopy-surgical		No
D7875	Arthroscopy-surg synovectomy		No
D7876	Arthroscopy-surgery discectomy		No
D7877	Arthroscopy-surg debridement		No
D7880	Occlusal orthotic device		No
D7899	unspecified TMD therapy, by report		Yes
D7910	Suture small wounds up to 5 cm		No
D7911	Complicated suture-up to 5 cm		No
D7912	Complex suture-more than 5cm		No
D7920	Skin graft		No
D7940	Osteoplasty-orthognathic defrm		No
D7941	Osteotomy - ramus, closed		No
D7943	Osteotomy-ramus, w bone graft		No
D7944	Osteotomy per sextant or quad		No
D7945	Osteotomy - body of mandible		No
D7946	LeFort I (maxilla - total)		No
D7947	LeFort I (maxilla - segmented)		No
D7948	LeFort II or LeFort III		No
D7949	LeFort II or LeFort III		No
D7950	Graft of mandible/facial bones		No
*D7951	Sinus augmentation with bone or bone substitutes via a lateral open approach Code is only a covered benefit when associated with an implant or implant related service		Yes
*D7953	Bone replacement graft for ridge preservation - per site Code is only a covered benefit when associated with an implant or implant related service		Yes
D7960	Frenulectomy-separate proc		No
D7970	Excise hyperplastic tiss/arch		No
D7971	Excision pericoronal gingiva		No
D7972	Surg reduction of fibrous tuberosity		No
D7979	Non-Surgical		No
D7980	Sialolithotomy		No
D7981	Excision of salivary gland		No
D7982	Sialodochoplasty		No
D7983	Closure of salivary fistula		No
D7990	Emergency tracheotomy		No
D7991	Coronoidectomy		No
D7997	Appliance removal, incl removal of archbar		No
D7998	Intraoral placement of a fixation device not in conjunction with a fracture		No
D7999	Unspecified oral surgery proc		No
D8010	Limited Orthodontic Treatment Of The Primary Dentition	1 in Lifetime	Yes
D8020	Limited Orthodontic Treatment Of The Transitional Dentition	1 in Lifetime	Yes
D8030	Limited Orthodontic Treatment Of The Adolescent Dentition	1 in Lifetime	Yes

Code	Description of Service	Frequency Limits	Prior Authorization Required
D8040	Limited Orthodontic Treatment Of The Adult Dentition	1 in Lifetime	Yes
D8050	Interceptive Orthodontic Treatment Of The Primary Dentition	1 in Lifetime	Yes
D8060	Interceptive Orthodontic Treatment Of The Transitional Dentition	1 in Lifetime	Yes
D8070	Comprehensive Orthodontic Treatment Of The Transitional Dentition	1 in Lifetime	Yes
D8080	Comprehensive Orthodontic Treatment Of The Adolescent Dentition	1 in Lifetime	Yes
D8090	Comprehensive Orthodontic Treatment Of The Adult Dentition	1 in Lifetime	Yes
D8210	Removable Appliance Therapy	2 in Year	Yes
D8220	Fixed Appliance Therapy	1 in Lifetime	Yes
D8660	Pre-Orthodontic Treatment Visit	3 in Year	No
D8670	Periodic Orthodontic Treatment Visit (As Part Of Contract)	24 in Lifetime	No
D8680	Orthodontic Retention (Removal Of Appliances, Place Retainers)	1 in Lifetime	Yes
D8690	Orthodontic Treatment (Alternative Billing To A Contract Fee)	1 in Lifetime	Yes
D8692	Replacement Of Lost Or Broken Retainer	1 in Lifetime	No
D8999	Unspecified Orthodontic Procedure, By Report		Yes
D9110	Palliative (emergency) treat		No

Code	Description of Service	Frequency Limits	Prior Authorization Required
D9120	Fixed Partial Denture Sectioning	1 in Lifetime	No
D9222	Deep Sedation / General Anesthesia - first 15 minutes		No
D9223	Intravenous Moderate (Conscious)		No
D9239	Intravenous Moderate (Conscious) Sedation/Analgesia - First 15 Minutes		No
D9243	Intravenous Moderate (Conscious) Sedation/Analgesia - Each Subsequent 15 Minute		No
D9248	Non-intravenous conscious sedation	1 day	Yes
D9310	Consultation		No
D9410	House call		No
D9420	Hospital call		No
D9430	Office visit for observation		No
D9440	Office visit - after hours		No
D9610	Therapeutic drug injection		No
D9920	Behavior management, by report		No
D9944	Occlusal Guard-hard appliance, full arch		No
D9945	Occlusal Guard-soft appliance, full arch		No
D9946	Occlusal Guard-hard appliance, partial arch		No
D9999	Unspecified adjunctive proc		Yes
T1013	Sign language or oral interpretive services		No

* Implant benefits are available only for the Medicaid, HARP, MLTC and Medicaid Advantage plans and criteria in 6.1b is met.

4.1.b UnitedHealthcare Community Plan—NY: Dual Complete - Medicare SNP

Effective 1-1-2019

All benefits are subject to a $2000 Calendar Year Maximum

Code	Description of Service	Frequency LImits	Prior Authorization
D0999	FQHC Encounter Payment/Unspecified Diagnostic Procedures, By Report		No
D2950	Core Buildup, Including Any Pins When Required		Yes
D2952	Post And Core In Addition To Crown, Indirectly Fabricated		Yes
D2953	Each Additional Indirectly Fabricated Post - Same Tooth		Yes
D2954	Prefabricated Post And Core In Addition To Crown		Yes
D2957	Each Additional Prefabricated Post - Same Tooth		Yes
D3310	Endodontic therapy, anterior (exc final rest)	1 per lifetime	Yes
D3320	Endodontic therapy, bicuspid (exc final rest)	1 per lifetime	Yes
D3330	Endodontic therapy, molar (exc final rest)	1 per lifetime	Yes
D5110	Complete Denture - Maxillary	1 in 5 years	Yes
D5120	Complete Denture - Mandibular	1 in 5 years	Yes
D5130	Immediate Denture - Maxillary	1 in 5 years	Yes
D5140	Immediate Denture - Mandibular	1 in 5 years	Yes
D5211	Maxillary Partial Denture - Resin Base	1 in 5 years	Yes
D5212	Mandibular Partial Denture - Resin Base	1 in 5 years	Yes

Code	Description of Service	Frequency LImits	Prior Authorization
D5213	Maxillary Partial Denture - Cast Metal Framework With Resin Denture Bases	1 in 5 years	Yes
D5214	Mandibular Partial Denture - Cast Metal Framework With Resin Denture Bases	1 in 5 years	Yes
D5410	Immediate Denture - Mandibular		No
D5411	Maxillary Partial Denture - Resin Base		No
D5421	Mandibular Partial Denture - Resin Base		No
D5422	Maxillary Partial Denture - Cast Metal Framework With Resin Denture Bases		No
D5511	Mandibular Partial Denture - Cast Metal Framework With Resin Denture Bases		No
D5512	Adjust Complete Denture - Maxillary		No
D5520	Adjust Complete Denture - Mandibular		No
D5611	Replace Missing Or Broken Teeth - Complete Denture (Each Tooth)		No
D5612	Repair Resin Partial Denture Base - Mandibular		No
D5621	Repair Resin Partial Denture Base - Maxillary		No
D5622	Repair Cast Partial Framework - Mandibular		No
D5630	Repair Cast Partial Framework - Maxillary		No
D5640	Repair Or Replace Broken Retentive / Clasping Materials - Per Tooth		No
D5650	Replace Broken Teeth - Per Tooth		No
D5660	Add Tooth To Existing Partial Denture		No
D5730	Add Tooth To Existing Partial Denture	1 in 2 years	No
D5731	Add Clasp To Existing Partial Denture - Per Tooth	1 in 2 years	No
D5740	Reline Complete Maxillary Denture (Chairside)	1 in 2 years	No
D5741	Reline Complete Mandibular Denture (Chairside)	1 in 2 years	No
D5750	Reline Complete Maxillary Denture (Laboratory)	1 in 2 years	No
D5751	Reline Complete Mandibular Denture (Laboratory)	1 in 2 years	No
D5760	Reline Maxillary Partial Denture (Laboratory)	1 in 2 years	No
D5761	Reline Mandibular Partial Denture (Laboratory)	1 in 2 years	No
D6010	Surgical placement of implant body: endosteal implant		Yes
D6012	Surgical placement of interim implant body for transitional prosthesis: endosteal implant		Yes
D6040	Surgical placement: eposteal implant		Yes
D6050	Surgical placement: transosteal implant		Yes
D6055	Dental implant supported connecting bar		Yes
D6056	Prefabricated abutment - includes placement		Yes
D6057	Custom abutment - includes placement		Yes
D6058	Abutment supported porcelain/ceramic crown		Yes
D6059	Abutment supported porcelain fused to metal crown (high noble metal)		Yes
D6060	Abutment supported porcelain fused to metal crown (predominately base metal)		Yes
D6061	Abutment supported porcelain fused to metal crown (noble metal)		Yes
D6062	Abutment supported cast metal crown (high noble metal)		Yes
D6063	Abutment supported cast metal crown (predominately base metal)		Yes
D6064	Abutment supported cast metal crown (noble metal)		Yes
D6065	Implant supported porcelain/ceramic crown		Yes
D6066	Implant supported porcelain fused to metal crown		Yes
D6067	Implant supported metal crown		Yes
D6068	Abutment supported retainer for porcelain/ceramic FPD		Yes
D6069	Abutment supported retainer for porcelain fused to metal FPD (high noble metal)		Yes
D6070	Abutment Supported Retainer For Porcelain Fused To Metal Fpd (Base Metal)		Yes
D6071	Abutment Supported Retainer For Porcelain Fused To Metal Fpd (Noble Metal)		Yes
D6072	Abutment Supported Retainer For Cast Metal Fpd (High Noble Metal)		Yes

Code	Description of Service	Frequency LImits	Prior Authorization
D6073	Abutment Supported Retainer For Cast Metal Fpd (Base Metal)		Yes
D6074	Abutment Supported Retainer For Cast Metal Fpd (Noble Metal)		Yes
D6075	Implant Supported Retainer For Ceramic Fpd		Yes
D6076	Implant Supported Retainer For Porcelain Fused To Metal Fpd		Yes
D6077	Implant Supported Retainer For Cast Metal Fpd		Yes
D6080	Implant Maintenance Procedures, Including Removal And Reinsertion Of Prosthesis		Yes
D6090	Repair Implant Supported Prosthesis, By Report		Yes
D6091	Replacement Of Semi-Precision Or Precision Attachment		Yes
D6092	Re-Cement Or Re-Bond Implant/Abutment Supported Crown		Yes
D6093	Re-Cement Or Re-Bond Implant/Abutment Supported Fixed Partial Denture		Yes
D6094	Abutment Supported Crown (Titanium)		Yes
D6095	Repair Implant Abutment, By Report		Yes
D6096	Remove Broken Implant Retaining Screw		Yes
D6100	Implant Removal, By Report		Yes
D6190	Radiographic/Surgical Implant Index, By Report		Yes
D6194	Abutment Supported Retainer Crown For Fpd (Titanium)		Yes
D6199	Unspecified Implant Procedure, By Report		Yes
D6205	Pontic - Indirect Resin Based Composite		Yes
D6210	Pontic - Cast High Noble Metal		Yes
D6211	Pontic - Cast Predominantly Base Metal		Yes
D6212	Pontic - Cast Noble Metal		Yes
D6240	Pontic - Porcelain Fused To High Noble Metal		Yes
D6241	Pontic - Porcelain Fused To Predominantly Base Metal		Yes
D6242	Pontic - Porcelain Fused To Noble Metal		Yes
D6245	Pontic - Porcelain/Ceramic		Yes
D6250	Pontic - Resin With High Noble Metal		Yes
D6251	Pontic - Resin With Predominantly Base Metal		Yes
D6252	Pontic - Resin With Noble Metal		Yes
D6253	Provisional Pontic		Yes
D6545	Retainer - Cast Metal For Resin Bonded Fixed Prosthesis		Yes
D6548	Retainer - Porcelain/Ceramic For Resin Bonded Fixed Prosthesis		Yes
D6710	Retainer Crown - Indirect Resin Based Composite		Yes
D6720	Retainer Crown - Resin With High Noble Metal		Yes
D6721	Retainer Crown - Resin With Predominantly Base Metal		Yes
D6722	Retainer Crown - Resin With Noble Metal		Yes
D6740	Retainer Crown - Porcelain/Ceramic		Yes
D6750	Retainer Crown - Porcelain Fused To High Noble Metal		Yes
D6751	Retainer Crown - Porcelain Fused To High Noble Metal		Yes
D6752	Retainer Crown - Porcelain Fused To Predominantly Base Metal		Yes
D6780	Retainer Crown - Porcelain Fused To Noble Metal		Yes
D6781	Retainer Crown - 3/4 Cast High Noble Metal		Yes
D6782	Retainer Crown - 3/4 Cast Predominantly Base Metal		Yes
D6783	Retainer Crown - 3/4 Porcelain/Ceramic		Yes
D6790	Retainer Crown - Full Cast High Noble Metal		Yes
D6791	Retainer Crown - Full Cast Predominantly Base Metal		Yes
D6792	Retainer Crown - Full Cast Noble Metal		Yes
D6793	Provisional Retainer Crown		Yes

Code	Description of Service	Frequency LImits	Prior Authorization
D6794	Retainer Crown - Titanium		Yes
D6920	Connector Bar		Yes
D6930	Re-Cement Or Re-Bond Fixed Partial Denture		Yes
D6940	Stress Breaker		Yes
D6950	Precision Attachment		Yes
D6980	Fixed Partial Denture Repair		Yes
D7111	Extraction, Coronal Remnants - PrimaryTooth	1 per lifetime	No
D7140	Extraction, Erupted Tooth Or Exposed Root	1 per lifetime	No
D7210	Extraction, Erupted Tooth	1 per lifetime	No
D7250	Removal Of Residual Tooth (Cutting Procedure)	1 per lifetime	No
D7310	Alveoloplasty In Conjunction With Extractions - Four Or More Teeth		No
D7311	Alveoloplasty In Conjunction With Extractions - One To Three Teeth		No
D9110	Palliative (Emergency) Treatment Of Dental Pain - Minor Procedure		No

* Claim payment is based on Plan Benefits and Patient Eligibility on the date of service. This Benefit Guide is a quick reference guide and is not a guarantee of payment.

4.2 **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 (section 4.1) is excluded.

Please call Provider Services at **1-800-304-0634** if you have any questions regarding frequency limitations.

Additional Exclusions

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

4.3 Member Complaints and Appeals

Action Appeals

There are some treatments and services that you need to get approval for before you receive them or in order to be able to continue receiving them. This is called **prior authorization**. Asking for approval of a treatment or service is called a **service authorization request**. This process is described earlier in this handbook. Any decision to deny a service authorization request or to approve it for an amount that is less than requested is called an **action**.

If you are not satisfied with our decision about your care, there are steps you can take.

Your provider can ask for reconsideration.

If we made a decision that your service authorization request was not medically necessary or was experimental or investigational; and we did not talk to your doctor about it, your doctor may ask to speak with the plan's Medical Director. The Medical Director will talk to your doctor within one work day.

You can file an action appeal:

- If you are not satisfied with an action we took or what we decide about your service authorization request, you have 60 work days from the date of our letter/notice to you to file an action appeal.
- You can do this yourself or ask someone you trust to file the action appeal for you. You can call Member Services at **1-800-493-4647** if you need help filing an action appeal.
- We will not treat you any differently or act badly toward you because you file an action appeal.
- The action appeal can be made by phone or in writing. If you make an action appeal by phone, it must be followed up in writing. You must sign the written action appeal that you send to us. You or your designee must sign the written action appeal.

If you need our help because of a hearing or vision impairment, or if you need translation services, or help filling out the forms we can help you.

Please send all written appeals to:

Member Complaints, Grievances and Appeals
UnitedHealthcare Community Plan of New York
P.O. Box 31364
Salt Lake City, UT 84131-0364

Your action appeal will be reviewed under the fast track process if:

- If you or your doctor asks to have your action appeal reviewed under the fast track process. Your doctor would have to explain how a delay will cause harm to your health. If your request for fast track is denied, we will tell you and your action appeal will be reviewed under the standard process; **or**
- If your request was denied when you asked to continue receiving care that you are now getting or need to extend a service that has been provided; **or**
- If your request was denied when you asked for home health care after you were in the hospital; **or**
- If your request was denied when you asked for more inpatient substance use disorder treatment at least 24 hours before you were to leave the hospital.

Fast track action appeals can be made by phone and do not have to be followed up in writing.

What happens after we get your action appeal.

- Within 15 days, we will send you a letter to let you know we are working on your action appeal.
- Action appeals of clinical matters will be decided by qualified health care professionals who did not make the first decision, at least one of whom will be a clinical peer reviewer.
- Non-clinical decisions will be handled by persons who work at a higher level than the people who worked on your first decision.
- Before and during the action appeal, you or your designee can see your case file, including medical records and any other documents and records being used to make a decision on your case.

- You can also provide information to be used in making the decision in person or in writing. Call UnitedHealthcare Community Plan at **1-800-493-4647** if you are not sure what information to give us.
- You will be given the reasons for our decision and our clinical rationale, if it applies. If you are still not satisfied, any further appeal rights you have will be explained, or you or someone you trust can file a complaint with the New York State Department of Health at 1-800-206-8125.

Time frames for action appeals:

- **Standard action appeals:** If we have all the information we need, we will tell you our decision in thirty days from your action appeal. A written notice of our decision will be sent within 2 working days from when we make the decision.
- **Fast track action appeals:** If we have all the information we need, fast track action appeal decisions will be made in 2 working days from your action appeal.
  - We will tell you in 3 working days after giving us your action appeal, if we need more information.
  - If your request was denied when you asked for more inpatient substance use disorder treatment at least 24 hours before you were to leave the hospital, we will make a decision about your appeal within 24 hours.

We will tell you our decision by phone and send a written notice later.

If we need more information to make either a standard or fast track decision about your action appeal, we will:

- Write you and tell you what information is needed. If your request is in a fast track review, we will call you right away and send a written notice later.
- Tell you why the delay is in your best interest.
- Make a decision no later than 14 days from the day we asked for more information.

You, your provider, or someone you trust may also ask us to take more time to make a decision. This may be because you have more information to give the plan to help decide your case. This can be done by calling toll-free **1-800-493-4647** or writing. Please send written requests to:

UnitedHealthcare Community Plan of New York
P.O. Box 31364
Salt Lake City, UT 84131-0364

You or someone you trust can file a complaint with the plan if you don't agree with our decision to take more time to review your action appeal. You or someone you trust can file this complaint with the health plan by calling Member Services at **1-800-493-4647** (if you have trouble hearing, call the TDD Relay Service at 711) or with the New York State Department of Health by calling 1-800-206-8125.

If your original denial was because we said:

- The service was not medically necessary; or
- The service was experimental or investigational; or
- The out-of-network service was not different from a service that is available in our network; or
- The out-of-network service was available from a plan provider who has the training and experience to meet your needs; or
- We do not tell you our decision about your action appeal on time, the original denial against you will be reversed. This means your service authorization request will be approved.

Aid to continue while appealing a decision about your care.
In some cases you may be able to continue the services while you wait for your action appeal to be decided. **You may be able to continue the services that are scheduled to end or be reduced if you ask for a fair hearing:**

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

If your fair hearing results in another denial, you may have to pay for the cost of any continued benefits that you received. The decision you receive from the fair hearing officer will be final.

External Appeals

If the plan decides to deny coverage for a medical service you and your doctor asked for because:

- The service was not medically necessary; or
- The service was experimental or investigational; or
- The out-of-network service was not different from a service that is available in our network; or
- The out-of-network service was available from a plan provider who has the training and experience to meet your needs.

You can ask New York State for an independent external appeal. This is called an external appeal because it is decided by reviewers who do not work for the health plan or the state. These reviewers are qualified people approved by New York State. The service must be in the plan's benefit package or be an experimental treatment, clinical trial, or treatment for a rare disease. You do not have to pay for an external appeal.

Before you ask for an external appeal:

- You must file an action appeal with the plan and get the plan's final adverse determination; **or**
- If you have not gotten the service, and you ask for a fast track action appeal with the plan, you may ask for an expedited external appeal at the same time. Your doctor will have to say an expedited external appeal is necessary; **or**
- You and the plan may agree to skip the plan's appeals process and go directly to external appeal; **or**
- You can prove the plan did not follow the rules correctly when processing your action appeal.

You have 4 months after you receive the plan's final adverse determination to ask for an external appeal. If you and the plan agreed to skip the plan's appeals process, then you must ask for the external appeal within 4 months of when you made that agreement.

If you had a fast track action appeal and are not satisfied with the plan's decision, you can choose to file a standard action appeal with the plan or ask for an external appeal. If you choose to file a standard action appeal with the plan, and the plan upholds its decision, you will receive a new final adverse determination and have another chance to ask for an external appeal.

Additional appeals to your health plan may be available to you if you want to use them. However, if you want an external appeal, you must still file the application with the New York State Department of Financial Services within 4 months from the time the plan gives you the notice of final adverse determination or when you and the plan agreed to waive the plan's appeal process.

You will lose your right to an external appeal if you do not file an application for an external appeal on time.

To ask for an external appeal, fill out an application and send it to the Department of Financial Services. You can call Member Services at **1-800-493-4647** if you need help filing an appeal. You and your doctors will have to give information about your medical problem. The external appeal application says what information will be needed.

Here are some ways to get an application:

- Call the Department of Financial Services, 1-800-400-8882.
- Go to the Department of Financial Services' website at **dfs.ny.gov**.
- Contact the health plan at **1-800-493-4647**.

Your external appeal will be decided in 30 days. More time (up to five work days) may be needed if the external appeal reviewer asks for more information. You and the plan will be told the final decision within two days after the decision is made.

You can get a faster decision if:

- Your doctor says that a delay will cause serious harm to your health: or
- You are in the hospital after an emergency room visit and the hospital care is denied by the plan.

This is called an **expedited external appeal**. The external appeal reviewer will decide an expedited appeal in 72 hours or less.

If you asked for inpatient substance use disorder treatment at least 24 hours before you were to leave the hospital, the plan will continue to pay for your stay if:

- You ask for a fast track Internal Appeal within 24 hours, AND
- You ask for a fast track External Appeal at the same time.

The plan will continue to pay for your stay until there is a decision made on your appeals. Your plan will make a decision about your fast track Internal Appeal in 24 hours. The fast track External Appeal will be decided in 72 hours.

The reviewer will tell you and the plan the decision right away by phone or fax. Later, a letter will be sent that tells you the decision.

You may also ask for a fair hearing if the plan decided to deny, reduce or end coverage for a medical service. You may request a fair hearing and ask for an external appeal. If you ask for a fair hearing and an external appeal, the decision of the fair hearing officer will be the one that counts.

Fair Hearings

In some cases you may ask for a fair hearing from New York State.

- You are not happy with a decision your local Department of Social Services or the State Department of Health made about your staying or leaving UnitedHealthcare Community Plan.
- You are not happy with a decision that we made about medical care you were getting. You feel the decision limits your Medicaid benefits or that we did not make the decision in a reasonable amount of time.
- You are not happy about a decision we made that denied medical care you wanted. You feel the decision limits your Medicaid benefits.
- You are not happy about a decision we made to deny payment for care you received. You feel the decision limits your Medicaid benefits.
- You are not happy with a decision that your doctor would not order services you wanted. You feel the doctor's decision stops or limits your Medicaid benefits. You must file a complaint with UnitedHealthcare Community Plan. If UnitedHealthcare Community Plan agrees with your doctor, you may ask for a state fair hearing.
- The decision you receive from the fair hearing officer will be final.

If the services you are now getting are going to be reduced, stopped, or restricted, you can choose to ask to continue the services your doctor ordered while you wait for your case to be decided. You must ask for a fair hearing **within 10 days** from the date of the notice that says your care will change or by the time the action takes effect. However, if you choose to ask for services to be continued, and the fair hearing is decided against you, you may have to pay the cost for the services you received while waiting for a decision.

You can use one of the following ways to request a Fair Hearing:

1. By phone, call toll-free 1-800-342-3334
2. By fax, 518-473-6735
3. By internet: **www.otda.state.ny.us/oah/forms.asp**
4. By mail:
   NYS Office of Temporary and Disability Assistance
   Office of Administrative Hearings, Managed Care Hearing Unit
   P.O. Box 22023
   Albany, NY 12201-2023

When you ask for a fair hearing about a decision UnitedHealthcare Community Plan made, we must send you a copy of the **evidence packet**. This is information we used to make our decision about your care. The plan will give this information to the hearing officer to explain our action. If there is not time enough to mail it to you, we will bring a copy of the evidence packet to the hearing for you. If you do not get your evidence packet by the week before your hearing, you can call **1-800-493-4647** to ask for it.

The health plan is required to protect minor confidentiality (age 0 – 17) and therefore, will not be sending notices to members of claim payment denials.

Starting July 1, 2016, the Health Plan must further ensure the risk for accidental release of confidential health information is reduced for all minor members (0 – 17 years of age). To do so, the Health Plan will not be sending notices to members about claim payment denials including dental and behavioral health claims.

If you receive a bill for health care services, you may contact Member Services at **1-800-493-4647, TTY 711** for assistance and confirm your right to a State fair hearing if you disagree with the determination to deny payment for a health care service. UnitedHealthcare Community Plan will continue to ensure prompt response to your or your designee's request to see your case file (a case file contains information related to a specific service request and information reviewed by UnitedHealthcare Community Plan in the process of reaching a coverage determination). UnitedHealthcare Community Plan will adhere to confidentiality requirements and, where required by law or regulation, obtain appropriate authorization prior to release of protected health information that may be included in your case file.

Remember, you may complain anytime to the New York State Department of Health by calling 1-800-206-8125.

Complaint Process

Complaints.

We hope our health plan serves you well. If you have a problem, talk with your PCP, or call or write Member Services. Most problems can be solved right away. If you have a problem or dispute with your care or services, you can file a complaint with the plan. Problems that are not solved right away over the phone and any complaint that comes in the mail will be handled according to our complaint procedure described below.

You can ask someone you trust (such as a legal representative, a family member, or friend) to file the complaint for you. If you need our help because of a hearing or vision impairment, or if you need translation services, or help filing the forms, we can help you. We will not make things hard for you or take any action against you for filing a complaint.

You also have the right to contact the New York State Department of Health about your complaint at 1-800-206-8125 or write to:

NYS Department of Health Division of Managed Care
Bureau of Consumer Services
ESP Corning Tower, Room 2019
Albany, NY 12237

You may also contact your local Department of Social Services with your complaint at any time. You may call the New York State Department of Financial Services at 1-800-342-3736 if your complaint involves a billing problem.

How to file a complaint with our plan.

To file by phone, call Member Services toll-free at 1-800-493-4647, Monday – Friday 8:00 a.m. to 6:00 p.m. If we need more information to make a decision, we will tell you.

You can write us with your complaint or call the Member Services number and request a complaint form. It should be mailed to:

Member Complaints, Grievances and Appeals
UnitedHealthcare Community Plan of New York
P.O. Box 31364
Salt Lake City, UT 84131-0364

What happens next.

If we don't solve the problem right away over the phone or after we get your written complaint, we will send you a letter within 15 work days. The letter will tell you:

- Who is working on your complaint.
- How to contact this person.
- If we need more information.

Your complaint will be reviewed by one or more qualified people. If your complaint involves clinical matters, your case will be reviewed by one or more qualified health care professionals.

After we review your complaint.

- We will let you know our decision in 45 days of when we have all the information we need to answer your complaint, but you will hear from us in no more than 60 days from the day we get your complaint. We will write you and will tell you the reasons for our decision.

- When a delay would risk your health, we will let you know our decision in 48 hours of when we have all the information we need to answer your complaint, but you will hear from us in no more than 7 days from the day we get your complaint. We will call you with our decision or try to reach you to tell you. You will get a letter to follow up our communication in 3 work days.
- You will be told how to appeal our decision if you are not satisfied and we will include any forms you may need.
- If we are unable to make a decision about your complaint because we don't have enough information, we will send a letter and let you know.

Complaint Appeals

If you disagree with a decision we made about your complaint, you or someone you trust can file a **complaint appeal** with the plan.

How to make a complaint appeal.

- If you are not satisfied with what we decide, you have at least 60 business days after hearing from us to file an appeal;
- You can do this yourself or ask someone you trust to file the appeal for you;
- The appeal must be made in writing. If you make an appeal by phone, it must be followed up in writing. After your call, we will send you a form which is a summary of your phone appeal. If you agree with our summary, you must sign and return the form to us. You can make any needed changes before sending the form back to us. Please send all written correspondence to:

  Member Complaints, Grievances and Appeals
  UnitedHealthcare Community Plan of New York
  P.O. Box 31364
  Salt Lake City, UT 84131-0364

What happens after we get your complaint appeal.

After we get your complaint appeal, we will send you a letter within 15 work days. The letter will tell you:

- Who is working on your complaint appeal.
- How to contact someone at UnitedHealthcare about your complaint appeal.
- If we need more information.

Your complaint appeal will be reviewed by one or more qualified people at a higher level than those who made the first decision about your complaint. If your complaint appeal involves clinical matters, your case will be reviewed by one or more qualified health professionals, with at least one clinical peer reviewer, that were not involved in making the first decision about your complaint.

If we have all the information we need, you will know our decision in 30 work days. If a delay would risk your health, you will get our decision in 2 work days of when we have all the information we need to decide the appeal. You will be given the reasons for our decision and our clinical rationale, if it applies. If you are still not satisfied, you or someone on your behalf can file a complaint at any time with the New York State Department of Health at 1-800-206-8125.

4.4 **Provider Disputes:**

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

A **reprocessing or adjustment request** is a request to reprocess a claim. Examples include submitting a corrected billing, resubmitting a claim with requested information, data entry errors made on the claim or errors in participation status.

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

(800) 304-0634
NY Adjustment Unit
P O Box 1267
Milwaukee, WI 53201

Corrected claims should be submitted to:

PO Box 541
Milwaukee, WI 53201

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

Section 5: **Orthodontic Information**

5.1 **Orthodontic Eligibility:**

- All orthodontic services require prior authorization.
- Patients must be banded prior to their 21st birthday.
- Orthodontic services are covered for patient exhibiting a severe handicapping malocclusion.
- Active cases prior to 10/1/12 will continue to be reimbursed by the state. UnitedHealthcare will process cases that are approved and banded 10/1/12 and after.
- When a patient in active treatment has lost eligibility, additional reimbursement will be provided by the state fee for service program for:
  - 6 additional months or
  - 3 additional months and retention or
  - Retention alone

5.2 **Pre-Orthodontic Visit:**

- The pre-orthodontic visit diagnostic work up will be reimbursed using code D8660 and shall be reimbursed for all cases (whether approved or denied).
- The following services are to be billed and reimbursed separately:
  - D8660 – Orthodontic evaluation
  - D0210 – X-rays - full mouth series
  - D0330 – Panoramic X-ray
  - D0340 – Cephalometric X-rays
  - D0350 - Photographs
  - D0470 – Diagnostic casts (not required for prior authorization)

Orthodontic UM Criteria is limited to beneficiaries who:

1. are under 21 years of age;
2. exhibit a SEVERE PHYSICALLY HANDICAPPING MALOCCLUSION as defined below.

Physically handicapping malocclusion means severe dental defects which affect oral health, function and aesthetics. These include:

1. overjet of 6 millimeters or more;
2. overbite of 10mm and/or the lower anteriors contact palatal tissue;
3. openbite of 5 mm or more;
4. centric occlusion where it is difficult to replicate centric; and/or where there is a pseudo-crossbite (mandibular functional shift);
5. severe crowding of maxillary anteriors;
6. anterior crossbite due to prognathism; and,
7. blocked out maxillary cuspids that threaten the integrity of the anterior section of the arches.

Dentition. Only beneficiaries with late mixed dentition or permanent dentition, with the exception of cleft cases, severe dysplasias, and the other congenital defects as listed below are eligible. Qualifying congenital defects. These include:

1. cleft palate and cleft lip;
2. mandibular micrognathia;
3. extreme mandibular prognathism;
4. severe asymmetry;

5. ankylosis of the temporomandibular joint; and
6. other significant skeletal dysplasias.

Exclusions from eligibility. The following conditions are specifically EXCLUDED from coverage:

1. posterior crossbites only, where the teeth are in a good functional contact;
2. anterior diastemas (mild to moderate);
3. moderate crowding of lower anteriors; and
4. anterior crossbite of a single tooth not related to prognathism where there is adequate space to correct the crossbite

Submission Requirements:

1. Cephlametric X-ray
2. Panorex (Optional)
3. Photos (Optional)
4. Completed HLD Index
5. Narrative of Case

Code	Guidelines
D8660	**Pre-Orthodontic visit.** Allowed 3 times per year by different providers. Allowed once per year for same provider.
D8010, D8020, D8030, D8040, D8050, D8060	**Limited and Interceptive treatment.** A lump sum payment is made for these services. There is no additional reimbursement for monthly adjustments.
D8070, D8080, D8090	**Banding.**
D8670	**Monthly Payment.** Not payable within 30 days of banding. Payable once in a 30 day period, and no more than 24 times per lifetime.
D8680	**Retention.** This code is used for removal of appliances, construction and placement of retainers. Payable once per lifetime.
D8692	**Replacement of Lost or Broken retainer.** Must be within 1 year of D8680 and allowed once per lifetime.
D8999	**Lost Eligibility.** This code is used for submitting monthly treatment or retention for patient's that have lost eligibility. A description must be included on the claim.
D9310	**Consultation.** Can be submitted in lieu of D8660 by an orthodontist that will not be the treating dentist.

Continuation of Care

UnitedHealthcare will honor orthodontic approvals for cases in progress from another NY Managed Care Medicaid plan for members that

- have transferred to UnitedHealthcare from another Managed Care Organization, or
- no longer have access to the original treating orthodontist.

Providers are instructed to submit in-process continuation of care requests such as these to the following address:

NY Medicaid Dental Continuity of Care Requests
PO Box 1067
Milwaukee, WI 53201

Documentation Requirements:

The following documentation must accompany all in-process continuation of care requests:

- Copy of original Medicaid approval
- Evidence of banding date (usually copy of remit of paid D8080)
- Payment history
- If Continuation of Care submission is for new MCO and treating provider is the same, ADA form with code D8670

Once continuation of care authorization is granted, claims may be mailed to standard claims address.

If the Continuation of Care provider is a new provider, the contract case rate will be prorated based upon the documentation supplied subject to the members remaining months of treatment.

If the Continuation of Care provider is the same provider and there is only a change from one MCO to another, the provider will be reimbursed per their current contract case rate.

The initial provider may be subject to a partial recoupment of the contracted case rate should it be determined there is a moderate amount of treatment time remaining that will be assumed by the new provider relative to the amounts paid to the initial provider.

It is UnitedHealthcare Dental contractual policy for all providers to complete treatment of orthodontic cases within the allotted 24 months following the original banding date. Any provider, for any reason, requesting continuity of care beyond 36 months will be denied.

Transfer Cases:

If a member's orthodontic care was approved and begun under UnitedHealthcare Community Plan, and the member is transferring to a new orthodontist under the plan, please contact the provider call center at **(800) 304-0634** for assistance in transferring the approved care to the new office.

Section 6: **Authorization for Treatment**

6.1 **Dental Treatment Requiring Authorization**

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

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

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

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

6.1.a **Prior Authorization Submission Criteria for Medicaid, CHP, MLTC, Medicaid Advantage and HARP**

Code	Description	Required Documents
D0367	Cone beam CT Capture	A panoramic radiograph (D0330) or similar film, along with documentation of medical necessity must be submitted narrative explaining medical necessity Criteria: Documentation describes medical necessity Documentation describes why radiographic images would not be appropriate
D0999	Unspecified diag proc	Description of procedure and narrative of medical necessity
D2710	Crown – resin (laboratory)	Full mouth or panorex X-rays
D2720	Crown – resin w/ high noble metal	Full mouth or panorex X-rays
D2721	Crown – resin with base metal	Full mouth or panorex X-rays
D2722	Crown – resin with noble metal	Full mouth or panorex X-rays
D2740	Crown – porcen/ceramic substrate	Full mouth or panorex X-rays
D2750	Crown – porc fused to high noble	Full mouth or panorex X-rays
D2751	Crown – porcelain fused to metal	Full mouth or panorex X-rays
D2752	Crown – porce fused noble metal	Full mouth or panorex X-rays
D2780	Crown – ¾ cast high noble metal	Full mouth or panorex X-rays
D2781	Crown – ¾ cast predominantly base metal	Full mouth or panorex X-rays
D2782	Crown – ¾ cast noble metal	Full mouth or panorex X-rays
D2790	Crown – full cast high noble	Full mouth or panorex X-rays
D2791	Crown – full cast base metal	Full mouth or panorex X-rays
D2792	Crown – full cast noble metal	Full mouth or panorex X-rays
D2952	Cast post & core plus crown	Pre-operative X-rays of adjacent teeth and opposing teeth
D2954	Prefabr post/core	Pre-operative X-rays of adjacent teeth and opposing teeth
D2980	Crown repair, by report	Description of procedure and narrative of medical necessity
D2999	Unspecified restorative proc	Description of procedure and narrative of medical necessity
D3310	Endodontic therapy, anterior (exc final rest)	Full mouth X-rays or panorex, fill X-ray with claim
D3320	Endodontic therapy, bicuspid (exc final rest)	Full mouth X-rays or panorex, fill X-ray with claim
D3330	Endodontic therapy, molar (exc final rest)	Full mouth X-rays or panorex, fill X-ray with claim
D3346	Retreat prior root canal – anter	Full mouth X-rays or panorex, fill X-ray with claim
D3347	Retreat prior root canal – bicus	Full mouth X-rays or panorex, fill X-ray with claim
D3348	Retreatment root canal – molar	Full mouth X-rays or panorex, fill X-ray with claim
D3999	Unspecified endodontic proc	Description of procedure and narrative of medical necessity

Code	Description	Required Documents
D4210	Gingivectomy – gingivoplast/quad	Pre-op X-rays, perio charting, narrative of medical necessity, photo (optional)
D4211	Gingevectomy or gingivoplasty,	Pre-op X-rays, perio charting, narrative of medical necessity, photo (optional)
***D4245**	Apically positioned flap	
D4249	Crown lengthening – hard tissue	Pre-op X-rays, perio charting, narrative of medical necessity, photo (optional)
***D4266**	Guided tissue regeneration - resorbable barrier, per site	Current dated radiographs of tooth/area of problem Complete 6 point periodontal charting
***D4267**	Guided tissue regeneration - non-resorbable barrier, per site (includes membrane removal)	Current dated radiographs of tooth/area of problem Complete 6 point periodontal charting
***D4273**	Autogenous connective tissue graft procedure (including donor and recipient surgical sites) first tooth, implant or edentulous tooth position in graft	Current dated radiographs of tooth/area of problem Complete 6 point periodontal charting
***D4275**	Non-autogenous connective tissue graft (including recipient site and donor material) - first tooth, implant, or edentulous tooth position in graft	Current dated radiographs of tooth/area of problem Complete 6 point periodontal charting
***D4277**	Free soft tissue graft procedure (including recipient and donor surgical sites) first tooth, implant, or edentulous tooth position in graft	Current dated radiographs of tooth/area of problem Complete 6 point periodontal charting
***D4278**	Free soft tissue graft procedure (including recipient and donor surgical sites) each additional contiguous tooth, implant, or edentulous tooth position in same graft site	Current dated radiographs of tooth/area of problem Complete 6 point periodontal charting
***D4283**	Autogenous connective tissue graft procedure (including donor and recipient surgical sites) - each additional contiguous tooth, implant or edentulous tooth position in same graft site	Current dated radiographs of tooth/area of problem Complete 6 point periodontal charting
***D4285**	Non-autogenous connective tissue graft procedure (including recipient surgical site and donor material) - each additional contiguous tooth, implant or edentulous tooth position in same graft site.	Current dated radiographs of tooth/area of problem Complete 6 point periodontal charting
D4341	Perio scaling & root plan/quad	Periodontal charting and pre-op X-rays
D4342	Periodontal scaling and root planing - 1 to 3 teeth per quadrant	1 in 24 months
D4355	Full mouth debridement	Periodontal charting and pre-op X-rays
D4910	Periodontal maintenance proc	Date of previous periodontal surgical or scaling and root planning with claim
D4999	Unspecified periodontal proc	Description of procedure and narrative of medical necessity
D5110	Complete denture – maxillary	Full mouth or panorex X-rays
D5120	Complete denture – mandibular	Full mouth or panorex X-rays
D5211	Maxillary part denture – resin	Full mouth or panorex X-rays
D5212	Mandibular part denture – resin	Full mouth or panorex X-rays
D5213	Maxillary part denture – cst mtl	Full mouth or panorex X-rays
D5214	Mandibular part denture – cst metal	Full mouth or panorex X-rays
D5225	Partial denture – flexible base – maxillary	Full mouth or panorex X-rays
D5226	Partial denture – flexible base – mandibular	Full mouth or panorex X-rays
D5899	Unspec removable prostho proc, by report	Description of procedure and narrative of medical necessity
D5999	Maxillofacial prosthesis	Description of procedure and narrative of medical necessity
D6010	Surgical placement of implant body	Letter from the patient's dentist explaining why other covered functional alternatives for prosthetic replacement will not correct the patient's dental condition and why the patient requires implants • Complete treatment plan addressing all phases of care is required and should include the following: - All areas of pathology - Interarch distance - Tooth number - Type and location of implants to be placed - Design and type of planned restoration(s)/prosthetics - Sufficient number of current, diagnostic radiographs allowing for the evaluation of the entire dentition • Letter from patient's physician explaining how implants will alleviate the patient's medical condition, list of all medications currently being taken and all conditions currently being treated • Full mouth radiographs or diagnostic panoramic film including periapical radiographs of site requesting dental implant(s)

Code	Description	Required Documents
D6013	Surgical placement of mini implant	Letter from the patient's dentist explaining why other covered functional alternatives for prosthetic replacement will not correct the patient's dental condition and why the patient requires implants • Complete treatment plan addressing all phases of care is required and should include the following: - All areas of pathology - Interarch distance - Tooth number - Type and location of implants to be placed - Design and type of planned restoration(s)/prosthetics - Sufficient number of current, diagnostic radiographs allowing for the evaluation of the entire dentition • Letter from patient's physician explaining how implants will alleviate the patient's medical condition, list of all medications currently being taken and all conditions currently being treated • Full mouth radiographs or diagnostic panoramic film including periapical radiographs of site requesting dental implant(s)
D6052	Semi-precision attachment abutment	Periapical radiograph of integrated implant Panoramic film or sufficient number of radiographs showing the complete arch and the placed implant(s)
D6055	Connecting bar - implant supported or abutment supported	Periapical radiograph of integrated implant Panoramic film or sufficient number of radiographs showing the complete arch and the placed implant(s)
D6056	Prefabricated abutment - includes modification and placement	Periapical radiograph of integrated implant Panoramic film or sufficient number of radiographs showing the complete arch and the placed implant(s)complete arch and the placed implant(s)
D6057	Custom fabricated abutment - includes placement	Periapical radiograph of integrated implant Panoramic film or sufficient number of radiographs showing the complete arch and the placed implant(s)
D6058	Abutment supported porcelain/ceramic crown	Periapical radiograph of integrated implant Intraoral photo of the healed abutment showing healthy gingiva
D6059	Abutment supported porcelain fused to metal crown (high noble metal)	Periapical radiograph of integrated implant • Intraoral photo of the healed abutment showing healthy gingiva
D6060	Abutment supported porcelain fused to metal crown (predominantly base metal)	Periapical radiograph of integrated implant Intraoral photo of the healed abutment showing healthy gingiva
D6061	Abutment supported porcelain fused to metal crown (noble metal)	Periapical radiograph of integrated implant • Intraoral photo of the healed abutment showing healthy gingiva
D6062	Abutment supported cast metal crown (high noble metal)	Periapical radiograph of integrated implant • Intraoral photo of the healed abutment showing healthy gingiva
D6063	Abutment supported cast metal crown (predominately base metal)	Periapical radiograph of integrated implant • Intraoral photo of the healed abutment showing healthy gingiva
D6064	Abutment supported cast metal crown (noble metal)	Periapical radiograph of integrated implant • Intraoral photo of the healed abutment showing healthy gingiva
D6065	Implant supported porcelain/ceramic crown	Periapical radiograph of integrated implant • Intraoral photo of the healed abutment showing healthy gingiva
D6066	implant supported porcelain fused to metal crown (titanium, titanium alloy, high noble metal	Periapical radiograph of integrated implant • Intraoral photo of the healed abutment showing healthy gingiva
D6067	Implant supported metal crown (titanium, titanium alloy, high noble metal)	Periapical radiograph of integrated implant • Intraoral photo of the healed abutment showing healthy gingiva
D6081	Scaling and debridement in the presence of inflammation or mucositis of a single implant, including cleaning on the implant surfaces, without flap entry and closure	Documentation describing medical necessity
D6090	Repair implant supported prosthesis	Documentation describing medical necessity
D6091	Replacement of semi-precision or precision attachment (male or female component) of implant/abutment supported posthesis, per attachment	Documentation describing medical necessity
D6092	Re-cement or re-bond implant/abutment supported fixed partial denture	Documentation describing medical necessity
D6093	Re-cement or re-bond implant/abutment supported crown	Documentation describing medical necessity
D6094	Abutment supported crown (titanium)	Periapical radiograph of integrated implant • Intraoral photo of the healed abutment showing healthy gingiva
D6095	Repair implant abutment	Documentation describing medical necessity
D6096	Remove broken implant retaining screw	Documentation describing medical necessity
D6100	Implant removal	Documentation describing medical necessity

Code	Description	Required Documents
D6101	Debridement of a peri-implant defect or defects surrounding a single implant, and surface cleaning of the exposed implant surfaces, including flap entry and closure	Periapical radiographic of defect Documentation describing medical necessity Intraoral photo of defect area
D6102	Debridement and osseous contouring of a peri-implant defect or defects surrounding a single implant and includes surface cleaning of the exposed implant surfaces, including flap entry and closure	Periapical radiographic of defect Documentation describing medical necessity Intraoral photo of defect area
D6103	Bone graft for repair of peri-implant defect - does not include flap entry and closure	Periapical radiographic of defect Documentation describing medical necessity Intraoral photo of defect area
D6104	Bone graft at time of implant	Periapical radiographic of defect Documentation describing medical necessity Intraoral photo of defect area
D6110	Implant/abutment supported removable denture for edentulous arch - maxillary	Periapical radiograph of integrated implant • Intraoral photo of healed abutment showing healthy gingiva
D6111	Implant/abutment supported removable denture for edentulous arch - mandibular	Periapical radiograph of integrated implant • Intraoral photo of healed abutment showing healthy gingiva
D6112	Implant/abutment supported removable denture for partially edentulous arch - maxillary	Periapical radiograph of integrated implant • Intraoral photo of healed abutment showing healthy gingiva
D6113	Implant/abutment supported removable denture for partially edentulous arch - mandibular	Periapical radiograph of integrated implant • Intraoral photo of healed abutment showing healthy gingiva
D6190	Radiographic/surgical implant	Documentation describing medical necessity
D6199	Unspecified implant procedure,	Documentation describing medical necessity
D6210	Pontic – cast high noble metal	Full mouth or panorex X-rays
D6211	Pontic – cast base metal	Full mouth or panorex X-rays
D6212	Pontic – cast noble metal	Full mouth or panorex X-rays
D6240	Pontic – porc fused – high noble	Full mouth or panorex X-rays
D6241	Pontic – porcelain fused metal	Full mouth or panorex X-rays
D6242	Pontic – porce fused – noble metal	Full mouth or panorex X-rays
D6250	Pontic – resin with high noble met	Full mouth or panorex X-rays
D6251	Pontic – resin with base metal	Full mouth or panorex X-rays
D6252	Pontic – -resin with noble metal	Full mouth or panorex X-rays
D6545	Retainer – cast metal fixed	Full mouth or panorex X-rays
D6720	Crown – resin w/high noble metal	Full mouth or panorex X-rays
D6721	Crown – resin w/base metal	Full mouth or panorex X-rays
D6722	Crown – resin w/noble metal	Full mouth or panorex X-rays
D6750	Crown – porc fused high noble	Full mouth or panorex X-rays
D6751	Crown – porc fused to metal	Full mouth or panorex X-rays
D6752	Crown – porc fused noble metal	Full mouth or panorex X-rays
D6780	Crown – 3/4 cst high noble metal	Full mouth or panorex X-rays
D6790	Crown – full cast high noble	Full mouth or panorex X-rays
D6791	Crown – full cast base metal	Full mouth or panorex X-rays
D6792	Crown – full cast noble metal	Full mouth or panorex X-rays
D6970	Cast post/core & fixed retain	Pre-operative X-rays of adjacent teeth and opposing teeth
D6972	Prefab post & core + retainer	Pre-operative X-rays of adjacent teeth and opposing teeth
D6980	Fixed partial denture repair	Narrative of medical necessity with pre authorization
D6999	Fixed prosthodontic procedure	Description of procedure and narrative of medical necessity
D7899	unspecified TMD therapy, by report	
D7951	Sinus augmentation with bone or bone substitutes via a lateral open approach	Radiographs of area Narrative of necessity
D7953	Bone replacement graft for ridge preservation - per site	Radiographs of area Narrative of necessity
D8010	Limited Orthodontic Treatment Of The Primary Dentition	Cephelometric X-rays, Completed HLD index, Narrative of Case. Photos and Panorex X-rays are optional.

Code	Description	Required Documents
D8020	Limited Orthodontic Treatment Of The Transitional Dentition	Cephelometric X-rays, Completed HLD index, Narrative of Case. Photos and Panorex X-rays are optional.
D8030	Limited Orthodontic Treatment Of The Adolescent Dentition	Cephelometric X-rays, Completed HLD index, Narrative of Case. Photos and Panorex X-rays are optional.
D8040	Limited Orthodontic Treatment Of The Adult Dentition	Cephelometric X-rays, Completed HLD index, Narrative of Case. Photos and Panorex X-rays are optional.
D8050	Interceptive Orthodontic Treatment Of The Primary Dentition	Cephelometric X-rays, Completed HLD index, Narrative of Case. Photos and Panorex X-rays are optional.
D8060	Interceptive Orthodontic Treatment Of The Transitional Dentition	Cephelometric X-rays, Completed HLD index, Narrative of Case. Photos and Panorex X-rays are optional.
D8070	Comprehensive Orthodontic Treatment Of The Transitional Dentition	Cephelometric X-rays, Completed HLD index, Narrative of Case. Photos and Panorex X-rays are optional.
D8080	Comprehensive Orthodontic Treatment Of The Adolescent Dentition	Cephelometric X-rays, Completed HLD index, Narrative of Case. Photos and Panorex X-rays are optional.
D8090	Comprehensive Orthodontic Treatment Of The Adult Dentition	Cephelometric X-rays, Completed HLD index, Narrative of Case. Photos and Panorex X-rays are optional.
D8210	Removable Appliance Therapy	
D8220	Fixed Appliance Therapy	
D8680	Orthodontic Retention (Removal Of Appliances, Place Retainers)	
D8690	Orthodontic Treatment (Alternative Billing To A Contract Fee)	
D8999	Unspecified Orthodontic Procedure, By Report	
D9999	Unspecified adjunctive proc	

6.1.b **Prior Authorization Clinical Criteria for Medicaid, CHP, MLTC, Medicaid Advantage and HARP**

Unspecified procedures, by report

- Procedure cannot be adequately described by an existing code

Cast crowns / Resin- based composite

- Lessthan8pointsof(natural/prosthetic)posteriorcontactformembers21andoverforposteriorteeth
- Tooth to be crowned has contact in the opposing arch
- Molar tooth that has had RCT previously approved for members over21
- Minimum 50% bone support
- No periodontal furcation
- No subcrestal caries
- Clinically acceptable RCT if present
- Planned RCT if necessary
- Anterior – 50% incisal edge / 4+ surfaces involved
- Bicuspid – 1 cusp / 3+ surfaces involved
- Molar – 2 cusps / 4+ surfaces involved
- Porcelain / metal crowns allowed on anterior and maxillary 1st bicuspid teeth only

Cast posts and cores / Prefabricated post and cores

- Minimum 50% bone support
- No periodontal furcation
- No subcrestal caries
- Clinically acceptable RCT if present
- Planned RCT if necessary
- Insufficient remaining tooth structure

Crown repair
- Documentation supports procedure

Root canals
- Less than 8 points of (natural/prosthetic) posterior contact for members 21 and over for posterior teeth
- Molar is critical abutment for partial denture for members over 21
- Minimum 50% bone support
- No periodontal furcation
- No subcrestal caries
- Evidence of apical pathology /fistula
- Pain from percussion /temp
- Closed apex

Root canal retreatment
- Less than 8 points of (natural/prosthetic) posterior contact for members 21 and over for posterior teeth
- Minimum 50% bone support
- No periodontal furcation
- No subcrestal caries
- Evidence of apical pathology /fistula
- Pain from percussion /temp

Gingivectomy or gingivoplasty
- Hyperplasia or hypertrophy from drug therapy, hormonal disturbances or congenital defects
- Generalized 5mm or more pocketing indicated on the perio charting and novertical bone defects

Scaling and root planning
- Four or more teeth in thequadrant
- 5 mm or more pocketing on 2 or more teeth indicated on the periocharting
- Presence of root surface calculus and noticeable loss of bone support on X-rays

Crown Lengthening
- Healthy periodontal environment
- Intact dentition except for the tooth in question
- Minimum 50% bone support post surgery
- No periodontal furcation
- No subcrestal caries

Periodontal maintenance
- Periodontal scaling and root planning procedure more than 90 days previous

Full dentures
- Existing denture greater than 5 years old
- Remaining teeth do not have adequate bone support or are restorable

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

Partial dentures
- Less than 8 points of (natural/prosthetic) posterior contact for members 21 and over for posterior teeth
- Replacing one or more anterior teeth
- Existing partial denture greater than 5 years old
- Remaining teeth have greater than 50% bone support and are restorable

Fixed bridge work

- Normally considered beyond the scope of the program
- Patient under 21 years of age
- Only teeth missing are 1 maxillary anterior or 2 mandibular anteriors
- Pulpal anatomy allows crown preparation without pulpal exposure
- Documented evidence of good oral hygiene and minimal decay

Fixed partial denture repair

- Documentation supports need for procedure

Implants Effective 11/12/18 dental implants are covered by New York Medicaid when medically necessary. Prior approval with ALL listed specific documentation is required.

- **Implant medical necessity criteria:**
  - Documented reasons of inability for other covered functional alternatives to be used for prosthetic replacement and correction of the patient's dental condition
  - Documentation of a medical/surgical condition or complication that prevents the effective use of removable prosthesis.
- **Clinical Requirements (treatment must be reviewed at each stage):**
  - Submitted clinical documentation must show healthy bone and periodontium
  - If bone graft augmentation is requested, documentation must show medical necessity. If approved there must be a 4 to 6 month healing period prior to implant placement, and radiographic evidence of satisfactory healing/bone fill
  - Radiographs must show fully osseointegrated surgical implant body in place for 4-6 months with good crown /root ratio before implant prosthesis is placed
  - If periodontal surgical procedures are needed either prior to implant placement or for treatment of an existing implant, documentation must show medical necessity
- **Limitations and Exclusions:**
  - Not covered if an alternate prosthesis would suffice
  - Not covered for adults 21 and over if the member has a total of at least eight posterior teeth contacting when they chew, as this is considered functional occlusion.
  - Treatment on an existing implant / implant prosthetic will be evaluated on a case-by-case basis
  - The following codes are a covered benefit ONLY when associated with a covered implant or implant related service: **D4245, D4266, D4267, D4273, D4275, D4277, D4278, D4283, D4285, D7951, D7953**
    For bone augmentation or periodontal surgical services needed in preparation of implant placement, prior authorization MUST show medical necessity and be submitted at the same time the implant body placement is prior authorized (D4266, D4267, D7951, D7953)
    For periodontal surgical services needed to repair a peri-implant defect, documentation submitted for prior authorization MUST show medical necessity for an existing implant defect. These codes will NOT be a covered benefit for treatment related to natural teeth **(D4245, D4266, D4267, D4273, D4275, D4277, D4278, D4283, D4285)**
- **Required Documentation:**
- **Implant Body (D6010, D6013):**
  - Letter from the patient's dentist explaining why other covered functional alternatives for prosthetic replacement will not correct the patient's dental condition and why the patient requires implants
  - Complete treatment plan addressing all phases of care is required and should include the following:
    · All areas of pathology
    · Interarch distance
    · Tooth number
    · Type and location of implants to be placed
    · Design and type of planned restoration(s)/prosthetics

· Sufficient number of current, diagnostic radiographs allowing for the evaluation of the entire dentition

- Letter from patient's physician explaining how implants will alleviate the patient's medical condition, list of all medications currently being taken and all conditions currently being treated
- Full mouth radiographs or diagnostic panoramic film including periapical radiographs of site requesting dental implant(s)

- **Implant Supporting Structures (D6052, D6055, D6056, D6057):**
  - Periapical radiograph of integrated implant
  - Panoramic film or sufficient number of radiographs showing the complete arch and the placed implant(s)
- **Implant Prosthesis (D6058 – D6067, D6094):**
  - Periapical radiograph of integrated implant
  - Intraoral photo of the healed abutment showing healthy gingiva
- **Implant Related Treatment Radiographic / Surgical Index, Provisional Crown, Maintenance, Scaling, Repair (D6081, D6085, D6090, D6091, D6092, D6093, D6095, D6096, D6100, D6190, D6199):**
  - Documentation describing medical necessity
- **Implant Surgical Services (D6101 – D6104):**
  - Periapical radiographic of defect
  - Documentation describing medical necessity
  - Intraoral photo of defect area
- **Implant/Abutment Supported Removable Dentures (D6110 – D6113):**
  - Periapical radiograph of integrated implant
  - Intraoral photo of healed abutment showing healthy gingiva
- **Surgical Procedures in Preparation of Implant Body Placement (D4266, D4267, D7951, D7953)**
  - Radiographs of area
  - Documentation describing medical necessity
- **Surgical Procedures for Peri-implantitis and/or Periodontal Defects Associated with Implants (D4245, D4266, D4267, D4273, D4275, D4277, D4278, D4283, D4285)**
  - Radiographs of area
  - Complete 6 point periodontal charting
  - Documentation describing medical necessity

Occlusal guard

- Medically necessary for temporomandibular dysfunction (TMD) or bruxism

OR (Hospital Operating Room or Outpatient Facility) request

- Patient under six (6) years of age with extensive treatment needed
- Documentation supports indication of patient with a medical condition—(cardiac, cerebral palsy, epilepsy, or other condition that would render the patient non-compliant. Failed local anesthesia or situational anxiety will not qualify.)

Orthodontia

- Refer to the Orthodontic Information section for approval criteria.

6.1.c Prior Authorization Submission Criteria for Medicare

Code	Description	Required Documents
D2950	Core Buildup, Including Any Pins When Required	Pre-op x-rays
D2952	Post And Core In Addition To Crown, Indirectly Fabricated	Pre-op x-rays
D2953	Each Additional Indirectly Fabricated Post - Same Tooth	Pre-op x-rays
D2954	Prefabricated Post And Core In Addition To Crown	Pre-op x-rays
D2957	Each Additional Prefabricated Post - Same Tooth	Pre-op x-rays

Code	Description	Required Documents
D3310	Endodontic Therapy, Anterior Tooth (Excluding Final Restoration)	Pre-op x-rays
D3320	Endodontic Therapy, Bicuspid Tooth (Excluding Final Restoration)	Pre-op x-rays
D3330	Endodontic Therapy, Molar (Excluding Final Restoration)	Pre-op x-rays
D5110	Complete Denture - Maxillary	FMX or panorex x-rays
D5120	Complete Denture - Mandibular	FMX or panorex x-rays
D5130	Immediate Denture - Maxillary	FMX or panorex x-rays
D5140	Immediate Denture - Mandibular	FMX or panorex x-rays
D5211	Maxillary Partial Denture - Resin Base	FMX or panorex x-rays
D5212	Mandibular Partial Denture - Resin Base	FMX or panorex x-rays
D5213	Maxillary Partial Denture - Cast Metal Framework With Resin Denture Bases	FMX or panorex x-rays
D5214	Mandibular Partial Denture - Cast Metal Framework With Resin Denture Bases	FMX or panorex x-rays
D6010	Surgical Placement Of Implant Body: Endosteal Implant	Pre-op x-rays
D6012	Surgical Placement Of Interim Implant Body: Endosteal Implant	Pre-op x-rays
D6040	Surgical Placement: Eposteal Implant	Pre-op x-rays
D6050	Surgical Placement: Transosteal Implant	Pre-op x-rays
D6055	Connecting Bar - Implant Supported Or Abutment Supported	Pre-op x-rays
D6056	Prefabricated Abutment - Includes Modification And Placement	Pre-op x-rays
D6057	Custom Fabricated Abutment - Includes Placement	Pre-op x-rays
D6058	Abutment Supported Porcelain/Ceramic Crown	Pre-op x-rays
D6059	Abutment Supported Porcelain Fused To Metal Crown (High Noble Metal)	Pre-op x-rays
D6060	Abutment Supported Porcelain Fused To Metal Crown (Predominantly Base Metal)	Pre-op x-rays
D6061	Abutment Supported Porcelain Fused To Metal Crown (Noble Metal)	Pre-op x-rays
D6062	Abutment Supported Cast Metal Crown (High Noble Metal)	Pre-op x-rays
D6063	Abutment Supported Cast Metal Crown (Predominantly Base Metal)	Pre-op x-rays
D6064	Abutment Supported Cast Metal Crown (Noble Metal)	Pre-op x-rays
D6065	Implant Supported Porcelain/Ceramic Crown	Pre-op x-rays
D6066	Implant Supported Porcelain Fused To Metal Crown	Pre-op x-rays
D6067	Implant Supported Metal Crown	Pre-op x-rays
D6068	Abutment Supported Retainer For Porcelain/Ceramic Fpd	Pre-op x-rays
D6069	Abutment Supported Retainer For Porcelain Fused To Metal Fpd (High Noble Metal)	Pre-op x-rays
D6070	Abutment Supported Retainer For Porcelain Fused To Metal Fpd (Base Metal)	Pre-op x-rays
D6071	Abutment Supported Retainer For Porcelain Fused To Metal Fpd (Noble Metal)	Pre-op x-rays
D6072	Abutment Supported Retainer For Cast Metal Fpd (High Noble Metal)	Pre-op x-rays
D6073	Abutment Supported Retainer For Cast Metal Fpd (Base Metal)	Pre-op x-rays
D6074	Abutment Supported Retainer For Cast Metal Fpd (Noble Metal)	Pre-op x-rays
D6075	Implant Supported Retainer For Ceramic Fpd	Pre-op x-rays
D6076	Implant Supported Retainer For Porcelain Fused To Metal Fpd	Pre-op x-rays
D6077	Implant Supported Retainer For Cast Metal Fpd	Pre-op x-rays
D6080	Implant Maintenance Procedures, Including Removal And Reinsertion Of Prosthesis	Narrative of medical necessity with claim
D6090	Repair Implant Supported Prosthesis, By Report	Narrative of medical necessity with claim
D6091	Replacement Of Semi-Precision Or Precision Attachment	Narrative of medical necessity with claim
D6092	Recement Implant/Abutment Supported Crown	Narrative of medical necessity with claim
D6093	Recement Implant/Abutment Supported Fixed Partial Denture	Narrative of medical necessity with claim
D6094	Abutment Supported Crown (Titanium)	Pre-op x-rays
D6095	Repair Implant Abutment, By Report	Narrative of medical necessity with claim
D6096	Remove broken implant retaining Screw	Pre-op x-rays
D6100	Implant Removal, By Report	Pre-op x-ray of crown and narrative of medical necessity

Code	Description	Required Documents
D6190	Radiographic/Surgical Implant Index, By Report	Narrative of medical necessity with claim
D6194	Abutment Supported Retainer Crown For Fpd (Titanium)	Pre-op x-rays
D6199	Unspecified Implant Procedure, By Report	Description of procedure and narrative of medical necessity
D6205	Pontic - Indirect Resin Based Composite	Pre-op x-rays
D6210	Pontic - Cast High Noble Metal	Pre-op x-rays
D6211	Pontic - Cast Predominantly Base Metal	Pre-op x-rays
D6212	Pontic - Cast Noble Metal	Pre-op x-rays
D6240	Pontic - Porcelain Fused To High Noble Metal	Pre-op x-rays
D6241	Pontic - Porcelain Fused To Predominantly Base Metal	Pre-op x-rays
D6242	Pontic - Porcelain Fused To Noble Metal	Pre-op x-rays
D6245	Pontic - Porcelain/Ceramic	Pre-op x-rays
D6250	Pontic - Resin With High Noble Metal	Pre-op x-rays
D6251	Pontic - Resin With Predominantly Base Metal	Pre-op x-rays
D6252	Pontic - Resin With Noble Metal	Pre-op x-rays
D6253	Provisional Pontic	Pre-op x-rays
D6545	Retainer - Cast Metal For Resin Bonded Fixed Prosthesis	Pre-op x-rays
D6548	Retainer - Porcelain/Ceramic For Resin Bonded Fixed Prosthesis	Pre-op x-rays
D6710	Crown - Indirect Resin Based Composite	Pre-op x-rays
D6720	Crown - Resin With High Noble Metal	Pre-op x-rays
D6721	Crown - Resin With Predominantly Base Metal	Pre-op x-rays
D6722	Crown - Resin With Noble Metal	Pre-op x-rays
D6740	Crown - Porcelain/Ceramic	Pre-op x-rays
D6750	Crown - Porcelain Fused To High Noble Metal	Pre-op x-rays
D6751	Crown - Porcelain Fused To Predominantly Base Metal	Pre-op x-rays
D6752	Crown - Porcelain Fused To Noble Metal	Pre-op x-rays
D6780	Crown - 3/4 Cast High Noble Metal	Pre-op x-rays
D6781	Crown - 3/4 Cast Predominantly Base Metal	Pre-op x-rays
D6782	Crown - 3/4 Cast Noble Metal	Pre-op x-rays
D6783	Crown - 3/4 Porcelain/Ceramic	Pre-op x-rays
D6790	Crown - Full Cast High Noble Metal	Pre-op x-rays
D6791	Crown - Full Cast Predominantly Base Metal	Pre-op x-rays
D6792	Crown - Full Cast Noble Metal	Pre-op x-rays
D6793	Provisional Retainer Crown	Pre-op x-rays
D6794	Crown - Titanium	Pre-op x-rays
D6920	Connector Bar	Pre-op x-rays
D6930	Recement Fixed Partial Denture	Pre-op x-rays
D6940	Stress Breaker	Pre-op x-rays
D6950	Precison Attachment	Pre-op x-rays
D6980	Fixed Partial Denture Repair	Narrative of medical necessity with claim

6.1.d **Prior Authorization Submission Criteria for Medicare**

Core buildup D2950
- Minimum 50% bone support
- No periodontal furcation
- No subcrestal caries
- Clinically acceptable RCT
- Cuspid – 1 cusp / 2+ surfaces involved
- Bicuspid – 1 cusp / 3+ surfaces involved
- Molar – 2 cusps / 4+ surfaces involved

Cast posts and cores / Prefabricated post and cores D2952 – D2954, D2957
- Minimum 50% bone support
- No periodontal furcation
- No subcrestal caries
- Clinically acceptable RCT

Root canals D3310 – D3330
- Minimum 50% bone support
- No periodontal furcation
- No subcrestal caries
- Evidence of apicalpathology/fistula
- Pain from percussion /temp
- Closed apex

Implant, surgical placement D6010, D6012, D6040, D6050
- Documentation shows healthy bone and periodontium

Implant, supporting structures D6055 – D6057
- Documentation shows fully integrated surgical implant with good crown / root ratio
- Healthy bone and periodontium surrounding surgical implant

Implant single crowns, abutment or implant supported D6058 – D6067, D6094
- Documentation shows fully integrated surgical implant with good crown / root ratio
- Healthy bone and periodontium surrounding surgical implant

Remove broken Implant retaining screw D6096
- Documentation supports need to remove screw

Implant fixed partial denture, abutment or implant supported D6068 – D6077, D6194
- Documentation shows fully integrated surgical implant with good crown / root ratio
- Healthy bone and periodontium surrounding surgical implant

Implant maintenance / repair D6080, D6090, D6095
- Documentation describes medical necessity

Replacement of semi-precision or precision attachment D6091
- Documentation supports need to replace attachment

Remove broken Implant retaining screw D6096
- Documentation supports need to remove screw

Recement implant /abutment supported crown/fixed partial denture D6092, D6093
- Documentation describes medical necessity

Implant removal, by report D6100
- Documentation describes medical necessity for surgical removal of an implant

Radiographic / surgical implant index, by report D6190
- Documentation describes medical necessity for implant planning

Fixed partial denture pontics / retainers D6205 – D6212, D6240 – D6252, D6545, D6548, D6710 – D6792, D6794, D6975
- Minimum 50% bone support on abutments
- No periodontal furcation on abutments
- No subcrestal caries on abutments
- Clinically acceptable RCT on abutments
- One of the abutment crowns is defective on existing bridge
- One of the abutment crowns has recurrent decay on existing bridge
- One of the abutment crowns needs root canal on existing bridge

Provisional pontic / retainer D6253, D6793
- Documentation describes medical necessity

Recement fixed partial denture D6930
- Documentation describes medical necessity

Connector bar / stress breaker / precision attachment D6920, D6940, D6950
- Attachment will significantly enhance function

Fixed partial denture repair, by report D6980
- Documentation describes medical necessity

Unspecified procedures, by report D6199
- Procedure cannot be adequately described by an existing code

6.1.e **Authorization Decisions – Turnaround Times & Filing Limits**

UnitedHealthcare will render a decision and notify member and provider by phone and in writing within three 3 business days of receipt of necessary information or for UnitedHealthcare Community Plan for Families/Adults, as fast as the enrollee's condition requires and (1) within 3 business days of receipt of an expedited authorization request or (2) in all other cases, within 3 business days of receipt of necessary information but no more than 14 days of the request.

Services must be performed within 180 days from the date that the approval notification is received by the practitioner.

Providers will receive a verbal notification of the decision within 3 days of receipt of the prior authorization request.

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

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

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

6.1.f **Payment for non-covered services:**

When non-covered services are provided for Medicaid, CHP, MLTC, Medicaid Advantage, HARP and Dual Complete members, providers shall hold members and UnitedHealthcare harmless except as outlined below.

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

- That the member was informed and given written acknowledgment regarding proposed treatment plan and associated costs in advance of rendering treatment;
- That those specific services are not covered under the member's plan and that the member is financially liable for such services rendered.

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

6.1.g **After Hours Emergency**

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

1. Confirm patient eligibility on the date of service through our website **uhcproviders.com**, or our Interactive Voice Response system **1-800-304-0634**.
2. Consult the benefit guide included in this Manual to determine if services are covered under the plan and if prior authorization is required for the service.
3. Covered services that do not require prior authorization can be rendered.
4. If prior authorization is required for a needed service, the provider should relieve the patient's immediate pain with covered services that do not require prior authorization. (e.g., palliative treatment or sedative filling). The provider will submit a written request for prior authorization, and may call the provider call center on the next business day to request information for submitting an expedited prior authorization request.

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

6.1.h **Missed Appointment Fees**

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

Medicaid and CHP members are held harmless and cannot be billed for a missed appointment, whether or not the member gave prior notice to the provider office.

Section 7: **Radiology Requirements**

To learn what Prior Authorization requests would require radiographs, refer to section 5.1.a of the Manual (Prior Authorization Submission Criteria).

Guidelines for providing radiographs are as follows:

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

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

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

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

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

Section 8: **Claim Submission Procedures**

8.1 **Claim Submission Best Practices & Required Elements**

Dental Claim Form

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

Claim Submission Options

Electronic Claims

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

Electronic claims processing requires access to a computer and usually the use of practice management software. Electronically generated claims can be submitted through a clearinghouse or directly to our claims processing system via the Internet. Most systems have the ability to detect missing information on a claim form and notify you when errors need to be corrected. Electronic submission is private as the information being sent is encrypted. Please call **1-800-304-0634** for more information regarding electronic claims submission.

Payer ID GP133

Paper Claims

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

All dental claims must be legible. Computer-generated forms are recommended. Additional documentation and radiographs should be attached, when applicable. Such attachments are required for pre-treatment estimates and for the submission of claims for complex clinical procedures.

Dental Claim Form Required Information

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

Header Information

Indicate the type of transaction by checking the appropriate box: Statement of Actual Services or Request for Pre-Treatment Estimate.

Subscriber information

- Name (Last, First and Middle Initial)
- Address, City, State, ZIP Code
- Date of Birth
- Gender
- Subscriber ID number

Patient information

- Name (Last, First and Middle Initial)
- Address, City, State, ZIP Code
- Date of Birth
- Gender
- Patient ID number

Primary Payer Information

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

Other Coverage

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

Other Insured's Information (only if other coverage exists)

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

- Name of subscriber/policy holder (Last, First and Middle Initial)
- Date of Birth and Gender
- Subscriber Identification number
- Relationship to the Member

Billing Dentist or Dental Entity

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

- Name
- Address, City, State, ZIP Code
- License number
- TIN
- Phone number

National Provider Identifier (NPI)

Treating Dentist and Treatment Location

List the following information regarding the dentist that provided treatment:

- Certification – Signature of dentist and the date the form was signed
- Name (use name provided on the Practitioner Application)
- License number
- TIN
- Address, City, State, ZIP Code
- Phone number
- National Provider Identifier(NPI)

Record of Services Provided

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

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

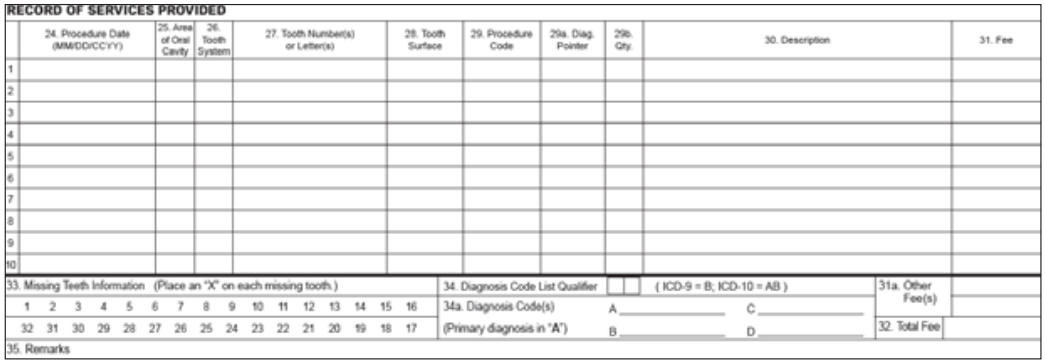
Missing Teeth Information

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

Remarks Section

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

ICD10 Instructions



RECORD OF SERVICES PROVIDED

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

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

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

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

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

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

31a. Other Fee(s)

32. Total Fee

35. Remarks

Instructions:

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

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

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

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

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

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

By Report Procedures

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

Using Current ADA Codes

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

Insurance Fraud

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

Any person who knowingly files a claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties. By signing a claim for services, the practitioner certifies that the services shown on the claim were medically indicated and necessary for the health of the patient

and were personally furnished by the practitioner or an employee under the practitioner's direction. The practitioner certifies that the information contained on the claim is true and accurate.

8.2 Claim Appeals

A provider appeal must be submitted within 60 calendar days after the receipt of the Provider Remittance Advice and/or decision. Instances where a provider is pursuing an appeal on behalf of a member are subject to the Member Appeal process in this Manual.

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

8.3 HIPAA-Compliant 837D File

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

8.4 Coordination of Benefits (COB)

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

The practitioner office is required to identify when a patient has coverage through multiple carriers and to inform UnitedHealthcare of such on each impacted claim form.

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

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

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

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

8.5 Timely Submission

All **Medicaid, CHP, MLTC, Medicaid Advantage and HARP** claims for primary insurance coverage should be submitted within 120 days of the date of service. Claims for secondary insurance coverage must be submitted within 68 days from the date that the provider received the explanation of benefits from the primary insurance carrier.

UnitedHealthcare will reconsider claims denied for timely filing when a provider can demonstrate that the untimely submission was due to a one-time unusual circumstance. The provider must have an established pattern of timely claims submission and the claim must be received within 365 days from the date of service in order for UnitedHealthcare to reconsider the denial.

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

All **Medicare** claims should be submitted within 1 year of the date of service.

8.6 Claim Adjudication and Periodic Overview

100% of clean EDI claims adjudicated within 30 days

100% of clean Paper claims adjudicated within 45 days

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

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

8.7 Explanation of Dental Plan Reimbursement

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

Below is a list and description of each field:

PROVIDER NAME AND ID NUMBER Treating dentist's name and practitioner ID number

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

AMOUNT BILLED Amount submitted by provider

AMOUNT PAYABLE Amount payable after benefits have been applied

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

OTHER INSURANCE Amount payable by another carrier

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

NET AMOUNT Total amount paid

PATIENT NAME

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

PATIENT DOB

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

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

ENCOUNTER NUMBER Claim reference number

BENEFIT LEVEL In our out-of-network coverage

LINE ITEM NUMBER Reference number for item number within a claim

DOS Date of service for service performed.

CDT CODE

TOOTH NO Tooth/teeth number

SURFACE(S) Surface(s) of tooth/teeth

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

QTY OR NO OF UNITS Quantity or number of units. Default to 1.

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

PAYABLE AMOUNT Contracted amount

COPAY AMOUNT Member responsibility

COINSURANCE AMOUNT Member responsibility of total payment amount

DEDUCTIBLE AMOUNT Member responsibility before benefits begin

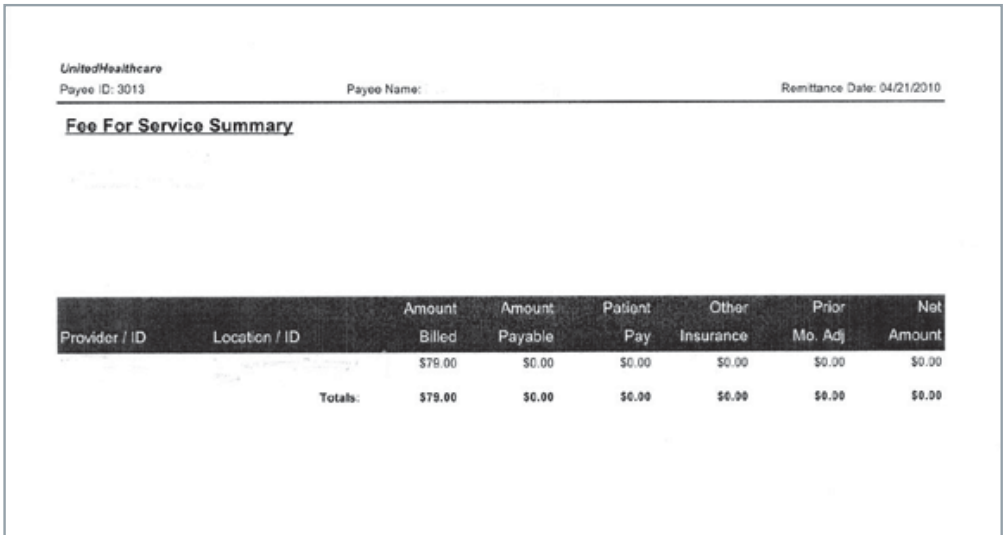
PATIENT PAY Amount to be paid by the member

OTHER INSURANCE AMOUNT Amount paid by other carriers

NET AMOUNT Final amount to be paid

EXCEPTION CODES Codes that explain how the claim was adjudicated

8.8.a **Explanation of Benefits Sample (Front)**



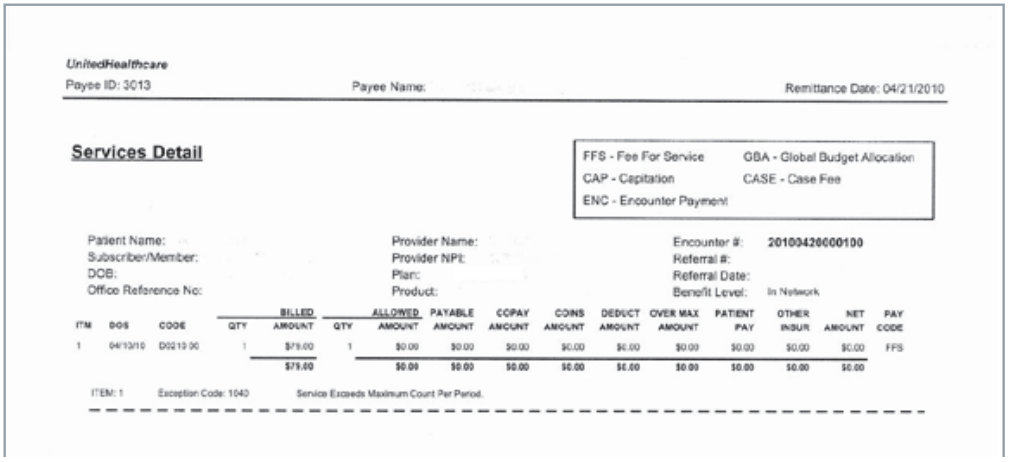
UnitedHealthcare

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

Fee For Service Summary

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

8.8.a **Explanation of Benefits Sample (Back)**



UnitedHealthcare

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

Services Detail

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

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

Provider Name:
Provider NPI:
Plan:
Product:

Encounter #: 20100420000100
Referral #:
Referral Date:
Benefit Level: In Network

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

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

Section 9: **Quality Management**

9.1 **Quality Improvement Program (QIP) Description**

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

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

The QIP is in place to:

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

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

A complete copy of our QIP policy and procedure is available upon request by contacting Provider Services at **844-275-8750**.

9.2 **Credentialing**

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

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

Before an applicant dentist is accepted as a participating provider, the dentist's credentials are evaluated. Initial facility site visits are required for some plans and/or markets. Please note that a site visit is required for each location. If a new location is added after initial contracting is completed, a site visit may be required for the new location before patients can be seen. Your Professional Networks Representative will inform you of any facility visits needed during the recruiting process. Offices must pass the facility review prior to activation.

The Dental Director and the Credentialing Committee review the information submitted in detail based on approved credentialing criteria. UnitedHealthcare will request a resolution of any discrepancy in credentialing forms submitted. Practitioners have the right to review and correct erroneous information and to be informed of the status of their application. Please refer to the Appendix of this manual for additional details regarding practitioner rights.

Credentialing criteria are reviewed by advisory committees, which include input from practicing network providers to make sure that criteria are within generally accepted guidelines. You have the right to appeal any decision regarding your participation made by UnitedHealthcare based on information received during the credentialing or recredentialing process. To initiate an

appeal of a credentialing or recredentialing decision, please follow the instructions provided in the determination letter received from the Credentialing department.

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

Provisional credentialing is extended to NY practitioners that are joining an existing participating provider group or have recently moved to NY, on the 91st day after receipt of the application. The practitioner will be notified in writing of their provisional status.

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

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

If you are new to CAQH ProView, visit ADA.org/godigital to get started.

If you are already using CAQH ProView, we are able to accept your CAQH ID number provided that your profile data, credentialing documents and attestation show Complete and Current.

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

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

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

A list of the documents required for Initial Credentialing and Recredentialing is as follows:

Initial Credentialing

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

Recredentialing

- Completed Recredentialing application
- Signed and dated Attestation
- Current copy of their state license
- Current copy of their Drug Enforcement Agency (DEA) certificate

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

Any questions regarding your initial or recredentialing status can be directed to Provider Services at **1-800-822-5353**.

9.3 **Site Visits**

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

Providers must keep separate medical records for each enrollee. Records must be kept for a period of six years following the date of service rendered to enrollees and for a minor, three years after majority or six years after the date of service, whichever is later.

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

9.4 **Preventive Health Guidelines**

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

UnitedHealthcare's National Clinical Policy and Technology Committee reviews current professional guidelines and processes while consulting the latest literature, including but not limited to current ADA Current Dental Terminology (CDT), and specialty guidelines as suggested by organizations such as the American Academy of Pediatric Dentistry, American Academy of Periodontology, American Association of Endodontists, American Association of Oral and Maxillofacial Surgeons, and the American Association of Dental Consultants. Additional resources include publications such as the Journal of Evidence-Based Dental Practice, online resources obtained via the Library of Medicine, and evidence-based clearinghouses such as the Cochrane Oral Health Group and Centre for Evidence Based Dentistry as well as respected public health benchmarks such as Healthy People 2020 and the Surgeon General's Report on Oral Health in America. Preventive health focuses primarily on the prevention, assessment for risk, and early treatment of caries and periodontal diseases, but also encompasses areas including prevention of malocclusion, oral cancer prevention and detection, injury prevention, avoidance of harmful habits and the impact of oral disease on overall health. Preventive health recommendations for children are intended to be consistent with American Academy of Pediatric Dentistry periodicity recommendations.

Caries Management begins with a complete evaluation including an assessment for risk.

- X-ray periodicity – X-ray examination should be tailored to the individual patient and should follow current professionally accepted dental guidelines necessary for appropriate diagnosis and monitoring.
- Recall periodicity – Frequency of recall examination should also be tailored to the individual patient based on clinical assessment and risk assessment.
- Preventive interventions – Interventions to prevent caries should consider AAPD periodicity guidelines while remaining tailored to the needs of the individual patient and based on age, results of a clinical assessment and risk, including application of prophylaxis, fluoride application, placement of sealants and adjunctive therapies where appropriate.
- Consideration should be given to conservative nonsurgical approaches to early caries, such as Caries Management by Risk Assessment (CAMBRA), where the lesion is non-cavitating, slowing progressing or restricted to the enamel or just the dentin; or alternatively, where appropriate, to minimally invasive approaches, conserving tooth structure whenever possible.

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

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

Oral cancer screening should be performed for all adults and children in late adolescence or younger if there is a personal or family history, if the patient uses tobacco products, or if there are additional factors in the patient history, which in the judgment of the practitioner elevate their risk. Screening should be done at the initial evaluation and again at each recall. Screening should include, at a minimum, a manual/ visual exam, but may include newer screening procedures, such as light contrast or brush biopsy, for the appropriate patient.

Additional areas for prevention evaluation and intervention includes malocclusion, prevention of sports injuries and harmful habits (including but not limited to digit- and pacifier-sucking, tongue thrusting, mouth breathing, intraoral and perioral piercing, and the use of tobacco products). Other preventive concerns may include preservation of primary teeth, space maintenance and eruption of permanent dentition. UnitedHealthcare may perform clinical studies and conduct interventions in the following target areas:

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

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

Section 10: **Utilization Management Program**

10.1 **Utilization Management**

Through Utilization Management practices, UnitedHealthcare aims to provide its members cost-effective, quality dental care through participating providers. By integrating data from a variety of sources, including individual Financial Analysis reporting, Utilization Review, claims data and individual audit reporting, UnitedHealthcare can evaluate group and individual practice patterns and identify those patterns which deviate from the norm.

By identifying and correcting aberrant provider practice patterns, we can not only reduce the overall impact of such behavior on the cost of care, but also improve the quality of dental care delivered.

10.2 **Community Practice Patterns**

Utilization analysis is completed using data from a variety of sources. The process compares group performance across a variety of procedure categories and subcategories including diagnostic, preventive, minor restorative (fillings), major restorative (crowns), endodontics, periodontics, fixed prosthetics (bridges), removable prosthetics (dentures), oral surgery and adjunctive procedures. The percentage of procedures performed in any given category relative to total procedures are compared with benchmarks such as similarly designed UnitedHealthcare plans, to determine if utilization for that category is within expected levels. This method, which looks at the mix of procedures and incurred claims, was chosen in part because it is consistent with other forms of reporting at UnitedHealthcare.

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

10.3 **Evaluation of Utilization Management Data**

Once the initial Utilization Management data is analyzed, if a dentist is identified as having potentially aberrant practice patterns, utilization may be reviewed at the individual claims level. For each specific dentist, an Audit Report may be run that identifies all procedures performed on all patients for a specified time period. For those dentists who practice at multiple sites, these reports are typically done on a site-by-site basis.

Examples of aberrant patterns could include upcoding, unbundling, miscoding, excessive treatments per patient (e.g., doing 15 restorations at one sitting), duplicate billing, or duplicate payments. Once completed, a sample of patients may be identified for chart audit. The number varies depending on the number of patients on the dentist's panel in the time period being studied and the severity of the problems noted.

10.4 **Utilization Review Data Results**

Review findings are shared with individual practitioners in order to provide feedback relative to their peers as well as recommended follow up.

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

- Provider Manual/Standards of Care
- Provider Training
- Continuing Education and Focus Groups
- Provider NewsFlash

Finally, internal interventions may be indicated. These can include improvements to existing policies and procedures, specific interventions and creation of feedback mechanisms to make sure that corrections take place.

In all instances, practitioners will be provided with contact information that they can call to review results and ask any questions they may have.

10.5 **Fraud and Abuse**

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

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

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

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

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

Section 11: **Evidence-Based Education**

11.1 **Evidence-Based Dentistry and the Clinical Policy and Technology Committee**

According to the American Dental Association®, Evidence-Based Dentistry can be defined as:

"...an approach to oral health care that requires the judicious integration of systematic assessments of clinically relevant scientific evidence, relating to the patient's oral and medical condition and history, with the dentist's clinical expertise and the patient's treatment needs and preferences."

The search for evidence usually begins with a clinical question. The process for answering that question can be described by the acronym P.I.C.O., which stands for:

- **P**roblem or **P**opulation
- **I**ntervention under investigation
- How it is being **C**ompared
- The expected **O**utcome

In trying to find the answers to a given clinical question, evidence is gathered in the form of information, typically from scientific journals. It is important to keep in mind though, that not all "evidence" is created equal. The "ladder of evidence" is as follows:

- Anecdote/Expert Opinion
- Case Study
- Case Series
- Retrospective Study
- Randomized Controlled Trial (RCT)
- Systematic Review (a review of RCTs)

Of course, systematic reviews or randomized controlled trials are not available to answer all clinical questions we might have. This is why we indicate that we are using the "best available current evidence."

Searching for evidence, we can consult a variety of sources including:

- Electronic indices — Medline®, PubMed®, Cochrane Library, National Guideline Clearinghouse (AHRQ)
- Hand search of the scientific literature
- Reference listings in other articles
- Alternative sources — theses, dissertations, conference reports, abstracts, unpublished studies ("gray literature")

Once data is collected, we want to review its usefulness in answering our question(s):

- How the study was designed
- How subjects for the study were chosen and grouped
- How statistics were applied — did it lead to the correct conclusions?

Sometimes a technique called meta-analysis is used. Meta-analysis is a term used to describe combining the analysis and summarizing the results of several individual studies into one analysis. Systematic reviews often make use of meta-analysis.

Once we have reviewed our data, we need to interpret the evidence, considering the strength of evidence, limitations of the review, implications for additional research and clinical implications. We also want to build consensus — bringing different expertise and opinions into the interpretation and working toward buy-in by as many stakeholders as possible.

How can evidence-based dentistry be used? It can be used in clinical practice to:

- Define a clinical problem or question
- Search for the best evidence
- Evaluate the evidence

- Determine how it would apply to the patient
- Determine treatment

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

- Practice guidelines, parameters and algorithms based on evidence and consensus
- Comparing dentist quality and utilization data against guidelines
- Chart auditing, site visits, credentialing

The development of evidence-based guidelines at UnitedHealthcare is the job of our Clinical Policy and Technology Committee.

The Committee consists of a mixture of employed and participating dentists. The participating dentists represent several specialties including general practice, endodontics, periodontics and oral surgery. In addition, we have access to academic institutions and other professional experts.

The Committee meets quarterly and reviews the evidence-based literature, making recommendations on clinical practice guidelines and new technologies. Our goal is not to create new guidelines but to review existing guidelines and scientific literature from sources such as specialty societies, guidelines clearinghouses such as the Cochrane Oral Health Group and National Guideline Clearinghouse, government agencies such as AHQR and NIDCR, electronic sites such as PubMed and the Centre for Evidence-Based Dentistry, and evidence-based journals such as the *Journal of Evidence-Based Dental Practice*.

Determinations are shared with dentists in our provider newsletter NewsFlash, and do influence a variety of business functions, including Utilization Management and claims criteria, marketing and underwriting collateral, and this Manual.

Recommendations can result in new products or enhanced benefits for members. Recent examples include: oral cancer screening benefit, implant benefit, enhanced benefits for periodontal maintenance and pregnant members, and delivery of locally placed antibiotics.

Evidence-based dentistry is a methodology to help reduce variation and determine “what works.” It can be utilized on the individual patient, practice, plan or population levels. Best of all, it’s more than a process — it’s a way of thinking about care.

Section 12: **Governing Administrative Policies**

12.1. **Appointment Scheduling Standards**

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

* Emergency Care or Urgent Appointments: Immediately or within 24 hours

* *Elective or Routine Care Appointments: Offered within 4 weeks of the request

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

*Urgent Care appointments would be needed if a patient is experiencing excessive bleeding, pain or trauma.

* *Providers are encouraged to schedule members appropriately to avoid inconveniencing the members with long wait times in excess of thirty (30) minutes. Members should be notified of anticipated wait times and given the option to reschedule their appointment.

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

Missed Appointments

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

12.2. **Emergency Coverage**

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

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

12.3 **New Associates**

As your practice expands and changes and new associates are added, you must contact us within 10 calendar days to request an application so that we may get them credentialed and set up as a participating provider. It is important to remember that associates may not see members as a participating provider until they've been credentialed by our organization.

If you have any questions or need to receive a copy of our provider application packet, please contact Provider Services at **1-800-822-5353**.

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

When there are demographic changes within your office, you must notify us at least 10 calendar days prior to the effective date of the change. This supports accurate claims processing as well as helps to make sure that member directories are up-to-date..

Changes should be faxed to: **1-866-829-1841**

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

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

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

If you have any questions, don't hesitate to contact Provider Services at 1-800-822-5353 for guidance.

12.5 **Office Conditions**

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

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

12.6 **Sterilization and Asepsis Control Fees**

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

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

12.7 **Recall System**

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

12.8 **Transfer of Dental Records**

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

12.9 **Non-Discrimination**

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

12.10 **Cultural Competency**

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

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

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

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

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

Section 13: **Plan Specific Information**

Product Overview

In New York, UnitedHealthcare offers the following products:

- Medicaid
- CHP
- HARP
- MLTC
- Dual Complete
- Medicaid Advantage

13.1 Medicaid and CHP

Medicaid

Medicaid is a program for New Yorkers who can't afford to pay for medical care.

CHP

Children must be under the age of 19 and be residents of New York State to be eligible for Child Health Plus. Whether a child qualifies for Children's Medicaid or Child Health Plus depends on gross family income.

13.2 Medicare Plans

UnitedHealthcare Dual Complete (Medicare)

UnitedHealthcare Dual Complete is a Special Needs Plan (SNP) for people with Medicare (Parts A & B) and Medicaid eligibility under Title XIX. This program, which is approved by the federal government is available to individuals who reside in Bronx, Kings, Nassau, New York, Queens and Richmond counties.

UnitedHealthcare Dual Advantage (Medicare)

UnitedHealthcare Dual Advantage Plan is the Medicaid benefit for Dual Eligible members that have both Medicaid and Medicare through UnitedHealthcare Community Plan. When a member has Dual Advantage and Medicaid through UnitedHealthcare Community Plan, Coordination of Benefits is automatic. Providers are required to submit only one claim. The single claim will be adjudicated under both benefit plans.

Please see the Covered Services sections within this manual for a detailed list of covered services.

Section 14: **Fraud Waste & Abuse Training**

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

1. Provide detailed information about the Federal False Claims Act,
2. Cite administrative remedies for false claims and statements,
3. Reference state laws pertaining to civil or criminal penalties for false claims and statements, and
4. With respect to the role of such laws in preventing and detecting fraud, waste and abuse in federal health care programs, include as part of such written policies, detailed provisions regarding care providers policies and procedures for detecting and preventing fraud, waste and abuse.

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

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

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

Appendix A

Practitioner Rights Bulletin

1. Providers applying for initial credentialing do not have appeal rights, unless required by State regulation.
2. Providers rejected for re-credentialing based on a history of adverse actions, and who have no active sanctions, have appeal rights only in states that require them or due to Quality of Care concerns against DBP members. An appeal, if allowed, must be submitted within 30 days of the date of the rejection letter. The provider has the right to be represented by an attorney or another person of the provider's choice.
3. Appeals are reviewed by Peer Review Committee (PRC). The PRC panel will include at least one member who is of the same specialty as the provider who is submitting the appeal.
4. PRC will consider all information and documentation provided with the appeal and make a determination to uphold or overturn the Credentialing Committee's decision. The PRC may request a corrective action plan, a Site Visit, and/or chart review.
5. Within ten days of making a determination, the PRC will send the provider, by certified mail, written notice of its final decision, including reasons for the decision.

To review your information

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

To correct erroneous information

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

To be informed of status of your application

You may submit your application status questions to us in writing (U.S. mail, e-mail, facsimile) or telephonically.

To appeal adverse Committee Decisions

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

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

Provider Terminations and Appeals

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

Breach of Provider Agreement

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

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

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

Quality-of-Care Issues.

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

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

Note

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

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

Review Process

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

1. Cases which meet disciplinary or malpractice criteria are initially reviewed by the Credentialing Committee. Other quality-of-care cases are reviewed by the Peer Review Committee.
2. The Committees make very effort to obtain a provider narrative and appropriate documents prior to making any determination.
3. The Committees may elect to accept, suspend, unpublish, place a provider on probation, require corrective action or terminate the provider.
4. The provider will be allowed to continue to provide services to members for a period of up to sixty (60) days from the date of the provider's notice of termination.
5. The Hearing Committee will immediately remove from our network any provider who is unable to provide health care services due to a final disciplinary action. In such cases, the provider must cease treating members upon receipt of this determination.

Appeals Process

1. Providers are notified in writing of their appeal rights within fifteen (15) calendar days of the Committee's determination. The letter will include the reason for denial/termination; notice that the provider has the right to request a hearing or review, at the provider's discretion, before a panel appointed by DBP UnitedHealthcare; notice of a thirty (30)-day time frame for the request; and, a time limit for the hearing date, which must be held within thirty (30) days after the receipt of a request for a hearing.
2. Providers must request an appeal in writing within thirty (30) calendar days of the date of notice of termination, and provide any applicable information and documentation to support the appeal.
3. The Hearing will be scheduled within thirty (30) days of the request for a hearing.
4. The appeal may be heard telephonically, unless the clinician requests an in-person hearing. In such cases, all additional costs relevant to the Hearing are the provider's responsibility.

5. The Hearing Committee includes at least three members appointed by DBP UnitedHealthcare, who are not in direct economic competition with the provider, and who have not acted as accuser, investigator, fact-finder, or initial decision-maker in the matter. At least one person on the panel will be the same discipline or same specialty as the person under review. The panel can consist of more than three members, provided the number of clinical peers constitute one-third or more of the total membership.
6. The Hearing Committee may uphold, overturn, or modify the original determination. Modifications may include, but are not limited to, placing the provider on probation, requiring completion of specific continuing education courses, requiring site or chart audits, or other corrective actions.
7. The decision of the Hearing Committee is sent to the provider by certified letter within thirty (30) calendar days.
8. Decisions of terminations shall be effective not less than thirty (30) days after the receipt by the provider of the Hearing Panel's decision.
9. In no event shall determination be effective earlier than sixty (60) days from receipt of the notice of termination.

Note

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

Appendix B

Medicaid waiver for the payment of non-covered services by Medicaid recipients

This MEDICAID WAIVER is intended for use for Medicaid recipients who seek non-covered (and in some instances, non-authorized) services under Medicaid and who are agreeing, prior to any services being rendered, to pay the service provider for such non-covered services, thereby "waiving" the recipients' rights protected generally under the Federal Regulations that prohibit providers from balance billing Medicaid recipients for services rendered.

With this MEDICAID WAIVER, the provider acknowledges that for services that are not authorized or covered by the Medicaid Managed Care Health Plan (including CHP and other Medicaid sponsored health care programs), the Medicaid Member must be informed of their payment responsibility prior to receiving the service and the Member must consent in writing.

Member Statement:

I understand that by signing this waiver form I am agreeing to be responsible to pay the provider for the services stated below as they are not covered or deemed medically necessary under my current health insurance.

That the specific service(s) sought are:

ADA Code and Description of Service _____

Fee: $ _____

That the service(s) sought is not a covered service under Medicaid guidelines;

That the service(s) is determined to be medically unnecessary before rendered;

That the provider does not participate in the Medicaid, either generally or for the services sought;

That I have been informed that one or more of the conditions listed (above) exists and, I voluntarily and knowingly agree to pay the provider for the charge they have indicated to me for these services.

By signing this waiver form, I certify that I am aware of the services covered by my health plan and of my rights under the Medicaid Program.

Member Name _____

Member Signature _____

Date _____