Dental Provider Manual

UnitedHealthcare—SmileDirectClub

2020

United Healthcare

Contents

Section 1: Introduction – Who we are

Welcome to UnitedHealthcare®

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

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

UnitedHealthcare offers a portfolio of products to its members, your patients, as well as to its participating dental offices. Products include Preferred Provider Organization (PPO), Exclusive Provider Organization (EPO), and In-Network Only (INO).

The products offered and how our plans are branded vary by market, based on how the products are licensed and the associated contracting entity.

This Provider Manual is designed as a comprehensive reference guide focusing on SmileDirectClub. 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. Please store these updates with this Provider Manual for future reference.

This manual is being provided in accordance with your executed agreement. If you have any questions or concerns about the information contained within this Provider Manual, please contact the UnitedHealthcare provider services team at **1-800-822-5353.**

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

Sincerely,

UnitedHealthcare, Professional Networks

Section 2: Resources & services

2.1. Quick reference guides – addresses and phone numbers

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

Our Provider Servicing Team is available to assist you in plan administration. Call our toll-free number during normal business hours to speak with knowledgeable specialists. They are trained to address eligibility, claims, plan information and contract inquiries.

Refer to the table below for available resources based on type of inquiry.

Resource			
You want to:	Provider Services Line – Dedicated Service Representatives Phone: 1-800-822-5353 Hours: 8 am–9 pm EST or 7 am–10 pm CST	Online: **uhcdental.com**	Interactive Voice Response (IVR) System Phone: 1-800-822-5353 Hours: 24 / 7
Inquire about a claim	✓	✓	✓
Ask a benefit / plan question (including prior authorization requirements)	✓	✓	✓
Inquire about eligibility	✓	✓	✓
Request an EOB	✓	✓	
Request a Fee Schedule	✓	✓	
Request a copy of your contract	✓		
Ask a question about your contract	✓		
Inquire about the In-Network Practitioner Listing	✓	✓	✓
Nominate a provider for participation	✓	✓	
Changes to Practice Information (e.g., associate updates, address changes, adding or deleting addresses, Tax Identification Number change, specialty designation, demographic updates)	✓	✓	
Request participation status change	✓		
Request documents	✓	✓	
Request benefit information	✓	✓	

Resource					
Need:	Address	Phone Number	Payer I.D.	Submission Guidelines	Form(s) Required
Claim Submission (initial)	CLAIMS UnitedHealthcare P.O. Box 30567 Salt Lake City, UT 84130-0567	**1-800-822-5353**	52133 Claim Filing indicator: "CL"	Within 180 days of the date of service	ADA Claim Form, 2012 version or later
Prior Authorization Requests*	PTE/Preauthorizations UnitedHealthcare P.O. Box 30552 Salt Lake City, UT 84130-0567	**1-800-822-5353**	52133		ADA Claim Form – check the box titled: Request for Predetermination / Preauthorization section of the ADA Dental Claim Form
Claim Adjustment Request or Requests for Reprocessing	Adjustments/ Resubmissions UnitedHealthcare P.O. Box 30567 Salt Lake City, UT 84130-0567	**1-800-822-5353**	52133	Within 60 days from receipt of payment	ADA Claim Form Provider narrative Reason for requesting adjustment or resubmission
Claim Disputes	Provider Disputes UnitedHealthcare P.O. Box 30567 Salt Lake City, UT 84130-0567	**1-800-822-5353**	n/a	Within 60 days from receipt of payment	ADA Claim Form Written summary of appeal
Coordination of Benefits	Claims UnitedHealthcare P.O. Box 30567 Salt Lake City, UT 84130-0567	**1-800-822-5353**	52133	Within 90 days of the date of service	ADA Claim Form Primary Payer's EOB showing the amount paid by the primary payer
Member Complaints and Appeals	UnitedHealthcare P.O. Box 30569 Salt Lake City, UT 84130-0567	**1-800-822-5353**	n/a	n/a	n/a

2.2.a Integrated Voice Response (IVR) System 1-800-822-5353

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

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

2.2.B Web site uhcdental.com

The UnitedHealthcare Web site, uhcdental.com, offers many time-saving features including eligibility verification, claims status, claim receipt acknowledgment and network specialist locations. Through this site, you may also enroll in Electronic Payments and Statements, a free direct deposit service.

You can also verify eligibility on our Web site at uhcdental.com 24 hours a day, seven days a week. In addition to current eligibility verification, our Web site offers other functionality for your convenience such as claims status, procedure level pricing, fee schedules, benefit information and a provider search.

We make it easy to get started

You can use our Online Guided Tour under the dentist site to take you through the registration process.

Once you have registered on our provider Web site at www.uhcdental, you can verify your patients' eligibility online with just a few clicks.

Please contact our Customer Service line if you have additional questions or need help registering on our Web site.

Note: Passwords are the responsibility of the dental office (see agreement during the registration process).

2.3. Electronic Payments and Statements

What is Electronic Payments and Statements (EPS)?

Electronic Payments and Statements (EPS) is a no cost, practical solution to provide electronic delivery of payments and explanations of benefits (EOBs) to dental providers and other health care professionals.

EPS is fast, easy and secure. You will be notified by email the day deposits are made. No more time wasted on trips to the bank to make deposits. Claims payments will be made directly to your bank account, five to seven days faster than paper checks.

With Electronic Payments and Statements (EPS), your claim payments, explanations of benefits, and Pre-Treatment Estimates (PTEs) are delivered electronically, allowing your office faster payment, easier reconciliation, less paperwork and much greater efficiency.

EPS eliminates:

- Check clearing wait time
- Check processing fees
- Searching through files for claim and payment information
- Frustrating reconciliation tasks
- Endless piles of paper and mail

EPS provides:

- Secure, direct deposit
- Online payment and claim information
- Fast and easy information searches
- Simplified reconciliation
- Reduced paper usage and waste
- Update banking information

How to enroll:

Navigate to the Optum EPS website at myservices.optumhealthpaymentservices.com. There you will find additional information, how to enroll and FAQs. Once enrolled select your TIN(s) from the drop-down box and then complete the required enrollment fields - the entire process should not take more than five minutes per TIN. Should you need any assistance with EPS enrollment or support after enrolled please call at **1-877-620-6194.**

Section 3: Plan eligibility

Eligibility may be verified one of three ways:

1. At our Web site (uhcdental.com)

2. Through our Interactive Voice Response (IVR) available through the Provider Services line

3. By speaking with a Provider Services Representative

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

3.1 Member identification card

Members are issued an identification (ID) card to all recipients enrolled in benefits. When members of a family enroll, separate cards may be issued to each family member. The ID cards are customized with the Plan logo and include the toll-free customer service number. ID cards also include the member's group ID number.

The ID card has instructions for both members (how to access care) and providers (eligibility verification). ID cards should be presented by members when services are rendered.

Presentation by a person with an ID card is not a guarantee of payment. It is the responsibility of the provider to verify eligibility at the time of service.

3.2 Eligibility verification

As outlined in your provider agreement, member eligibility must be verified prior to rendering services. This section contains helpful tips on how to establish eligibility through our Provider Servicing tools.

The Interactive Voice Response (IVR) system

Our Provider Services line provides IVR features that enable you to obtain up-to-the minute eligibility information with one quick telephone call. Eligibility may be verified for one or more members at a time by using either voice or touch-tone keypad, or a combination. This 24-hour-a-day, seven-day-a-week, toll-free access delivers immediate eligibility information directly by fax to your office.

The IVR is never busy, there is never a wait and is available 24 hours a day, seven days a week.
Provider services line: 1-800-822-5353

Important Note: A member's ID card is not proof of eligibility. 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.

It's easy to get started.

All you need is the following:

- A touch-tone phone
- The member's name, subscriber ID number and date of birth
- Your dental office fax number

When calling the Provider Services line, here's what you'll receive:

- Confirmation of the member's name
- Dependent information
- Plan details

Upon your request, our IVR system will automatically fax to your office all the information needed to effectively and efficiently serve your patients.

Use the touch-tone option if you are encountering problems with speech recognition.

Section 4: Member benefits/exclusions & limitations

4.1.A Limited orthodontic treatment

For the most recent and up to date clinical policy criteria and documentation requirements please follow **uhcdental.com > RESOURCES > CLINICAL GUIDELINES**, or you may use this **LINK**.

Code	Description	Age	Frequencies and limitations	Clinical review req
ORTHODONTICS				
Limited Orthodontic Treatment				
D8030	Limited orthodontic treatment of the adolescent dentition	0 - 99	Buy-Up Only- Plans with Ortho	N
D8040	Limited orthodontic treatment of the adult dentition	0 - 99	Buy-Up Only- Plans with Ortho	N

4.2 Exclusions & limitations

Exclusions

All treatment not set forth in the provider agreement is excluded and is limited to only treatment set forth in the provider agreement.

4.3 Member appeals and inquiries

Members and providers acting on a member's behalf have the right to appeal how a claim was paid or how a utilization management decision was made.

Appeals regarding a denial of coverage based on dental necessity must be submitted within 60 days of the date of notification of an adverse decision unless otherwise prescribed by state regulations.

Appeals may be filed in writing or by fax and must include:

- Member name
- Claim ID
- Nature of the appeal including identification of the service
- Appropriate supporting documentation (such as X-rays or periodontal charting) and a narrative stating why the service should be covered.

Appeal reviews will be completed within state mandated time frames upon receipt of all necessary information. Providers and/or members will be notified of an appeal determination within the state law statute requirements.

Expedited appeals:

In time-sensitive circumstances in which the time frame for issuing determinations could seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function, an expedited appeal may be requested.

Expedited Appeals may be submitted by the member, the member's representative, or by the practitioner acting on behalf of the member in writing, telephonically, or by fax.

Determinations will be completed within 48 hours of receipt of all required documentation or within the time frame required by state law, statute, or act.

Please refer to the Resources and Services section of this manual for appeal address and fax number information. Our Provider Services line is also available for any questions.

Section 5: Radiographs

5.1 Radiographs

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

Guidelines for providing radiographs are as follows:

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

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

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

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

Section 6: Claim submission procedures

6.1 Claim submission required elements & best practices

Dental claim form

The most current Dental ADA claim form must be submitted for payment of services rendered or to obtain a Pre-Treatment Estimate.*

Claim submission options

Electronic claims

Electronic claims processing requires access to a computer and usually the use of practice management software. Electronically generated claims can be submitted through a clearinghouse or directly to our claims processing system via the Internet. Most systems have the ability to detect missing information on a claim form and notify you when errors need to be corrected. Electronic submission is private as the information being sent is encrypted. Please call **1-877-620-6194** for more information regarding electronic claims submission.

Paper claims

Due to periodic revisions and varying practice management systems, dental insurance claim forms exist in various formats. Use of the most recently revised American Dental Association (ADA), 2012, format is recommended. Claims and pre-treatment estimates can be submitted directly through the portal at www.uhcdental.com where you can also upload x-rays, case notes and periodontal charts. The portal will indicate when required information is missing from the submission.

Dental claim form required information

One claim form should be used for each member 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

Member information

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

*It is recommended that pre-treatment estimates be obtained for high-dollar procedures such as crowns, bridges and dentures.

Primary payer information

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

Other coverage

If the member 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 member 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

Treating dentist

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

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
- Charges for dentist's fee/charges for the procedure.
- Total sum of all charges

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.

Subscriber / member authorization

Signature of subscriber or member authorizing payment of dental benefits is required. A claim form that indicates a signature is "on file" for a particular member will be accepted. The dentist must keep a copy of a signed claim in the member record.

Paper claims

All dental claims must be legible. Computer-generated forms are recommended. Additional documentation and radiographs should be attached when applicable. Such attachments are required for pre-treatment estimates and for the submission of claims for complex clinical procedures. Please refer to the Exclusions & Limitations section of this manual to find the recommendations for dental services.

By report procedures

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

Using current ADA codes

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

Tips on claim submission

The National Association of Dental Plans says dentists will be reimbursed more quickly if they include the information below on their dental claim forms.

- Attending dentist information should include dentist's name, address and tax identification number (TIN). If any of this information has changed from the last submission, or if the payer was not informed of the change, a delay can occur while verification of correct data is made.
- Patient information should include patient's full name, identification or member number and date of birth and relationship to the insured person (self, dependent or spouse).
- Date of service should be the day on which the service was performed.
- CDT codes of services performed – Dental claim logic systems are designed to read approved current CDT codes according to their definition. Internal codes, outdated codes or codes that are considered an integral part of another procedure can delay a claim while research is conducted.
- Tooth number or quadrant along with the surface, if appropriate, is required to identify where procedure was performed.
- Missing teeth information should be reported on claims for periodontal, prosthodontic (fixed and removable), or implant services procedures, if covered.
- Prior placement date for crowns, bridges – As many plans have frequency limitations on crowns and bridges, it is important to indicate whether this is an initial placement in the claim form box provided. If not an initial placement, the prior placement date should be indicated and an explanation included in the narrative. This is a particular problem when older versions of the ADA claim form are utilized.
- Narratives are an essential ingredient to help the treating dentist explain why a certain procedure was recommended. Payers will not try to validate the course of treatment but will assign benefits according to the plan purchased for that particular patient. If it isn't part of their benefit design, then the dentist can charge the member accordingly.
- Coordination of benefits – 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.

- Remarks – The Remarks section of the claim form should only be used to provide additional explanation of the procedures performed. For most payers, information included in this section will remove a claim from auto-adjudication, thus delaying the processing.

6.1.A Pre-Treatment Estimate (PTE)

A pre-treatment estimate is a summary estimating how planned treatment will be adjudicated according to the member's plan design and enrollment status at the time the PTE is reviewed. These estimates may be submitted on an ADA claim form and are not a guarantee of coverage or how the claim will be ultimately adjudicated.

Pre-treatment estimates are strongly encouraged to ensure that both the practice and the member fully understand how benefits will be applied, particularly for high-dollar procedures. Your office is encouraged to use features found on the UnitedHealthcare Web site (uhcdental.com) to do your own pre-treatment estimates. In addition, many practice management systems will perform this function (consult your office's practice management system support organization to determine the capabilities of your office's systems).

If a pre-treatment is older than 90 days, a new PTE must be attained prior to delivering clinical services.

6.2 Claims processing systems

UnitedHealthcare processes claims using a proprietary claims processing platform. Claims are edited and paid according to ADA Code and Dental Procedures. There are no modifiers associated with this code set.

Claims are edited and paid according to the specific plan design for a member's employer group. Please refer to the Exclusions and Limitations section of this manual for further information or access one of the resources outlined in Section 2.

Any specific plan design questions that would assist you in determining how to administer claims for a particular member can be answered by our Provider Services line.

6.3 Electronic claims submissions

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

UnitedHealthcare partners with electronic clearinghouses to support electronic claims submissions. While the payer ID may vary for some plans, the UnitedHealthcare number is 52133. Please refer to the Important Addresses and Phone Numbers section and Distributor Client List for additional information as needed.

If you wish to submit claims electronically, please contact your clearinghouse to initiate this process. If you do not currently work with a clearinghouse, you may either sign up with one to initiate this process or simply register with our preferred vendor.

6.4 HIPAA compliant 837D file

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

6.5 HIPAA compliant 835 file

An 835 is an electronic remittance detailing payments and/or adjustments including cancellations, recoveries, reversals, etc., made on claims submitted electronically via an 837D transaction file or via paper.

For practitioners participating in Electronic Payments and Statements (EPS), the 835 file can be accessed via EPS. You must be an EPS participant to access this information.

If you're not already participating with EPS and would like to take advantage of this cost-savings opportunity, simply visit uhcdental.com. The Electronic Payments and Statements section in this manual provides a detailed overview of this service and how to enroll.

For general questions, eligibility and/or claim status inquiries, please call **1-877-620-6194**. Additional tools and resources can also be found online at uhcdental.com.

6.6 Paper claims submission

To receive payment for services, practices must submit claims via paper or electronically. Network dentists are recommended to submit an American Dental Association (ADA) Dental Claim Form (2012 version or later).

Please refer to section 6.1 for more information on claims submission best practices and required information.

Our Quick Reference Guide will provide you with the appropriate claims address information to ensure your claims are routed to the correct resource for payment.

6.7 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. It is each provider's responsibility to assist in correct coordination of benefits by notifying all payers so that claims may be paid correctly.

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 that 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.

6.8 Dental claim filing limits and adjustments

All Dental Claims should be submitted within ninety (90) days from the date of service (30 days is preferred). Payment may be considered after the date of service for up to three hundred and sixty-five (365) days. This may vary for some plans.

All adjustments or requests for reprocessing must be made within sixty (60) days from receipt of payment. An adjustment can be requested telephonically by calling Dental Health Providers at **1-800-822-5353**.

6.9 Claim adjudication and periodic overview

In accordance with UnitedHealthcare's standard practice, clean claims will be adjudicated and paid within the applicable time frames allowed for such payment under State and Federal Law.

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 in general, 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.

Invalid or incomplete claims:

- If claims are submitted with missing information or incomplete claim forms, the claim will be returned or rejected with a request for the missing required information to be sent.
- If the claim is missing a tooth number or surface, a letter will be generated to the provider requesting this information.
- If the procedure code is invalid or expired, a letter will be sent to the provider requesting the appropriate code.

- If there are inadequate provider details to process under the submitting provider, the claim will be returned with a letter requesting appropriate provider information.
- If the member is not found or ineligible, the claim will be returned.

6.10 Explanation of provider remittance advice

The Provider Remittance Advice is a claim detail of each member 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 OR MBR NAME AND ID NO
Treating dentist's name, NPI submitted with claim, Member's name and Subscriber's ID number. To conform to HIPAA regulations, the subscriber's alternate ID number is shown in place of the Social Security number.

GROUP NO
Group ID number assigned to the member's plan

CLAIM NO
Number assigned to the claim

ADA CODE
Procedure code submitted pertaining to the service

DESCRIPTION
Description of the procedure code

DATE OF SERVICE
Date when services were rendered

TOOTH NO
Tooth number or the quadrant pertaining to the procedure

AMOUNT CLAIMED
Amount submitted by provider

AMOUNT ALLOWED
Provider's contracted fee amount

DEDUCT APPLIED
Applicable plan deductible

OTHER INS
Member's primary insurance if applicable

MEMBER RESP
Member's copayment that pertains to the procedure

AMOUNT PAID
Claim paid amount

EOB CODE
Refers to the explanations provided within the EOB that explain how the procedure adjudicated

6.11 Provider claim appeal and inquiry process

Appeal rights vary by business and/or state. Refer to the appeals language on the back of the EOB for guidance with the appeals processes that are appropriate for each particular claim.

There are two types of provider appeals:

Utilization Management (UM) Appeal: Any appeal that is based on dental necessity and/or would require review by a dental clinician. UM appeals must include a narrative and any supporting documentation including X-rays.

Administrative Appeal: Appeals that are not based on dental necessity. This type of appeal would include but is not limited to appeals for timely filing of claims, member's eligibility, over/underpayment adjustment requests, etc. Administrative appeals must include a narrative.

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

Section 7: Quality management

7.1 Quality Improvement Program (QIP) description

UnitedHealthcare has established and maintains 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 ensure that quality of care is being reviewed; that problems are being identified and that follow up is planned where indicated. The program is directed by state, federal and client requirements. The program addresses various service elements including accessibility, availability and continuity of care. It also monitors the provisions and utilization of services to ensure that professionally recognized standards of care are being met. The QIP Description is reviewed annually and updated as needed.

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

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

A complete copy of our QIP policy and procedure is available upon request by contacting our Provider Services line at **1-800-822-5353.**

7.2 Credentialing

To become a participating provider in UnitedHealthcare's network, all applicants must be fully credentialed and approved by our Credentialing Committee. In addition, to remain a participating provider, all practitioners must go through periodic recredentialing approval (typically every 3 years unless otherwise mandated by the state in which you practice).

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

Before an applicant dentist is accepted as a participating provider, the dentist's credentials are evaluated. Initial facility site visits are required for each location specified by the state requirements for some plans and/or markets. Offices must pass the facility review prior to activation. Your Professional Networks Representative will inform you of any facility visits needed during the recruiting process.

The Dental Director and the Credentialing Committee review the information submitted in detail based on approved credentialing criteria. UnitedHealthcare will request a resolution of any discrepancy in credentialing forms submitted. Practitioners have the right to review and correct erroneous information and to be informed of the status of their application. Credentialing criteria are reviewed by advisory committees, which include input from practicing network providers to make sure that criteria are within generally accepted guidelines. You have the right to appeal any recredentialing decision regarding your participation made by UnitedHealthcare based on information received during the recredentialing process. Appeals do not

apply to credentialing providers unless state law dictates otherwise. To initiate an appeal of a recredentialing decision, follow the instructions provided in the determination letter received from the Credentialing Department. Appeals will be accepted and reviewed for states with appeal rights.

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

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

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

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

Recredentialing requests are sent 6 months prior to the recredentialing due date. The CVO will make 3 attempts to procure a completed recredentialing application from the provider, and if they are unsuccessful, UnitedHealthcare will also make an additional 3 attempts, at which time if there is no response, a termination letter will be sent to the provider as per their provider agreement.

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

Initial credentialing

- Completed application
- Signed and dated Attestation
- Current copy of their state license
- Current copy of their Drug Enforcement Agency (DEA) certificate
- Current copy of their Controlled Dangerous Substance (CDS) certificate, if applicable
- Current copy of their Sedation and/or General Anesthesia certificates, if applicable
- Copy of their Sedation and/or General Anesthesia training certificate/diploma, if applicable
- Signed and dated Sedation and/or General Anesthesia Attestation, if applicable
- Malpractice face sheet which shows their name on the certificate, expiration dates and limits — limits $1/3m
- Explanation of any adverse information, if applicable
- Five years' work in month/date format with no gaps of 6 months or more; if there are, an explanation of the gap should be submitted
- Education (which is incorporated in the application)
- Current Medicaid ID (as required by state)

Recredentialing

- Completed Recredentialing application
- Signed and dated Attestation
- Current copy of their state license
- Current copy of their Drug Enforcement Agency (DEA) certificate
- Current copy of their Controlled Dangerous Substance (CDS) certificate, if applicable
- Malpractice face sheet which shows their name on the certificate, expiration dates and limits— limits $1/3m
- Explanation of any adverse information, if applicable
- Current Medicaid ID (as required by state)

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

We also accept the Council for Affordable Quality Healthcare (CAQH) process for credentialing/recredentialing application submissions, unless state law requires differently.

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

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

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

7.2.A Confidentiality

Our staff treats information obtained in the credentialing process as confidential. We and our delegates maintain mechanisms to properly limit review of confidential credentialing information. Our contracts require Delegated Entities to maintain the confidentiality of credentialing information.

Credentialing staff or representatives will not disclose confidential care provider credentialing information to any persons or entity except with the express written permission of the care provider or as otherwise permitted or required by law.

7.2.B Inspection & audit

The Practice shall provide access at reasonable times upon demand by DBP and/or Governmental Agencies to periodically audit or inspect the equipment, books, documents and records of the provider relating to the performance of the provider agreement and the services provided to Enrollees.

7.3 Grievances

The member grievance process encompasses investigation, review and resolution of member issues related to the plan and/or contracted providers.

Issues are accepted via telephone, fax, email, letter, written grievance form, or through our Web portal. Grievance forms may be requested from our Customer Service Department, Web site or from a contracted dental provider office. UnitedHealthcare does not delegate grievance processing and resolution to any provider group.

All member benefit and quality of care grievances are received and reviewed in accordance with state and federal regulatory and client specific requirements both in terms of the notifications sent and the time frames allowed.

Your office is required to cooperate with UnitedHealthcare's Policies and Procedures; Member rights and Responsibilities; (including grievances) and Dental Records.

UnitedHealthcare shall have access to office records for that purpose and such information obtained from the records shall be kept confidential. Your office is required to comply with UnitedHealthcare's request for patient records and films, etc., within five business days of receiving the request.

Failure to comply will result in the grievance resolution in favor of the member. Additionally, your right to appeal the decision will be considered waived.

UnitedHealthcare recognizes the importance of thoroughly reviewing all appropriate documentation to determine if there are any potentially systemic problems.

Periodic reports on member grievance activities are made to all appropriate committees and the Board of Directors. UnitedHealthcare's Grievance policies are filed with the necessary regulatory agencies when required.

7.4 Preventive health guideline

The UnitedHealthcare approach to preventive health is a multi-focused strategy which includes several integrated areas. Preventive health focuses primarily on the prevention, assessment for risk, and early treatment of caries and periodontal

diseases, but also encompasses areas including prevention of malocclusion, oral cancer prevention and detection, injury prevention, avoidance of harmful habits and the impact of oral disease on overall health. We have a long history of working with customers on education and outreach programs focusing on wellness, oral health management and the relationship between oral disease and overall health.

We strive to ensure that all of our programs and review criteria are based on the most current clinical evidence. The UnitedHealthcare Dental Clinical Policy and Technology Committee (DCPTC) researches, develops and implements the clinical practice guidelines recommendations, based on principles of evidence-based dentistry, that are then reviewed and endorsed by the UnitedHealthcare National Medical Care Management Committee (NMCMC). Our guidelines are consistent with the most current scientific literature, along with the American Dental Association's (ADA's) current CDT- codes and specialty guidelines as suggested by organizations such as the American Academy of Periodontology, American Academy of Pediatric Dentistry, American Association of Endodontists, American College of Prosthodontists and American Association of Oral and Maxillofacial Surgeons. We also refer to additional resources such as the Journal of Evidence Based Dental Practice, the online Library of Medicine, and evidence-based clearinghouses such as the Cochrane Oral Health Group and Centre for Evidence-Based Dentistry. Other sources of input are the respected public health benchmarks, such as Healthy People 2020 and the Surgeon General's Report on Oral Health in America, along with government organizations such as the National Institutes of Health and Center for Disease Control.

Preventive health recommendations for children are intended to be consistent with American Academy of Pediatric Dentistry periodicity recommendations.

Caries management – Begins with a complete evaluation including an assessment for risk.

- X-ray periodicity – X-ray examination should be tailored to the individual patient based on the patient's health history and risk assessment/vulnerability to oral disease and should follow current professionally accepted dental guidelines necessary for appropriate diagnosis and monitoring.
- Recall periodicity — Frequency of recall examination should also be tailored to the individual patient based on clinical assessment and risk assessment.
- Preventive interventions — Interventions to prevent caries should consider AAPD periodicity guidelines while remaining tailored to the needs of the individual patient based on age, health history, and risk assessment/vulnerability to oral disease. These preventative interventions include but are not limited to regular prophylaxis, fluoride application, placement of sealants, dietary counseling and adjunctive therapies where appropriate.
- Caries Classification and Risk Assessment Systems - methods of caries detection, classification, and risk assessment combined with prevention strategies, can help to reduce patient risk of developing advanced disease and may even arrest the disease process. Consideration should be given to these conservative nonsurgical approaches to early caries; or alternatively, where appropriate, to minimally invasive approaches, conserving tooth structure whenever possible.

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

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

Oral cancer screening – Should be performed for all adults and children in late adolescence or younger if there is a personal or family history, if the patient uses tobacco products, or if there are additional factors in the patient history, which in the judgment of the practitioner elevate their risk.

- Screening should be done at the initial evaluation and again at each recall.
- Screening should include, at a minimum, a manual/visual exam, but may include newer screening procedures, such as light contrast or brush biopsy, for the appropriate patient.

Additional areas for prevention evaluation and intervention – Include malocclusion, prevention of sports injuries and harmful habits (including, but not limited to, digit- and pacifier-sucking, tongue thrusting, mouth breathing, intraoral and perioral piercing, and the use of tobacco products). Other preventive concerns may include preservation of primary teeth, space maintenance and eruption of permanent dentition.

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

Section 8: Utilization management program

8.1 Utilization management

Through utilization management practices, UnitedHealthcare aims to provide members with cost-effective, quality dental care through participating providers. By integrating data from a variety of sources, including provider analytics, utilization review, prior authorization, claims data and audits, UnitedHealthcare can evaluate group and individual practice patterns and identify those patterns that demonstrate significant variation from norms.

By identifying and remediating providers who demonstrate unwarranted variation, we can reduce the overall impact of such variation on cost of care, and improve the quality of dental care delivered.

8.2 Community practice patterns

Utilization analysis is completed using data from a variety of sources. The process compares group performance across a variety of procedure categories and subcategories including diagnostic, preventive, minor restorative (fillings), major restorative (crowns), endodontics, periodontics, fixed prosthetics (bridges), removable prosthetics (dentures), oral surgery and adjunctive procedures. The quantity and distribution of procedures performed in each category are compared with benchmarks such as similarly designed UnitedHealthcare plans and peers to determine if utilization for each category and overall are within expected levels.

Significant variation might suggest either over-utilization 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.

8.3 Evaluation of utilization management data

Once the initial Utilization Management data is analyzed, if a dentist is identified as having practice patterns demonstrating significant variation, his or her utilization may be reviewed further. For each specific dentist, a Peer Comparison Report may be generated and analysis may be performed that identifies all procedures performed on all patients for a specified time period. Potential causes of significant variation include upcoding, unbundling, miscoding, excessive treatment, under-treatment, duplicate billing, or duplicate payments. Providers demonstrating significant variation may be selected for counseling or other corrective actions.

8.4 Utilization management analysis results

Utilization analysis findings may be shared with individual providers in order to present feedback about their performance relative to their peers.

Feedback and recommended follow-up may also be communicated to the provider network as a whole. This is done by using a variety of currently available communication tools including: (bullet) Provider Manual/Standards of Care

- Provider Training
- Continuing Education
- Provider News Bulletins

8.5 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 over payments 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.

8.6 Utilization review

UnitedHealthcare shall perform utilization review on all submitted claims. Utilization review (UR) is a clinical analysis performed to confirm that the services in question are or were necessary dental services as defined in the member's certificate of coverage. UR may occur after the dental services have been rendered and a claim has been submitted (retrospective review).

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

Retrospective reviews and prior authorization reviews are performed by licensed dentists.

Utilization review is completed based on the following:

- To ascertain that the procedure meets our clinical criteria for necessary dental services, which is approved by the Clinical Policy and Technology Committee, Clinical Affairs Committee, and state regulatory agencies where required.
- To determine whether an alternate benefit should be provided.
- To determine whether the documentation supports the submitted procedure.
- To appropriately apply the benefits according to the member's specific plan design.

(See Section 4 for treatment codes that require clinical review and documentation requirements)

Section 9: Evidence-based dentistry & the Clinical Policy & Technology Committee

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

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

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

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

- Systematic review and meta-analysis
- Randomized controlled trials (RCT)
- Retrospective studies
- Case series
- Case studies
- Anecdotal/expert opinion (including professional society statements, white papers and practice guidelines)

Evidence is found in a variety of sources including:

- Electronic database searches such as Medline®, PubMed®, and the Cochrane Library.
- Hand search of the scientific literature
- Recognized dental school textbooks

Evidence based dentistry can be used clinically to guide treatment decisions, and aid health plans in the development of benefits. At UnitedHealthcare, we use evidence as the foundation of our efforts, including:

- Practice guidelines, parameters and algorithms based on evidence and consensus.
- Comparing dentist quality and utilization data
- Conducting audits and site visits
- Development of dental policies and coverage guidelines

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

Section 10: Practice capacity & appointment scheduling standards

UnitedHealthcare is committed to ensuring that its providers are accessible and available to their members for the full range of services specified in the UnitedHealthcare Provider Agreement and Provider Manual.

Participating providers must comply with any state-mandated appointment scheduling requirements for Elective or Routine Care Appointments.

In states where there are specified access and availability standards, UnitedHealthcare will monitor the access and availability of our participating providers through a variety of methods, including member feed- back/surveys, a review of appointment books, spot checks of waiting room activity, investigation of member complaints and random calls to provider offices. Any noted concerns are discussed with the participating provider(s), and corrective action may be taken.

Walk-in appointment standards

Dental offices that operate by "walk-in" or "first come, first served" appointments are monitored for access and waiting times, where applicable.

Missed appointments

Offices should inform patients of office policies relating to missed appointments and any fees that will be incurred.

1. Appointment scheduling guidelines may vary by state. It is recommended that you confirm whether or not the state in which you're providing services has any state-specific mandates.
2. Emergency Care appointments would be needed if a patient is experiencing excessive bleeding, pain or trauma.
3. Providers are encouraged to schedule member appointments 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.

10.1 New associates

As your practice expands and changes, and as new associates are added, please contact us to request an application so that they may be credentialed and listed as participating providers.

It is important to remember that an associate may not see members as a participating provider until he/she has been credentialed by our organization.

If you have any questions or need to receive a copy of our provider application packet, please contact our Provider Services line at **1-855-918-2265**.

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

When there are demographic changes within your office, it is important to notify us as soon as possible so that we may update our records. This supports accurate claims processing as well as helps to ensure that member directories are up to date.

Changes should be submitted to:

UnitedHealthcare - RMO
ATTN: 224-Prov Misc Mail WPN
PO BOX 30567
SALT LAKE CITY, UT 84130

Credentialing updates should be sent to:

UnitedHealthcare Credentialing
2300 Clayton Road, Suite 1000
Concord, CA 94520

Requests must be made in writing with corresponding and/or backup documentation. For example, a tax identification number (TIN) change would require submission of a copy of the new W9, versus an office closing notice where we'd need the notice submitted in writing on office letterhead. Changes may also be faxed to **1-855-363-9691**.

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

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

If you have any questions, don't hesitate to contact Provider Services at **1-855-918-2265** for guidance.

10.3 Sterilization and asepsis control

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.

While standard practice is for sterilization costs to be included within office procedure charges, should your office charge this fee separately, these fees must be made known to patients in advance. This may not be a covered code on our fee schedules.

10.4 Recall system

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

10.5 Transfer of dental records

Your office shall copy all requested member dental files to another participating dentist as designated by UnitedHealthcare or as requested by the member. The member cannot be held liable for the cost of copying the patient dental files if the member is transferring to another provider. If your office terminates from UnitedHealthcare, dismisses the member from your practice or is terminated by UnitedHealthcare, the cost of copying files shall be borne by your office. Your office shall cooperate with UnitedHealthcare in maintaining the confidentiality of such member dental records at all times, in accordance with state and federal law.

10.6 Nondiscrimination

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

10.7 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 11: Appendix — Provider information

11.1 Definitions

11.1.A Preferred Provider Organizations (PPO)

In PPO plans, practitioners treat members at an agreed-upon rate for each procedure. There is an annual maximum of benefit paid out by the plan that varies by employer group. Typically, fees are paid partially by the member and partially by the insurance company.

Distinctions among the different types of plans are as follows:

Traditional PPO plans – Members can seek care and still receive benefits if they go out of network. However, members' out-of-pocket expenses are less if they seek care from a participating dentist who charges contracted rates.

Incentive PPO plans – Members have a richer benefit level (percentage covered) if they seek care at a participating dental office.

Passive PPO plans – Members have the same benefit level (percentage covered) whether or not they use a participating office. However, if the member seeks care from a participating dentist, his/her out-of-pocket costs are lower.

In-Network Only (INO) plans – Members only receive benefits if a participating dentist provides care. The plan benefits are the same as for the PPO network, with deductibles, maximums and coinsurance payments. Members must be referred to participating specialists (excluding orthodontists) under this plan to receive benefits.

Participating practitioners in these and other plans offered receive free advertising through online and print directory publications, and gain access to hundreds of employees within the local community.

11.1.B Discount plans

Discount Plans differ from traditional plans in that there are no claims to file or submit, and they are not insurance plans. The payment comes directly and solely from the member at the time of service. The member (or spouse/dependent) is entitled to a discount in accordance with the terms of your contract with UnitedHealthcare. The fee schedule is exactly the same as the UnitedHealthcare PPO fee schedule.

Members are educated to understand that the discount plans are not insurance and they are expected to pay in full upon delivery of service.

11.1.C Private label clients

UnitedHealthcare partners with other insurance carriers and entities to assist in providing access to dental care through our network. In addition, they leverage our dental claims adjudication capabilities. In some instances, these carriers or entities retain their own company and/or product brand and the UnitedHealthcare relationship is invisible to their members. When other insurance carriers or entities use our network in this manner, it is referred to as a Private Label Arrangement.

As a participating practitioner with the National PPO Plan, you will have access to private label members using the same contracted fee schedule that is outlined in your agreement. Private label members seeking treatment may show a membership identification card that is different from the typical UnitedHealthcare identification card. However, our name and information will appear on the back of the ID card so that you know which network the member is covered through.

Please see the Client (Distributor) Reference Guide in prior sections of this manual for examples of private label carriers we partner with.

11.1.D Distributor clients

Distributor clients are clients who have contracted with UnitedHealthcare to utilize our network of dental practitioners, in much the same way as any other PPO client contracts with us to use our dental network. The distinction is that the claims are processed by the Distributor Client. The allowed amounts paid are in accordance with the terms of your agreement with UnitedHealthcare. The fee schedule is the exact same as the UnitedHealthcare PPO fee schedule.

Attachments

11.2 Member EOB sample

20190416-000001 UHC01R 201904165010000200 30904596 04/16/19-MD-N-P--N-N

United Healthcare
P.O. Box 30567
Salt Lake City, UT 84130-0567

EXPLANATION OF DENTAL PLAN REIMBURSEMENT THIS IS NOT A BILL

Sheet: Page 1 of 4
Date: 04/16/2019
Check No: 0030904596
Check Amt: $825.00

DPS$$$PKG
SMILE PROUD TEXAS PC FKA GARY
PO BOX 744896
ATLANTA GA 30374-4896

DEN-PEOB1

United Healthcare
P.O. Box 30567
Salt Lake City, UT 84130-0567

Citibank, N.A.
One Penns Way
New Castle, DE 19720

62-20/311 **0030904596**

Date 04/16/19

PAY: **********$825.00

Void If Not Cashed Within 90 Days

<< NOT NEGOTIABLE >>

Pay Eight Hundred Twenty Five Dollars and Zero Cents**********

TO THE ORDER OF
SMILE PROUD TEXAS PC FKA GARY
PO BOX 744896
ATLANTA GA 30374

Authorized Signature Required

Attachments

11.2 Member EOB sample—continued

20190416-000001 UHC01R 20190416501000200 30904596 04/16/19-MD-N-P--N-N

United Healthcare
P.O. Box 30567
Salt Lake City, UT 84130-0567

EXPLANATION OF DENTAL PLAN REIMBURSEMENT
THIS IS NOT A BILL

Sheet: Page 3 of 4
Date: 04/16/2019
Check No: 0030904596
Check Amt: $825.00

SMILE PROUD TEXAS PC FKA GARY
PO BOX 744896
ATLANTA GA 30374-4896

PROVIDER OR MBR NAME AND ID NO; PROVIDER NETWORK STATUS; GROUP NO; CLAIM NO ADA CODE DESCRIPTION	DATE OF SERVICE	TOOTH NO	AMOUNT CLAIMED	AMOUNT ALLOWED	DEDUCT APPLIED	OTHER INS	PATIENT RESP	AMOUNT PAID	EOB CODE
ERIC NEUER NPI Submitted: Not Submit CLEAR, SOLID *****311101; In Network; 13147590; 191020000100									
ADA CODE D8030 limited orthodontic treatment of the adolescent dentition	03/16/19	01 32	1,850.00	1,650.00	0.00	0.00	825.00	825.00	BZ9
SUB-TOTAL			1,850.00	1,650.00	0.00	0.00	825.00	825.00	

Notes:

BZ9 This reflects only the portion of services (not) covered by your plan. You may be eligible for extra savings offered by SmileDirectClub.

	AMOUNT CLAIMED	AMOUNT ALLOWED	DEDUCT APPLIED	OTHER INS	PATIENT RESP	AMOUNT PAID
TOTAL	1,850.00	1,650.00	0.00	0.00	825.00	825.00

Attachments

11.2 Member EOB sample—continued

APPEALS PROCEDURE

You or your authorized representative have the right to file an appeal regarding the coverage decision that resulted in non-coverage of this claim. You or your authorized representative may request the coverage decision appeal by submitting your request in writing within 180 days of receipt of the denial to the following address: **Attention: Appeals, P.O. Box 30569, Salt Lake City, UT 84130-0569.** We will notify you in writing of our final decision within 30 business days after receiving your appeal. Your written request for review should include:

- The member's name, identification number, and group policy number
- The actual service for which a no benefit coverage decision was made
- The reasons why you feel benefit coverage should be provided
- Any available medical information to support your reasons for reversing the benefit decision, if applicable

Finally, the following information may be of additional help to you and is included pursuant to regulation:

There is help available to you if you wish to dispute the coverage decision of the plan. You may contact the Health Education and Advocacy Unit of Maryland's Consumer Protection Division at:

Health Education and Advocacy Unit
Consumer Protection Division
Office of the Attorney General
200 Saint Paul Place
Baltimore, MD 21202-2021
Telephone: 410-528-1840 or Toll Free (within Maryland) 1-877-261-8807; Fax: 410-576-6571
Email Address: HEAU@OAG.STATE.MD.US

The Health Education and Advocacy Unit can help you, your authorized representative, and your health care provider in filing an appeal under our internal appeal process. That unit can also attempt to mediate a resolution to your dispute. The Health Education and Advocacy Unit is not available to represent or accompany you during any proceeding of the internal grievance process.

You may have the right to file a civil action under ERISA if all required reviews of your claim have been completed.

(PR9933)

11.4 Fraud, waste and abuse provider 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.
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

11.5 Determination of "necessary" services

A review of an issue for appropriateness of dental services is a prospective or retrospective review performed by licensed dentists who examine the proposed service or submitted claim to determine if the services performed will be/were necessary.

Medical necessity is completed based on the following:

- To ascertain that the procedure meets our clinical criteria, which is approved by the Clinical Policy and Technology Committee, Clinical Affairs Committee, and state regulatory agencies where required.
- To determine whether an alternate benefit should be provided.
- To determine whether the documentation supports the submitted procedure.
- To appropriately apply the benefits according to the member's specific plan design.

11.6 Provider rights bulletin

If you elect to participate/continue to participate with the plan, please complete the application in its entirety; sign and date the Attestation Form, and provide current copies of the requested documents. You also have the following rights:

To review your information

You may review any information the plan has utilized to evaluate your credentialing application, including information received from any outside source (e.g., malpractice insurance carriers; state license boards), with the exception of references or other peer-review protected information.

To correct erroneous information

If 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. Within two business days, the plan 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 in writing 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 days of the date of receipt of the rejection/denial letter.

NY 137 Rule

If you are a provider in NY who is new to the area or is joining a participating group with the plan, you have a right to provisional credentialing if the process takes more than 90 days.

All written/telephonic inquiries about credentialing or recredentialing must be sent to the following addresses or phone numbers:

Credentialing Department
2300 Clayton Road
Suite 1000
Concord, CA 94520

Phone: 1-855-918-2265

Fax: 1-855-363-9691

United Healthcare