Dental Provider Manual

UnitedHealthcare Community Plan of Texas

Provider Services: 1-877-378-5301

United Healthcare Community Plan

Contents

Section 1: Introduction — who we are

Welcome to UnitedHealthcare Community Plan

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

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

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

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

Our Commercial program plan requirements are contained in a separate Provider Manual. If you support one of our Commercial plans and need that Manual, please contact Provider Services at **1-800-822-5353** (Please note: all other concerns should be directed to **1-877-378-5301**).

If you have any questions or concerns about the information contained within this Manual, please contact the UnitedHealthcare Community Plan Provider Services team at **1-877-378-5301**.

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

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

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

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

Sincerely,

UnitedHealthcare Community Plan, Professional Networks

Section 2: Office administration

2.1 Office site quality

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

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

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

2.2 Office conditions

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

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

2.3 Sterilization and asepsis-control fees

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

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

2.4 Recall system

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

2.5 Transfer of dental records

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

2.6 Office hours

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

2.7 Protect confidentiality of member data

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

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

2.8 Provide access to your records

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

2.9 Inform members of advance directives

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

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

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

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

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

2.10 Participate in quality initiatives

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

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

2.11 New associates

As your practice expands and changes and new associates are added, you must contact us within 10 calendar days to request an application so that we may get them credentialed and set up as a participating provider.

It is 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 **1-877-378-5301**.

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

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

Changes should be submitted to:

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

Credentialing updates should be sent to:

2300 Clayton Road
Suite 1000
Concord, CA 94520

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

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

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

If you have any questions, don't hesitate to contact Provider Services at **1-877-378-5301** for guidance.

Section 3: Patient eligibility verification procedures

3.1 Member eligibility

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

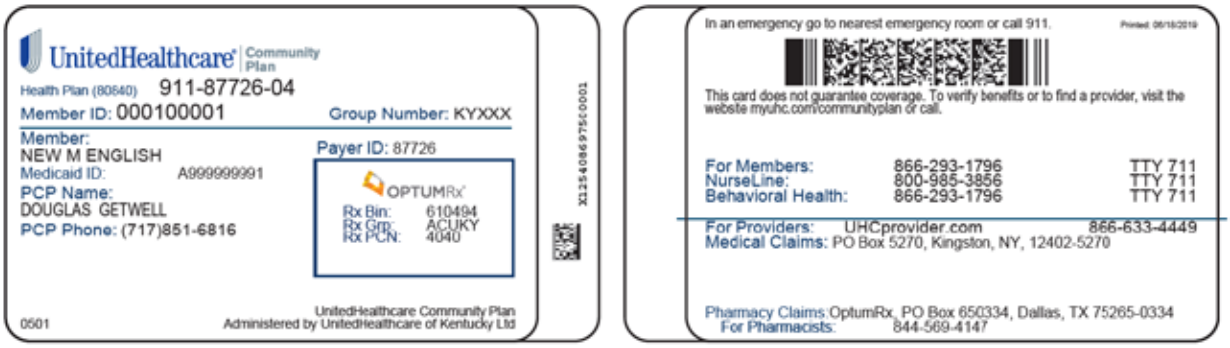
We receive daily updates on member eligibility and can provide the most up-to-date information available.

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

3.2 Identification card

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

A member ID card is not a guarantee of payment. It is the responsibility of the provider to verify eligibility at the time of service. To verify a member's dental coverage, go to **UHCDentalProviders.com** or contact the dental Provider Services line at **1-877-378-5301**. A sample ID card is provided below. The member's actual ID card may look slightly different.



3.3 Eligibility verification

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

The username and password that are established during the registration process will be used to access the website. One username and password are granted for each payee ID number. Please call **1-877-378-5301** from 8:00 AM to 6:00 PM M-F EST for assistance with any technical website issues.

UnitedHealthcare Community Plan also offers an Interactive Voice Response (IVR) system for eligibility verification; simply call **1-877-378-5301** to access real-time information, 24 hours a day, 7 days a week.

Section 4: Patient access

4.1 Appointment scheduling standards

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

- **Urgent care appointments** Within 48 hours
- **Routine care appointments** Offered within 30 calendar days of the request

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

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

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

4.2 Emergency coverage

All network dental providers must be available to members during normal business hours. Practitioners will provide members access to emergency care 24 hours a day, 7 days a week through their practice or through other resources (such as another practice or a local emergency care facility). The out-of-office greeting must instruct callers what to do to obtain services after business hours and on weekends, particularly in the case of an emergency.

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

4.3 Specialist referral process

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

To obtain a list of participating dental network specialists, go to our website at **UHCDentalProviders.com** or contact Provider Services at **1-877-378-5301**.

4.4 Missed appointments

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

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

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

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

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

4.5 Nondiscrimination

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

4.6 Cultural competency

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

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

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

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

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

Section 5: Utilization Management program

5.1 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.

5.2 Community practice patterns

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

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

5.3 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.

5.4 Utilization Management analysis results

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

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

- Provider Manual/Standards of Care
- Provider Training
- Continuing Education
- Provider News Bulletins

5.5 Utilization review

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

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

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

Utilization review is completed based on the following:

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

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

Section 6: Quality management

6.1 Quality Improvement Program (QIP) description

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

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

The QIP description is reviewed and updated annually:

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

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

6.2 Credentialing

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

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

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

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

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

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

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

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

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

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

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

Initial credentialing

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

Recredentialing

- Completed Recredentialing application
- Signed and dated Attestation
- Current copy of their state license
- Current copy of their Drug Enforcement Agency (DEA) certificate
- Current copy of their Controlled Dangerous Substance (CDS) certificate, if applicable

- 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.

6.3 Site visits

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

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

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

6.4 Preventive health guideline

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

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

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

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

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

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

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

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

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

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

6.5 Addressing the opioid epidemic

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

Brief summary of framework

Prevention: Prevent Opioid-Use Disorders before they occur through pharmacy management, provider practices, and education.

Treatment: Access and reduce barriers to evidence-based and integrated treatment.

Recovery: Support care management and referral to person-centered recovery resources.

Harm Reduction: Access to Naloxone and facilitating safe use, storage, and disposal of opioids.

Strategic community relationships and approaches: Tailor solutions to local needs.

Enhanced solutions for pregnant mom and child: Prevent neonatal abstinence syndrome and supporting moms in recovery.

Enhanced data infrastructure and analytics: Identify needs early and measure progress.

Increasing education & awareness of opioids

It is critical you are up-to-date on the cutting edge research and evidence-based clinical practice guidelines. We keep Opioid Use Disorders (OUD) related trainings and resources available on our provider portal to help ensure you have the information you need, when you need it. For example, state-specific Behavioral Health Toolkits are developed to provide access to clinical practice guidelines, free substance use disorders/OUD assessments and screening resources, and other important

state-specific resources. Additionally, Pain Management Toolkits are available and provide resources to help you identify our members who present with chronic physical pain and may also be in need of behavioral health services to address the psychological aspects of pain. Continuing education is available and includes webinars such as, “The Role of the Health Care Team in Solving the Opioid Epidemic,” and “The Fight Against the Prescription Opioid Abuse Epidemic.” While resources are available, we also workto help ensure you have the educational resources you need. For example, our Drug Utilization Review Provider Newsletter includes opioid trends, prescribing, and key resources.

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

Prevention

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

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

Section 7: Fraud, waste, and abuse training

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

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

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

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

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

Section 8: Governance

8.1 Practitioner rights bulletin

- Providers applying for initial credentialing do not have appeal rights, unless required by state regulation.
- Providers rejected for re-credentialing based on a history of adverse actions, and who have no active sanctions, have appeal rights only in states that require them or due to Quality of Care concerns against DBP members. An appeal, if allowed, must be submitted within 30 calendar days of the date of the rejection letter. The provider has the right to be represented by an attorney or another person of the provider's choice.
- Appeals are reviewed by Peer Review Committee (PRC). The PRC panel will include at least one member who is of the same specialty as the provider who is submitting the appeal.
- PRC will consider all information and documentation provided with the appeal and make a determination to uphold or overturn the Credentialing Committee's decision. The PRC may request a corrective action plan, a Site Visit, and/or chart review.
- Within 10 calendar 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**

8.2 Provider terminations and appeals

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

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

- Failure to comply with DBP UnitedHealthcare's credentialing or recredentialing procedures
- Violations of DBP UnitedHealthcare's Policies and Procedures or the provisions of the Provider Manual

- Insufficient malpractice coverage with refusal to obtain such
- Information supplied (such as licensure, dental school and training) is not supported by primary source verification
- Failure to report prior, present or pending disciplinary action by any government agency
- Any federal or state sanction that precludes participation in Government Programs (such providers will be excluded from participation in our Medicaid panel)
- Failure to report fraud or malpractice claims

8.3 Quality of care issues

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

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

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

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

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

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

8.4 Appeals process

- Providers are notified in writing of their appeal rights within fifteen (15) calendar days of the Committee's determination. The letter will include the reason for denial/termination; notice that the provider has the right to request a hearing or review, at the provider's discretion, before a panel appointed by UnitedHealthcare; notice of a thirty (30) calendar-day time frame for the request; and, a time limit for the hearing date, which must be held within thirty (30) calendar days after the receipt of a request for a hearing.
- Providers must request an appeal in writing within ninety (90) calendar days of the date of notice of termination, and provide any applicable information and documentation to support the appeal.
- The Hearing will be scheduled within thirty (30) calendar days of the request for a hearing.
- The appeal may be heard telephonically, unless the clinician requests an in-person hearing. In such cases, all additional costs relevant to the Hearing are the provider's responsibility.

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

Appendices for the State of Texas

Appendix A: Resources and services — how we help you

A.1 Quick reference guide

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

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

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

You want to:	**Provider Services Line— Dedicated Service Representatives Phone: 1-877-378-5301 Hours: 8 a.m.-6 p.m. (EST) Monday-Friday**	**Online UHCDentalProviders.com**	**Interactive Voice Response (IVR) System and Voicemail Phone: 1-877-378-5301 Hours: 24 hours a day, 7 days a week**
Ask a Benefit/Plan Question (including prior authorization requirements)	✓	✓	
Ask a question about your contract	✓		
Changes to practice information (e.g., associate updates, address changes, adding or deleting addresses, Tax Identification Number change, specialty designation)	✓	✓	
Inquire about a claim	✓	✓	✓
Inquire about eligibility	✓	✓	✓
Inquire about the In-Network Practitioner Listing	✓	✓	✓
Nominate a provider for participation	✓	✓	
Request a copy of your contract	✓		
Request a Fee Schedule	✓	✓	
Request an EOB	✓	✓	
Request an office visit (e.g., staff training)	✓		
Request benefit information	✓	✓	
Request documents	✓	✓	
Request participation status change	✓		

A.2 Provider web portal

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

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

To register on the site, you will need your Payee ID number. To receive your Payee ID and for other Provider Web Portal assistance, call **1-877-378-5301**.

A.3 Addresses and phone numbers

Need:	Address:	Phone Number:	Payer I.D.:	Submission Guidelines:	Form(s) Required:
Claim Submission (initial)	Claims: UnitedHealthcare Dental P.O. Box 1471 Milwaukee WI 53201	**1-877-378-5301**	GP133	Within 95 calendar days from the date of service For secondary claims, within 30 calendar days from the primary payer determination	ADA* Claim Form, 2012 version or later
Corrected Claims	Corrected Claims: UnitedHealthcare Dental P.O. Box 481 Milwaukee, WI 53201	**1-877-378-5301**	N/A	Within 30 calendar days from date of service.	ADA Claim Form Reason for requesting adjustment or resubmission
Claim Appeals (Appeal of a denied or reduced payment)	Provider Disputes: UnitedHealthcare Dental P.O. Box 1427 Milwaukee, WI 53201	**1-877-378-5301**	N/A	Within 60 calendar days after the claim determination	Supporting documentation, including claim number is required for processing.
Prior Authorization Requests	Pre-authorizations: UnitedHealthcare Dental P.O. Box 1511 Milwaukee WI 53201	**1-877-378-5301**	GP133	N/A	ADA Claim Form – check the box titled: Request for Predetermination / Preauthorization section of the ADA Dental Claim Form
Member Benefit Appeal for Service Authorization (Appeal of a denied or reduced service)	UnitedHealthcare Community Attn: Appeals and Grievances Unit P.O. Box 31364 Salt Lake City, UT 84131-0364	**1-888-887-9003,** TTY **711**	N/A	Within 60 calendar days from the date of the adverse benefit determination	N/A

A.4 Integrated Voice Response (IVR) system — 1-877-378-5301

We have a toll-free Integrated Voice Response (IVR) system that enables you to access information 24 hours a day, 7 days a week, by responding to the system's voice prompts.

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

A.5 UHC On Air

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

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

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

Appendix B: Member benefits/exclusions and limitations

For the most updated member benefits, exclusions, and limitations please visit our website at **UHCDentalProviders.com**. We align benefit design to meet all regulatory requirements by Texas Medicaid and the Texas Legislature including the Texas Medicaid Provider Billing Manual.

B.1 Exclusions & limitations

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

Any service not listed as a covered service in the benefit grids (Appendix B.2) is excluded.

Please call Provider Services at **1-877-378-5301** if you have any questions regarding frequency limitations.

General exclusions

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

B.2 Benefit grid

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

Covered Services for UnitedHealthcare Texas Medicaid

Product Overview

For UnitedHealthcare Texas, we offer the following plans:

- UnitedHealthcare of Texas STAR Medicaid Dental Plan
- UnitedHealthcare of Texas STAR+PLUS Medicaid Dental Plan
- UnitedHealthcare Connected™ Medicare-Medicaid Dental Plan

B.2.1 Benefit Overview: UnitedHealthcare of Texas STAR Medicaid Dental Plan

Value-added adult dental benefit services for members age 21 and over are covered under this plan. It includes preventive and diagnostic services. The plan has a $250 maximum annual benefit. Covered services are paid at 100 percent of the provider fee schedule amount with no deductible or copay amount.

Should you have any questions regarding the benefits, please contact the Dental Provider Services Department at **1-877-378-5301.**

B.2.1.a UnitedHealthcare of Texas STAR Medicaid Dental Plan

Code	Description	Frequency Limits	Auth Required?	Required Documents
D0120	Periodic Oral Evaluation - Established Patient	1 per 6 month period	No	
D0140	Limited Oral Evaluation - Problem Focused	1 per 6 month period	No	
D0150	Comprehensive Oral Evaluation - New Or Established Patient	1 per 12 month period	No	
D0210	Intraoral - Complete Series of Radiographic Images	1 per 3 years	No	
D1110	Prophylaxis - Adult	1 per 6 month period	No	

B.2.2 Benefit Overview: UnitedHealthcare of Texas STAR+PLUS Medicaid Dental Plan

The UnitedHealthcare of Texas STAR+PLUS Medicaid plan has 3 dental products: the Standard dental benefit, the Skilled Nursing Facilities (SNF) dental benefit and the Waiver dental benefit. The products are described below.

B.2.2.a UnitedHealthcare of Texas STAR+PLUS/SNF Dental Plan

Value-added adult dental benefit services for members age 21 and over are covered under this plan. It includes diagnostic, preventive, minor restorative and oral surgery services. The plan has a $500 maximum annual benefit. Covered services are paid at 100 percent of the provider fee schedule amount with no deductible or copay amount. Should you have any questions regarding the benefits, please contact the Dental Provider Services Department at **1-877-378-5301.**

Code	Description	Frequency Limits	Auth Required?	Required Documents
D0120	Periodic Oral Evaluation - Established Patient	1 per 6 month period		
D0140	Limited Oral Evaluation - Problem Focused	1 per 6 month period		
D0150	Comprehensive Oral Evaluation - New Or Established Patient	1 per 12 month period		
D0210	Intraoral - Complete Series of Radiographic Images	1 per 3 years		
D1110	Prophylaxis - Adult	1 per 6 month period		
D4341	Periodontal Scaling And Root Planing - Four Or More Teeth Per Quadrant	4 quadrant per year, any combination of D4341 or D4342, no more than 2 quadrants payable per visit	Yes	Periodontal charting and pre-op x-rays
D4342	Periodontal Scaling And Root Planing - One To Three Teeth Per Quadrant	4 quadrant per year, any combination of D4341 or D4342, no more than 2 quadrants payable per visit	Yes	Periodontal charting and pre-op x-rays

B.2.2.b UnitedHealthcare of Texas STAR+PLUS Waiver Medicaid Dental Plan

STAR+PLUS members who qualify for the 1915(c) STAR+PLUS Waiver services program are eligible for dental services that are not covered under the standard STAR+PLUS benefit.

In order to qualify for the Waiver Services benefit, a member must be an eligible STAR+PLUS Long-Term Care facility member, who is either disabled, chronically ill, or has another qualifying condition as outlined by the Texas Health and Human Services Commission (HHSC).

To confirm member eligibility under STAR+PLUS Waiver plan, call our Provider Service Center at **1-877-378-5301.** Always verify eligibility via our website, or Provider Services Call Center before treating patients.

Dental services must be provided by a participating UnitedHealthcare STAR+PLUS Waiver network dentist, who is enrolled as a Medicaid provider with Texas Medicaid Healthcare Partnership. Allowable Waiver program dental services include:

- Emergency dental treatment procedures necessary to control bleeding, relieve pain and eliminate swelling;
- Acute infection: preventive procedures required to prevent the imminent loss of teeth;
- Treatment of injuries to the teeth or supporting structures;
- Dentures and the cost of fitting and preparing for dentures, including extractions, molds, etc.; and
- Routine and preventive dental treatment.
- Participating Dentist will discount non-covered services by 25 percent off their usual fees. Members can be billed for the balance after the discount for non-covered services.

Cosmetic dental services are not covered under the plan. For more information regarding dental services covered under the Waiver program, call our Provider Service Center at **1-877-378-5301.**

There is a $5,000 Annual Maximum benefit under the Waiver services program.

The $5,000 annual maximum expires 1 year after the member's effective date under the Waiver program.

Example: If a member is effective under the waiver program on Nov. 1, 2020, then the $5,000.00 annual maximum is good through Oct. 31, 2021.

B.2.3 Benefit Overview: UnitedHealthcare Connected™ Medicare–Medicaid Dental Plan (Texas MMP)

The UnitedHealthcare Connected™ (Medicare-Medicaid plan) has two dental benefit levels, the Standard dental benefit and the Waiver dental benefit. Both are described separately below. Should you have any questions regarding the benefits, contact the Dental Provider Services Department at **1-877-378-5301.**

B.2.3.a Benefit Overview: UnitedHealthcare Connected™ Medicare- Medicaid Dental Plan (Standard Benefit)

Value-added adult dental benefit services for members age 21 and over are covered under this plan. It includes diagnostic, preventive, minor restorative and oral surgery services. The plan has a $1,000 maximum annual benefit. Covered services are paid at 100 percent of the provider fee schedule amount with no deductible or copay amount. Should you have any questions regarding the benefits, contact the Dental Provider Services Department at **1-877-378-5301.**

Code	Description	Limitations	Prior Auth Needed	Clinical Documentation
D0120	Periodic Oral Evaluation - Established Patient	1 per 12 month period	No	N/A
D0140	Limited Oral Evaluation - Problem Focused	2 Per 12 month period	No	N/A
D0150	Comprehensive Oral Evaluation - New or Established Patient	1 per 12 month period	No	N/A
D0160	Detailed And Extensive Oral Evaluation - Problem Focused, By Report	1 per 1 plan year per patient	No	N/A
D0210	Intraoral - Complete Series of Radiographic Images	1 per 3 years	No	N/A
D0220	Intraoral - Periapical First Radiographic Image	1 per 12 month period	No	N/A
D0230	Intraoral - Periapical Each Additional Radiographic Image	1 per 12 month period	No	N/A
D0270	Bitewing - Single Radiographic Image	1 per 12 month period for any combination of d0270, D0272, D0273, or d0274	No	N/A
D0272	Bitewings - Two Radiographic Images	1 per 12 month period for any combination of d0270, D0272, D0273, or d0274	No	N/A
D0273	Bitewings - Three Radiographic Images	1 per 1 plan year (codeset: d0270, D0272, D0273, D0274, D0277)	No	N/A

Code	Description	Limitations	Prior Auth Needed	Clinical Documentation
D0274	Bitewings - Four Radiographic Images	1 per 12 month period for any combination of d0270, D0272, D0273, or d0274	No	N/A
D0277	Vertical Bitewings - 7 to 8 Radiographic Images	1 per 1 plan year (codeset: d0270, D0272, D0273, D0274, D0277)	No	N/A
D0330	Panoramic Radiographic Image	1 per 3 years	No	N/A
D1110	Prophylaxis Adult	1 per 12 month period	No	N/A
D1206	Topical Application of Fluoride Varnish	1 per 12 month period	No	N/A
D1208	Topical Application of Fluoride - Excluding Varnish	1 per 12 month period	No	N/A
D1310	Nutritional Counseling For Control of Dental Disease	1 per 1 plan year per patient	No	N/A
D1354	Interim Caries Arresting Medicament Application - Per Tooth	Unlimited	No	N/A
D2140	Amalgam - One Surface, Primary or Permanent	Unlimited	No	N/A
D2150	Amalgam - Two Surfaces, Primary or Permanent	Unlimited	No	N/A
D2160	Amalgam - Three Surfaces, Primary or Permanent	Unlimited	No	N/A
D2161	Amalgam - Four or More Surfaces, Primary or Permanent	Unlimited	No	N/A
D2330	Resin-Based Composite - One Surface, Anterior	Unlimited	No	N/A
D2331	Resin-Based Composite - Two Surfaces, Anterior	Unlimited	No	N/A
D2332	Resin-Based Composite - Three Surfaces, Anterior	Unlimited	No	N/A
D2335	Resin-Based Composite - Four or More Surfaces Involving Incisal Angle (Anterior)	Unlimited	No	N/A
D2391	Resin-Bsed Composite - One Surface Posterior	Unlimited	No	N/A
D2392	Resin-Based Composite - Two Surfaces, Posterior	Unlimited	No	N/A
D2393	Resin-Based Composite - Three Surfaces, Posterior	Unlimited	No	N/A
D2394	Resin-Based Composite - Four or More Surfaces, Posterior	Unlimited	No	N/A
D2510	Inlay - Metallic - One Surface	1 per 5 floating year per tooth	No	N/A
D2520	Inlay - Metallic - Two Surfaces	1 per 5 floating year per tooth	No	N/A
D2530	Inlay - Metallic - Three or More Surfaces	1 per 5 floating year per tooth	No	N/A
D2542	Onlay - Metallic - Two Surfaces	1 per 5 floating year per tooth	Yes	Current X-rays, narrative of med. necessity and/or treatment plan
D2543	Onlay - Metallic - Three Surfaces	1 per 5 floating year per tooth	Yes	Current X-rays, narrative of med. necessity and/or treatment plan
D2544	Onlay - Metallic - Four or More Surfaces	1 per 5 floating year per tooth	Yes	Current X-rays, narrative of med. necessity and/or treatment plan
D2610	Inlay - Porcelain/Ceramic - One Surface	1 per 5 floating year per tooth	No	N/A
D2620	Inlay - Porcelain/Ceramic - Two Surfaces	1 per 5 floating year per tooth	No	N/A
D2630	Inlay - Porcelain/Ceramic - Three or More Surfaces	1 per 5 floating year per tooth	No	N/A
D2642	Onlay - Porcelain/Ceramic - Two Surfaces	1 per 5 floating year per tooth	Yes	Current X-rays, narrative of med. necessity and/or treatment plan

Code	Description	Limitations	Prior Auth Needed	Clinical Documentation
D2643	Onlay - Porcelain/Ceramic - Three Surfaces	1 per 5 floating year per tooth	Yes	Current X-rays, narrative of med. necessity and/or treatment plan
D2644	Onlay - Porcelain/Ceramic - Four or More Surfaces	1 per 5 floating year per tooth	Yes	Current X-rays, narrative of med. necessity and/or treatment plan
D4341	Periodontal Scaling And Root Planing - Four or More Teeth Per Quadrant	4 Quadrant per year, any combination of d4341 or d4342, no more than 2 quadrants payable per visit	Yes	Periodontal charting and Pre-op X-rays
D4342	Periodontal Scaling And Root Planing - One to Three Teeth Per Quadrant	4 Quadrant per year, any combination of d4341 or d4342, no more than 2 quadrants payable per visit	Yes	Periodontal charting and Pre-op X-rays
D4355	Full Mouth Debridement to Enable a Comprehensive Evaluation And Diagnosis On a Subsequent Visit	1 per 3 floating year per patient	No	N/A
D4381	Localized Delivery of Antimicrobial Agents Via a Controlled Release Vehicle Into Diseased Crevicular Tissue, Per Tooth	Unlimited	Yes	Periodontal charting and Pre-op X-rays
D4910	Periodontal Maintenance	3 Per 1 plan year per patient	No	N/A
D5110	Complete Denture - Maxillary	1 per 5 floating year per patient	Yes	FMX or Panorex X-rays
D5120	Complete Denture - Mandibular	1 per 5 floating year per patient	Yes	FMX or Panorex X-rays
D5130	Immediate Denture - Maxillary	1 per 1 lifetime per patient	Yes	FMX or Panorex X-rays
D5140	Immediate Denture - Mandibular	1 per 1 lifetime per patient	Yes	FMX or Panorex X-rays
D5211	Maxillary Partial Denture - Resin Base (Including Retentive/Clasping Materials, Rests And Teeth)	1 per 5 floating year (codeset: d5211, D5213, D5225)	Yes	FMX or Panorex X-rays
D5212	Mandibular Partial Denture - Resin Base (Including Retentive/Clasping Materials, Rests And Teeth)	1 per 5 floating year (codeset: d5212, D5214, D5226)	Yes	FMX or Panorex X-rays
D5213	Maxillary Partial Denture - Cast Metal Framework With Resin Denture Bases (Including Any Conventional Clasps, Rests And Teeth)	1 per 5 floating year (codeset: d5211, D5213, D5225)	Yes	FMX or Panorex X-rays
D5214	Mandibular Partial Denture - Cast Metal Framework With Resin Denture Bases (Including Any Conventional Clasps, Rests And Teeth)	1 per 5 floating year (codeset: d5212, D5214, D5226)	Yes	FMX or Panorex X-rays
D5221	Immediate Maxillary Partial Denture - Resin Base (Including Any Conventional Clasps, Rests And Teeth)	1 per 5 floating year per patient	No	N/A
D5222	Immediate Mandibular Partial Denture - Resin Base (Including Any Conventional Clasps, Rests And Teeth)	1 per 5 floating year per patient	No	N/A
D5225	Maxillary Partial Denture - Flexible Base (Including Any Clasps, Rests And Teeth)	1 per 5 floating year (codeset: d5211, D5213, D5225)	No	N/A
D5226	Mandibular Partial Denture - Flexible Base (Including Any Clasps, Rests And Teeth)	1 per 5 floating year (codeset: d5212, D5214, D5226)	No	N/A
D5410	Adjust Complete Denture - Maxillary	2 Per 1 plan year per patient	No	N/A
D5411	Adjust Complete Denture - Mandibular	2 Per 1 plan year per patient	No	N/A
D5421	Adjust Partial Denture - Maxillary	2 Per 1 plan year per patient	No	N/A
D5422	Adjust Partial Denture - Mandibular	2 Per 1 plan year per patient	No	N/A
D5511	Repair Broken Complete Denture Base, Mandibular	1 per 1 plan year per patient	No	N/A

Code	Description	Limitations	Prior Auth Needed	Clinical Documentation
D5512	Repair Broken Complete Denture Base, Maxillary	1 per 1 plan year per patient	No	N/A
D5520	Replace Missing or Broken Teeth - Complete Denture (Each Tooth)	1 per 1 plan year per patient	No	N/A
D5611	Repair Resin Partial Denture Base, Mandibular	1 per 1 plan year per patient	No	N/A
D5612	Repair Resin Partial Denture Base, Maxillary	1 per 1 plan year per patient	No	N/A
D5621	Repair Cast Partial Framework, Mandibular	1 per 1 plan year per patient	No	N/A
D5622	Repair Cast Partial Framework, Maxillary	1 per 1 plan year per patient	No	N/A
D5630	Repair or Replace Broken Retentive/Clasping Material - Per Tooth	1 per 1 plan year per patient	No	N/A
D5640	Replace Broken Teeth - Per Tooth	1 per 1 plan year per patient	No	N/A
D5650	Add Tooth to Existing Partial Denture	1 per 1 plan year per patient	No	N/A
D5660	Add Clasp to Existing Partial Denture - Per Tooth	1 per 1 plan year per patient	No	N/A
D5730	Reline Complete Maxillary Denture (Chairside)	1 per 1 plan year per patient	No	N/A
D5731	Reline Complete Mandibular Denture (Chairside)	1 per 1 plan year per patient	No	N/A
D5740	Reline Maxillarly Partial Denture (Chairside)	1 per 1 plan year (codeset: d5740, D5760)	No	N/A
D5741	Reline Mandibular Partial Denture (Chairside)	1 per 1 plan year (codeset: d5741, D5761)	No	N/A
D5750	Reline Complete Maxillary Denture (Laboratory)	1 per 1 plan year per patient	No	N/A
D5751	Reline Complete Mandibular Denture (Laboratory)	1 per 1 plan year per patient	No	N/A
D5760	Reline Maxillary Partial Denture (Laboratory)	1 per 1 plan year (codeset: d5740, D5760)	No	N/A
D5761	Reline Mandibular Partial Denture (Laboratory)	1 per 1 plan year (codeset: d5741, D5761)	No	N/A
D5850	Tissue Conditioning, Maxillary	2 Per 1 plan year per patient	No	N/A
D5851	Tissue Condiditoning, Mandibular	2 Per 1 plan year per patient	No	N/A
D6210	Pontic - Cast High Noble Metal	1 per 5 plan year (codeset: d6210, D6211, D6212, D6214, D6240, D6241, D6242, D6245)	Yes	Pre-op X-rays
D6211	Pontic - Cast Predominantly Base Metal	1 per 5 plan year (codeset: d6210, D6211, D6212, D6214, D6240, D6241, D6242, D6245)	Yes	Pre-op X-rays
D6212	Pontic - Cast Noble Metal	1 per 5 plan year (codeset: d6210, D6211, D6212, D6214, D6240, d6241, D6242, D6245)	Yes	Pre-op X-rays
D6214	Pontic - Titanium	1 per 5 plan year (codeset: d6210, D6211, D6212, D6214, D6240, d6241, D6242, D6245)	No	N/A
D6240	Pontic - Porcelain Fused to High Noble Metal	1 per 5 plan year (codeset: d6210, D6211, D6212, D6214, D6240, d6241, D6242, D6245)	Yes	Pre-op X-rays
D6241	Pontic - Porcelain Fused to Predominantly Base Metal	1 per 5 plan year (codeset: d6210, D6211, D6212, D6214, D6240, D6241, D6242, D6245)	Yes	Pre-op X-rays
D6242	Pontic - Porcelain Fused to Noble Metal	1 per 5 plan year (codeset: d6210, D6211, D6212, D6214, D6240, D6241, D6242, D6245)	Yes	Pre-op X-rays
D6245	Pontic - Porcelain/Ceramic	1 per 5 plan year (codeset: d6210, D6211, D6212, D6214, D6240, D6241, D6242, D6245)	Yes	FMX & charting
D6740	Retainer Crown - Porcelain/Ceramic	1 per 5 plan year (codeset: d6740, D6750, D6751, D6752, D6790, D6791, D6792, D6794,)	Yes	FMX & charting

Code	Description	Limitations	Prior Auth Needed	Clinical Documentation
D6750	Retainer Crown - Porcelain Fused to High Noble Metal	1 per 5 plan year (codeset: d6740, D6750, D6751, D6752, D6790, D6791, D6792, D6794,)	Yes	Pre-op X-rays
D6751	Retainer Crown - Porcelain Fused to Predominantly Base Metal	1 per 5 plan year (codeset: d6740, D6750, D6751, D6752, D6790, D6791, D6792, D6794,)	Yes	Pre-op X-rays
D6752	Retainer Crown - Porcelain Fused to Noble Metal	1 per 5 plan year (codeset: d6740, D6750, D6751, D6752, D6790, D6791, D6792, D6794,)	Yes	Pre-op X-rays
D6790	Retainer Crown - Full Cast High Noble Metal	1 per 5 plan year (codeset: d6740, D6750, D6751, D6752, D6790, D6791, D6792, D6794,)	Yes	Pre-op X-rays
D6791	Retainer Crown - Full Cast Predominantly Base Metal	1 per 5 plan year (codeset: d6740, D6750, D6751, D6752, D6790, D6791, D6792, D6794,)	Yes	Pre-op X-rays
D6792	Retainer Crown - Full Cast Noble Metal	1 per 5 plan year (codeset: d6740, D6750, D6751, D6752, D6790, D6791, D6792, D6794,)	Yes	Pre-op X-rays
D6794	Retainer Crown - Titanium	1 per 5 plan year (codeset: d6740, D6750, D6751, D6752, D6790, D6791, D6792, D6794,)	Yes	FMX or pan w/ perio chart
D6930	Re-Cement or Re-Bond Fixed Partial Denture	Unlimited	No	N/A
D7111	Extraction, Coronal Remnants - Primary Tooth	1 per 1 lifetime per tooth	No	N/A
D7140	Extraction, Erupted Tooth or Exposed Root (Elevation And/Or Forceps Removal)	1 per 1 lifetime (codeset: d7140, D7210, D7250)	No	N/A
D7210	Extraction, Erupted Tooth Requiring Removal of Bone And/Or Sectioning of Tooth, And Including Elevation of Mucoperiosteal Flap If Indicated	1 per 1 lifetime (codeset: d7140, D7210, D7250)	No	N/A
D7250	Removal of Residual Tooth Roots (Cutting Procedure)	1 per 1 lifetime (codeset: d7140, d7210, D7250)	No	N/A
D7310	Alveoloplasty In Conjunction With Extractions - Four or More Teeth or Tooth Spaces, Per Quadrant	1 per 1 plan year per quadrant	No	N/A
D7311	Alveoloplasty In Conjunction With Extractions - One to Three Teeth or Tooth Spaces Per Quadrant	1 per 1 plan year per quadrant	No	N/A
D7320	Alveoloplasty Not In Conjunction With Extractions - Four or More Teeth or Tooth Spaces, Per Quadrant	1 per 1 plan year per quadrant	No	N/A
D7321	Alveoloplasty Not In Conjunction With Extractions - One to Three Teeth or Tooth Spaces, Per Quadrant	1 per 1 plan year per quadrant	No	N/A
D7510	Incision And Drainage of Abscess - Intraoral Soft Tissue	Unlimited	No	N/A
D7511	Incision And Drainage of Abscess - Intraoral Soft Tissue - Complicated (Includes Drainage of Multiple Fascial Spaces)	Unlimited	No	N/A
D7880	Occlusal Orthotic Device, By Report	1 per 3 floating year per patient	No	N/A
D9110	Palliative (Emergency) Treatment of Dental Pain - Minor Procedure	Unlimited	No	N/A
D9219	Evaluation For Moderate Sedation, Deep Sedation, or General Anesthesia	Unlimited	No	N/A
D9230	Inhalation of Nitrous Oxide/Analgesia, Anxiolysis	Unlimited	No	N/A
D9910	Application of Desensitizing Medicament	1 per 1 day per patient	No	N/A
D9943	Occlusal Guard Adjustment	2 Per 1 plan year per patient	No	N/A
D9944	Occlusal Guard - Hard Appliance, Full Arch	1 per 3 floating year per patient	No	N/A

B.2.3.b Benefit Overview: UnitedHealthcare Connected™ Medicare- Medicaid Dental Plan (Waiver Benefit)

There is a $5,000 Annual Maximum benefit under the Waiver services program.

The $5,000 annual maximum expires 1 year after the member's effective date under the Waiver program. Example: If a member is effective under the waiver program on Nov. 1, 2020, then the $5,000.00 annual maximum is good through Oct. 31, 2021.

B.3 Payment for non-covered services

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

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

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

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

B.4 Non covered services disclosure form

This Non covered services disclosure form 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 UnitedHealthcare Dental (including 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 _____

Appendix C: Authorization for treatment

C.1 Dental treatment requiring authorization

To make sure that desirable quality of care standards are achieved and to maintain the overall clinical effectiveness of the program, there are times when prior authorization is required prior to the delivery of clinical services. These services may include specific restorative, endodontic, periodontic, prosthodontic and oral surgery procedures. For a complete listing of procedures requiring authorization, refer to the benefit grid.

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

For questions concerning prior authorization, dental claim procedures, or to request clinical criteria, please call the Provider Services Line at **1-877-378-5301**.

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

Authorization Submission Mailing Address:

Pre-authorizations:
UnitedHealthcare
P.O. Box 1511
Milwaukee WI 53201

C.2 Authorization timelines

The following timelines will apply to requests for authorization:

- We will make a determination on standard authorizations within 3 business days of receipt of the request. Written notification of denied determinations will be sent within 3 business days of receipt of the request.
- We will make a determination on standard authorizations within 72 hours of receipt of the request. Written notification of denied determinations will be sent within 3 business days of receipt of the request.
- Authorization approvals will expire 180 calendar days from the date of determination.

C.3 Evidence-Based Dentistry and the Dental Clinical Policy and Technology Committee (DCPTC)

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

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

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

- Systematic review and meta-analysis

- Randomized controlled trials (RCT)
- Retrospective studies
- Case series
- Case studies

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

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

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

C.4 Clinical criteria and documentation requirements for services requiring authorization

Cone Beam CT Capture and Interpretation (0364)

- Documentation describes medical necessity and why radiographic images would not be appropriate/sufficient and why CBCT is needed to safely render treatment

Inlays (D2510 – D2530)

- Documentation states why an inlay is necessary instead of a standard filling

Onlays / Crowns /Coping (D2542 – D2544, D2710 – D2794, D2975)

- Root canals
  - Clinically acceptable RCT
  - Minimum 50% bone support
  - No periodontal furcation
  - No subcrestal caries
- Non-Root Canals
  - Anterior – 50% incisal edge / 4+ surfaces involved
  - Bicuspid – 1 cusp / 3+ surfaces involved
  - Molar – 2 cusps / 4+ surfaces involved
  - Minimum 50% bone support
  - No periodontal furcation
  - No subcrestal caries

Provisional Crown / Pontic / Retainer (D2799, D6253, D6793)

- Documentation describes medical necessity and provisional crown need for a minimum of 6 months.
- Not to be used as a temporary crown for a routine prosthetic restoration

Core Buildup, Including Any Pins When Required (D2950)

- Indicated for teeth with significant loss of coronal tooth structure due to caries or trauma in which insufficient tooth structure remains to adequately retain an indirect restoration.

Cast Posts and Cores / Prefabricated Post and Cores (D2952 – D2954)

- Indicated for endodontically treated teeth with significant loss of coronal tooth structure in which insufficient tooth structure remains to adequately retain an indirect restoration
- For Posts: when there is inadequate remaining tooth structure to support a core

Additional Procedures to Construct New Crown Under Existing Partial (D2971)

- Documentation supports procedure, missing teeth on at least one side of requested crown

Root canals (D3310 – D3330) and Root Canal Retreatment (D3346 – D3348)

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

Treatment of Root Canal Obstruction (D3331)

- Documentation supports an obstruction of the root canal system and endodontic retreatment is needed

Apexification / Recalcification (D3351 – D3353)

- Deep caries
- Traumatic fracture with near pulpal exposure
- Pain from percussion, temperature
- History of trauma
- Presence of open root apex / apices

Apicoectomy / Periradicular Surgery / Retrograde Filling / Root Amputation (D3410 – D3450)

- Minimum 50% bone support
- No caries below bone level
- Repair of root perforation or resorptive defect
- Exploratory curettage for root fractures
- Removal of extruded filling materials or instruments
- Removal of broken tooth fragments
- Sealing of accessory canals, etc.

Intentional Re-implantation (D3470)

- Persistent periradicular pathosis following endodontic treatment
- Nonsurgical retreatment is not possible or has an unfavorable prognosis
- Periradicular surgery is not possible or involves a high degree of risk to adjacent anatomical structures

Gingivectomy or Gingivoplasty (D4210, D4211)

- Hyperplasia or hypertrophy from drug therapy, hormonal disturbances or congenital defects
- Generalized 5 mm or more pocketing indicated on the periodontal charting

Gingivectomy or Gingivoplasty to Allow Access for Restorative Procedure (D4212)

- Documentation shows medical necessity for procedure to permit access to finish margin of restoration

Flap Procedures (D4240, D4241, D4245)

- The presence of moderate to deep probing depths
- Moderate/severe gingival enlargement or extensive areas of overgrowth
- Loss of attachment
- The need for increased access to root surface and/or alveolar bone when previous non-surgical attempts have been unsuccessful
- The diagnosis of a cracked tooth, fractured root or external root resorption when this cannot be accomplished by non-invasive methods

Clinical Crown Lengthening (D4249)

- In an otherwise periodontally healthy area to allow a restorative procedure on a tooth with little to no crown exposure
- To allow preservation of the biological width for restorative procedures

Osseous Surgery (D4260, D4261)

- Patients with a diagnosis of moderate to advanced or refractory periodontal disease
- When less invasive therapy (i.e., non-surgical periodontal therapy, flap procedures) has failed to eliminate disease

Bone Replacement Graft (D4263, D4264) and Biologic Materials to Aid in Soft and Osseous Tissue Regeneration (D4265)

- Documentation supports need to correct bone defect

Guided Tissue Regeneration (D4266, D4267)

- Intrabony/infrabony vertical defects
- Class II furcation involvements
- To enhance periodontal tissue regeneration and healing for mucogingival defects in conjunction with mucogingival surgeries
- Surgical Revision (D4268)
- Documentation supports need to refine results of previous surgical procedure

Tissue Grafts (Pedicle Soft tissue Graft (D4270), Autogenous Connective Tissue Graft (D4273), Non-Autogenous Connective Tissue Graft (D4275), Combined Connective Tissue and Double Pedicle Graft (4276), Free Soft Tissue Graft Procedure (including donor site surgery) (D4277)

- Unresolved sensitivity in areas of Recession
- Progressive recession or chronic inflammation
- Teeth with subgingival restorations where there is little or no attached gingiva to improve plaque control

Mesial/Distal Wedge (D4274)

- The presence of moderate to deep probing depths (greater than 5mm) on a surface adjacent to an edentulous/terminal tooth area

Provisional Splinting (D4320, D4321)

- Multiple teeth that have become mobile due to loss of alveolar bone loss and periodontium

Scaling and Root Planning

- D4341 (Four or more teeth per quadrant)
  - Probing depths of at least 5 mm or greater
  - Radiographic evidence of bone loss
- D4342 (One to teeth per quadrant)
  - Probing depths of at least 5 mm or greater
  - Radiographic evidence of bone loss

Scaling in the Presence of Generalized Gingival Inflammation – Full Mouth (D4346)

- Indicated for the removal of plaque, calculus and stains from supra- and sub-gingival tooth surfaces when there is generalized moderate or severe gingival inflammation in the absence of periodontitis

Localized Delivery of Antimicrobial Agents (D4381) and Gingival Irrigation (D4921)

- Documented 5 mm or more probing depths around tooth indicated on perio charting with inflammation present.

Periodontal Maintenance (D4910)

- To maintain the results of surgical and non-surgical periodontal treatment
- As an extension of active periodontal therapy at selected intervals

Complete Dentures (D5110, D5120) and Immediate Dentures (D5130, D5140)

- Remaining teeth do not have adequate bone support or are not restorable
- Existing denture greater than 5 years old and unserviceable (narrative must explain why any existing denture is not serviceable or cannot be relined or rebased)

Partial Dentures (D5211 – D5214) and Immediate Partial Dentures (D5221, D5222, D5224)

- Replacing one or more anterior teeth
- Replacing three or more posterior teeth (excluding 3rd molars)
- Existing partial denture greater than 5 years old and unserviceable
- Remaining teeth have greater than 50% bone support and are restorable

Unilateral Partial Denture (D5282, D5283)

- Replacing one or more missing teeth in one quadrant
- Existing partial denture greater than 5 years old and unserviceable
- Remaining teeth have greater than 50% bone support and are restorable

Interim Dentures (D5810, D2811, D5820, D5821)

- While tissue is healing following extractions
- Maintenance of a space for future permanent treatment such as an implant, bridge or definitive fixed prosthesis
- To condition teeth and ridge tissue for optimum support of a definitive removable partial denture
- To maintain established jaw relation until all restorative treatment has been completed and a definitive partial denture can be constructed

Precision Attachment, By Report (D5862)

- Documentation supports why attachment will significantly enhance function

Overdenture (D5863 – D5866)

- To preserve the integrity of the edentulous ridge
- When the teeth available as retainers have a good long-term prognosis

Implant, Surgical Placement (D6010, D6011 – D6013)

- Documentation shows healthy bone and periodontium

Implant, Supporting Structures (D6056 - 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 D6059)

- Documentation shows fully integrated surgical implant with good crown / root ratio
- Healthy bone and periodontium surrounding surgical implant

Implant Repair (D6090), Bone Graft for Repair of Peri-Implant Defect (D6103) and Bone Graft at Time of Implant Placement (D6104)

- Documentation supports medical necessity

Implant / Abutment Supported Removable or Fixed / Interim Fixed Dentures (D6110 – D6119)

- Documentation shows fully integrated surgical implant with good crown / root ratio
- Healthy bone and periodontium surrounding surgical implant

Fixed Partial Denture Pontics / Retainers (D6205 – D6252, D6545 –D6792, D6794)

- 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

Other Fixed Partial Denture Services (Connector bar / stress breaker / precision attachment) (D6920, D6940, D6950)

- Documentation supports why it is needed to brace individual Retainer/Abutment teeth for enhanced stabilization

Fixed partial denture repair, by report (D6980)

- Documentation describes medical necessity

Impacted Teeth – (asymptomatic impactions will not be approved) (D7220 – D7241)

- Documentation describes pain, swelling, etc. around tooth (must be symptomatic) and documentation noted in patient record
- Tooth impinges on the root of an adjacent tooth, is horizontal impacted, or shows a documented enlarged tooth follicle or potential cystic formation
- Documentation supports procedure for unusual surgical complications
- X-rays matches type of impaction code described

Surgical Removal of Residual Tooth Roots (D7250)

- Tooth root is completely covered by tissue on x-ray and/or documentation indicates cutting of soft tissue and bone, removal of tooth structures and closure
- Documentation describes pain, swelling, etc around tooth (must be symptomatic) and documentation noted in patient record

Coronectomy (D7251)

- Documentation describes neurovascular complication if entire impacted tooth is removed

Oroantral Fistula Closure (D7260)

- Due to extraction, oral infection or sinus infection

Tooth Reimplantation / Transplantation (D7272)

- Documentation describes accident and / or medical necessity

Surgical Access of An Unerupted Tooth (D7280)

- Documentation supports impacted/unerupted tooth
- Tooth is beyond one year of normal eruption pattern

Other Surgical Services (Mobilization of erupted tooth (D7282), Placement of device to facilitate eruption (D7283), Transseptal Fiberotomy / Supra crestal Fiberotomy, by report (D7291), Corticotomy (D7296, D7297)

- Documentation supports need for procedure

Vestibuloplasty - Increase Relative Alveolar Ridge Height (D7340, D7350) and Excision of Bone Tissue (D7471 – D7473, D7485)

- Documentation supports medical necessity for fabrication of a prosthesis

Partial Ostectomy (D7550) and Maxillary Sinusotomy (D7560)

- Documentation describes presence or description of non-vital bone or foreign body or root fracture

Maxilla - Open Reduction (D7710)

- Documentation describes accident, operative report and medical necessity

Collection and Application of Autologous Blood Concentrate Product (D7921)

- Narrative, x-rays or photos support medical necessity for procedure

Bone Replacement Graft for Ridge Preservation (D7953)

- Correct vertical / horizontal bone defect in preparation for surgical implant
- Prepare alveolar contour for planned prosthetic reconstruction

Appliance Removal (not by dentist who placed appliance) (D7997)

- Documentation describes removal not by dentist who placed appliance

Deep sedation / General anesthesia - IV moderate (conscious) sedation / Analgesia (Dental Office Setting) - 1 or more of the criteria below (D9222, D9223, D9239, D9243)

- Extractions of impacted teeth or surgical exposure of unerupted cuspids
- 2 or more extractions in 2 or more quadrants
- 4 or more extractions in 1 quadrant
- Excision of lesions greater than 1.25 cm
- Surgical recovery from the maxillary antrum
- Documentation that patient is less than 9 years old with extensive treatment (described)
- Documentation of failed local anesthesia and documentation noted in patient record
- Documentation of situational anxiety and documentation noted in patient record
- Documentation and narrative of medical necessity supported by submitted medical records
- (cardiac, cerebral palsy, epilepsy or condition that would render patient noncompliant)

Therapeutic Parenteral Drugs (D9610, D9612)

- Description of drugs (antibiotics, steroids, anti-inflammation or other therapeutic medication) and parental administration

Drugs or Medicaments Dispensed in The Office for Home Use (D9630)

- Description of oral antibiotics, oral analgesics, topical fluoride or other drugs / medicaments for home use
- Does not include writing prescriptions

Occlusal Guard / Repair or Reline / Adjustment (D9944-D9946)

- Medically necessary for bruxism, grinding or other occlusal factors
- Not for temporomandibular dysfunction (TMD)
- Narrative supports need for repair, reline or adjustment

Occlusion Analysis – Mounted Case (D9950), Occlusal Adjustment – Limited (D9951), Occlusal Adjustment – Complete (D9952)

- Documentation describes medical necessity

Unspecified procedures, by report (D0999, D1999, D2999, D3999, D4999, D5899, D5999, D6199, D6999, D7899, D7999, D8999, D9999)

- Procedure cannot be adequately described by an existing code

C.5 Radiology requirements

Guidelines for providing radiographs are as follows:

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

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

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

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

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

C.6 Appeals, State Fair Hearings and Complaints (Grievances)

Providers may have members that want to file a grievance, appeal or request a State Fair Hearing. Providers may assist or instruct members on how to do so. These processes are explained in detail in the Member Handbook.

Excerpts from the Member Handbook are provided below for your reference. The Member Handbook may be updated, so for the most current information, please refer to the Member Handbook.

If you have a complaint, call us toll-free at 1-888-887-9003 to tell us about your problem. A UnitedHealthcare Community Plan Member Services Advocate can help you file a complaint. Most of the time, we can help you right away or at the most within a few days.

For written complaints, send your letter to UnitedHealthcare Community Plan. You must state your name, your member ID number, your telephone number and address, and the reason for your complaint. Please send your letter to:

UnitedHealthcare Community Plan
Attn: Complaint and Appeals Department
P.O. Box 31364
Salt Lake City, UT 84131-0364

Once you have gone through the UnitedHealthcare Community Plan complaint process, you can complain to the Health and Human Services Commission (HHSC) by calling toll-free: 1-866-566-8989. If you would like to make your complaint in writing, please send it to the following address:

Texas Health and Human Services Commission
Attn: Resolution Services
Health Plan Operations - H-320
P.O. Box 85200
Austin, TX 78708-5200

If you can get on the internet, you can send your complaint in an email to HPM_Complaints@hhsc.state.tx.us.

Ombudsman Program

UnitedHealthcare Community Plan members can access an independent ombudsman through our new internal complaints unit. Referrals can be made by a member advocate based on interaction with members that appear to need an independent advocate to work through their concerns. In addition, the ombudsman may make referrals to UnitedHealthcare Community Plan complaints unit concerning members of their organization needing help. UnitedHealthcare Community Plan has contracts with several non-profit entities to provide support for members. Call 1-888-887-9003 to talk to a Member Advocate.

There is no time limit on filing a complaint with UnitedHealthcare Community Plan. UnitedHealthcare Community Plan will send you a letter telling you what we did about your complaint. You will get the letter within 30 days from when your complaint got to UnitedHealthcare Community Plan.

Appeals

Authorization Decisions—Turnaround Times and Filing Limits
Non-orthodontic services must be performed within 180 days from the date that the approval notification is received by the practitioner.

Authorization Appeal and Inquiry Process
If you have additional information that you believe may impact any authorization decisions, you may contact our Provider Services at **1-877-378-5301.**

Appeals may be submitted verbally or in writing, and must be received by UnitedHealthcare no later than **60 calendar days** from the date that UnitedHealthcare advised the provider of the authorization decision. The appeal should contain the following information:

- Member name and UnitedHealthcare member identification (ID) number.
- Provider name and UnitedHealthcare provider number.
- Provider's address and phone number.
- Requested procedure(s) or service(s).
- Date of denial (if known).
- Diagnosis and justification for the procedure or service.
- A copy of the original denial.
- A copy of the member's consent if the provider is appealing on behalf of the member.

UnitedHealthcare Community Plan will send you a letter if a covered service that you requested is not approved or if payment is denied in whole or in part. If you are not happy with our decision, call UnitedHealthcare Community Plan within 30 days from when you get our letter. You must appeal within 10 days of the date on the letter to make sure your services are not stopped.

You can appeal by sending a letter to UnitedHealthcare Community Plan or by calling UnitedHealthcare Community Plan. You can ask for up to 14 days of extra time for your appeal. UnitedHealthcare Community Plan can take extra time on your appeal if

it is better for you. If this happens, UnitedHealthcare Community Plan will tell you in writing the reason for the delay. You can call Member Services and get help with your appeal. When you call Member Services, we will help you file an appeal. Then we will send you a letter and ask you or someone acting on your behalf to sign a form.

UnitedHealthcare Community Plan has up to 30 calendar days to decide if your request for care is medically needed and covered. We will send you a letter of our decision within 30 days. In some cases you have the right to a decision within 1 business day. If your provider requests, we must give you a quick decision. You can get a quick decision if your health or ability to function could be seriously hurt by waiting.

An Expedited Appeal is when the health plan has to make a decision quickly based on the condition of your health, and taking the time for a standard appeal could jeopardize your life or health. You may ask for this type of appeal in writing or by phone. Make sure you write "I want a quick decision or an expedited appeal," or "I feel my health could be hurt by waiting for a standard decision." To request a quick decision by phone, call UnitedHealthcare Community Plan Member Services at **1-888-887-9003.**

We can record your verbal request. Your request will then be made into a written request. We will send a form to you to complete, sign and return to us as soon as possible.

Mail written requests to:

UnitedHealthcare Community Plan
Attn: Complaint and Appeals Department
P.O. Box 31364
Salt Lake City, UT 84131-0364

UnitedHealthcare Community Plan must decide this type of appeal in 1 working day from the time we get the information and request. If UnitedHealthcare Community Plan denies an expedited appeal, the appeal is processed through the normal appeal process, which will be resolved within 30 days. You will receive a letter explaining why and what other choices you may have.

If you are in the hospital, ask someone to help you mail, fax or call in your request for this type of appeal. You may also call UnitedHealthcare Community Plan Member Services at 1-888-887-9003 and ask someone to help you start an appeal or ask your doctor to do it for you.

C.7 Appeal determination timeframe:

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

C.8 State Fair Hearing

Members can request a state fair hearing after the health plan's appeals process.

If you, as a member of the health plan, disagree with the health plan's decision, you have the right to ask for a fair hearing.

You may name someone to represent you by writing a letter to the health plan telling them the name of the person you want to represent you. A doctor or other medical provider may be your representative. If you want to challenge a decision made by your health plan, you or your representative must ask for the fair hearing within 120 days of the date on the health plan's letter with the decision. If you do not ask for the fair hearing within 120 days, you may lose your right to a fair hearing. To ask for a fair hearing, you or your representative should call UnitedHealthcare Community Plan at 1-888-887-9003 or send a letter to the health plan at:

UnitedHealthcare Community Plan
Attn: Fair Hearings Coordinator
14141 Southwest Freeway, Suite 800
Sugar Land, TX 77478

You have the right to keep getting any service the health plan denied or reduced, at least until the final hearing decision is made if you ask for a fair hearing by the later of: 1) 10 calendar days following the MCO's mailing of the notice of the Action, or 2) the day the health plan's letter says your service will be reduced or end. If you do not request a fair hearing by this date, the service the health plan denied will be stopped. If you ask for a fair hearing, you will get a packet of information letting you know the

date, time and location of the hearing. Most fair hearings are held by telephone. At that time, you or your representative can tell why you need the service the health plan denied. HHSC will give you a final decision within 90 days from the date you asked for the hearing.

The member may have someone attend with them. This may be a family member, friend, care provider or lawyer. Written consent is required.

Processes related to reversal of our initial decision

If the state fair hearing outcome is to not deny, limit, or delay services while the member is waiting on an appeal, then we provide the services:

- As quickly as the member's health condition requires or
- No later than 72 hours from the date UnitedHealthcare Community Plan receives the determination reversal.

If the State Fair Hearing decides UnitedHealthcare Community Plan must approve appealed services, we pay for the services as specified in the policy and/or regulation.

Appendix D: Claim submission procedures

D.1 Claim submission options

D.1.a Electronic claims

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

Electronic claims processing requires access to a computer and usually the use of practice management software. Electronically generated claims can be submitted through a clearinghouse or directly to our claims processing system via the internet. UnitedHealthcare Community Plan partners with electronic clearinghouses to support electronic claims submissions. If you wish to submit claims electronically, contact your clearinghouse to initiate this process.

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

Electronic submission is private as the information being sent is encrypted. Call **1-877-378-5301** for more information regarding electronic claims submission.

HIPAA-Compliant 837D File

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

D.1.b Paper claims

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

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

Refer to Section 9.2 for more information on claims submission best practices and required information. Section 2.3 will provide you with the appropriate claims address information to ensure your claims are routed to the correct resource for payment.

D.2 Claim submission requirements and best practices

D.2.a Dental claim form required information

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

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

Header information

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

Subscriber information

- Name (last, first and middle initial)

- Address (street, city, state, ZIP code)
- Date of birth
- Gender
- Subscriber ID number

Patient Information

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

Primary Payer Information

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

Other Coverage

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

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

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

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

Billing Dentist or Dental Entity

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

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

Treating Dentist and Treatment Location

List the following information regarding the dentist that provided treatment:

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

Record of Services Provided

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

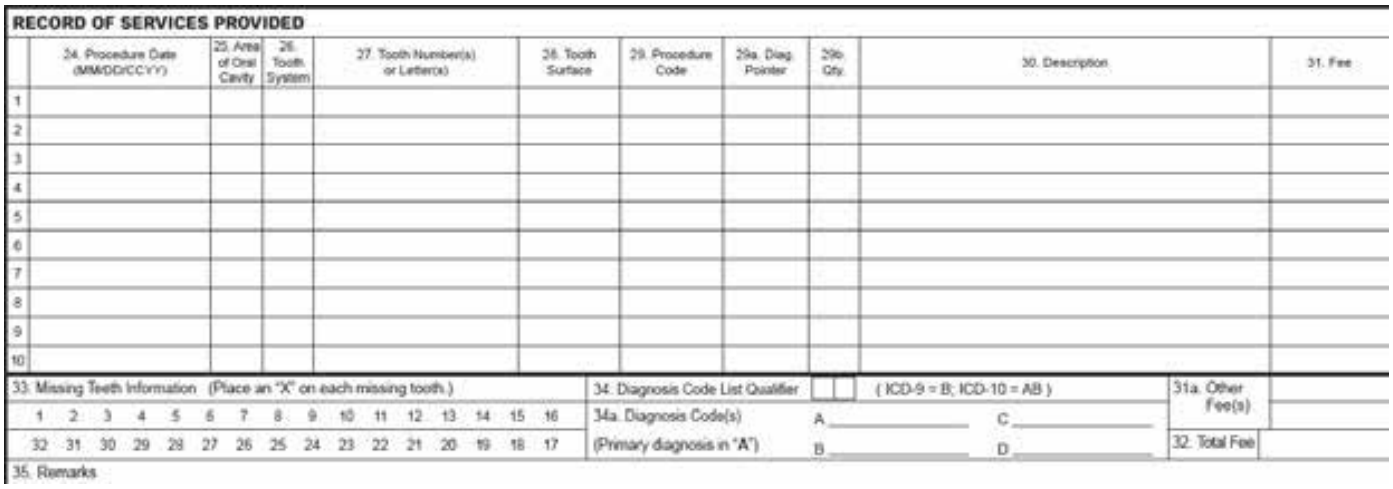
Missing Teeth Information

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

Remarks Section

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

ICD-10 instructions



RECORD OF SERVICES PROVIDED

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

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

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

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

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

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

A _____ C _____

B _____ D _____

31a. Other Fee(s)

32. Total Fee

35. Remarks

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

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

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

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

34a **Diagnosis Code(s):** Enter up to 4 applicable diagnosis codes after each letter (A.-D.). The primary diagnosis code is entered adjacent to the letter "A."

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

By Report Procedures

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

Using Current ADA Codes

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

Supernumerary Teeth

UnitedHealthcare Dental recognizes tooth letters "A" through "T" for primary teeth and tooth numbers "1" to "32" for permanent teeth. Supernumerary teeth should be designated by using codes AS through TS or 51 through 82. Designation of the tooth can be determined by using the nearest erupted tooth. If the tooth closest to the supernumerary tooth is # 1 then the supernumerary tooth should be charted as #51, likewise if the nearest tooth is A the supernumerary tooth should be charted as. These procedure codes must be referenced in the patient's file for record retention and review. Patient records must be kept for a minimum of 7 years.

Insurance fraud

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

Any person who knowingly files a claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties. By signing a claim for services, the practitioner certifies that the services shown on the claim were medically indicated and necessary for the health of the patient and were personally furnished by the practitioner or an employee under the practitioner's direction. The practitioner certifies that the information contained on the claim is true and accurate.

Invalid or incomplete claims:

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

D.2.b Coordination of Benefits (COB)

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

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

D.2.c Timely submission (Timely filing)

All claims should be submitted within 95 calendar days from the date of service.

All adjustments or requests for reprocessing must be made within within 60 calendar days from date of service, or date of eligibility posting, only if the initial submission time period has been met. An adjustment can be requested in writing or telephonically.

Secondary claims must be received within 30 calendar days of the primary payer's determination (see section 9.2.b).

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

D.3 Timely payment

- 90% of all clean claims will be paid or denied within 30 calendar days of receipt.
- 99% of all clean claims will be paid or denied within 45 calendar days of receipt.

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

D.4 Provider remittance advice

D.4.a Explanation of dental plan reimbursement (remittance advice)

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

Below is a list and description of each field:

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

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

AMOUNT BILLED - Amount submitted by provider

AMOUNT PAYABLE - Amount payable after benefits have been applied

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

OTHER INSURANCE - Amount payable by another carrier

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

NET AMOUNT (Summary Page) - Total amount paid

PATIENT NAME

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 - Dates of Service: Dates that services are rendered/performed

CDTCODE - Current Dental Terminology - Procedure code of service performed

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

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

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

PAYABLE AMOUNT - Contracted amount

COPAY AMOUNT - Member responsibility

COINSURANCE AMOUNT - Member responsibility of total payment amount

DEDUCTIBLE AMOUNT - Member responsibility before benefits begin

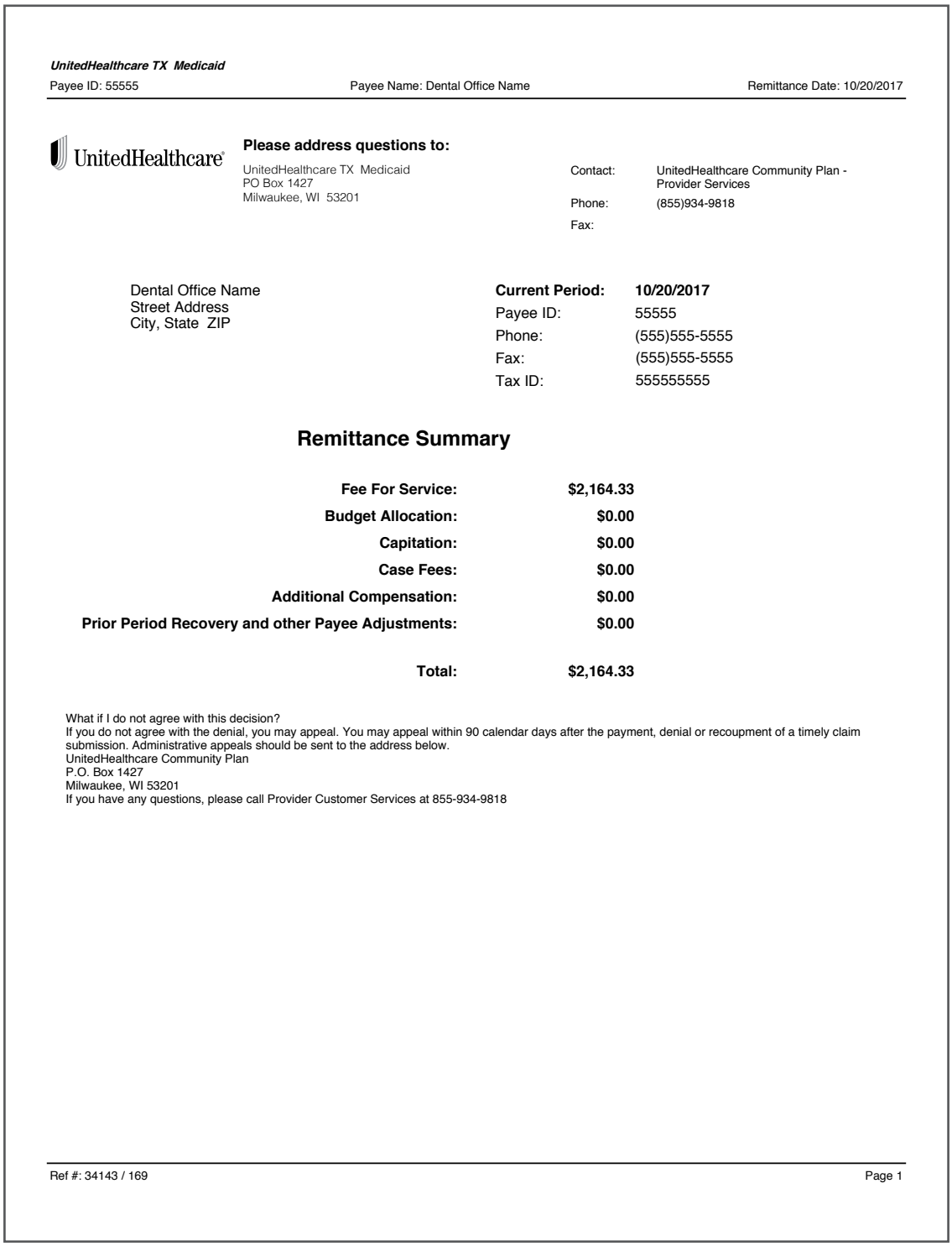
PATIENT PAY - Amount to be paid by the member

OTHER INSURANCE AMOUNT - Amount paid by other carriers

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

EXCEPTION CODES - Codes that explain how the claim was adjudicated

D.4.b Provider Remittance Advice sample (page 1)



UnitedHealthcare TX Medicaid

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

UnitedHealthcare

Please address questions to:

UnitedHealthcare TX Medicaid
PO Box 1427
Milwaukee, WI 53201

Contact: UnitedHealthcare Community Plan - Provider Services
Phone: (855)934-9818
Fax:

Dental Office Name
Street Address
City, State ZIP

Current Period: **10/20/2017**
Payee ID: 55555
Phone: (555)555-5555
Fax: (555)555-5555
Tax ID: 555555555

Remittance Summary

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

What if I do not agree with this decision?
If you do not agree with the denial, you may appeal. You may appeal within 90 calendar days after the payment, denial or recoupment of a timely claim submission. Administrative appeals should be sent to the address below.
UnitedHealthcare Community Plan
P.O. Box 1427
Milwaukee, WI 53201
If you have any questions, please call Provider Customer Services at 855-934-9818

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D.4.c Provider Remittance Advice sample (page 2)

UnitedHealthcare TX Medicaid

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

Fee For Service Summary

Dental Office Name
Street Address
City, State ZIP

Provider / ID	Location / ID	Amount Billed	Amount Payable	Patient Pay	Other Insurance	Prior Mo. Adj	Net Amount
Provider Name/ 55555	Dental Office Name / 55555	$4,785.00	$1,870.84	$0.00	$0.00	$0.00	$1,870.84
Provider Name / 55555	Dental Office Name / 55555	$1,110.00	$109.37	$0.00	$0.00	$0.00	$109.37
Provider Name / 55555	Dental Office Name / 55555	$450.00	$184.12	$0.00	$0.00	$0.00	$184.12
	Totals:	**$6,345.00**	**$2,164.33**	**$0.00**	**$0.00**	**$0.00**	**$2,164.33**

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D.4.d Provider Remittance Advice sample (page 3)

UnitedHealthcare TX Medicaid

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

Services Detail

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

Patient Name: Last, First Name
Subscriber/Member: 555555555 / 00
DOB: 00/00/0000
Office Reference No: 555555555
Provider Name: Last, First Name
Provider NPI: 5555555555
Plan: UnitedHealthcare Texas
Product: UHC TX Medicaid
Encounter #: **55555555555555**
Referral #:
Referral Date:
Benefit Level: In Network

ITM	DOS	CODE	POS	BILLED QTY	BILLED AMOUNT	ALLOWED QTY	ALLOWED AMOUNT	PAY %	PAYABLE AMOUNT	COPAY AMOUNT	COINS AMOUNT	DEDUCT AMOUNT	PATIENT PAY	OTHER INSUR	NET AMOUNT	PAY CODE
1	10/16/17	D2740 4	11	1	$885.00	0	$0.00	100.00 %	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	FFS
2	10/16/17	D2954 4	11	1	$225.00	1	$109.37	100.00 %	$109.37	$0.00	$0.00	$0.00	$0.00	$0.00	$109.37	FFS
					$1,110.00		**$109.37**		**$109.37**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$109.37**	

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

Patient Name: Last, First Name
Subscriber/Member: 555555555 / 00
DOB: 00/00/0000
Office Reference No: 555555555
Provider Name: Last, First Name
Provider NPI: 5555555555
Plan: UnitedHealthcare Texas
Product: UHC TX Medicaid Adult
Encounter #: **55555555555555**
Referral #:
Referral Date:
Benefit Level: In Network

ITM	DOS	CODE	POS	BILLED QTY	BILLED AMOUNT	ALLOWED QTY	ALLOWED AMOUNT	PAY %	PAYABLE AMOUNT	COPAY AMOUNT	COINS AMOUNT	DEDUCT AMOUNT	PATIENT PAY	OTHER INSUR	NET AMOUNT	PAY CODE
1	10/12/17	D2392 29 DO	11	1	$135.00	1	$71.84	100.00 %	$71.84	$0.00	$0.00	$0.00	$0.00	$0.00	$71.84	FFS
2	10/12/17	D7140 30	11	1	$160.00	1	$52.28	100.00 %	$52.28	$0.00	$0.00	$0.00	$0.00	$0.00	$52.28	FFS
					$295.00		**$124.12**		**$124.12**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$124.12**	

Patient Name: Last, First Name
Subscriber/Member: 555555555 / 00
DOB: 00/00/0000
Office Reference No: 555555555
Provider Name: Last, First Name
Provider NPI: 5555555555
Plan: UnitedHealthcare Texas
Product: UHC TX Medicaid Adult
Encounter #: **55555555555555**
Referral #:
Referral Date:
Benefit Level: In Network

ITM	DOS	CODE	POS	BILLED QTY	BILLED AMOUNT	ALLOWED QTY	ALLOWED AMOUNT	PAY %	PAYABLE AMOUNT	COPAY AMOUNT	COINS AMOUNT	DEDUCT AMOUNT	PATIENT PAY	OTHER INSUR	NET AMOUNT	PAY CODE
1	10/12/17	D0120 00	11	1	$50.00	1	$0.00	100.00 %	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	FFS
2	10/12/17	D0220 00	11	1	$25.00	1	$9.58	100.00 %	$9.58	$0.00	$0.00	$0.00	$0.00	$0.00	$9.58	FFS
3	10/12/17	D0230 00	11	1	$20.00	1	$7.98	100.00 %	$7.98	$0.00	$0.00	$0.00	$0.00	$0.00	$7.98	FFS
4	10/12/17	D0274 00	11	1	$50.00	1	$21.63	100.00 %	$21.63	$0.00	$0.00	$0.00	$0.00	$0.00	$21.63	FFS
5	10/12/17	D2392 13 DO	11	1	$135.00	1	$71.84	100.00 %	$71.84	$0.00	$0.00	$0.00	$0.00	$0.00	$71.84	FFS
					$280.00		**$111.03**		**$111.03**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$111.03**	

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

Patient Name: Last, First Name
Subscriber/Member: 555555555 / 00
DOB: 00/00/0000
Office Reference No: 555555555
Provider Name: Last, First Name
Provider NPI: 5555555555
Plan: UnitedHealthcare Texas
Product: UHC TX Medicaid
Encounter #: **55555555555555**
Referral #:
Referral Date:
Benefit Level: In Network

ITM	DOS	CODE	POS	BILLED QTY	BILLED AMOUNT	ALLOWED QTY	ALLOWED AMOUNT	PAY %	PAYABLE AMOUNT	COPAY AMOUNT	COINS AMOUNT	DEDUCT AMOUNT	PATIENT PAY	OTHER INSUR	NET AMOUNT	PAY CODE
1	10/12/17	D0150 00	11	1	$55.00	1	$39.66	100.00 %	$39.66	$0.00	$0.00	$0.00	$0.00	$0.00	$39.66	FFS
2	10/12/17	D0210 00	11	1	$125.00	1	$40.72	100.00 %	$40.72	$0.00	$0.00	$0.00	$0.00	$0.00	$40.72	FFS
3	10/12/17	D1120 00	11	1	$60.00	1	$21.95	100.00 %	$21.95	$0.00	$0.00	$0.00	$0.00	$0.00	$21.95	FFS
4	10/12/17	D1208 00	11	1	$25.00	1	$11.98	100.00 %	$11.98	$0.00	$0.00	$0.00	$0.00	$0.00	$11.98	FFS
					$265.00		**$114.31**		**$114.31**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$114.31**	

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D.5 Corrected claim process

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

Corrected claims
UnitedHealthcare Dental
P.O. Box 481
Milwaukee, WI 53201

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

D.6 Appealing a denied claim payment

Providers have the right to appeal a claim payment that is fully or partially denied. A claim payment appeal, also known as a Provider Contract Dispute, must be submitted within 60 calendar days of the payment or denial. To appeal a denied payment, please send information to:

Appeals for denied claims payment
Provider Disputes:
UnitedHealthcare Dental
P.O. Box 1427
Milwaukee, WI 53201

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

D.7 Overpayment

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

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

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

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

D.8 Tips for successful claims resolution

- Do not let claim issues grow or go unresolved.
- Call Provider Services if you can't verify a claim is on file.
- Do not resubmit validated claims on file unless submitting a corrected claim with the required indicators.

- File adjustment requests and claims disputes within contractual time requirements.
- If you must exceed the maximum daily frequency for a procedure, submit the medical records justifying medical necessity. If you have questions, call Provider Services.
- UnitedHealthcare Community Plan is the payer of last resort. This means you must bill and get an EOB from other insurance or source of health care coverage before billing UnitedHealthcare Community Plan. Secondary claims must be received within six months from the date of service, even if the primary carrier has not made payment.
- When submitting appeal or reconsiderations requests, provide the same information required for a clean claim. Explain the discrepancy, what should have been paid and why.

Appendix E: Member rights and responsibilities

For the most updated information regarding Member Rights and Responsibilities, please review the Member Handbook.

E.1 Member rights

You have the right to respect, dignity, privacy, confidentiality and nondiscrimination. That includes the right to:

- Be treated fairly and with respect.
- Know that your medical records and discussions with your providers will be kept private and confidential.

You have the right to a reasonable opportunity to choose a health care plan and Primary Care Provider. This is the doctor or health care provider you will see most of the time and who will coordinate your care. You have the right to change to another plan or provider in a reasonably easy manner. That includes the right to:

- Be told how to choose and change your health plan and your Primary Care Provider.
- Choose any health plan you want that is available in your area and choose your Primary Care Provider from that plan.
- Change your Primary Care Provider.
- Change your health plan without penalty.
- Be told how to change your health plan or your Primary Care Provider.

You have the right to ask questions and get answers about anything you do not understand. That includes the right to:

- Have your provider explain your health care needs to you and talk to you about the different ways your health care problems can be treated.
- Be told why care or services were denied and not given.

You have the right to agree to or refuse treatment and actively participate in treatment decisions. That includes the right to:

- Work as part of a team with your provider in deciding what health care is best for you.
- Say yes or no to the care recommended by your provider.

You have the right to use each complaint and appeal process available through the managed care organization and through Medicaid, and get a timely response to complaints, appeals and fair hearings. That includes the right to:

- Make a complaint to your health plan or to the state Medicaid program about your health care, your provider or your health plan.
- Get a timely answer to your complaint.
- Use the plan's appeal process and be told how to use it.
- Ask for a fair hearing from the state Medicaid program and get information about how that process works.

You have the right to timely access to care that does not have any communication or physical access barriers. That includes the right to:

- Have telephone access to a medical professional 24 hours a day, 7 days a week to get any emergency or urgent care you need.
- Get medical care in a timely manner.
- Be able to get in and out of a health care provider's office. This includes barrier free access for people with disabilities or other conditions that limit mobility, in accordance with the Americans with Disabilities Act.
- Have interpreters, if needed, during appointments with your providers and when talking to your health plan. Interpreters include people who can speak in your native language, help someone with a disability, or help you understand the information.
- Be given information you can understand about your health plan rules, including the health care services you can get and how to get them.

You have the right to not be restrained or secluded when it is for someone else's convenience, or is meant to force you to do something you do not want to do, or is to punish you.

You have a right to know that doctors, hospitals, and others who care for you can advise you about your health status, medical care, and treatment. Your health plan cannot prevent them from giving you this information, even if the care or treatment is not a covered service.

You have a right to know that you are not responsible for paying for covered services. Doctors, hospitals, and others cannot require you to pay copayments or any other amounts for covered services.

You have a right to make recommendations regarding the organization's member rights and responsibilities policy.

E.2 Member responsibilities

You must learn and understand each right you have under the Medicaid program. That includes the responsibility to:

- Learn and understand your rights under the Medicaid program.
- Ask questions if you do not understand your rights.
- Learn what choices of health plans are available in your area.

You must abide by the health plan's and Medicaid's policies and procedures. That includes the responsibility to:

- Learn and follow your health plan's rules and Medicaid rules.
- Choose your health plan and a Primary Care Provider quickly.
- Make any changes in your health plan and Primary Care Provider in the ways established by Medicaid and by the health plan.
- Keep your scheduled appointments.
- Cancel appointments in advance when you cannot keep them.
- Always contact your Primary Care Provider first for your non-emergency medical needs.
- Be sure you have approval from your Primary Care Provider before going to a specialist.
- Understand when you should and should not go to the emergency room.

You must share information about your health with your Primary Care Provider and learn about service and treatment options. That includes the responsibility to:

- Tell your Primary Care Provider about your health.
- Talk to your providers about your health care needs and ask questions about the deferent ways your health care problems can be treated.
- Help your providers get your medical records.

You must be involved in decisions relating to service and treatment options, make personal choices, and take action to keep yourself healthy. That includes the responsibility to:

- Work as a team with your provider in deciding what health care is best for you.
- Understand how the things you do can affect your health.
- Do the best you can to stay healthy.
- Treat providers and staff with respect.
- Talk to your provider about all of your medications.

If you think you have been treated unfairly or discriminated against, call the U.S. Department of Health and Human Services (HHS) toll-free at 1-800-368-1019. You can also view information concerning the HHS Ofce of Civil Rights online at **www.hhs.gov/ocr**.

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