Provider Manual

UnitedHealthcare Louisiana Medicaid

Fall 2019

UnitedHealthcare®

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Section 1: **Introduction—Who We Are**

Welcome to UnitedHealthcare®

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

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

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

This Provider Manual (the "Manual") is designed as a comprehensive reference guide for the dental plans in your area, primarily UnitedHealthcare. 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, contact Provider Services at **1-800-822-5353**. Note: All other concerns should be directed to **1-855-812-9210**.

If you have any questions or concerns about the information contained within this Manual, please contact the UnitedHealthcare Provider Services team at **1-855-812-9210**.

Unless otherwise specified herein, this Manual is effective on January 1, 2020 for dental providers currently participating in the UnitedHealthcare network, and effective immediately for newly contracted dental providers.

Please note: "You" or "your" refers to any provider subject to this Manual. "Us", "we" or "our" refers to UnitedHealthcare on behalf of itself and its other affiliates for those products and services subject to this Manual.

The 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 beneficiaries in your community.

Sincerely,

UnitedHealthcare Professional Networks

Section 2: **Resources & Services—Supporting your Needs**

2.1 Quick Reference Guides –

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

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

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

	Resource:		
You want to:	**Provider Services Line–Dedicated Service Representatives** Phone: **1-844-275-8751** Hours: 7 a.m.-5 p.m. (ET) Monday – Friday, CST	**Online** **uhcproviders.com**	**Interactive Voice Response (IVR) System** Phone: **1-844-275-8751** Hours: 24/7
Ask a Benefit/Plan Question (including prior authorization requirements)	✓	✓	
Ask a question about your contract	✓		
Changes to practice information (e.g., associate updates, address changes, adding or deleting addresses, Tax Identification Number change, specialty designation, demographic updates, etc.)	✓	✓	
Inquire about a claim	✓	✓	✓
Inquire about eligibility	✓	✓	✓
Inquire about the In-Network Practitioner Listing	✓	✓	✓
Nominate a provider for participation	✓	✓	
Request a copy of your contract	✓		
Request a Fee Schedule	✓	✓	
Request an EOB	✓	✓	
Request an office visit (e.g., staff training)	✓		
Request benefit information	✓	✓	
Request documents	✓	✓	
Request participation status change	✓		

Need:	Resource: Address:	Phone Number	Payor I.D.	Submission Guidelines	Form(s) Required
Claim Submission (initial)	**Claims:** UnitedHealthcare P.O. Box 2180 Milwaukee, WI 53201 Or submission via the Provider Web Portal at **uhcproviders.com**	1-800-508-4881	GP133	Within the following number of days from the date of service: 180 days for Medicaid	ADA Claim Form, 2012 version or later
Prior Authorization Requests	**Prior Authorizations:** Not Required				
Provider Administrative Appeals	**Adjustments/ Resubmissions:** UnitedHealthcare PO Box 1266, Milwaukee, WI 53201	1-800-508-4881	GP133	Within 90 days from receipt of payment	ADA Claim Form - Provider narrative supporting appeal
UnitedHealthcare Member Complaints & Appeals	UnitedHealthcare P.O. Box 31364 Salt Lake City, UT 84131	Medicaid: 1-866-675-1607	N/A	N/A	N/A

2.2.a Integrated Voice Response (IVR) System – 1-800-508-4881

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

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

2.2.b Website

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

To use the website, please go to **uhcproviders.com** and register as a participating user. For assistance, please call **1-800-508-4881**.

2.3 Provider Web Portal

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

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

- Verifying Member eligibility.
- Checking patient treatment history for specific services.
- Submitting claims for services rendered by simply entering procedure codes, tooth numbers, etc.
- Submitting authorization requests, using interactive clinical algorithms when appropriate.
- Sending electronic attachments, such as digital x-rays, EOBs, and treatment plans.

- Checking the status of submitted claims and authorizations.
- Accessing and reviewing remittance information.
- Downloading and printing Provider Manuals, Clinical Criteria, Provider Newsletters and Fee Schedules.
- Setting up office appointment schedules, which can automatically verify eligibility and pre-populate claim forms for online submission.
- Reviewing Provider clinical profiling data relative to peers. Uploading and downloading documents using a secure encryption protocol.
- Participating in surveys to rate provider satisfaction

2.4 Registration

To register for our Provider Web Portal visituhcproviders.com, click on the Providers login tab, and follow the **Register Now** link.

There is no need to download or purchase software.

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

- Select "As a payee" for the option to view remittances.
- Contact Provider Services at **1-844-275-8751** to obtain your Payee ID number.

Introduction

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

Verify member eligibility

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

Manage claims

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

Section 3: **Patient Eligibility Verification Procedures**

3.1 Member Eligibility

UnitedHealthcare Medicaid, 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 Member Identification Card

Health plan Identification Cards (ID) are issued to all recipients enrolled in benefits that cover all services; there will not be a separate Dental card for UnitedHealthcare Medicaid and Medicare plans. The ID cards are customized with the UnitedHealthcare logo and include the toll-free customer service number for the health plan.

Medicaid ID cards issued by the state of Louisiana do not guarantee payment under the UnitedHealthcare Medicaid plans. It is the provider's responsibility to verify member eligibility with the UnitedHealthcare plan prior to rendering service.

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 **uhcproviders.com** or contact the dental Provider Services line at **1-800-508-4881.**

3.3 Eligibility Verification

Eligibility can be verified on our website at www.uhcproviders.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.

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

- Payee ID number from a remittance advice

The username and password that are established during the registration process will be used to access the website. One username and password are granted for each payee ID number. Please call **1-800-508-4881** during normal business hours for assistance with website issues.

UnitedHealthcare also offers an Interactive Voice Response (IVR) system; simply call **1-800-508-4881.** Through our IVR system, you may access real-time information, 24 hours a day, 7 days a week. The UnitedHealthcare IVR system enables you to do the following:

- Verify eligibility
- Obtain claim status.

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

4.1 Covered Services

Dental Benefits

Limited adult dental benefit services for members age 21 and over are covered under this plan, including preventive and diagnostic services, minor restorations, and extractions. Annual Maximum of $500. The plan does not require prior authorizations and does not have a deductible or coinsurance.

For a complete listing of covered services and frequency limits, please see the list of covered services document. Should you have any questions regarding the benefits, please contact the Dental Provider Services Department at **1-844-275-8751.**

Code	Description	Frequency	Service Category
D0120	Periodic oral evaluation	2 per 12 months	Diagnostic
D0140	Limited oral evaluation - Problem focused	1 per 12 month period	Diagnostic
D0150	Comprehensive oral evaluation - New or established patient	1 per 12 month period	Diagnostic
D0210	Intraoral - Complete series (including bitewings)	1 per 3 years	Diagnostic
D0220	Intraoral - Periapical - First film	1 per 12 month period	Diagnostic
D0230	Intraoral - Periapical - Each additional film	1 per 12 month period	Diagnostic
D0270	Bitewing - Single film	1 per 12 month period for any combination of D0270, D0272, D0273, or D0274	Diagnostic
D0272	Bitewings - Two films	1 per 12 month period for any combination of D0270, D0272, D0273, or D0274	Diagnostic
D0273	Bitewings - Three films	1 per 12 month period for any combination of D0270, D0272, D0273, or D0274	Diagnostic
D1110	Prophylaxis - Adult	2 per 12 month period	Preventive
D2140	Amalgam - One surface, Primary or Permanent		Minor Restorative
D2150	Amalgam - Two surfaces, Primary or Permanent		Minor Restorative
D2160	Amalgam - Three Surfaces, Primary or Permanent		Minor Restorative
D2161	Amalgam - Four or More Surfaces, Primary or Permanent		Minor Restorative
D2330	Resin-Based Composite - One Surface, Anterior		Minor Restorative
D2331	Resin-Based Composite - Two Surfaces, Anterior		Minor Restorative
D2332	Resin-Based Composite - Three Surfaces, Anterior		Minor Restorative
D2335	Resin-Based Composite - Four or More Surfaces or Involving Incisal Angle (Anterior)		Minor Restorative
D2391	Resin-Based Composite -One Surface, Posterior		Minor Restorative
D2392	Resin-based composite - Two surfaces, Posterior		Minor Restorative
D2393	Resin-based composite - Three surfaces, Posterior		Minor Restorative
D2394	Resin-based composite - Four or more surfaces, Posterior		Minor Restorative
D7140	Extraction, Erupted Tooth or Exposed Root		Oral Surgery
D7210	Extraction, Erupted Tooth*		Oral Surgery
D7250	Removal of Residual Tooth (Cutting Procedure)*		Oral Surgery

*pre-authorization required.

4.2 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 grid (section 4.1) is excluded. Please call Provider Services if you have any questions regarding frequency limitations.

Additional Exclusions

1. Dental services that are not necessary.
2. Hospitalization or other facility charges.
3. Any dental procedure performed solely for cosmetic/aesthetic reasons.
4. Reconstructive surgery, regardless of whether or not the surgery is incidental to a dental disease, injury, or congenital anomaly when the primary purpose is to improve physiological functioning of the involved part of the body.
5. 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.
6. Charges for failure to keep a scheduled appointment without giving the dental office.

4.3 Member Complaints and Appeals and Inquiries

If you want to appeal a decision made by UnitedHealthcare.

If a member believes that UnitedHealthcare has denied a service that should be covered from the schedule of covered services listed in section 4.1, the member , or provider with your providers written consent, have the right to appeal that decision within 90 days of the date of your denial letter. You can do this by calling Member Services at 1-866-675-1607, TTY: 711, and asking to have the decision reviewed. We will review your appeal as soon as possible, and always within 10 calendar days of your request.

Grievances and Appeals:

UnitedHealthcare Community Plan
P.O. Box 31364
Salt Lake City, UT 84131

4.4 Provider Disputes

Claims Disputes
United Healthcare Dental
PO Box 361
Milwaukee, WI 53201

Section 5: **Claim Submission Procedures**

5.1 Claim Submission Best Practices & Required Elements

Dental Claim Form

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

Claim Submission Options

Electronic Claims

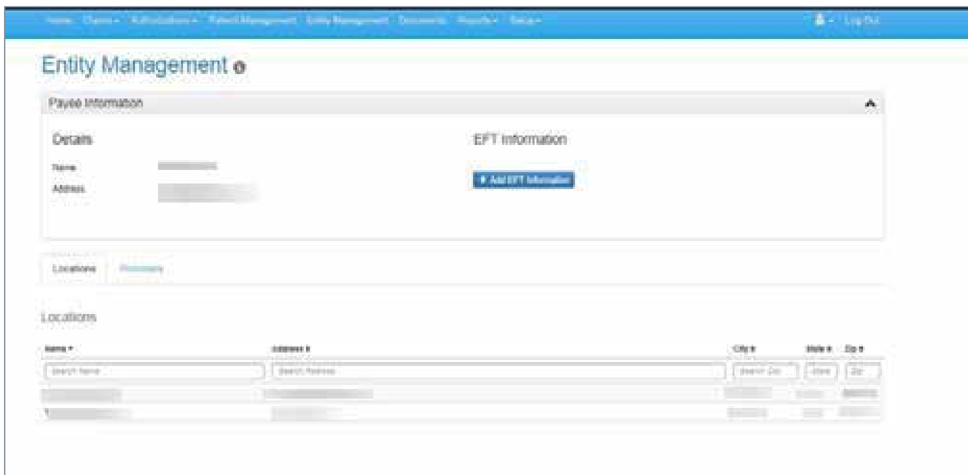
Electronic claims processing requires access to a computer and usually the use of practice management software. Electronically generated claims can be submitted through a clearinghouse or directly to our claims processing system via the Internet at www.uhcproviders.com. Most systems have the ability to detect missing information on a claim form and notify you when errors need to be corrected. Electronic submission is private as the information being sent is encrypted. Please call 1-800-508-4881 for more information regarding electronic claims submission.

Payor ID GP133

Electronic Funds Transfer

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

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



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

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

Electronic Funds Transfer (Eft) Authorization Agreement

Electronic Funds Transfer (EFT) Authorization Agreement

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

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

Instructions for the

Electronic Funds Transfer (EFT) Authorization Agreement

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

Three Easy Steps for EFT Enrollment

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

Why enroll in EFT?

Direct Checking and Savings Account Payments

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

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

Why use the web portal?

Online Resources for Enrolled Providers

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

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

5.6 Claim Adjudication & Periodic Overview

Claim Processing Standards:

- At least 90% of all clean claims will be processed or paid within 15 business days of the date of receipt*
- At least 99% of all clean claims will be processed or paid within 30 calendar days of the date of receipt
- Fully adjudicate (pay or deny) all pended claims within sixty (60) calendar days of the date of receipt.

5.7 Claim Submission Best Practices and Required Elements

5.7.1 Dental Claim Form

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

5.7.2 Claim Submission Options

Electronic Claims

Electronic claims processing requires access to a computer and usually the use of practice management software. Electronically generated claims can be submitted through a clearinghouse or directly to our claims processing system via the internet. Most systems have the ability to detect missing information on a claim form and notify you when errors need to be corrected.

Electronic submission is private as the information being sent is encrypted. Call 1-800-508-4881 for more information regarding electronic claims submission.

Note: Our Payer ID is GP133.

Paper Claims

Due to periodic revisions and varying practice management systems, dental insurance claim forms exist in various formats. Use of the 2012 or later American Dental Association (ADA) form is required.

5.7.3 Dental Claim Form Required Information

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 or Request for Pre-Treatment Estimate.

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 and 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
- Taxonomy

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.

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

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.

Timely Submission

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

Paper Claims

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

By Report Procedures

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

Using Current ADA Codes

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

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 ____ B ____ C ____ D ____

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

35. Remarks

Instructions:

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

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

34 **Diagnosis Code List Qualifier:** Enter the appropriate code to identify the diagnosis code source:
B = ICD-9-CM **AB** = ICD-10-CM (as of October 1, 2013)
This information is required when the diagnosis may have an impact on the adjudication of the claim in cases where specific dental procedures may minimize the risks associated with the connection between the patient’s oral and systemic health conditions.

34a **Diagnosis Codes(s):** Enter up to four applicable diagnosis codes after each letter (A. – D.). The primary diagnosis code is entered adjacent to the letter “A.”
This information is required when the diagnosis may have an impact on the adjudication of the claim in cases where specific dental procedures may minimize the risks associated with the connection between the patient’s oral and systemic health conditions.

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.

5.8 Electronic Claims Submissions

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).

UnitedHealthcare partners with electronic clearing houses to support electronic claims submissions. While the payer ID may vary for some plans, the UnitedHealthcare number for Community Plan members is GP133. Please refer to the Important Addresses and Phone Numbers section for additional information as needed.

If you wish to submit claims electronically, contact your clearinghouse to initiate this process.

5.9 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.

5.10 Paper Claims Submission

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

Refer to Section 7.1 for more information on claims submission best practices and required information.

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

5.11 Coordination of Benefits (COB)

Coordination of Benefits (COB) is used when a member is covered by more than 1 dental insurance policy. By coordinating benefit payments, the member receives maximum benefits available under each plan. Coordination of Benefits rules are mandated by the Department of Insurance and it is each provider's responsibility to correctly coordinate benefits.

The practitioner office is required to identify when a patient has coverage through multiple carriers and to inform DBP on the claim form.

If the patient is covered by more than 1 dental carrier, or if the procedure is also covered under the patient's health plan, include any explanation of benefits or remittance notice from the other payer. Payers are required by state law or regulation to coordinate benefits when more than 1 entity is involved— this is not a payer choice. The objective is to ensure the dentist is reimbursed appropriately by the proper payer first (primary) with any other payer coordinating the benefit on the balance.

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

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

5.12 Dental Claim Filing Limits and Adjustments

All Dental Claims must be submitted within 90 days of the date of service.

All claim appeals must be submitted within 60 days of the denial notice. Refer to the Quick Reference Guide for address and phone number information.

5.13 Claim Adjudication and Periodic Overview

Claim Processing Standards:

- 90 percent of Clean Claims will be adjudicated within 30 days of receipt of the claim.

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.

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.

5.14 Explanation of Dental Plan Reimbursement

The Practitioner 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 - Treating dentist's name, practitioner ID number

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

AMOUNT BILLED - Amount submitted by provider

AMOUNT PAYABLE - Amount payable after benefits have been applied

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

OTHER INSURANCE - Amount payable by another carrier

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

NET AMOUNT (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., DBP 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 CDTCODE TOOTH NO .SURFACE(S)

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

5.15 Explanation of Benefits Sample (Page 1)

UnitedHealthcare Dental

Payee ID: Payee Name: First Lastname Remittance Date: 12/20/2010

UnitedHealthcare **Please address questions to:**

UnitedHealthcare Dental

1001 Brinton Road
Pittsburgh, PA 15221

Contact: United Healthcare Dental - Provider Services

Phone:

Fax:

FPO

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Current Period: 12/20/2010

Payee ID:

Phone:

Fax:

Tax ID:

Remittance Summary

Fee For Service:	**$2,300.00**
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:	**$2,300.00**

Administrative Appeals by Practitioners: Requests for reconsideration of administrative denials of claims submi tted by practitioners must be received with required documentation within 60 days of the notice of denial. Late appeals will not be considered. Practitioners should send requests for reconsideration of administrative denials to the following address:

UnitedHealthcare
Attn: Appeals and Grievances
P.O. Box 31364
Salt Lake City, UT 84131

IMPORTANT NOTICE: Effective with claims and pre-authorizations received July 5, 2010 and later, in order to maintain HIPAA compliance, only ADA 2012 Dental Claim forms will be accepted when submitting claims and pre-authorizations. All other forms, including ADA forms from years prior to 2012, will not be accepted and will result in a rejection of the claim or pre-authorization request. Additionally, please send clearly marked 'Corrected Claims' on ADA 2012 forms, to the Appeals mailbox. Please contact the customer service toll free number if you have questions. If you are in need of the new Dental Claim forms, please visit the ADA website at www.ada.org for ordering information.

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5.15.a Explanation of Benefits Sample (Page 2)

UnitedHealthcare Dental

Payee Name: Remittance Date: 12/20/2010

Fee For Service Summary

Provider / ID	Location / ID	Amount Billed	Amount Payable	Patient Pay	Other Insurance	Prior Mo. Adj	Net Amount
First Lastname / 1234	First Lastname / 5678	$2,300.00	$2,300.00	$0.00	$0.00	$0.00	$2,300.00
	Totals: $	2,300.00	$2,300.00 $	0.00	$0.00 $	0.00 $	2,300.00

FPO

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5.15.b Explanation of Benefits Sample (Page 3)

UnitedHealthcare Dental -

Payee Name:

Remittance Date: 12/20/2010

Services Detail

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

Patient Name:	Provider Name:	Encounter #:	20101202000737
Subscriber/Member:	Provider NPI:	Referral #:	
DOB:	Plan:	Referral Date:	
Office Reference No:	Product:	Benefit Level:	In Network

ITM	DOS	CODE	QTY	BILLED AMOUNT	QTY	ALLOWED AMOUNT	PAYABLE AMOUNT	COPAY AMOUNT	COINS AMOUNT	DEDUCT AMOUNT	OVER MAX AMOUNT	PATIENT PAY	OTHER INSUR	NET AMOUNT	PAY CODE
1	11/29/10	D7210 1	1	$230.00	1	$230.00	$230.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$230.00	FFS
2	11/29/10	D7210 2	1	$230.00	1	$230.00	$230.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$230.00	FFS
3	11/29/10	D7210 19	1	$230.00	1	$230.00	$230.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$230.00	FFS
4	11/29/10	D7210 20	1	$230.00	1	$230.00	$230.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$230.00	FFS
5	11/29/10	D7210 21	1	$230.00	1	$230.00	$230.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$230.00	FFS
6	11/29/10	D7210 22	1	$230.00	1	$230.00	$230.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$230.00	FFS
7	11/29/10	D7210 26	1	$230.00	1	$230.00	$230.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$230.00	FFS
8	11/29/10	D7210 27	1	$230.00	1	$230.00	$230.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$230.00	FFS
9	11/29/10	D7210 28	1	$230.00	1	$230.00	$230.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$230.00	FFS
10	11/29/10	D7210 29	1	$230.00	1	$230.00	$230.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$230.00	FFS
				$2,300.00		$2,300.00	$2,300.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$2,300.00	

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Section 6: **Quality Management**

6.1 Quality Improvement Program (QIP) Description

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

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

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

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

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

A complete copy of our QIP policy and procedure is available upon request by contacting Provider Services at **1-855-812-9210.**

6.2 Credentialing

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

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

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

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

initiate an appeal of a recredentialing decision, follow the instructions provided in the determination letter received from the Credentialing Department. Appeals will be accepted and reviewed for states with appeal rights.

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

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

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

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

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

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

Initial credentialing

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

Recredentialing

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

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

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

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

If you are new to CAQH ProView, visit ADA.org/godigital to get started. If you are already using CAQH ProView, we are able to accept your CAQH ID number provided that your profile data, credentialing documents and attestation show Complete and Current.

Confidentiality

Our staff treats information obtained in the credentialing process as confidential. We and our delegates maintain mechanisms to properly limit review of confidential credentialing information. Our contracts require Delegated Entities to maintain the confidentiality of credentialing information. Credentialing staff or representatives will not disclose confidential care provider credentialing information to any persons or entity except with the express written permission of the care provider or as otherwise permitted or required by law.

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 recordkeeping, 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.

6.4 Preventive Health Guideline

The UnitedHealthcare approach to preventive health is a multi-focused strategy which includes several integrated areas. Preventive health focuses primarily on the prevention, assessment for risk, and early treatment of caries and periodontal diseases, but also encompasses areas including prevention of malocclusion, oral cancer prevention and detection, injury prevention, avoidance of harmful habits and the impact of oral disease on overall health. We have a long history of working with customers on education and outreach programs focusing on wellness, oral health management and the relationship between oral disease and overall health.

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

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

Caries Management begins with a complete evaluation including an assessment for risk.X-ray periodicity – X-ray examination should be tailored to the individual patient based on the patient's health history and risk assessment/vulnerability to oral disease and should follow current professionally accepted dental guidelines necessary for appropriate diagnosis and monitoring.

- Recall periodicity — Frequency of recall examination should also be tailored to the individual patient based on clinical assessment and risk assessment.
- Preventive interventions — Interventions to prevent caries should consider AAPD periodicity guidelines while remaining tailored to the needs of the individual patient based on age, health history, and risk assessment/vulnerability to oral disease. These preventative

interventions include but are not limited to regular prophylaxis, fluoride application, placement of sealants, dietary counseling and adjunctive therapies where appropriate.

- Caries Classification and Risk Assessment Systems - methods of caries detection, classification, and risk assessment combined with prevention strategies, can help to reduce patient risk of developing advanced disease and may even arrest the disease process. Consideration should be given to these conservative nonsurgical approaches to early caries; or alternatively, where appropriate, to minimally invasive approaches, conserving tooth structure whenever possible.

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

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

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

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

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

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

Section 7: **Utilization Management Program**

7.1 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.

7.2 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.

7.3 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.

7.4 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

7.5 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.

7.6 Fraud and Abuse

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

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

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

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

All Network Providers and third-party contractors are expected to promptly report any perceived or alleged instances of fraud. Reporting may be made directly to the compliance helpline at 1-800-455-4521.

Section 8: **Evidence-Based Education**

8.1 Evidence-based Dentistry & the Clinical Policy & Technology Committee

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 United Healthcare, 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
- (bullet)Case studies
- Anecdotal/expert opinion (including professional society statements, white papers and practice guidelines)

Evidence is found in a variety of sources including:

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

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

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

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

Section 9: **Governing Administrative Policies**

9.1 Appointment Scheduling Standards

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

- **Emergency appointments** . . . . Immediately
- **Urgent care appointments**. . . . . Within 24 hours
- **Routine care appointments**. . . . . Offered within 30 calendar days of the request

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

- A true emergency is defined as services required for treatment of severe pain, swelling, bleeding or immediate diagnosis and treatment of unforeseen dental conditions which if not immediately diagnosed and treated, would lead to disability or death.
- Urgent care appointments would be needed if a patient is experiencing excessive bleeding, pain or trauma.
- Providers are encouraged to schedule members appropriately to avoid inconveniencing the members with long wait times in excess of thirty (30) minutes. Members should be notified of anticipated wait times and given the option to reschedule their appointment.

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

9.2 Missed Appointments

Offices should inform patients of office policies relating to missed appointments and any fees that may be incurred as a result.

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

9.4 New Associates

As your practice expands and changes and new associates are added, please contact us 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, contact our Provider Services Line at **1-855-812-9210.**

9.5 Change of Address, Phone Number, Email, Fax or Tax Identification Number (TIN)

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

Changes should be submitted to:

UnitedHealthcare
Government Programs Provider Relations
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 the changes apply.

UnitedHealthcare reserves the right to conduct an on-site 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 for guidance.

9.6 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.

9.7 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.

9.8 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.

9.9 Transfer of Dental Records

Your office shall copy all requested member dental files to another participating dentist as designated by UnitedHealthcare or as requested by the member. The member is responsible for the cost of copying the patient dental files if the member is transferring to another provider. If your office terminates from UnitedHealthcare,

dismisses the member from your practice or is terminated by UnitedHealthcare, the cost of copying files shall be borne by your office. Your office shall cooperate with UnitedHealthcare in maintaining the confidentiality of such member dental records at all times, in accordance with state and federal law.

9.10 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.

9.11 Cultural Competency

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

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

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

This website contains valuable materials that will assist dental providers and their staff to become culturally competent: **http://www.hrsa.gov/culturalcompetence/index.html**

APPENDIX A: **Attachments**

A.1 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:

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

A.2 Practitioner Rights Bulletin

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

To review your information

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; 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 fifteen (15) business days of receipt of the information. You will have an additional fifteen (15) business days to submit your reply in writing; within two (2) 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 in writing or telephonically.

To appeal adverse Committee Decisions

1. Providers applying for initial credentialing do not have appeal rights, unless required by State regulation.
2. Providers rejected for recredentialing based on a history of adverse actions, and who have no active sanctions, have appealrights only in states that require them or due to Quality of Care concerns against DBP members. An appeal, if allowed, mustbe submitted within 30 days of the date of the rejection letter. The provider has the right to be represented by an attorney oranother person of the provider's choice.
3. Appeals are reviewed by Peer Review Committee (PRC). The PRC panel will include at least 1 member who is of the samespecialty as the provider who is submitting the appeal.
4. PRC will consider all information and documentation provided with the appeal and make a determination to uphold or overturnthe Credentialing Committee's decision. The PRC may request a corrective action plan, a Site Visit and/or chart review.
5. Within 10 days of making a determination, the PRC will send the provider, by certified mail, written notice of its finaldecision, including reasons for the decision.

Credentialing Supervisor
Credentialing Department
2300 Clayton Road, Suite 100
Concord, CA 94520

All documents regarding the recruitment and contracting of providers, payment arrangements, and detailed product information are confidential proprietary information that may not be disclosed to any third party without the express written consent of UnitedHealthcare, Inc.

CMS Preclusion List

The Centers for Medicare and Medicaid Services (CMS) has a Preclusion List effective for claims with dates of service on or after January 1, 2019. The Preclusion List applies to both Medicare Advantage (MA) plans as well as Part D plans.

The Preclusion is comprised of a list of prescribers and individuals or entities who:

- Are revoked from Medicare, are under an active reenrollment bar, and CMS has determined that the underlying conduct that led to the revocation is detrimental to the best interests of the Medicare program; or
- Have engaged in behavior for which CMS could have revoked the prescriber, individual or entity to the extent possible if they had been enrolled in Medicare and that the underlying conduct that would have led to the revocation is detrimental to the best interests of the Medicare program.

Providers receive notification from CMS of their placement on the Preclusion List, via letter, and will have the opportunity to appeal with CMS before the preclusion is effective. There is no opportunity to appeal with UnitedHealthcare. If you are listed on the Preclusion list you cannot participate with any UnitedHealthcare plan.

Through the Preclusion List, which CMS updates monthly, CMS advises MA and Part D plans of the date upon which providers' claims must be rejected or denied due to precluded status ("claim-rejection date"). As of the claim-rejection date, a precluded provider's claims will no longer be paid, pharmacy claims will be rejected, and the provider will be terminated from the UnitedHealthcare network; additionally, the precluded provider must hold Medicare beneficiaries harmless from financial liability for services or items provided on or after the claim-rejection date.

All documents regarding the recruitment and contracting of providers, payment arrangements, and detailed product information are confidential proprietary information that may not be disclosed to any third party without the express written consent of Dental Benefit Providers, Inc.

UnitedHealthcare Dental® coverage provided by or through UnitedHealthcare Insurance Company, located in Hartford, Connecticut, or its affiliates. Administrative services provided by Dental Benefit Providers, Inc., Dental Benefit Administrative Services (CA only), United HealthCare Services, Inc. or their affiliates. Plans sold in Texas use policy form number DPOL.06.TX (11/15/2006) and associated COC form number DCOC.CER.06.

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