Dental Provider Manual

UnitedHealthcare Community Plan of Wisconsin

July 2019

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Introduction—Who We Are

Section 1: **Welcome to UnitedHealthcare®**

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

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

We offer a portfolio of products including, but not limited to: Medicaid and Medicare 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 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 **1-888-249-8833**).

If you have any questions or concerns about the information contained within this Manual, please contact the UnitedHealthcare Provider Services team at **1-888-249-8833**.

Unless otherwise specified herein, this Manual is effective on March 1, 2018 for dental providers currently participating in the UnitedHealthcare 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. "Manual" refers to this Provider Manual. "You" or "your" refers to any provider subject to this Manual. "Us", "we" or "our" refers to UnitedHealthcare on behalf of itself and its other affiliates for those products and services subject to this Manual.

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

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

Sincerely,

UnitedHealthcare, Professional Networks

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

2.1 Quick Reference Guides—Addresses and Phone Numbers

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

Our **Provider Services Line** and Provider Services teams are available to assist you with any questions you may have. Our toll-free provider services number is available during normal business hours and is staffed with knowledgeable specialists. They are trained to handle specific dentist 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: 1-888-249-8833 Hours: 8 a.m.-5 p.m. (CST) Monday-Friday	Online uhcproviders.com	Interactive Voice Response (IVR) System Phone: 1-888-249-8833 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	✓		

	RESOURCE:				
NEED:	**Address:**	**Phone Number:**	**Payer I.D.:**	**Submission Guidelines:**	**Form(s) Required:**
Claim Submission (initial)	**Claims:** UnitedHealthcare PO Box 583 Milwaukee, WI 53201	**1-888-249-8833**	GP133	Within 90 calendar days from the date of service	ADA* Claim Form, 2012 version or later
Prior Authorization Requests	**PTE/Preauthorizations:** UnitedHealthcare PO Box 363 Milwaukee, WI 53201	**1-888-249-8833**	GP133	N/A	ADA Claim Form – check the box titled: Request for Predetermination/ Preauthorization section of the ADA Dental Claim Form
Provider Administrative Appeals (Claim Appeals)	**UnitedHealthcare:** Appeals Coordinator PO Box 1698 Milwaukee, WI 53201	**1-888-249-8833**	GP133	Within 90 days from the date of payment or claim determination.	ADA Claim Form Provider narrative supporting appeal
Reprocessing & Adjustment Requests, Corrective Claims, In & Out of Network Provider Disputes	**Provider Disputes:** UnitedHealthcare PO Box 481 Milwaukee, WI 53201	**1-888-249-8833**	N/A	Within 90 days from receipt of payment	ADA Claim Form Reason for requesting adjustment or resubmission
UnitedHealthcare Member Complaints & Appeals	**UnitedHealthcare:** Appeals Coordinator PO Box 31364 Salt Lake City, UT 84131	**1-800-504-9660**	N/A	Within 45 days of the action being appealed	N/A
UnitedHealthcare Provider UM Appeals (on behalf of member)	**UnitedHealthcare:** Appeals Coordinator PO Box 31364 Salt Lake City, UT 84131	**1-800-504-9660**	N/A	Within 45 days of the action being appealed	N/A
For Hearing Requests	Department of Administration Hearing and Appeals PO Box 7875 Madison, WI 53707-7875	**1-800-760-0001 or 1-800-291-2002**	N/A	Within 45 days of the action being appealed	N/A

2.2 Integrated Voice Response (IVR) System—1-888-249-8833

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).

2.3 Website

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

To use the website, go to **uhcproviders.com** and register as a participating user. For assistance, call **1-888-249-8833**.

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 **Member Identification Card**

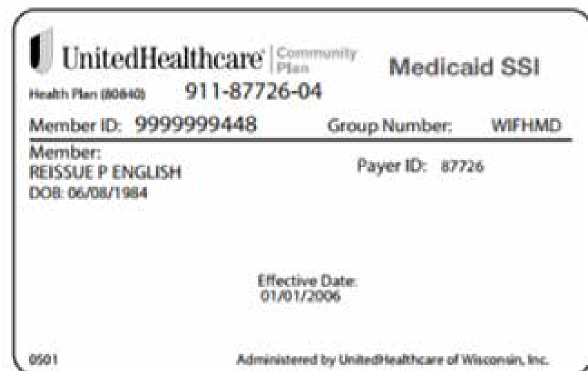
Members are issued an identification (ID) card by UnitedHealthcare Community Plan. There will not be separate dental cards for UnitedHealthcare Community Plan members. The ID cards are customized with the UnitedHealthcare Community Plan logo and include the toll-free customer service number for the health 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 **uhcproviders.com** or contact the dental Provider Services line at **1-888-249-8833**.

A Forward Health sample ID card, front and back, is provided below. The member's actual ID card may look slightly different.

A UnitedHealthcare Community Plan of Wisconsin sample ID card, front and back, 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 **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 **1-888-249-8833** during normal business hours for assistance with website issues.

UnitedHealthcare also offers an Interactive Voice Response (IVR) system; simply call **1-888-249-8833**. 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

3.4 Specialist Referral Process

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

To obtain a list of participating dental network specialists, go to our website at **uhcproviders.com** or contact Provider Services at **1-888-249-8833**.

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

4.1 Covered Services for Wisconsin BadgerCare Plus and Medicaid SSI Plans serviced by UnitedHealthcare Community Plan of Wisconsin

Provider Quick Covered Services Reference Guide for the UnitedHealthcare Community Plan of Wisconsin.

Covered services are paid at 100% of the provider fee schedule amount with no deductible.

UnitedHealthcare Community Plan offers dental coverage to eligible members in alignment with ForwardHealth dental guidelines.

ForwardHealth dental guidelines may be found at www.forwardhealth.wi.gov. There, you will access the “Online Handbooks” link and choose the “BadgerCare Plus and Medicaid” and “Dental” selections.

UnitedHealthcare Wisconsin Dental Benefits					
Code	**Description**	**Age Limits**	**Frequency/ Limitation**	**Auth Required?**	**Required Documents**
D0120	Periodic Oral Evaluation - Established Patient	0-999	1 per 6 MONTH	No	N/A
D0120	Periodic Oral Evaluation - Established Patient	0-999	1 per 12 MONTH	No	N/A
D0140	Limited Oral Evaluation - Problem Focused	0-999	1 per 6 MONTH	No	N/A
D0150	Comprehensive Oral Evaluation - New Or Established Patient	0-999	1 per 3 FLOATING YEAR	No	N/A
D0160	Detailed And Extensive Oral Evaluation - Problem Focused, By Report	0-999	1 per 3 FLOATING YEAR	No	N/A
D0170	Re-Evaluation - Limited, Problem Focused	0-999	1 per 1 FLOATING YEAR	No	N/A
D0191	Assessment Of A Patient	0-999	1 per 6 MONTH	No	N/A
D0210	Intraoral - Complete Series of Radiographic Images	0-999	1 per 3 FLOATING YEAR	No	N/A
D0220	Intraoral - Periapical First Radiographic Image	0-999	1 per 1 DAY	No	N/A
D0230	Intraoral - Periapical Each Additional Image	0-999	3 per 1 DAY	No	N/A
D0240	Intraoral - Occlusal Radiographic Image	0-999	2 per 1 DAYS	No	N/A
D0250	Extraoral - 2D Projection Radiographic image	0-999	1 per 1 DAY	No	N/A
D0260	Extraoral - Each Additional Radiographic Image	0-999	2 per 1 DAYS	No	N/A
D0270	Bitewing - Single Radiographic Image	0-999	2 per 6 MONTH	No	N/A
D0272	Bitewings - Two Radiographic Images	0-999	1 per 6 MONTH	No	N/A
D0273	Bitewings - Three Radiographic Images	0-999	1 per 6 MONTH	No	N/A
D0274	Bitewings - Four Radiographic Images	0-999	1 per 6 MONTH	No	N/A
D0277	Vertical Bitewings - 7 To 8 Radiographic Images	21-999	1 per 12 MONTH	No	N/A
D0330	Panoramic Radiographic Image	0-999	1 per 1 DAY	No	N/A
D0340	2D Cephalometric Radiographic Image	0-20		No	N/A
D0350	Oral/Facial Photographic Images	0-20		No	N/A
D0470	Diagnostic Casts	0-999		No	N/A
D0486	Accession Of Transepithelial Cytologic Sample, Microscopic Examination	0-999		No	N/A
D0999	Unspecified Diagnostic Procedures, By Report	13-20	2 per 1 FLOATING YEAR	Yes	Description of procedure and narrative of medical necessity
D1110	Prophylaxis - Adult	13-999	1 per 6 MONTH	No	N/A
D1110	Prophylaxis - Adult	13-999	1 per 12 MONTH	No	N/A
D1110	Prophylaxis - Adult	13-999	4 per 1 FLOATING YEAR	No	N/A

UnitedHealthcare Wisconsin Dental Benefits					
Code	Description	Age Limits	Frequency/ Limitation	Auth Required?	Required Documents
D1120	Prophylaxis - Child	0-12	1 per 6 MONTH	No	N/A
D1120	Prophylaxis - Child	0-12	4 per 1 FLOATING YEAR	No	N/A
D1206	Topical Application Of Fluoride Varnish	0-999	1 per 12 MONTH	No	N/A
D1206	Topical Application Of Fluoride Varnish	0-999	2 per 12 MONTH	No	N/A
D1206	Topical Application Of Fluoride Varnish	0-999	4 per 1 FLOATING YEAR	No	N/A
D1208	Topical Application of Fluoride	0-999	1 per 12 MONTH	No	N/A
D1208	Topical Application of Fluoride	0-999	2 per 12 MONTH	No	N/A
D1208	Topical Application of Fluoride	0-999	4 per 1 FLOATING YEAR	No	N/A
D1351	Sealant - Per Tooth	0-20	1 per 3 FLOATING YEAR	No	N/A
D1351	Sealant - Per Tooth	21-999	1 per 3 FLOATING YEAR	No	N/A
D1354	Interim Caries Arresting Medicament Application - per tooth	0-999	1 per 6 MONTH	No	N/A
D1510	Space Maintainer - Fixed - Unilateral	0-20	1 per 1 FLOATING YEAR	No	N/A
D1516	Space Maintainer - Fixed - Bilateral, maxillary	0-20	1 per 1 FLOATING YEAR	No	N/A
D1517	Space Maintainer - Fixed - Bilateral, mandibular	0-20	1 per 1 FLOATING YEAR	No	N/A
D1550	Re-Cement Or Re-Bond Space Maintainer	0-20	2 per 1 DAYS	No	N/A
D1555	Removal Of Fixed Space Maintainer	0-999		No	N/A
D1575	Distal shoe space maintainer - fixed	0-20	1 per 1 FLOATING YEAR	No	N/A
D2140	Amalgam - One Surface, Primary Or Permanent	0-999	1 per 3 FLOATING YEAR	No	N/A
D2150	Amalgam - Two Surfaces, Primary Or Permanent	0-999	1 per 3 FLOATING YEAR	No	N/A
D2160	Amalgam - Three Surfaces, Primary Or Permanent	0-999	1 per 3 FLOATING YEAR	No	N/A
D2161	Amalgam - Four Or More Surfaces, Primary Or Permanent	0-999	1 per 3 FLOATING YEAR	No	N/A
D2330	Resin-Based Composite - One Surface, Anterior	0-999	1 per 3 FLOATING YEAR	No	N/A
D2331	Resin-Based Composite - Two Surfaces, Anterior	0-999	1 per 3 FLOATING YEAR	No	N/A
D2332	Resin-Based Composite - Three Surfaces, Anterior	0-999	1 per 3 FLOATING YEAR	No	N/A
D2335	Resin-Based Composite - Four Or More Surfaces Or Involving Incisal Angle	0-999	1 per 3 FLOATING YEAR	No	N/A
D2390	Resin-Based Composite Crown, Anterior	0-999	1 per 5 FLOATING YEAR	No	N/A
D2391	Resin-Based Composite - One Surface, Posterior	0-999	1 per 3 FLOATING YEAR	No	N/A
D2392	Resin-Based Composite - Two Surfaces, Posterior	0-999	1 per 3 FLOATING YEAR	No	N/A
D2393	Resin-Based Composite - Three Surfaces, Posterior	0-999	1 per 3 FLOATING YEAR	No	N/A
D2394	Resin-Based Composite - Four Or More Surfaces, Posterior	0-999	1 per 3 FLOATING YEAR	No	N/A
D2791	Crown - Full Cast Predominantly Base Metal	0-999	1 per 5 FLOATING YEAR	No	N/A
D2910	Re-Cement Or Re-Bond Inlay, Onlay, Veneer Or Partial Coverage Restoration	0-999		No	N/A

UnitedHealthcare Wisconsin Dental Benefits					
Code	**Description**	**Age Limits**	**Frequency/ Limitation**	**Auth Required?**	**Required Documents**
D2915	Re-Cement or Re-Bond Cast Indirectly Fabricated Or Pre-Fabricated Post and Core	0-999		No	N/A
D2920	Re-Cement or Re-Bond Crown	0-999		No	N/A
D2929	Prefabricated Porcelain / Ceramic Crown - Primary Tooth	0-999	1 per 1 FLOATING YEAR	No	N/A
D2930	Prefabricated Stainless Steel Crown - Primary Tooth	0-999	1 per 1 FLOATING YEAR	No	N/A
D2931	Prefabricated Stainless Steel Crown - Permanent Tooth	0-999	1 per 5 FLOATING YEAR	No	N/A
D2932	Prefabricated Resin Crown	0-999	1 per 5 FLOATING YEAR	No	N/A
D2933	Prefabricated Stainless Steel Crown With Resin Window	0-999	1 per 5 FLOATING YEAR	No	N/A
D2934	Prefabricated Esthetic Coated Stainless Steel Crown - Primary Tooth	0-20	1 per 1 FLOATING YEAR	No	N/A
D2940	Protective Restoration	0-999		No	N/A
D2951	Pin Retention - Per Tooth, In Addition To Restoration	0-999	1 per 3 FLOATING YEAR	No	N/A
D2952	Post And Core In Addition To Crown, Indirectly Fabricated	0-999	1 per 1 LIFETIME	No	N/A
D2954	Prefabricated Post And Core In Addition To Crown	0-999	1 per 1 LIFETIME	No	N/A
D2971	Additional Procedures To Construct New Crown Under Existing Partial	0-999		No	N/A
D2999	Unspecified Restorative Procedure, By Report	0-20		Yes	Description of procedure and narrative of medical necessity
D3220	Therapeutic Pulpotomy	0-999	1 per 1 LIFETIME	No	N/A
D3221	Pulpal Debridement - Primary And Permanent Teeth	0-999		No	N/A
D3222	Partial Pulpotomy For Apexogenesis - Permanent Tooth	0-12		No	N/A
D3310	Endodontic Therapy, Anterior Tooth (Excluding Final Restoration)	0-999	1 per 1 LIFETIME	Yes	Pre-op x-rays (excluding bitewings), 4 or more teeth
D3320	Endodontic Therapy Premolar Tooth (Excluding Final Restoration)	0-999	1 per 1 LIFETIME	Yes	Pre-op x-rays (excluding bitewings), 4 or more teeth
D3330	Endodontic Therapy, Molar tooth (Excluding Final Restoration)	0-999	1 per 1 LIFETIME	Yes	Pre-op x-rays (excluding BWX)
D3351	Apexification / Recalcification - Initial Visit	0-20		No	N/A
D3352	Apexification / Recalcification - Interim	0-20	2 per 1 LIFETIME	No	N/A
D3353	Apexification / Recalcification - Final Visit	0-20	1 per 1 LIFETIME	No	N/A
D3410	Apicoectomy - Anterior	0-999		No	N/A
D3430	Retrograde Filling - Per Root	0-999		No	N/A
D4210	Gingivectomy Or Gingivoplasty - Four Or More Contiguous Teeth	0-999		Yes	Pre-op x-rays, perio charting, narrative of medical necessity, photo (optional)
D4211	Gingivectomy Or Gingivoplasty - One To Three Contiguous Teeth	0-999		Yes	Pre-op x-rays, perio charting, narrative of medical necessity, photo (optional)
D4341	Periodontal Scaling And Root Planing - Four Or More Teeth Per Quadrant	13-999	1 per 3 FLOATING YEAR	Yes	Periodontal charting and pre-op x-rays
D4342	Periodontal Scaling And Root Planing - One To Three Teeth Per Quadrant	13-999	1 per 3 FLOATING YEAR	Yes	Periodontal charting and pre-op x-rays
D4346	Scaling in moderate or severe gingival inflammation	0-999		No	N/A
D4355	Full Mouth Debridement	13-999	1 per 3 FLOATING YEAR	Yes	Pre-op x-rays or photos
D4910	Periodontal Maintenance	13-999	1 per 1 FLOATING YEAR	Yes	Date of previous perio surgical or S&C service with claim
D4999	Unspecified Periodontal Procedure, By Report	0-20		Yes	Description of procedure and narrative of medical necessity

UnitedHealthcare Wisconsin Dental Benefits					
Code	Description	Age Limits	Frequency/ Limitation	Auth Required?	Required Documents
D5110	Complete Denture - Maxillary	0-999	2 per 5 FLOATING YEAR	Yes	FMX or Panorex, or Administrator/member statement on loss/theft
D5120	Complete Denture - Mandibular	0-999	2 per 5 FLOATING YEAR	Yes	FMX or Panorex, or Administrator/member statement on loss/theft
D5211	Maxillary Partial Denture - Resin Base	0-999	2 per 5 FLOATING YEAR	Yes	FMX or Panorex, or Administrator/member statement on loss/theft
D5212	Mandibular Partial Denture - Resin Base	0-999	2 per 5 FLOATING YEAR	Yes	FMX or Panorex, or Administrator/member statement on loss/theft
D5213	Maxillary Partial Denture - Cast Metal Framework With Resin Denture Bases	0-999	2 per 5 FLOATING YEAR	Yes	FMX or Panorex, or Administrator/member statement on loss/theft
D5214	Mandibular Partial Denture - Cast Metal Framework With Resin Denture Bases	0-999	2 per 5 FLOATING YEAR	Yes	FMX or Panorex, or Administrator/member statement on loss/theft
D5225	Maxillary Partial Denture - Flexible Base	0-999	2 per 5 FLOATING YEAR	Yes	FMX or Panorex, or Administrator/member statement on loss/theft
D5226	Mandibular Partial Denture - Flexible Base	0-999	2 per 5 FLOATING YEAR	Yes	FMX or Panorex, or Administrator/member statement on loss/theft
D5511	Repair Broken Complete Denture Base - Mandibular	0-999		No	N/A
D5512	Repair Broken Complete Denture Base - Maxillary	0-999		No	N/A
D5520	Replace Missing Or Broken Teeth - Complete Denture (Each Tooth)	0-999		No	N/A
D5611	Repair Resin Partial Denture Base - Mandibular	0-999		No	N/A
D5612	Repair Resin Partial Denture Base - Maxillary	0-999		No	N/A
D5621	Repair Cast Partial Framework - Mandibular	0-999		No	N/A
D5622	Repair Cast Partial Framework - Maxillary	0-999		No	N/A
D5630	Repair Or Replace Broken Retentive / Clasping Materials - Per Tooth	0-999		No	N/A
D5640	Replace Broken Teeth - Per Tooth	0-999		No	N/A
D5650	Add Tooth To Existing Partial Denture	0-999		No	N/A
D5660	Add Clasp To Existing Partial Denture - Per Tooth	0-999		No	N/A
D5670	Replace All Teeth And Acrylic On Cast Metal Framework (Maxillary)	0-999		Yes	Date of service with claim
D5671	Replace All Teeth And Acrylic On Cast Metal Framework (Mandibular)	0-999		Yes	Date of service with claim
D5750	Reline Complete Maxillary Denture (Laboratory)	0-999	1 per 3 FLOATING YEAR	No	N/A
D5751	Reline Complete Mandibular Denture (Laboratory)	0-999	1 per 3 FLOATING YEAR	No	N/A
D5760	Reline Maxillary Partial Denture (Laboratory)	0-999	1 per 3 FLOATING YEAR	No	N/A
D5761	Reline Mandibular Partial Denture (Laboratory)	0-999	1 per 3 FLOATING YEAR	No	N/A
D5932	Obturator Prosthesis, Definitive	0-999	1 per 6 MONTH	No	N/A
D5955	Palatal Lift Prosthesis, Definitive	0-999	1 per 6 MONTH	No	N/A
D5991	Vesiculobullous Disease Medicament Carrier	0-999		No	N/A
D5999	Unspecified Maxillofacial Prosthesis, By Report	0-999		Yes	Description of procedure and narrative of medical necessity
D6211	Pontic - Cast Predominantly Base Metal	0-999		Yes	Pre-op x-rays of adjacent teeth and opposing teeth
D6241	Pontic - Porcelain Fused To Predominantly Base Metal	0-999		Yes	Pre-op x-rays of adjacent teeth and opposing teeth

UnitedHealthcare Wisconsin Dental Benefits					
Code	**Description**	**Age Limits**	**Frequency/ Limitation**	**Auth Required?**	**Required Documents**
D6545	Retainer - Cast Metal For Resin Bonded Fixed Prosthesis	0-999		Yes	Pre-op x-rays of adjacent teeth and opposing teeth
D6751	Retainer Crown - Porcelain Fused To Predominantly Base Metal	0-999		Yes	Pre-op x-rays of adjacent teeth and opposing teeth
D6791	Retainer Crown - Full Cast Predominantly Base Metal	0-999		Yes	Pre-op x-rays of adjacent teeth and opposing teeth
D6930	Re-Cement Or Re-Bond Fixed Partial Denture	0-999		No	N/A
D6940	Stress Breaker	0-999		Yes	Document describing type of device and narrative of medical necessity
D6980	Fixed Partial Denture Repair	0-999		Yes	Narrative of medical necessity with claim
D6985	Pediatric Partial Denture, Fixed	0-12		No	N/A
D7111	Extraction, Coronal Remnants - PrimaryTooth	0-999	1 per 1 LIFETIME	No	N/A
D7140	Extraction, Erupted Tooth Or Exposed Root	0-999	1 per 1 LIFETIME	No	N/A
D7210	Extraction, Erupted Tooth	0-999	1 per 1 LIFETIME	No	N/A
D7220	Removal Of Impacted Tooth - Soft Tissue	0-999	1 per 1 LIFETIME	No	N/A
D7230	Removal Of Impacted Tooth - Partially Bony	0-999	1 per 1 LIFETIME	No	N/A
D7240	Removal Of Impacted Tooth - Completely Bony	0-999	1 per 1 LIFETIME	No	N/A
D7241	Removal Of Impacted Tooth - Completely Bony, Unusual Surgical Complications	0-999	1 per 1 LIFETIME	No	N/A
D7250	Removal Of Residual Tooth (Cutting Procedure)	0-999	1 per 1 LIFETIME	No	N/A
D7260	Oroantral Fistula Closure	0-999		No	N/A
D7261	Primary Closure Of Sinus Perforation	0-999		No	N/A
D7270	Reimplantation And/Or Stabilization Of Accidentally Evulsed / Displaced Tooth	0-999		No	N/A
D7280	Exposure of an Unerupted Tooth	0-20		No	N/A
D7282	Mobilization Of Erupted Or Malpositioned Tooth To Aid Eruption	0-20		No	N/A
D7283	Placement Of Device To Facilitate Eruption Of Impacted Tooth	0-20		No	N/A
D7285	Incisional Biopsy Of Oral Tissue - Hard (Bone, Tooth)	0-999	1 per 1 DAY	No	N/A
D7286	Incisional Biopsy Of Oral Tissue - Soft	0-999	1 per 1 DAY	No	N/A
D7287	Exfoliative Cytological Sample Collection	0-999	1 per 1 DAY	No	N/A
D7288	Brush Biopsy - Transepithelial Sample Collection	0-999	1 per 1 DAY	No	N/A
D7310	Alveoloplasty In Conjunction With Extractions - Four Or More Teeth	0-999		Yes	Pre-operative x-rays (excluding bitewings) with claim
D7311	Alveoloplasty In Conjunction With Extractions - One To Three Teeth	0-999		Yes	Pre-operative x-rays (excluding bitewings) with claim
D7320	Alveoloplasty Not In Conjunction With Extractions - Four Or More Teeth	0-999		Yes	Pre-operative x-rays (excluding bitewings) and narr of med nec with claim
D7321	Alveoloplasty Not In Conjunction With Extractions - One To Three Teeth	0-999		Yes	Pre-operative x-rays (excluding bitewings) and narr of med nec with claim
D7410	Excision Of Benign Lesion Up To 1.25 Cm	0-999	1 per 1 DAY	No	N/A
D7411	Excision Of Benign Lesion Greater Than 1.25 Cm	0-999	1 per 1 DAY	No	N/A
D7412	Excision Of Benign Lesion, Complicated	0-999	1 per 1 DAY	No	N/A
D7413	Excision Of Malignant Lesion Up To 1.25 Cm	0-999	1 per 1 DAY	No	N/A
D7414	Excision Of Malignant Lesion Greater Than 1.25 Cm	0-999	1 per 1 DAY	No	N/A
D7415	Excision Of Malignant Lesion, Complicated	0-999	1 per 1 DAY	Yes	Copy of pathology report with claim
D7440	Excision Of Malignant Tumor - Lesion Diameter Up To 1.25 Cm	0-999	1 per 1 DAY	Yes	Copy of pathology report with claim

UnitedHealthcare Wisconsin Dental Benefits					
Code	**Description**	**Age Limits**	**Frequency/ Limitation**	**Auth Required?**	**Required Documents**
D7441	Excision Of Malignant Tumor - Lesion Diameter Greater Than 1.25 Cm	0-999	1 per 1 DAY	Yes	Copy of pathology report with claim
D7450	Removal Of Benign Odontogenic Cyst Or Tumor - Dia Up To 1.25 Cm	0-999	1 per 1 DAY	No	N/A
D7451	Removal Of Benign Odontogenic Cyst Or Tumor - Dia Greater Than 1.25 Cm	0-999	1 per 1 DAY	No	N/A
D7460	Removal Of Benign Nonodontogenic Cyst Or Tumor - Dia Up To 1.25 Cm	0-999	1 per 1 DAY	No	N/A
D7461	Removal Of Benign Nonodontogenic Cyst Or Tumor - Dia Greater Than 1.25 Cm	0-999	1 per 1 DAY	No	N/A
D7471	Removal Of Lateral Exostosis (Maxilla Or Mandible)	0-999		Yes	Narrative of medical necessity, xrays or photos optional
D7472	Removal Of Torus Palatinus	0-999		Yes	Narrative of medical necessity, xrays or photos optional
D7473	Removal Of Torus Mandibularis	0-999		Yes	Narrative of medical necessity, xrays or photos optional
D7485	Reduction Of Osseous Tuberosity	0-999		Yes	Narrative of medical necessity, xrays or photos optional
D7490	Radical Resection Of Maxilla Or Mandible	0-999		Yes	Narrative of medical necessity, xrays or photos optional
D7510	Incision And Drainage Of Abscess - Intraoral Soft Tissue	0-999		No	N/A
D7511	Incision And Drainage Of Abscess - Intraoral Soft Tissue - Complicated	0-999		No	N/A
D7520	Incision And Drainage Of Abscess - Extraoral Soft Tissue	0-999		No	N/A
D7521	Incision And Drainage Of Abscess - Extraoral Soft Tissue - Complicated	0-999		No	N/A
D7530	Removal Of Foreign Body From Mucosa	0-999		No	N/A
D7540	Removal Of Reaction Producing Foreign Bodies	0-999		No	N/A
D7550	Partial Ostectomy/Sequestrectomy For Removal Of Non-Vital Bone	0-999		Yes	Narrative of medical necessity with claim, x-rays or photos optional
D7560	Maxillary Sinusotomy For Removal Of Tooth Fragment Or Foreign Body	0-999		Yes	Narrative of medical necessity with claim, x-rays or photos optional
D7610	Maxilla - Open Reduction (Teeth Immobilized, If Present)	0-999		Yes	Narrative of medical necessity with claim, x-rays or photos optional
D7620	Maxilla - Closed Reduction (Teeth Immobilized, If Present)	0-999		Yes	Narrative of medical necessity with claim, x-rays or photos optional
D7630	Mandible - Open Reduction (Teeth Immobilized, If Present)	0-999		Yes	Narrative of medical necessity with claim, x-rays or photos optional
D7640	Mandible - Closed Reduction (Teeth Immobilized, If Present)	0-999		Yes	Narrative of medical necessity with claim, x-rays or photos optional
D7650	Malar And/Or Zygomatic Arch - Open Reduction	0-999		Yes	Narrative of medical necessity with claim, x-rays or photos optional
D7660	Malar And/Or Zygomatic Arch - Closed Reduction	0-999		Yes	Narrative of medical necessity with claim, x-rays or photos optional
D7670	Alveolus - Closed Reduction, May Include Stabilization Of Teeth	0-999		Yes	Narrative of medical necessity with claim, x-rays or photos optional
D7671	Alveolus - Open Reduction, May Include Stabilization Of Teeth	0-999		Yes	Narrative of medical necessity with claim, x-rays or photos optional

UnitedHealthcare Wisconsin Dental Benefits					
Code	**Description**	**Age Limits**	**Frequency/ Limitation**	**Auth Required?**	**Required Documents**
D7680	Facial Bones - Complicated Reduction With Fixation And Multiple Surgical	0-999		Yes	Narrative of medical necessity with claim, x-rays or photos optional
D7710	Maxilla - Open Reduction	0-999		Yes	Narrative of medical necessity with claim, x-rays or photos optional
D7720	Maxilla - Closed Reduction	0-999		Yes	Narrative of medical necessity with claim, x-rays or photos optional
D7730	Mandible - Open Reduction	0-999		Yes	Narrative of medical necessity with claim, x-rays or photos optional
D7740	Mandible - Closed Reduction	0-999		Yes	Narrative of medical necessity with claim, x-rays or photos optional
D7750	Malar And/Or Zygomatic Arch - Open Reduction	0-999		Yes	Narrative of medical necessity with claim, x-rays or photos optional
D7760	Malar And/Or Zygomatic Arch - Closed Reduction	0-999		Yes	Narrative of medical necessity with claim, x-rays or photos optional
D7770	Alveolus - Open Reduction Stabilization Of Teeth	0-999		Yes	Narrative of medical necessity with claim, x-rays or photos optional
D7771	Alveolus - Closed Reduction Stabilization Of Teeth	0-999		Yes	Narrative of medical necessity with claim, x-rays or photos optional
D7780	Facial Bones - Complicated Reduction With Fixation And Multiple Approaches	0-999		Yes	Narrative of medical necessity with claim, x-rays or photos optional
D7810	Open Reduction Of Dislocation	0-999		Yes	Narrative of medical necessity with claim, x-rays or photos optional
D7820	Closed Reduction Of Dislocation	0-999	1 per 1 DAY	Yes	Narrative of medical necessity with claim, x-rays or photos optional
D7830	Manipulation Under Anesthesia	0-999		Yes	Narrative of medical necessity with claim, x-rays or photos optional
D7840	Condylectomy	0-999		Yes	Narrative of medical necessity with claim, x-rays or photos optional
D7850	Surgical Discetomy, With/Without Implant	0-999		Yes	Narrative of medical necessity with claim, x-rays or photos optional
D7860	Arthrotomy	0-999		Yes	Narrative of medical necessity with claim, x-rays or photos optional
D7871	Non-Arthroscopic Lysis And Lavage	0-999	1 per 3 FLOATING YEAR	Yes	Narrative of medical necessity with claim, x-rays or photos optional
D7899	Unspecified Tmd Therapy, By Report	0-999		Yes	Description of procedure and narrative of medical necessity
D7910	Suture Of Recent Small Wounds Up To 5 Cm	0-999	1 per 1 DAY	Yes	Narrative of medical necessity with claim, x-rays or photos optional
D7911	Complicated Suture - Up To 5 Cm	0-999	1 per 1 DAY	Yes	Narrative of medical necessity with claim, x-rays or photos optional
D7912	Complicated Suture - Greater Than 5 Cm	0-999	1 per 1 DAY	Yes	Narrative of medical necessity with claim, x-rays or photos optional

UnitedHealthcare Wisconsin Dental Benefits					
Code	**Description**	**Age Limits**	**Frequency/ Limitation**	**Auth Required?**	**Required Documents**
D7940	Osteoplasty - For Orthognathic Deformities	0-20		Yes	Narrative of medical necessity with claim, x-rays or photos optional
D7950	Osseous, Osteoperiosteal, Or Cartilage Graft Of The Mandible Or Maxilla	0-999		Yes	Narrative of medical necessity with claim, x-rays or photos optional
D7951	Sinus Augmentation With Bone Or Bone Substitutes Via A Lateral Open Approach	0-999		No	N/A
D7960	Frenulectomy - Also Known As Frenectomy Or Frenotomy - Separate Procedure	0-20		Yes	Narrative of medical necessity, xrays or photos optional
D7970	Excision Of Hyperplastic Tissue - Per Arch	0-999		Yes	Pre-op x-rays, narrative of medical necessity, photos optional
D7972	Surgical Reduction Of Fibrous Tuberosity	0-999		Yes	Pre-op x-rays,narr of medical nec with claim,photos optional
D7979	Non-Surgical Sialolithotomy	0-999		Yes	Narrative of medical necessity, xrays or photos optional
D7980	Surgical Sialolithotomy	0-999		Yes	Narrative of medical necessity with claim, x-rays or photos optional
D7991	Coronoidectomy	0-999		Yes	Narrative of medical necessity with claim, x-rays or photos optional
D7997	Appliance Removal (Not By Dentist Who Placed Appliance)	0-999		No	N/A
D7999	Unspecified Oral Surgery Procedure, By Report	0-999		Yes	Description of procedure and narrative of medical necessity
D8010	Limited Orthodontic Treatment Of The Primary Dentition	0-20		Yes	Panorex or full mouth x-rays, cephalometric x-ray, diagnostic quality photos
D8020	Limited Orthodontic Treatment Of The Transitional Dentition	0-20		Yes	Panorex or full mouth x-rays, cephalometric x-ray, diagnostic quality photos
D8030	Limited Orthodontic Treatment Of The Adolescent Dentition	0-20		Yes	Panorex or full mouth x-rays, cephalometric x-ray, diagnostic quality photos
D8040	Limited Orthodontic Treatment Of The Adult Dentition	0-20		Yes	Panorex or full mouth x-rays, cephalometric x-ray, diagnostic quality photos
D8050	Interceptive Orthodontic Treatment Of The Primary Dentition	0-20		Yes	Panorex or full mouth x-rays, cephalometric x-ray, diagnostic quality photos
D8060	Interceptive Orthodontic Treatment Of The Transitional Dentition	0-20		Yes	Panorex or full mouth x-rays, cephalometric x-ray, diagnostic quality photos
D8070	Comprehensive Orthodontic Treatment Of The Transitional Dentition	0-20		Yes	Pan or FMX, ceph x-ray,diagnostic quality photos,salzmann score sheet
D8080	Comprehensive Orthodontic Treatment Of The Adolescent Dentition	0-20		Yes	Pan or FMX, ceph x-ray,diagnostic quality photos,salzmann score sheet
D8090	Comprehensive Orthodontic Treatment Of The Adult Dentition	0-20		Yes	Pan or FMX, ceph x-ray,diagnostic quality photos,salzmann score sheet
D8210	Removable Appliance Therapy	0-20		Yes	Panorex and/or cephalometirc, narrative of medical necessity
D8220	Fixed Appliance Therapy	0-20		Yes	Panorex and/or cephalometirc, narrative of medical necessity

UnitedHealthcare Wisconsin Dental Benefits					
Code	**Description**	**Age Limits**	**Frequency/ Limitation**	**Auth Required?**	**Required Documents**
D8660	Pre-Orthodontic Treatment Examination To Monitor Growth And Development	0-20		No	N/A
D8670	Periodic Orthodontic Treatment Visit	0-20	24 per 1 LIFETIME	No	N/A
D8680	Orthodontic Retention (Removal Of Appliances, Place Retainers)	0-20		Yes	Diagnostic quality photos
D8692	Replacement Of Lost Or Broken Retainer	0-20		Yes	Narrative of active orthodontic case
D8693	Re-Cement Or Re-Bonding Fixed Retainers	0-999		Yes	Narrative of active orthodontic case
D8695	Removal Of Fixed Orthodontic Appliances	0-20	1 per 1 LIFETIME	No	N/A
D9110	Palliative (Emergency) Treatment Of Dental Pain - Minor Procedure	0-999		No	N/A
D9222	Deep Sedation/General Anesthesia - First 15 Minutes	0-999	1 per 1 DAY	Yes	Narrative of medical necessity with claim
D9223	Deep Sedation / General Anesthesia - Each subsequent 15 Minute Increment	0-999		Yes	Narrative of medical necessity with claim
D9230	Inhalation Of Nitrous/Analgesia, Anxiolysis	0-999	1 per 1 DAY	No	N/A
D9239	Intravenous Moderate (Conscious) Sedation/Analgesia - First 15 Minutes	0-999		Yes	Narrative of medical necessity with claim
D9243	Intravenous Moderate (Conscious) Sedation/Analgesia - Each Subsequent 15 Minute	0-999		Yes	Narrative of medical necessity with claim
D9248	Non-Intravenous Conscious Sedation	0-999		Yes	Narrative of medical necessity with claim
D9410	House/Extended Care Facility Call	0-999	1 per 333 DAYS	No	N/A
D9420	Hospital Or Ambulatory Surgical Center Call	0-999		No	N/A
D9610	Therapeutic Parenteral Drug, Single Administration	0-999		No	N/A
D9612	Therapeutic Parenteral Drugs, Two Or More Administrations	0-999		No	N/A
D9613	Sustained Release Therapeutic Drug	0-999		No	N/A
D9910	Application Of Desensitizing Medicament	0-999		No	N/A
D9944	Occlusal Guard-hard appliance, full arch	0-999		Yes	Narrative of medical necessity
D9945	Occlusal Guard-soft appliance, full arch	0-999		Yes	Narrative of medical necessity
D9946	Occlusal Guard-hard appliance, partial arch	0-999		Yes	Narrative of medical necessity
D9999	Unspecified Adjunctive Procedure, By Report	0-999		Yes	Description of procedure and narrative of medical necessity

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 at **1-888-249-8833** if you have any questions regarding frequency limitations.

Additional Exclusions

1. Unnecessary dental services.
2. Hospitalization or other facility charges.
3. Any dental procedure performed solely for cosmetic/aesthetic reasons.
4. Reconstructive surgery, regardless of whether or not the surgery is incidental to a dental disease, injury, or congenital anomaly when the primary purpose is to improve physiological functioning of the involved part of the body.
5. Any dental procedure not directly associated with dental disease.
6. Any procedure not performed in a dental setting that has not had prior authorization.

7. Procedures that are considered experimental, investigational or unproven. This includes pharmacological regimens not accepted by the American Dental Association Council on Dental Therapeutics. The fact that an experimental, investigational or unproven service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in coverage if the procedure is considered to be experimental, investigational or unproven in the treatment of that particular condition.
8. Service for injuries or conditions covered by workers' compensation or employer liability laws, and services that are provided without cost to the covered persons by any municipality, county or other political subdivision. This exclusion does not apply to any services covered by Medicaid or Medicare.
9. Expenses for dental procedures begun prior to the covered person's eligibility with the plan.
10. Dental services otherwise covered under the policy, but rendered after the date that an individual's coverage under the policy terminates, including dental services for dental conditions arising prior to the date that an individual's coverage under the policy terminates.
11. Services rendered by a provider with the same legal residence as a covered person or who is a member of a covered person's family, including a spouse, brother, sister, parent or child.
12. Charges for failure to keep a scheduled appointment without giving the dental office proper notification.

4.3 Complaint, grievance and appeal rights.

Your Right to Appeal

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. Please note that the Member Handbook may be updated periodically, so for the most current information, please refer to the Member Handbook, which may be accessed at **uhccommunityplan.com**.

Complaint, grievance and appeal rights

A complaint or grievance is an expression of dissatisfaction about any matter other than an appeal.

An appeal means a request for review of a denied or limited service.

You have special rights when you make a complaint, file a grievance or ask for an appeal:

- You may ask anyone you choose to help you make a complaint, file a grievance or ask for an appeal.
- If you do not speak or understand English, we can explain to you what our complaint, grievance and appeal policy is in your language.
- We cannot end or decrease your care because you made a complaint, filed a grievance or asked for an appeal.
- You may file your grievance directly with UnitedHealthcare or the State.
- UnitedHealthcare will respond to your written grievance or appeal within 10 business days of receipt or within 2 business days for emergency or urgent situations.

State of Wisconsin HMO Ombudsman program.

The state has designated Ombuds (individuals who provide neutral, confidential and informal assistance) who can help you with any questions or problems you have as an HMO member. The Ombuds can tell you how to get the care you need from your HMO. The Ombuds can also help you solve problems or complaints you may have about the HMO program or your HMO. Call **1-800-760-0001** and ask to talk to an Ombuds.

Complaints, grievances and appeals.

We would like to know if you have a complaint about your care at UnitedHealthcare. Please call a UnitedHealthcare Member Advocate at **1-888-246-8140** if you have a complaint or write to us at:

UnitedHealthcare Community Plan, HMO Medicaid Advocate
10701 W. Research Drive
Milwaukee, WI 53226

or

Grievances and Appeals Department
P.O. Box 31364
Salt Lake City, UT 84131

If you want to talk to someone outside UnitedHealthcare Community Plan about the problem, call the HMO Enrollment Specialist at **1-800-291-2002**. The HMO Enrollment Specialist may be able to help you solve the problem or write a formal grievance to UnitedHealthcare Community Plan or to the BadgerCare Plus and Medicaid SSI programs.

The address to complain to the Wisconsin Medicaid SSI Program is:

Medicaid SSI Program
Managed Care Ombuds
P.O. Box 6470
Madison, WI 53716-0470
1-800-760-0001

If your complaint or grievance needs action right away because a delay in treatment would greatly increase the risk to your health, please call Member Services as soon as possible at **1-800-504-9660, TTY 711**.

You will not be treated differently from other members because you file a complaint or grievance. Your health care benefits will not be affected.

When benefits are denied (Fair Hearings).

You have the right to appeal to the State of Wisconsin Division of Hearing and Appeals (DHA) for a fair hearing if you believe your benefits are wrongly denied, limited, reduced, delayed or stopped by UnitedHealthcare. An appeal must be made no later than 45 days after the date of the action being appealed. If you appeal this action to DHA before the effective date, the service may continue. You may need to pay for the cost of services if the hearing decision is not in your favor.

If you want a fair hearing, send a written request to:

Department of Administration
Division of Hearing and Appeals
P.O. Box 7875
Madison, WI 53707-7875

The hearing will be held with an administrative judge in the county where you live. You have the right to bring a friend or be represented at the hearing. If you need a special arrangement for a disability, or for English language translation, please call **1-608-266-3096** (voice) or **1-608-264-9853** (hearing impaired).

We cannot treat you differently than other members because you request a fair hearing. Your health care benefits will not be affected.

If you need help writing a request for a fair hearing, please call either the BadgerCare Plus and Medicaid SSI Ombuds at **1-800-760-0001** or the HMO Enrollment Specialist at **1-800-291-2002**.

Civil rights complaints.

UnitedHealthcare provides coverage for Medicaid SSI covered services to all eligible members regardless of age, race, religion, color, handicap, sex, physical condition, sexual orientation, national origin, marital status, arrest or conviction record, or military participation.

All persons or organizations associated with UnitedHealthcare who refer or recommend members for services shall do so in the same manner for all members.

If you believe your rights have been violated, you may file a complaint by writing to:

Grievances and Appeals Department
P.O. Box 31364
Salt Lake City, UT 84131

Section 5: **Authorization for Treatment**

5.1 **Dental Treatment Requiring Authorization**

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

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

Prior authorization means the practitioner must submit those procedures for approval with clinical documentation supporting necessity before initiating treatment. For questions concerning prior authorization, dental claim procedures, or to request clinical criteria, please call the Provider Services Line at **1-888-249-8833**. Documentation or questions regarding prior authorizations can also be sent to:

UnitedHealthcare
PO Box 363
Milwaukee, WI 53201

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*".

Authorized services must be performed within 180 calendar days from the date of approval.

United HealthCare will comply with the Prior Authorization guidelines set forth in the MO Medicaid Managed Care Contract and subsequent Amendments (http://dss.mo.gov/business-processes/managed-care/).

When submitting for prior authorization /retrospective review of these procedures, please note the documentation requirements when sending in the information.

Criteria utilized for medical necessity determination were developed from information collected from American Dental Association's Code Manuals, clinical articles and guidelines, as well as dental schools, practicing dentists, insurance companies, other dental related organizations, and local state or health plan requirements.

The criteria reviewers will look for in order to approve the request is listed below. Should the procedure need to be initiated under an emergency condition to relieve pain and suffering, you are to provide treatment to alleviate the patient's condition. However, to receive reimbursement for the treatment, the same criteria /documentation must be provided (with the claim for payment) and the same criteria must be met to receive payment for the treatment.

Root canals

- Minimum 50% bone support
- No periodontal furcation
- No subcrestal caries
- Evidence of apical pathology/fistula
- Pain from percussion / temp
- Closed apex
- Evidence of good periodontal health (AAP periodontal classification of Type I or II)
- Evidence visible on radiographs that at least 50 percent of the clinical crown is intact

Gingivectomy or gingivoplasty

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

Scaling and root planning

- D4341: Four or more teeth have at least one pocket measurement of 5–6 millimeters in a quadrant.
- D4342: One to three teeth have at least one pocket measurement of 5–6 millimeters in a quadrant.
- At least 50 percent of bony support is intact for the teeth to be treated. Calculus should be visible on the X-ray.

- If the patient is new and a full-mouth debridement is included in the treatment plan, at least four weeks of healing time has passed following debridement.
- Noticeable loss on bone support or calculus (root surface) should be visible on the x-ray

Full Mouth Debridement

- Extensive coronal calculus on 50% of teeth
- No other periodontal therapy (D4341, D4342, D4910) will be authorized within four weeks after full-mouth debridement.

Periodontal Maintenance

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

Full Dentures

- Remaining teeth do not have adequate bone support or are restorable
- Existing denture greater than 5 years old
- Exception/Situational Criteria:
  - **Edentulous Members (2889)**
    - If a member has been edentulous for more than five years and has never worn a prosthesis, then no denture is ordinarily approved unless the dentist submits the following:
      - A favorable prognosis
      - An analysis of the oral tissue status (e.g., muscle tone, ridge height, muscle attachments, etc.)
      - Justification indicating why a member has been without a prosthesis
    - If a member has not worn an existing prosthesis for three years, no new prosthesis will usually be authorized unless unusual mitigating circumstances and medical necessity are documented and verified by a physician.
    - When a member has a history of an inability to tolerate and wear a prosthetic appliance due to psychological or physiological reasons, then a new prosthesis will not be approved.
  - **Full Dentures with Few Remaining Teeth (2890)**
    - Wisconsin Medicaid may reimburse for full dentures when a member has only one or two remaining teeth per arch if this treatment would maintain proper anchorage and if the denture could be converted to a full denture by a simple repair, in the event of tooth loss. The ForwardHealth dental consultant determines the appropriateness of this situation at the time prior authorization is requested.
  - **Lost, Stolen, or Severely Damaged Prostheses (2893)**
    - Removable prosthodontic services are provided at considerable expense to BadgerCare Plus. PA requests for lost, severely damaged, or stolen prostheses are only approved when:
    - The member has exercised reasonable care in maintaining the denture.
    - The prosthesis was being used up to the time of the loss or theft.
    - The loss or theft is not a repeatedly occurring event.

Partial Denture

- Any of the following:
  - One or more anterior teeth are missing.
  - The member has less than two posterior teeth per quadrant in occlusion with the opposing quadrant.
  - The member has at least six missing teeth per arch, including third molars.
  - The member requires replacement of anterior teeth for employment reasons
  - Medically necessary for nutritional reasons documented by a physician
  - Unusual clinical situations where a partial is determined to be necessary based on a comprehensive review of the dental and medical histories.
  - Remaining teeth have greater than 50% bone support and are restorable
  - Existing denture greater than 5 years old

Denture Repair

- Not Covered within 6 months of original delivery of denture
- Old, worn dentures with severely worn teeth or fractures due to age should be replaced.
- The following repairs are not covered by BadgerCare Plus:
  - Extensive repairs of marginally functional dentures.
  - Repairs to a denture when a new denture would be better for the health of the member.

Denture rebases/relines

- Dentures greater than 6 months old (should be verified by system)
- Relining complete and partial upper and lower dentures is limited to once every three years, per arch, when an existing denture is loose or ill-fitting or there is considerable amount of tissue shrinkage or weight loss.

Maxillofacial prosthetics

- Documentation describes accident, facial trauma, disease, facial reconstruction or other medical necessity need

Fixed partial denture pontics/retainers

- The member has periodontally healthy teeth.
- Minimum 50% bone support
- No periodontal furcation
- No subcrestal caries
- Clinically acceptable RCT
- Anterior - 50% incisal edge / 4+ surfaces involved
- Bicuspid – 1 cusp / 3+ surfaces involved
- Molar – 2 cusps / 4+ surfaces involved

Connector bar / stress breaker / precision attachment

- The member has periodontally healthy teeth
- Attachment will significantly enhance function

Fixed partial denture repair, by report

- Documentation describes medical necessity

Alveoloplasty

- In preparation for a prosthesis
- Other treatments such as radiation therapy and transplant surgery

Excision of lesion/tumor

- Copy of pathology report with claim

Excision of bone tissue

- Necessary for fabrication of a prosthesis

Radical resection of maxilla or mandible

- Documentation supports medical necessity

Partial ostectomy

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

Maxillary sinusotomy
- Documentation describes presence or description of root fracture of foreign body in maxillary antrum

Fractures – simple/compound
- Documentation describes accident, operative report and medical necessity

Reduction and dislocation and management of TMJ dysfunctions
- Narrative, x-rays or photos support medical necessity for procedure
- Only TMJ surgeries with favorable prognosis for surgery are considered for approval.

Suture repairs
- Documentation describes accident
- Not for tooth extraction or to close surgical incision

Osteoplasty
- Documentation describes and supports congenital defect condition
- The most severe cases of protruding or retruding mandible or maxillae where conventional orthodontics cannot provide a stable and acceptable outcome.
- The most severe cases of open bite where conventional orthodontics cannot provide a stable and acceptable outcome.
- A significant skeletal malocclusion where conventional orthodontics cannot provide a stable and acceptable outcome.
- Severe malocclusions caused by disease or injury where conventional orthodontics cannot provide a stable and acceptable outcome.
- If the deformity has been caused by disease or injury, a physician's statement is required.

Other repair procedures (Oral & Maxillofacial Surgery)
- Narrative, x-rays or photos support medical necessity for procedure

Frenulectomy
- Documentation describes tongue tied, diastema or tissue pull condition
- The member's frenum creates a central incisor diastema.
- The member's frenum creates ankyloglossia.
- The member's frenum creates periodontal defects.
- The member's frenum requires removal to complete orthodontic services.
- The member's frenum interferes with denture stabilization, due to its high attachment on the ridge.

Excision of hyperplastic tissue
- Documentation describes medical necessity due to ill-fitting denture

Surgical reduction of fibrous tuberosity
- Documentation indicates medical necessity for future denture placement

Sialolithotomy
- Documentation describes evidence of salivary blockage

Excision of salivary gland, by report
- Documentation describes evidence of salivary blockage and inability to open duct

Surgical reduction of fibrous tuberosity
- Documentation indicates medical necessity for future denture placement

Sialolithotomy
- Documentation describes evidence of salivary blockage

Excision of salivary gland, by report
- Documentation describes evidence of salivary blockage and inability to open duct

Deep sedation/General anesthesia: Intravenous moderate (conscious) sedation/Analgesia

- 1 or more of the criteria below:
  - Extractions of impacted or unerupted cuspids or wisdom 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)
- The services are not allowed simply to control apprehension, even when providing emergency services.

Inhalation of Nitrous Oxide

- Any of the following:
  - Documentation (treatment history) supports indication of non-cooperative patient under age 9
  - The member has been medically diagnosed with a permanent physical, developmental, or intellectual disability, or has a documented medical condition that impairs their ability to maintain oral hygiene.
  - The member has been medically diagnosed with an anxiety disorder by a qualified health care professional (Anxiety disorders include, but are not limited to, panic disorders [episodic paroxysmal anxiety] without agoraphobia, generalized anxiety disorders, other mixed anxiety disorders, other specified anxiety disorders, and unspecified anxiety disorders).
  - The member has documented behavioral issues or failed behavioral interventions.
  - The services are not allowed simply to control apprehension, even when providing emergency services

OR (Hospital Operating Room or Outpatient Facility) request

- Hospitalization for the express purpose of controlling apprehension is not a Medicaid-reimbursable service.
- Examples of conditions that providers are required to document in the member's medical record when providing treatment in a hospital include, but are not limited to, the following:
  - Members with physical or developmental disabilities resulting in uncontrolled behavior.
  - Children who require extensive operative procedures.
  - Members who are hospitalized.
  - Geriatric patients who require monitoring of vital signs.
  - Members who have a medical history of uncontrolled bleeding, severe cerebral palsy, or uncontrolled diabetes.
- Members who require extensive oral and maxillofacial procedures, such as orthognathic surgery, cleft palate surgery, or
  - TMJ (temporomandibular joint) surgery.

Fixed or removable appliance therapy

- Documentation of thumb sucking or tongue thrusting habit

Limited/interceptive treatment

- Partial treatment to correct crowding in one arch
- Minor tooth movement
- Uprighting teeth
- Rotating teeth
- Opening space(s)

- Closing space(s)
- Palatal expansion, skeletal disharmonies, space deficiency to lessen future effects of malformation dentition (primary / transitional dentition)

Comprehensive orthodontic treatment

- Any one of the following:
  - A severe and handicapping malocclusion determined by a minimum Salzmann Index of 30.
  - In extenuating circumstances, the dental consultant may, after comprehensive review of the case, determine that a severe handicapping malocclusion does exist, and approve the orthodontia treatment even though the Salzmann score is less than 30 (example: cleft lip or palate).
  - Transfer cases from out-of-state or within state must fulfill BadgerCare Plus criteria of age and Salzmann Index at time of initial treatment (banding).
  - If the request for orthodontic services is the result of a personality or psychological problem or condition and a member does not meet the criteria listed above, then a referral from a mental health professional is required.
  - Orthodontic treatment is not authorized for cosmetic reasons.

Pre–orthodontic treatment visit

- Part of approved comprehensive orthodontic treatment

Orthodontic retention

- Documentation shows completed comprehensive orthodontic treatment

Orthodontic repair / replacement of lost or broken retainer / rebonding or recementation

- Narrative of active orthodontic case
- Narrative required to indicate when and how the retainer was lost and present a plan to prevent future loss.
- Multiple lost retainers (due to member negligence) will not be replaced.

5.1.a **Payment for Non-Covered Services**

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

In instances when non-covered services are recommended by the provider or requested by the member, an Informed Consent Form or similar waiver 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: That 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, in excess of cost sharing as required under the Member’s benefit plan.

5.1.b **After-Hours Emergency**

When a provider treats a patient outside of the normal business hours of 8 a.m. to 6 p.m., Monday through Friday, providers should:

1. Confirm patient eligibility on the date of service through our website, or our Interactive Voice Response system.
2. Consult the benefit guide included in this Manual to determine if services are covered under the plan and if prior authorization is required for the service.
3. Provide covered services that do not require prior authorization.

4. If prior authorization is required for a needed service, the provider should relieve the patient's immediate pain with covered services that do not require prior authorization (e.g., palliative treatment or sedative filling). The provider will submit a written request for prior authorization, and may call the provider call center on the next business day to request information for submitting an expedited prior authorization request.

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

Section 6: **Radiology Requirements**

To learn what Prior Authorization requests would require radiographs, refer to Section 4.1 and Section 5.1 of the Manual.

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: **www.uhcproviders.com**.

Section 7: **Claim Submission Procedures**

7.1 Claim submission best practices and 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. 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 **1-888-249-8833** for more information regarding electronic claims submission

Please note that our **Payor 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.

Dental claim form required information

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

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

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.

Timely submission

All claims should be submitted within 90 days of 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.

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 **www.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 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.

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.

7.2 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 payor 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, please contact your clearinghouse to initiate this process.

7.3 HIPAA-compliant 837D file

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

7.4 Paper claims submission

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

Please 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.

7.5 Coordination of benefits (COB)

Coordination of Benefits (COB) is used when a member is covered by more than one dental insurance policy. By coordinating benefit payments, the member receives maximum benefits available under each plan. Coordination of Benefits rules are mandated by the 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 Dental on the claim form.

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

7.6 Dental Claim Filing Limits & Adjustments

All Dental Claims must be submitted within ninety (90) days from the date of service.

All adjustments or requests for reprocessing must be made within ninety (90) calendar days from receipt of payment. An adjustment can be requested in writing or telephonically. Please refer to the Quick Reference Guide for address and phone number information.

7.7 Claims Adjudication & Periodic Overview

Claim Processing Standards:

- 90% of adjudicated clean claims will be paid within 30 days of receipt of a clean claim
- 99% of adjudicated clean claims will be paid within 90 days of receipt of a clean claim
- 100% of adjudicated clean claims will be paid within 180 days of receipt of a clean 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.

If the claim is missing a tooth number or surface, a letter will be generated to the provider requesting this information.

7.8 Explanation of dental plan reimbursement

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

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

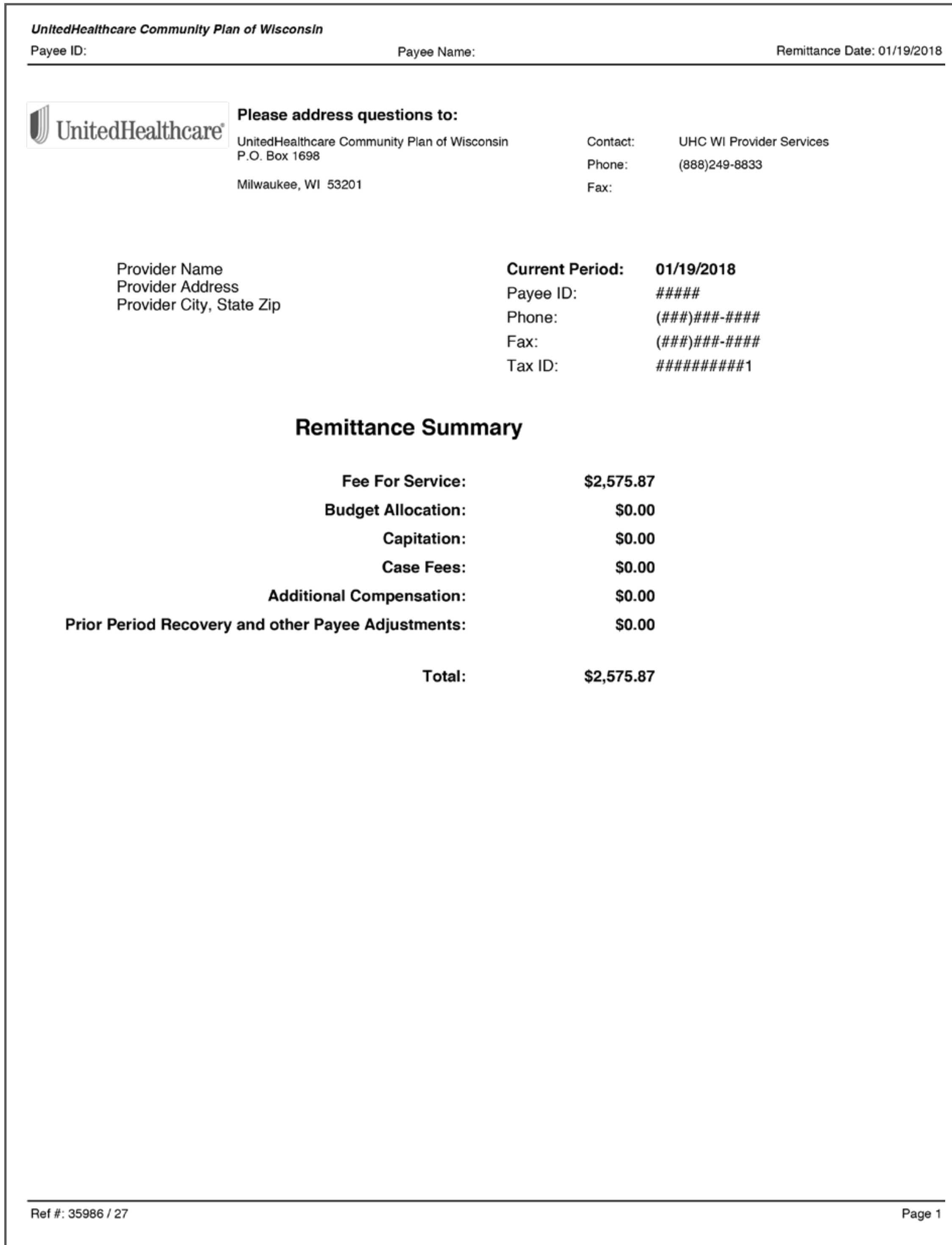
PATIENT PAY - Amount to be paid by the member

OTHER INSURANCE AMOUNT - Amount paid by other carriers

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

EXCEPTION CODES - Codes that explain how the claim was adjudicated

7.9 Explanation of Benefits Sample (Page 1)



UnitedHealthcare Community Plan of Wisconsin

Payee ID: Payee Name: Remittance Date: 01/19/2018

UnitedHealthcare

Please address questions to:

UnitedHealthcare Community Plan of Wisconsin
P.O. Box 1698
Milwaukee, WI 53201

Contact: UHC WI Provider Services
Phone: (888)249-8833
Fax:

Provider Name
Provider Address
Provider City, State Zip

Current Period: **01/19/2018**
Payee ID: #####
Phone: (###)###-####
Fax: (###)###-####
Tax ID: ##########1

Remittance Summary

Fee For Service:	**$2,575.87**
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:	**$2,575.87**

Ref #: 35986 / 27 Page 1

Explanation of Benefits Sample (Page 2)

UnitedHealthcare Community Plan of Wisconsin

Payee ID: Payee Name: Remittance Date: 01/19/2018

This decision is based on our understanding and interpretation of available coverage policies, national guidelines and standards, plan provisions, as well as any coverage available under the State of Wisconsin Department of Health Services including the Wisconsin Medical Assistance Program (WMAP) dental guidelines.

IF YOU DO NOT AGREE WITH THIS DECISION, YOU MAY PROVIDE ANY ADDITIONAL INFORMATION THAT YOU FEEL MIGHT ALTER THE DECISION BY CONTACTING PROVIDER SERVICES AT (888) 249-8833.

The member or, with written consent, their authorized representative may file a pre-service appeal or request a Fair Hearing. This information is provided in the member's notification letter.

The provider has the right to appeal to the Department of Health Services if we fail to respond to your appeal within 45 days or if you are not satisfied with the appeal response. To ask the state to review our decision, you may appeal to:

Forward Health Medicaid Appeals
P.O. Box 6470
Madison, WI 53716-0470
FAX: 608-224-6318

Administrative appeals should be sent within 60 days of this notice to the address below.

UnitedHealthcare Community Plan
ATTN: Dental Appeals Coordinator
P.O. Box 1698
Milwaukee, WI 53201

IMPORTANT NOTICE: In order to maintain HIPAA compliance, effective with claims received October 1, 2015, only ADA 2012 or later Dental Claim forms will be accepted when submitting claims and pre-authorizations. All other forms, including ADA forms dated prior to 2012, will not be accepted and will result in a rejection of the claim or pre-authorization request.

Additionally, when making a correction to a previously submitted claim, please send it clearly marked "Corrected Claims" on an ADA 2012 or later form 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.

To report potential billing irregularities, please call our Fraud Hotline at 1-888-233-4877.

Ref #: 35986 / 28 Page 2

Explanation of Benefits Sample (Page 3)

UnitedHealthcare Community Plan of Wisconsin

Payee ID: Payee Name: Remittance Date: 01/19/2018

Fee For Service Summary

Provider Name
Provider Address
Provider City, State ZIP

Provider / ID	Location / ID		Amount Billed	Amount Payable	Patient Pay	Other Insurance	Prior Mo. Adj	Net Amount
			$9,095.00	$2,575.87	$0.00	$0.00	$0.00	$2,575.87
		Totals:	**$9,095.00**	**$2,575.87**	**$0.00**	**$0.00**	**$0.00**	**$2,575.87**

Ref #: 35986 / 29 Page 3

Explanation of Benefits Sample (Page 4)

UnitedHealthcare Community Plan of Wisconsin

Payee ID: Payee Name: Remittance Date: 01/19/2018

Services Detail

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

Patient Name:	Provider Name:	Encounter #:
Subscriber/Member:	Provider NPI:	Referral #:
DOB:	Plan: UnitedHealthcare Community Plan - WI	Referral Date:
Office Reference No:	Product: WI Standard SSI Medicaid Exempt	Benefit Level: In Network

ITM	DOS	CODE	POS	QTY	BILLED AMOUNT	QTY	ALLOWED AMOUNT	PAY %	PAYABLE AMOUNT	COPAY AMOUNT	COINS AMOUNT	DEDUCT AMOUNT	PATIENT PAY	OTHER INSUR	NET AMOUNT	PAY CODE
1	01/08/18	D0140 00	11	1	$75.00	1	$18.71	100.00 %	$18.71	$0.00	$0.00	$0.00	$0.00	$0.00	$18.71	FFS
2	01/08/18	D0330 00	11	1	$110.00	1	$38.10	100.00 %	$38.10	$0.00	$0.00	$0.00	$0.00	$0.00	$38.10	FFS
3	01/08/18	D7210 1	11	1	$250.00	1	$86.40	100.00 %	$86.40	$0.00	$0.00	$0.00	$0.00	$0.00	$86.40	FFS
4	01/08/18	D7210 2	11	1	$250.00	1	$86.40	100.00 %	$86.40	$0.00	$0.00	$0.00	$0.00	$0.00	$86.40	FFS
5	01/08/18	D7210 6	11	1	$250.00	1	$86.40	100.00 %	$86.40	$0.00	$0.00	$0.00	$0.00	$0.00	$86.40	FFS
6	01/08/18	D7210 7	11	1	$250.00	1	$86.40	100.00 %	$86.40	$0.00	$0.00	$0.00	$0.00	$0.00	$86.40	FFS
7	01/08/18	D7210 10	11	1	$250.00	1	$86.40	100.00 %	$86.40	$0.00	$0.00	$0.00	$0.00	$0.00	$86.40	FFS
8	01/08/18	D7210 15	11	1	$250.00	1	$86.40	100.00 %	$86.40	$0.00	$0.00	$0.00	$0.00	$0.00	$86.40	FFS
9	01/08/18	D7210 16	11	1	$250.00	1	$86.40	100.00 %	$86.40	$0.00	$0.00	$0.00	$0.00	$0.00	$86.40	FFS
					$1,935.00		**$661.61**		**$661.61**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$661.61**	

Patient Name:	Provider Name:	Encounter #:
Subscriber/Member:	Provider NPI:	Referral #:
DOB:	Plan: UnitedHealthcare Community Plan - WI	Referral Date:
Office Reference No:	Product: WI Standard SSI Medicaid Exempt	Benefit Level: In Network

ITM	DOS	CODE	POS	QTY	BILLED AMOUNT	QTY	ALLOWED AMOUNT	PAY %	PAYABLE AMOUNT	COPAY AMOUNT	COINS AMOUNT	DEDUCT AMOUNT	PATIENT PAY	OTHER INSUR	NET AMOUNT	PAY CODE
1	12/21/17	D0140 00	11	1	$75.00	1	$18.71	100.00 %	$18.71	$0.00	$0.00	$0.00	$0.00	$0.00	$18.71	FFS
2	12/21/17	D0330 00	11	1	$110.00	1	$38.10	100.00 %	$38.10	$0.00	$0.00	$0.00	$0.00	$0.00	$38.10	FFS
3	12/21/17	D7140 7	11	1	$155.00	1	$39.76	100.00 %	$39.76	$0.00	$0.00	$0.00	$0.00	$0.00	$39.76	FFS
4	12/21/17	D7140 8	11	1	$155.00	1	$39.76	100.00 %	$39.76	$0.00	$0.00	$0.00	$0.00	$0.00	$39.76	FFS
5	12/21/17	D7140 9	11	1	$155.00	1	$39.76	100.00 %	$39.76	$0.00	$0.00	$0.00	$0.00	$0.00	$39.76	FFS
6	12/21/17	D7140 10	11	1	$155.00	1	$39.76	100.00 %	$39.76	$0.00	$0.00	$0.00	$0.00	$0.00	$39.76	FFS
7	12/21/17	D7210 3	11	1	$250.00	1	$86.40	100.00 %	$86.40	$0.00	$0.00	$0.00	$0.00	$0.00	$86.40	FFS
8	12/21/17	D7210 4	11	1	$250.00	1	$86.40	100.00 %	$86.40	$0.00	$0.00	$0.00	$0.00	$0.00	$86.40	FFS
9	12/21/17	D7210 5	11	1	$250.00	1	$86.40	100.00 %	$86.40	$0.00	$0.00	$0.00	$0.00	$0.00	$86.40	FFS
10	12/21/17	D7210 6	11	1	$250.00	1	$86.40	100.00 %	$86.40	$0.00	$0.00	$0.00	$0.00	$0.00	$86.40	FFS
11	12/21/17	D7210 11	11	1	$250.00	1	$86.40	100.00 %	$86.40	$0.00	$0.00	$0.00	$0.00	$0.00	$86.40	FFS
12	12/21/17	D7210 12	11	1	$250.00	1	$86.40	100.00 %	$86.40	$0.00	$0.00	$0.00	$0.00	$0.00	$86.40	FFS
13	12/21/17	D7210 13	11	1	$250.00	1	$86.40	100.00 %	$86.40	$0.00	$0.00	$0.00	$0.00	$0.00	$86.40	FFS
14	12/21/17	D7210 14	11	1	$250.00	1	$86.40	100.00 %	$86.40	$0.00	$0.00	$0.00	$0.00	$0.00	$86.40	FFS
					$2,805.00		**$907.05**		**$907.05**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$907.05**	

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Explanation of Benefits Sample (Page 5)

UnitedHealthcare Community Plan of Wisconsin

Payee ID: Payee Name: Remittance Date: 01/19/2018

Patient Name: Provider Name: Encounter #:
Subscriber/Member: Provider NPI: Referral #:
DOB: Plan: UnitedHealthcare Community Plan - WI Referral Date:
Office Reference No: Product: WI Standard SSI Medicaid Exempt Benefit Level: In Network

ITM	DOS	CODE	POS	QTY	BILLED AMOUNT	QTY	ALLOWED AMOUNT	PAY %	PAYABLE AMOUNT	COPAY AMOUNT	COINS AMOUNT	DEDUCT AMOUNT	PATIENT PAY	OTHER INSUR	NET AMOUNT	PAY CODE
1	01/09/18	D7473 00	11	1	$500.00	1	$0.00	100.00 %	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	FFS
2	01/09/18	D7473 00	11	1	$500.00	1	$0.00	100.00 %	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	FFS
3	01/09/18	D9230 00	11	1	$80.00	1	$0.00	100.00 %	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	FFS
					$1,080.00		**$0.00**		**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	

ITEM: 1 Exception Code: 1045 The member's coverage was not in effect on the date the service was provided.
ITEM: 2 Exception Code: 1045 The member's coverage was not in effect on the date the service was provided.
ITEM: 3 Exception Code: 1045 The member's coverage was not in effect on the date the service was provided.

Patient Name: Provider Name: Encounter #:
Subscriber/Member: Provider NPI: Referral #:
DOB: Plan: UnitedHealthcare Community Plan - WI Referral Date:
Office Reference No: Product: WI Standard SSI Medicaid Exempt Benefit Level: In Network

ITM	DOS	CODE	POS	QTY	BILLED AMOUNT	QTY	ALLOWED AMOUNT	PAY %	PAYABLE AMOUNT	COPAY AMOUNT	COINS AMOUNT	DEDUCT AMOUNT	PATIENT PAY	OTHER INSUR	NET AMOUNT	PAY CODE
1	01/09/18	D0140 00	11	1	$75.00	1	$18.71	100.00 %	$18.71	$0.00	$0.00	$0.00	$0.00	$0.00	$18.71	FFS
2	01/09/18	D0330 00	11	1	$110.00	1	$38.10	100.00 %	$38.10	$0.00	$0.00	$0.00	$0.00	$0.00	$38.10	FFS
3	01/09/18	D7210 3	11	1	$250.00	1	$86.40	100.00 %	$86.40	$0.00	$0.00	$0.00	$0.00	$0.00	$86.40	FFS
4	01/09/18	D7210 32	11	1	$250.00	1	$86.40	100.00 %	$86.40	$0.00	$0.00	$0.00	$0.00	$0.00	$86.40	FFS
					$685.00		**$229.61**		**$229.61**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$229.61**	

Patient Name: Provider Name: Encounter #:
Subscriber/Member: Provider NPI: Referral #:
DOB: Plan: UnitedHealthcare Community Plan - WI Referral Date:
Office Reference No: Product: WI Standard SSI Medicaid Exempt Benefit Level: In Network

ITM	DOS	CODE	POS	QTY	BILLED AMOUNT	QTY	ALLOWED AMOUNT	PAY %	PAYABLE AMOUNT	COPAY AMOUNT	COINS AMOUNT	DEDUCT AMOUNT	PATIENT PAY	OTHER INSUR	NET AMOUNT	PAY CODE
1	12/12/16	D7210 18	11	1	$250.00	1	$86.40	100.00 %	$86.40	$0.00	$0.00	$0.00	$0.00	$0.00	$86.40	FFS
2	12/12/16	D7210 19	11	1	$250.00	1	$86.40	100.00 %	$86.40	$0.00	$0.00	$0.00	$0.00	$0.00	$86.40	FFS
3	12/12/16	D7210 20	11	1	$250.00	1	$86.40	100.00 %	$86.40	$0.00	$0.00	$0.00	$0.00	$0.00	$86.40	FFS
4	12/12/16	D7210 21	11	1	$250.00	1	$86.40	100.00 %	$86.40	$0.00	$0.00	$0.00	$0.00	$0.00	$86.40	FFS
5	12/12/16	D7210 22	11	1	$250.00	1	$86.40	100.00 %	$86.40	$0.00	$0.00	$0.00	$0.00	$0.00	$86.40	FFS
6	12/12/16	D7210 27	11	1	$250.00	1	$86.40	100.00 %	$86.40	$0.00	$0.00	$0.00	$0.00	$0.00	$86.40	FFS
7	12/12/16	D7210 29	11	1	$250.00	1	$86.40	100.00 %	$86.40	$0.00	$0.00	$0.00	$0.00	$0.00	$86.40	FFS
8	12/12/16	D7210 30	11	1	$250.00	1	$86.40	100.00 %	$86.40	$0.00	$0.00	$0.00	$0.00	$0.00	$86.40	FFS
9	12/12/16	D7210 32	11	1	$250.00	1	$86.40	100.00 %	$86.40	$0.00	$0.00	$0.00	$0.00	$0.00	$86.40	FFS
					$2,250.00		**$777.60**		**$777.60**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$777.60**	

Patient Name: Provider Name: Encounter #:
Subscriber/Member: Provider NPI: Referral #:
DOB: Plan: UnitedHealthcare Community Plan - WI Referral Date:
Office Reference No: Product: WI Standard SSI Medicaid Exempt Benefit Level: In Network

ITM	DOS	CODE	POS	QTY	BILLED AMOUNT	QTY	ALLOWED AMOUNT	PAY %	PAYABLE AMOUNT	COPAY AMOUNT	COINS AMOUNT	DEDUCT AMOUNT	PATIENT PAY	OTHER INSUR	NET AMOUNT	PAY CODE
1	01/09/18	D0140 00	11	1	$75.00	1	$0.00	100.00 %	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	FFS
2	01/09/18	D0330 00	11	1	$110.00	1	$0.00	100.00 %	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	FFS
3	01/09/18	D7140 20	11	1	$155.00	1	$0.00	100.00 %	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	FFS
					$340.00		**$0.00**		**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	

ITEM: 1 Exception Code: 1045 The member's coverage was not in effect on the date the service was provided.
ITEM: 2 Exception Code: 1045 The member's coverage was not in effect on the date the service was provided.
ITEM: 3 Exception Code: 1045 The member's coverage was not in effect on the date the service was provided.

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7.10 Provider Disputes

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

A provider appeal must be submitted within 90 days after the receipt of the Provider Remittance Advice and/ or decision. Instances where a provider is pursuing an appeal on behalf of a member are subject to the Member Appeal process in this Manual.

A Reprocessing or Adjustment Request is a request to reprocess a claim. Examples include submitting a corrected bill, resubmitting a claim with requested information, data entry errors made on the claim or errors in participation status.

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

1-888-249-8833
UnitedHealthcare Dental
P.O. Box 1427
Milwaukee, WI 53201

When a claim is reprocessed as a result of a Reprocessing or Adjustment Request or Contractual Dispute, providers will receive a new remittance advice within 30 calendar days of receipt of the Reprocessing/ Adjustment Request or Contractual Dispute. If the Reprocessing or Adjustment Request or Contractual Dispute does not result in the reprocessing of a claim, providers will receive written notification of the outcome within 30 calendar days of receipt of the Reprocessing or Adjustment Request or Contractual Dispute.

Administrative Appeals:

Appeals that are not based on medical necessity. This type of appeal would include, but is not limited to: appeals for timely filing of claims, member eligibility, over/underpayment adjustment requests. Administrative appeals must include a narrative and copy of the Provider Remittance Advice. Refer to the Quick Reference Guide section for appeal submission addresses.

Section 8: **Quality Management**

8.1 Quality Improvement Program (QIP) Description

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

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

The QIP description is reviewed and updated annually:

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 **1-888-249-8833**.

8.2 Credentialing

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

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

Before an applicant dentist is accepted as a participating provider, the dentist's credentials are evaluated. Initial facility site visits are required for some plans and/or markets. Please note that a site visit is required for each location. If a new location is added after initial contracting is completed, a site visit 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 will request a resolution of any discrepancy in credentialing forms submitted. Practitioners have the right to review and correct erroneous information and to be informed of the status of their application. Please refer to the Appendix of this Manual for additional details regarding practitioner rights.

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

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

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

A list of the documents required for Initial Credentialing and Recredentialing is as follows (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)
- Billing NPI
- Billing Medicaid ID

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.

8.3 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.

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."

8.4 Preventive Health Guideline

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

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

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

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

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

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

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

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

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

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

Section 9: **Utilization Management Program**

9.1 **Utilization management**

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

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

9.2 **Community practice patterns**

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

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

9.3 **Evaluation of utilization management data**

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

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

9.4 **Utilization review data results**

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

Feedback and recommended follow-up may also be communicated to the provider group network as a whole.

This is done by using a variety of currently available communication tools including:

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

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

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

9.5 Fraud and Abuse

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

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

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

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

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

Section 10: **Evidence-Based Education**

10.1 Evidence-Based Dentistry and the Clinical Policy and Technology Committee

According to the ADA, Evidence-Based Dentistry can be defined as:

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

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

- **P**roblem or **P**opulation
- **I**ntervention under Investigation
- How it is being **c**ompared
- The expected **o**utcome

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

- Anecdote/expert opinion
- Case study
- Case series
- Retrospective study
- Randomized controlled trial (RCT)
- Systematic review (a review of RCTs)

Of course, systematic reviews or randomized controlled trials are not available to answer all clinical questions we might have. This is why we indicate that we are using the “best available current evidence.” Searching for evidence, we can consult a variety of sources including:

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

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

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

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

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

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

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

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

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

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

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

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

The Committee meets quarterly and reviews the evidence-based literature, making recommendations on clinical practice guidelines and new technologies. Whenever possible, we review and adopt existing guidelines and scientific literature from sources such as specialty societies, guidelines clearinghouses such as the Cochrane Oral Health Group and National Guideline Clearinghouse, government agencies such as AHRQ and NIDCR, electronic sites such as PubMed and the Centre for Evidence-Based Dentistry, and evidence-based journals such as the *Journal of Evidence-Based Dental Practice*.

Determinations are shared with dentists in our provider newsletter *Newsflash*, and become part of our business functions, including our clinical programs, utilization management and claims criteria, marketing and underwriting collateral, and this Manual.

Recommendations can result in new products or enhanced benefits for members. Recent examples include: 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-based dentistry is a methodology to help reduce variation and determine “what works.” It can be used on the individual patient, practice, plan or population levels, and helps to ensure that our clinical programs and policies are grounded in science.

Section 11: **Governing Administrative Policies**

11.1 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 UnitedHealthcare 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 48 hours
- **Routine care appointments**. . . . . . . Offered within 45 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. A dental Urgent Care appointment is classified as a dental emergency by Forward Health. According to ForwardHealth, this includes a need for immediate dental services to treat severe dental pain, swelling, fever, infection, or injury to the teeth.
- 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 statemandated or plan requirements, and are monitored for access and waiting times, where applicable.

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

11.3 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, please contact our Provider Services Line at **1-800-822-5353**.

11.4 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 Operations
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 for guidance.

11.5 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.

11.6 Sterilization and Asepsis-Control Fees

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

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

11.7 Recall System

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

11.8 Transfer of Dental Records

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

11.9 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.

11.10 Cultural Competency

Cultural competence is of great importance to the field of dentistry. In an increasingly diverse society, it is necessary for dental professionals to be culturally competent healthcare 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 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.

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

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

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

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

Section 12: **Plan Specific Information**

12.1 **Plan-Specific Information**

In Wisconsin, UnitedHealthcare offers the following products for Wisconsin Medicaid SSI and BadgerCare Plus members.

- UnitedHealthcare Community Plan of Wisconsin

The dental benefit includes comprehensive dental coverage for Wisconsin Medicaid SSI and Badgercare Plus members that reside in regions 5 and 6, which include the following counties: Milwaukee, Waukesha, Racine, Kenosha, Ozaukee, and Washington. Dental Services are provided in alignment with ForwardHealth guidelines. A detailed listing of covered services may be found in Section 4 of this manual.

Appendix A: **Attachments**

A.1 **Medicaid Overview**

Dental services under Title XIX of the Social Security Act, the Medicaid program, are an optional service for the adult population (individuals age 21 and older). However, dental services are a required service for most Medicaid-eligible individuals under the age of 21, as a required component of the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit.

Individuals under age 21

EPSDT is Medicaid's comprehensive child health program. The programs' focus is on prevention, early diagnosis and treatment of medical conditions. EPSDT is a mandatory service required to be provided under a state's Medicaid program.

Individuals age 21 and older

States may elect to provide dental services to their adult Medicaid-eligible population or elect not to provide dental services at all as part of its Medicaid program. While most states provide at least emergency dental services for adults, less than half of the states provide comprehensive dental care. There are no minimum requirements for adult dental coverage.

A.2 **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 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

A.3 **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 appeal rights only in states that require them or due to Quality of Care concerns against UnitedHealthcare members. An appeal, if allowed, must be submitted within 30 days of the date of the rejection letter. The provider has the right to be represented by an attorney or another person of the provider's choice.
3. Appeals are reviewed by Peer Review Committee (PRC). The PRC panel will include at least 1 member who is of the same specialty as the provider who is submitting the appeal.
4. PRC will consider all information and documentation provided with the appeal and make a determination to uphold or overturn the Credentialing Committee's decision. The PRC may request a corrective action plan, a Site Visit and/or chart review.
5. Within 10 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.

UnitedHealthcare
Credentialing Supervisor
Dental Credentialing Department
2300 Clayton Rd, Suite 1000
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.

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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