Dental Provider Manual

UnitedHealthcare Community Plan of District of Columbia

DC Dual Choice Medicaid

Provider Services: 1-866-321-2789

2025

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United Healthcare® | Dental Benefit Providers®

Contents

Section 1: Introduction — who we are

Welcome to UnitedHealthcare Community Plan

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

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

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

This Provider Manual (the Manual) is designed as a comprehensive reference guide for the dental plans in your area, primarily UnitedHealthcare Community Plan Medicaid and Medicare plans. Here you will find the tools and information needed to successfully administer UnitedHealthcare plans. As changes and new information arise, it will be updated on the portal at **UHCdental.com/medicaid** under state-specific provider resources.

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**.

If you have any questions or concerns about the information contained within this Manual, please contact the UnitedHealthcare Community Plan Provider Services team at the telephone number listed on the cover of this document.

Unless otherwise specified herein, this Manual is effective the date found of the cover of this document for dental providers currently participating in the UnitedHealthcare Community Plan's network, and effective immediately for newly contracted dental providers.

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

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

UnitedHealthcare Community Plan supports the District of Columbia (D.C.) goals of increased access, improved health outcomes and reduced costs by offering Medicaid benefits to the following enrollees:

- Qualified Medicare Beneficiary Plus (QMB+): You get Medicaid coverage of Medicare cost-share and are also eligible for full Medicaid benefits. Medicaid pays your Medicare Part A and Part B premiums, deductibles, coinsurance and copayment amounts for Medicare covered services.
- Qualified Medicare Beneficiary (QMB): You get Medicaid coverage of Medicare cost-share but are not eligible for full Medicaid benefits. Medicaid pays your Medicare Part A and Part B premiums, deductibles, coinsurance and copayment amounts only for Medicare covered services.

- Full Benefits Dual Eligible (FBDE): You get Medicaid coverage of Medicare cost-share and are also eligible for full Medicaid benefits. Your cost share is 0% when the service is covered by both Medicare and Medicaid

Medicaid enrollment

Providers treating **Dual Choice** Enrollees must be enrolled with the District of Columbia, Department of Healthcare Finance, prior to rendering services. For details on how to enroll, please visit **www.dc-medicaid.com/dcwebportal/enrollOnline/create**.

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

Provider Online Academy

Provider Online Academy is a resource for 24/7, on-demand, interactive, and self-paced courses for providers that cover the following topics:

- Dental provider portal training guide and digital solutions
- Dental plans and products overview
- Up-to-date dental operational tools and processes
- State-specific training requirements

To access Provider Online Academy, visit **UHCdental.com/provideracademy**.

Section 2: Patient eligibility verification procedures

2.1 Enrollee eligibility

Enrollee eligibility or dental benefits may be verified online at **UHCdental.com/medicaid** or via phone at **1-866-321-2789.**

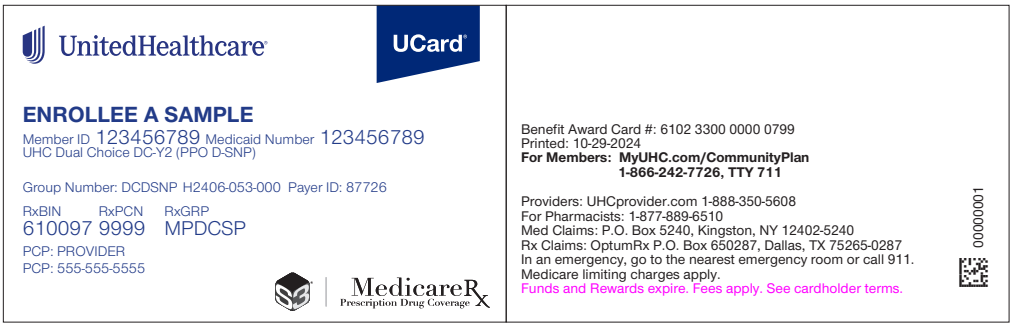
We receive daily updates on enrollee eligibility and can provide the most up-to-date information available.

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.**

2.2 Identification card

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

An enrollee 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 an enrollee's dental coverage, go to **UHCdental.com/medicaid** or contact the dental Provider Services line at **1-866-321-2789.**



2.3 Eligibility verification

Eligibility can be verified on our website at **UHCdental.com/medicaid** 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 via Dental Hub, you can verify your patients' eligibility online with just a few clicks.

UnitedHealthcare Community Plan also offers an Interactive Voice Response (IVR) system for eligibility verification. The IVR is available 24 hours a day, 7 days a week at **1-866-321-2789.**

2.4 Quick reference guide

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

Our Provider Services team is available during normal business hours to assist you with any questions you may have. They are trained to handle calls regarding eligibility, claims, benefits information, and contractual questions.

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

You want to:	Provider Services Line– Dedicated Service Representatives Hours: 8 a.m.-6 p.m. (EST) Monday-Friday	Online UHCdental.com/ medicaid	Interactive Voice Response (IVR) System and Voicemail 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	✓		

2.5 Website UHCdental.com/medicaid

The UnitedHealthcare Community Plan website at **UHCdental.com/medicaid** offers valuable resources, including access to standard forms, provider manuals, quick reference guides, training materials, and network specialists search tools.

Additionally, you can register for the provider portal, Dental Hub, directly from the website. The Dental Hub provides a range of time-saving features including eligibility verification, benefit information, claims submission and status, remittance, and more. Visit **UHCdental.com/medicaid** to register or log in to the Dental Hub as a participating user.

To register for the Dental Hub, you will need a W-9 and a recently paid claim, or the verification code included in your Welcome Letter. For additional assistance with the Dental Hub, call Provider Services at **1-866-321-2789.**

2.6 Integrated Voice Response (IVR) system

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 enrollee claim history search (by surfaced code and tooth number).

Section 3: Office administration

3.1 Office site quality

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

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

- Clean and orderly overall appearance.
- Available handicapped parking and handicapped accessible facilities.
- Available adequate waiting room space and dental operatories for providing enrollee care.
- Privacy in the operatory.
- Clearly marked exits.
- Accessible fire extinguishers.
- Post file inspection record in the last year.

3.2 Office conditions

Your dental office must meet applicable Occupational Safety & Health Administration (OSHA), CDC infection control guidelines 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.

3.3 Sterilization and infection control fees

Dental office infection control programs must meet the minimum requirements based on the Centers for Disease Control & Prevention's (CDC) guiding principles of infection control. All instruments should be 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 and District guidelines.

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

3.4 Recall system

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

3.5 Transfer of dental records

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

3.6 Office hours

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

3.7 Protect confidentiality of enrollee data

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

UnitedHealthcare District Dual Choice Plan uses enrollee information for treatment, operations and payment.

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

3.8 Provide access to your records

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

3.9 Inform enrollees of advance directives

The federal Patient Self-Determination Act (PSDA) gives patients the legal right to make choices about their medical care before incapacitating illness or injury through an advance directive. Under the federal act, you must provide written information to enrollees on District laws about advance treatment directives, enrollees' right to accept or refuse treatment, and your own policies regarding advance directives. To comply with this requirement, we inform enrollees of District laws on advance directives through enrollee documents and other communications.

3.10 Participate in quality initiatives

Thank you for your help in our quality assessment and improvement activities. The quality metrics we cover annually help increase enrollee satisfaction, improve the health outcomes of our populations, and reduce cost burden for our enrollees (supports the triple aim approach). You must follow our clinical guidelines, enrollee safety (risk reduction) efforts and data confidentiality procedures.

UnitedHealthcare District Dual Choice Plan clinical quality initiatives are based on optimal delivery of health care for particular diseases and conditions. This is determined by government agencies and professional specialty societies and can change from year to year. Your participation is vital to develop systems interventions to address underlying factors of disparate utilization, health-related behaviors, and health outcomes.

3.11 New associates

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

It is important to remember that associates may not see enrollees as a participating provider until they've been credentialed by our organization.

If you have any questions or need to receive a copy of our provider application packet, please contact Provider Services at the telephone number listed on the cover of this document.

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

As a participating provider, it is important to notify us of any demographic changes within your practice. This ensures accurate claims processing and helps maintain up-to-date directories for enrollees.

Requests for demographic changes must be submitted in writing with supporting documentation. For example, a TIN change requires a new W9, while an office closing notice must be on office letterhead. In addition, when making changes, the old information and the requested updates, including names, TINs, and Practitioner IDs for all affected associates must be provided.

Changes should be submitted to:

UnitedHealthcare – RMO
ATTN: 400-Provider Services
PO BOX 30567
SALT LAKE CITY, UT 84130

Fax: **1-855-363-9691**
Email: **dbpprvfx@uhc.com**

Credentialing updates should be sent to:

2300 Clayton Road
Suite 1000
Concord, CA 94520

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

If you have any questions, don't hesitate to contact Provider Services at the telephone number listed on the cover of this document for guidance.

Section 4: Patient access

4.1 Appointment scheduling standards

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

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

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

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

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

4.2 Emergency coverage

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

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

4.3 Specialist referral process

If an enrollee needs specialty care, we recommend an initial appointment with a participating general dentist, who will identify the appropriate specialist for the enrollee's needs. Services must be provided by a qualified specialist who is 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 **UHCdental.com/medicaid** or contact Provider Services at the telephone number listed on the cover of this document.

4.4 Missed appointments

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

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

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

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

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

4.5 Nondiscrimination

The practice shall not refuse an enrollment/assignment or disenroll an enrollee or discriminate against them based on age, sex, race, physical or behavioral handicap, national origin, religion, type of illness or condition. You may only direct the enrollee to another care provider type if that illness or condition may be better treated by someone else.

The practice shall comply with applicable Federal and State civil rights laws and does not discriminate, exclude people, or treat them different on the basis of any of the following: Race or ancestry, color, creed, religion, age, national origin, language, marital status, sex (including orientation and gender identity), medical condition or disability (including physical or behavioral impairment), pregnancy, family responsibilities, source of income, place of residence, political affiliation, personal appearance.

Section 5: Utilization Management program

5.1 Utilization Management

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

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

5.2 Community practice patterns

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

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

5.3 Evaluation of utilization management data

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

5.4 Utilization Management analysis results

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

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

- Provider Manual/Standards of Care
- Provider Training

- Continuing Education
- Provider News Bulletins

5.5 Utilization review

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

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

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

Utilization review is completed based on the following:

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

5.6 Evidence-Based Dentistry and the Dental Clinical Policy and Technology Committee (DCPTC)

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

An approach to oral health care that requires the judicious integration of systematic assessments of clinically relevant scientific evidence, relating to the patient's oral and medical condition and history, with the dentist's clinical expertise and the patient's treatment needs and preferences. Evidence-based dentistry is a methodology to help reduce variation and determine proven treatments and technologies. It can be used to support or refute treatment for the individual patient, practice, plan or population levels. At UnitedHealthcare Community Plan, it ensures that our clinical programs and policies are grounded in science. This can result in new products or enhanced benefits for enrollees. 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 enrollees, and delivery of locally placed antibiotics.

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

- Systematic review and meta-analysis
- Randomized controlled trials (RCT)
- Retrospective studies

- Case series
- Case studies

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

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

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

Section 6: Quality management

6.1 Quality Improvement Program (QIP) description

UnitedHealthcare Community Plan has established and continues to maintain an ongoing program of quality management and quality improvement to facilitate, enhance and improve enrollee 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 District, federal and client requirements. The QIP addresses various service elements including accessibility, availability and continuity of care. It also monitors the provisions and utilization of services to make sure they meet professionally recognized standards of care.

The QIP description is reviewed and updated annually:

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

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

6.2 Credentialing

To become a participating provider in UnitedHealthcare's network, applicants must complete the full credentialing process and receive approval from our Credentialing Committee. To maintain participation, all practitioners are required to undergo recredentialing - typically every three (3) years, unless otherwise mandated by state regulations.

Initial Credentialing

Before acceptance into the network, a dentist's credentials are thoroughly evaluated. UnitedHealthcare partners with SKYGEN Dental Hub to collect the necessary data for both credentialing and recredentialing. Timely responses to inquiries from SKYGEN or UnitedHealthcare are essential to ensure the process is complete efficiently.

Credentialing includes a review of state license status, sanctions or disciplinary actions, malpractice insurance coverage, and other relevant professional credentials. If any adverse findings are identified, we will request a written explanation, including details of the incident, its resolution, and a corrective action plan to prevent recurrence.

For certain plans or markets, initial facility site visits may be required based on state-specific regulations. Each location must pass the facility review before activation. Your Professional Networks Representative will inform you if a site visit is necessary during the recruitment process.

The Credentialing Committee evaluates all submitted information against established criteria, which are reviewed and approved with input from practicing network providers to ensure alignment with accepted industry standards. If discrepancies are found in submitted forms, UnitedHealthcare will request clarification or correction. Providers have the right to:

- Review and correct erroneous information
- Be informed of their application status

Recredentialing

Recredentialing is required to maintain participation and is a condition of your provider agreement. Failure to comply with the recredentialing process may result in termination for cause.

Recredentialing requests are sent months prior to the recredentialing due date. In the request, you will be directed to the SKYGEN Dental Hub to start the process. If SKYGEN is unsuccessful in obtaining a complete recredentialing packet, UnitedHealthcare will make additional outreach attempts. If there is no response, a termination letter will be issued to the provider.

In addition to the items verified in the initial credentialing process, UnitedHealthcare may also review provider performance measures such as, but not limited to:

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

For more details on credentialing, refer to the **Credentialing Guidelines** available at **UHCdental.com/resources**.

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

6.3 Site visits

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

The site visit focuses primarily on: dental record keeping, patient accessibility, infection 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 Peer Review Committee, leading to a corrective action plan or possible termination. If terminated, the dentist can reapply for network participation once a second review has been completed and a passing score has been achieved.

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

6.4 Preventive health guideline

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

UnitedHealthcare Community Plan's National Clinical Policy and Technology Committee reviews current professional guidelines and processes while consulting the latest literature, including, but not limited to, current ADA Current Dental Terminology (CDT), and specialty guidelines as suggested by organizations such as the American Academy of Pediatric Dentistry, American Academy of Periodontology, American Association of Endodontists, American Association of Oral and Maxillofacial Surgeons, and the American Association of Dental Consultants. Additional resources include publications such as the Journal of Evidence-Based Dental Practice, online resources obtained via the Library of Medicine, and evidence-based clearinghouses such as the Cochrane Oral Health Group and Centre for Evidence Based Dentistry as well as respected public health benchmarks such as 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.

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

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

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

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

6.5 Addressing the opioid epidemic

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

Brief summary of framework

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

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

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

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

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

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

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

Increasing education & awareness of opioids

It is critical you are up-to-date on the cutting edge research and evidence-based clinical practice guidelines. We keep Opioid Use Disorders (OUD) related trainings and resources available on our provider portal to help ensure you have the information you need, when you need it. For example, District-specific Behavioral Health Toolkits are developed to provide access to clinical practice guidelines, free substance use disorders/OUD assessments and screening resources, and other important District-specific resources. Additionally, Pain Management Toolkits are available and provide resources to help you identify our enrollees who present with chronic physical pain and may also be in need of behavioral health services to address the psychological aspects of pain. Continuing education is available and includes webinars such as, The Role of the Health Care Team in Solving the Opioid Epidemic, and The Fight Against the Prescription Opioid Abuse Epidemic. While resources are available, we also work to help ensure you have the educational resources you need. For example, our Drug Utilization Review Provider Newsletter includes opioid trends, prescribing, and key resources.

Access these resources at **UHCprovider.com** > Tools and resources > Resource library > Pharmacy resources > Drug lists and pharmacy > Opioid Programs and Resources - Community Plan (Medicaid).

Prevention

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

UnitedHealthcare Community Plan has implemented a 90 MED supply limit for the long-acting opioid class. The prior authorization criteria coincide with the CDC's recommendations for the treatment of chronic non-cancer pain. Prior authorization applies to all long-acting opioids. The CDC guidelines for opioid prevention and overdose can be found at **Preventing Opioid Overdose | Overdose Prevention | CDC**.

Section 7: Fraud, waste, and abuse training

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

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

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

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

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications-Items/MLN4649244

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 8: Governance

8.1 Provider rights bulletin

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

To review your information

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

To correct erroneous information

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

To be informed of status of your application

You may submit your application status questions in writing or telephonically.

To appeal adverse committee decisions

In the event you are denied participation or continued participation, you have the right to appeal the decision in writing within 30 days of the date of receipt of the rejection/denial letter.

UnitedHealthcare Dental
Credentialing Department
2300 Clayton Road
Suite 1000
Concord, CA 94520
Phone: **1-855-918-2265**
Fax: **1-844-881-4963**

8.2 Quality of care issues

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

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

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

- Advocating on behalf of an enrollee
- Filing a complaint against the MCO
- Appealing a decision of the MCO
- Providing information or filing a report pursuant to PHL4406-c regarding prohibition of plans
- Requesting a hearing or review

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

- Cases which meet disciplinary or malpractice criteria are initially reviewed by the Credentialing Committee. Other quality-of-care cases are reviewed by the Peer Review Committee.
- The Committees make every effort to obtain a provider narrative and appropriate documents prior to making any determination.
- The Committees may elect to accept, suspend, unpublish, place a provider on probation, require corrective action or terminate the provider.
- The provider will be allowed to continue to provide services to enrollees for a period of up to sixty (60) days from the date of the provider's notice of termination.
- If your network participation ends, you must transition your UnitedHealthcare Community Plan enrollees to timely and useful care. This may include providing service(s) for a reasonable time at our in-network rate. Provider Services is available to help you and our enrollees with the transition.
- The Hearing Committee will immediately remove from our network any provider who is unable to provide health care services due to a final disciplinary action. In such cases, the provider must cease treating enrollees upon receipt of this determination.

8.3 Cultural competency

To help you meet membership needs, UnitedHealthcare District Dual Choice Plan has developed a Cultural Competency Program. The goal of the program is to break down linguistic and cultural barriers to build trust and improve health outcomes. You must support our Cultural Competency Program. For more information, go to **UHCprovider.com/resourcelibrary** > Health Equity Resources > **Cultural Competency.**

Cultural competency training and education

Free continuing medical education (CME) and non-CME courses are available on our **Cultural Competency page** as well as other important resources.

Cultural competency information is stored within your provider profile and displayed within the directory. Showcase your cultural competencies by keeping your data current through our **data attestation process.**

Translation/interpretation/auxiliary aide services

You must provide language services and auxiliary aides, including, but not limited to, sign language interpreters to enrollees as required, to provide enrollees with an equal opportunity to access and participate in all health care services.

If the enrollee requests translation/interpretation/ auxiliary aide services, you must promptly arrange these services at no cost to the enrollee.

Enrollees have the right to a certified medical interpreter or sign language interpreter to accurately translate health information. Friends and family of enrollees with limited English proficiency, or enrollees who are deaf or hard of hearing, may arrange interpretation services only after you have explained our standard methods offered, and the enrollee refuses. Document the refusal of professional interpretation services in the enrollee's medical record.

- Any materials you have a enrollee sign, and any alternative check-in procedures (like a kiosk), must be accessible to an individual with a disability

Care for enrollees who are deaf or hard of hearing

You must provide a sign language interpreter if a enrollee requests one. You must also have written office procedures for taking phone calls or providing Virtual Visits to enrollees who are deaf or hard of hearing.

UnitedHealthcare District Dual Choice Plan provides the following:

Language interpretation line

We provide oral interpreter services Monday-Friday from 8 a.m.-8 p.m. ET.
To arrange for interpreter services, please call **1-877-842-3210** (TTY **711**).

I Speak language assistance card

This resource allows individuals to identify their preferred language and provides directions to arrange interpretation services for UnitedHealthcare enrollees.

Materials for limited English-speaking enrollees

We provide simplified materials for enrollees with limited English proficiency and who speak languages other than English or Spanish. We also provide materials for visually impaired enrollees.

For more information, go to **uhc.com > Language Assistance.**

Section 9: Claim submission procedures

9.1 Claim submission options

9.1.a Paper claims

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

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

FQHCs should be billed in line with the CMS requirement for Medicare primary services, and billed in line with District requirement if its a District primary service (T1015 with SE modifier).

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

9.1b Electronic claims

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

If you wish to submit claims electronically, please contact your clearinghouse to initiate this process. If you do not currently work with a clearinghouse, you may either sign up with one to initiate this process. The UnitedHealthcare Community Plan website (uhcdentalproviders.com) also offers the feature to directly submit your claims online through the provider portal / Dental Hub. Refer to Section 2.5 for more information on how to register as a participating user.

9.1.c Electronic payments

ePayment Center replaced the current electronic payment and statement process for UnitedHealthcare Dental Government Program Plans.

The ePayment center is an online portal which will allow you to enroll in electronic delivery of payments and electronic remittance advice (ERA).

Through the ePayment Center, we will continue to offer a no-fee Automated Clearing House (ACH) delivery of claim payments with access to remittance files via download. Delivery of 835 files to clearinghouses is available directly through the ePayment Center enrollment portal.

ePayment Center allows you to:

- Improve cash flow with faster primary payments and speed up secondary filing/patient collections
- Access your electronic remittance advice (ERA) remotely and securely 24/7
- Streamline reconciliation with automated payment posting capabilities
- Download remittances in various formats (835, CSV, XLS, PDF)
- Search payments history up to 7 years

To register:

1. Visit **UHCdental.epayment.center/register**
2. Follow the instructions to obtain a registration code
3. Your registration will be reviewed by a customer service representative and a link will be sent to your email once confirmed
4. Follow the link to complete your registration and setup your account
5. Log into **UHCdental.epayment.center**
6. Enter your bank account information
7. Select remittance data delivery options
8. Review and accept ACH Agreement
9. Click Submit
10. Upon completion of the registration process, your bank account will undergo a prenotification process to validate the account prior to commencing the electronic fund transfer delivery. This process may take up to 6 business days to complete

Need additional help? Call **1-855-774-4392** or email **help@epayment.center**.

In addition to a no-fee ACH option, other electronic payment methods are available through Zelis Payments.

The Zelis Payments advantage:

- Access all payers in the Zelis Payments network through one single portal
- Experience award winning customer service
- Receive funds weeks faster than mailed checks and improve the accuracy of your claim payments
- Streamline your operations and improve revenue stability with virtual card and ACH
- Protect your account with 24/7 Office of Foreign Assets Control (OFAC) fraud monitoring
- Reduce costs and boost efficiency by simplifying administrative work from processing payments
- Gain visibility and insights from your payment data with a secure provider portal. Download files (10 years of storage) in various formats (XLS, PDF, CSV or 835)

Each Zelis Payments product gives you multiple options to access data and customize notifications. You will have access to several features via the secure web portal.

All remittance information is available 24/7 via **provider.zelispayments.com** and can be downloaded into a PDF, CSV, or standard 835 file format. For any additional information or questions, please contact Zelis Payments Client Service Department at **1-877-828-8770**.

9.2 Claim submission requirements and best practices

9.2.a Dental claim form required information

One ADA claim form (2012 version or later) should be used for each patient and the claim should reflect only 1 treating dentist for services rendered. The claims must also have all necessary fields populated as outlined in the following:

Header information

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

Subscriber information

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

Patient information

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

Primary payer information

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

Other coverage

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

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

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

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

Billing dentist or dental entity

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

- Name

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

Treating dentist and treatment location

List the following information regarding the dentist that provided treatment:

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

Record of services provided

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

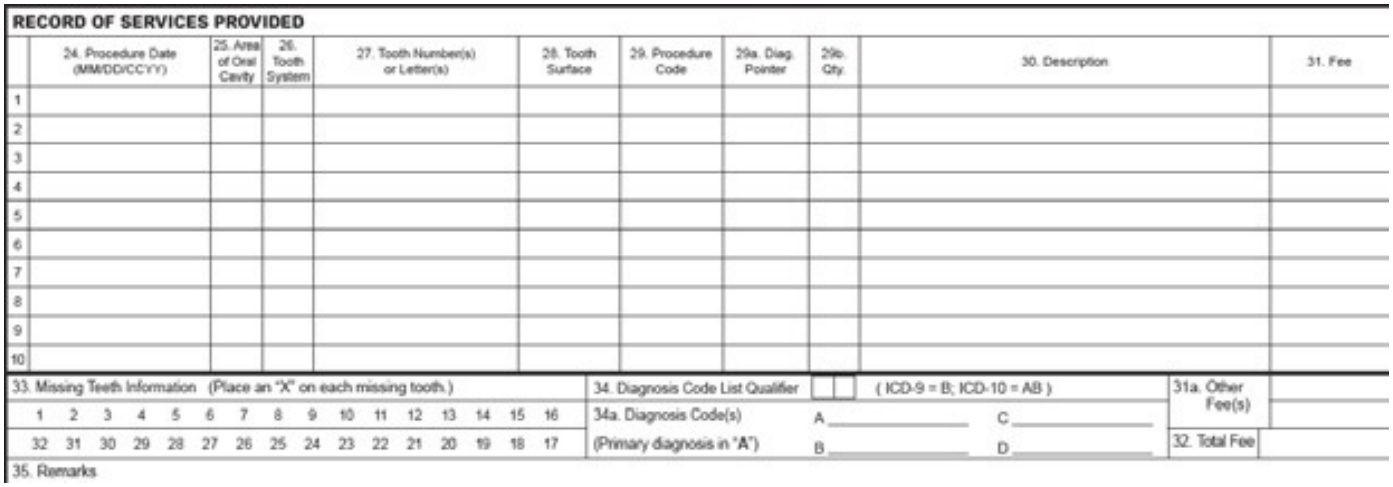
Missing teeth information

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

Remarks section

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

ICD-10 instructions



RECORD OF SERVICES PROVIDED

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

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

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

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

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

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

31a. Other Fee(s)

32. Total Fee

35. Remarks

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

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

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

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

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

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

By Report procedures

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

Using current ADA codes

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

Supernumerary teeth

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

Insurance fraud

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

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

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

Invalid or incomplete claims

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

9.2.b Coordination of Benefits (COB)

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

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

9.2.c Timely submission (Timely filing)

All claims should be submitted within 365 days from the date of service.

All adjustments or requests for reprocessing must be made within 365 days from date of service, or initial claim paid date, only if the initial submission time period has been met. An adjustment can be requested in writing or telephonically.

Secondary claims must be received within 180 calendar days of the primary payer's determination (see section 9.2.b).

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

9.3 Timely payment

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

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

9.4 Provider remittance advice

9.4.a Explanation of dental plan reimbursement (remittance advice)

The Provider Remittance Advice is a claim detail of each patient and each procedure considered for payment. Use these as a guide to reconcile enrollee 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 on the summary page:

PROVIDER/ID NUMBER - Treating dentist name and Practitioner ID number

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

AMOUNT BILLED - Amount submitted by provider

AMOUNT PAYABLE - Amount payable after benefits have been applied

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

OTHER INSURANCE - Amount payable by another carrier

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

NET AMOUNT - Total amount paid

Below is a list and description of each field on the services detail page:

PATIENT NAME

SUBSCRIBER/MEMBER NUMBER - Identifying number on the subscriber's ID card

DOB (Date of Birth) - Patient date of birth

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

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

ENCOUNTER NUMBER - Claim reference number

BENEFIT LEVEL - In or out-of-network coverage

LINE ITEM NUMBER - Reference number for item number within a claim

DOS (Date of Service) - Dates that services are rendered/performed

CODE - Procedure code of service performed

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

SURFACE(S) - Tooth Surface of service performed (if applicable)

POS (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 - Enrollee responsibility

COINSURANCE AMOUNT - Enrollee responsibility of total payment amount

DEDUCTIBLE AMOUNT - Enrollee responsibility before benefits begin

PATIENT PAY - Amount to be paid by the enrollee

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

9.4.b Provider Remittance Advice sample (page 1)

UnitedHealthcare MO Medicaid

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

UnitedHealthcare®

Please address questions to:

UnitedHealthcare MO Medicaid
PO Box 1427
Milwaukee, WI 53201

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

Dental Office Name
Street Address
City, State ZIP

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

Remittance Summary

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

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

Ref #: 34143 / 169 Page 1

9.4.c Provider Remittance Advice sample (page 2)

UnitedHealthcare MO Medicaid

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

Fee For Service Summary

Dental Office Name
Street Address
City, State ZIP

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

Ref #: 34143 / 170 Page 2

9.4.d Provider Remittance Advice sample (page 3)

UnitedHealthcare MO Medicaid

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

Services Detail

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

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

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

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

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

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

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

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

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

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

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

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9.5 Overpayment

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

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

If you prefer to mail a refund, send an Overpayment Return Check

Overpayment
P.O. Box 481
Milwaukee, WI 53201

Include the following information with the Overpayment Return Check:

- Name and contact information for the person authorized to sign checks or approve financial decisions.
- Enrollee identification number.
- Date of service.
- Original claim number (if known).
- Date of payment.
- Amount paid.
- Amount of overpayment.
- Overpayment reason.
- Check number

9.6 Tips for successful claims resolution

- Do not let claim issues grow or go unresolved.
- Call Provider Services if you can't verify a claim is on file.
- Do not resubmit validated claims on file unless submitting a corrected claim with the required indicators.
- File adjustment requests and claims disputes within contractual time requirements.
- If you must exceed the maximum daily frequency for a procedure, submit the medical records justifying medical necessity. If you have questions, call Provider Services.
- UnitedHealthcare Community Plan is the payer of last resort. This means you must bill and get an EOB from other insurance or source of health care coverage before billing UnitedHealthcare Community Plan. Secondary claims must be received within 180 calendar days from the date of service, even if the primary carrier has not made payment.
- When submitting appeal or reconsiderations requests, provide the same information required for a clean claim. Explain the discrepancy, what should have been paid and why.

9.7 Payment for non-covered services

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

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

- That the enrollee 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 enrollee's District Dual Choice Program and that the enrollee is financially liable for such services rendered.
- That the enrollee was advised that they have the right to request a determination from the insurance company prior to services being rendered.

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

9.8 Radiology requirements

Guidelines for providing radiographs are as follows:

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

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

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

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

Please note: Authorizations, including attachments, can be submitted online at no additional cost by logging into the Dental Hub at **UHCdental.com/medicaid**.

9.9 Corrected Claim Submission Guidelines

A corrected claim should **ONLY** be submitted when an original claim or service was **PAID** based upon incorrect information. As part of the process, the original claim will be recouped, and a new claim processed in its place with any necessary changes.

Examples of correction(s) for a prior **paid** claim are:

- Incorrect Provider NPI or location
- Payee Tax ID
- Incorrect Enrollee
- Procedure codes
- Services originally billed and paid at incorrect fees (including no fees)
- Services originally billed and paid without primary insurance

A corrected claim may be submitted using the methods below:

- Electronically through Clearing House

- Electronically through the Dental Hub.
- Paper to the mailing address below

  UnitedHealthcare Community Plan Corrected Claims
  P.O. Box 481
  Milwaukee, WI 53201

Electronic submission is the most efficient and preferred method. If providers do not have access to electronic submissions, and need to submit on paper, the following steps are required.

- Must be submitted to the Corrected Claims P.O. Box for proper processing and include the following:
  - 2012 version or later of the ADA claim form and all required information
  - The ADA form must be clearly noted Corrected Claim
  - In the remarks field (Box 35) on the ADA claim form indicate the original paid encounter number and record all corrections you are requesting to be made.
    Note: If all information does not fit in Box 35, please attach an outline of corrections to the claim form.

If a claim or service originally **DENIED** due to incorrect or missing information/authorization, or was not previously processed for payment, **DO NOT** submit a corrected claim. Denied services have no impact on enrollee tooth history or service accumulators, and, as such, do not require reprocessing. Submit a new claim with the updated information per your normal claim submission channels. Timely filing limitations apply when a denied claim is being resubmitted with additional information for processing.

If you received a claim or service denial which you do not agree with, including denials for no authorization, please refer to the appeals language on the Provider Remittance Advice for guidance with the appeals process applicable to the state plan.

Appendices for District Dual Choice

Appendix A: Resources and services — how we help you

Addresses and phone numbers

Need:	Address:	Phone Number:	Payer I.D.:	Submission Guidelines:	Form(s) Required:
Claim Submission (initial)	Claims: PO Box 2176 Milwaukee, WI 53201	**1-866-321-2789**	GP133	Within 365 days from the date of service For secondary claims, within 180 calendar days from the primary payer determination	ADA* Claim Form, 2012 version or later
Corrected Claims	Corrected Claims: PO Box 481 Milwaukee, WI 53201	**1-866-321-2789**	GP133	Within 365 days from inital paid date of claim	ADA Claim Form Reason for requesting adjustment or resubmission
Claim Appeals (Appeal of a denied or reduced payment)	Claim Appeals: PO Box 361 Milwaukee, WI 53201	**1-866-321-2789**	GP133	Within 60 calendar days after the claim determination	Supporting documentation, including claim number is required for processing.
Prior Authorization Requests	Pre-authorizations: PO Box 2053 Milwaukee, WI 53201	**1-866-321-2789**	GP133	N/A	ADA Claim Form – check the box titled: Request for Predetermination / Preauthorization section of the ADA Dental Claim Form
Enrollee Benefit Appeal for Service Authorization (Appeal of a denied or reduced service)	UnitedHealthcare Community Attn: Appeals and Grievances Unit P.O. Box 31364 Salt Lake City, UT 84131-0364	**1-866-321-2789**	N/A	Within 60 calendar days from the date of the adverse benefit determination	N/A

Appendix B: Enrollee benefits/exclusions and limitations

For the most updated enrollee benefits, exclusions, and limitations please visit our website at **UHCdental.com/medicaid**. We align benefit design to meet all regulatory requirements by your District's Medicaid and legislature included in your District's Medicaid Provider Billing Manual.

B.1 Exclusions & limitations

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

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

Please call Provider Services if you have any questions regarding frequency limitations.

General exclusions

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

B.2 Benefit grid

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

Code	Description	Age limits	Frequency limits	Auth required	Required docs	Clinical criteria
D0120	Periodic oral evaluation-established patient	21-999	1 per 6 months	N		
D0140	Limited Oral Evaluation - Problem Focused	21-999	1 per 6 months per provider or location	N		
D0150	Comprehensive oral evaluation-new or established patient	21-999	1 per 6 months Cannot be billed on the same DOS as D4355	N		
D0160	Detailed and Extensive Oral Evaluation- Problem Focused	21-999	1 per 6 months Cannot be billed on the same DOS as D4355	N		
D0170	Re-evaluation-Limited Problem Focused (Established patient; Not Post-Operative Visit)	21-999	1 per 6 months	N		
D0180	Comprehensive Periodontal Evaluation- New or Established Patient	21-999	1 per 12 months Cannot be billed on the same DOS as D0150 and D4355	N		
D0190	Screening of a Patient	21-999		N		
D0191	Assessment of a Patient	21-999		N		
D0210	Intraoral, complete series of radiographic images (including bitewings)	21-999	1 per 3 years Not in conjunction with D0330	N	Additional complete radiographic survey, full series of X-rays, or panoramic X-ray of the mouth requires prior authorization	
D0220	Intraoral, periapical, first radiographic image	21-999	1 per 1 day per location or provider	N		
D0230	Intraoral, periapical, each additional radiographic image	21-999	Any combination of D0220 and D0230 that exceeds the maximum allowable payment for a full mouth series of radiographs will be reimbursed at the D0210 rate	N		
D0240	Intraoral-occlusal radiographic image	21-999	2 per 1 calendar year	N		
D0270	Bitewing, single radiographic image	21-999	1 per 1 calendar year	N		
D0272	Bitewings, 2 radiographic image	21-999	1 per 1 calendar year	N		

Code	Description	Age limits	Frequency limits	Auth required	Required docs	Clinical criteria
D0274	Bitewings, 4 radiographic image	21-999	1 per 1 calendar year	N		
D0330	Panoramic Radiographic Image	21-999	1 per 3 years Not in conjunction with D0210	N		
D0340	2D Cephalometric Radiographic Image-acquisition measurement and analysis	21-999	1 per 3 calendar year	N		
D0350	2D Oral/Facial Photographic Image obtained intra-orally or extra-orally	21-999	1 per 1 calendar year	N		
D0364	Cone Beam CT capture and interpretation with limited field of view-Less than one whole jaw	21-999	1 per 1 calendar year	Y	Narrative of necessity Reason traditional radiographs would be insufficient	• Documentation describes medical necessity and why radiographic images would not be appropriate/ sufficient to safely render treatment
D0365	Cone Beam CT capture and interpretation with field of view of one full dental arch-Maxilla, with or without Cranium	21-999	1 per 1 calendar year	Y	Narrative of necessity Reason traditional radiographs would be insufficient	• Documentation describes medical necessity and why radiographic images would not be appropriate/ sufficient to safely render treatment
D0366	Cone Beam CT capture and interpretation with field of view of Both Jaws, with or without Cranium	21-999	1 per 1 calendar year	Y	Narrative of necessity Reason traditional radiographs would be insufficient	• Documentation describes medical necessity and why radiographic images would not be appropriate/ sufficient to safely render treatment
D0367	Cone Beam CT capture and interpretation with field of view of Both Jaws, with or without Cranium	21-999	1 per 1 calendar year	Y	Narrative of necessity Reason traditional radiographs would be insufficient	• Documentation describes medical necessity and why radiographic images would not be appropriate/ sufficient to safely render treatment
D0460	Pulp Vitality Tests	21-999	1 per 1 calendar day per provider	N		
D0470	Diagnostic Casts	21-999		N		
D0604	Antigen Testing for a public health related pathogen, including coronavirus	21-999		N		
D1110	Prophylaxis, adult	21-999	1 per 6 months	N		
D1206	Topical application of fluoride varnish	21-999	1 per 6 months	N		
D1208	Topical application of fluoride	21-999	1 per 6 months	N		
D1321	Counseling for the Control and Prevention of Adverse Oral, Behavioral, and Systemic Health Effects	21-999		N		
D1351	Sealant - per tooth	21-999	1 per lifetime per tooth	N		
D2140	Amalgam- one surface, primary or permanent	21-999	1 per 1 calendar year per tooth, per surface, per location	N		
D2150	Amalgam, 2 surfaces, primary or permanent	21-999	1 per 1 calendar year per tooth, per surface, per location	N		
D2160	Amalgam, 3 surfaces, primary or permanent	21-999	1 per 1 calendar year per tooth, per surface, per location	N		

Code	Description	Age limits	Frequency limits	Auth required	Required docs	Clinical criteria
D2161	Amalgam, 4 or more surfaces, primary or permanent	21-999	1 per 1 calendar year per tooth, per surface, per location	N		
D2330	Resin-Based Composite One Surface, Anterior	21-999	1 per 1 calendar year per tooth, per surface, per location	N		
D2331	Resin-Based Composite Two Surfaces, Anterior	21-999	1 per 1 calendar year per tooth, per surface, per location	N		
D2332	Resin-Based Composite Three Surfaces, Anterior	21-999	1 per 1 calendar year per tooth, per surface, per location	N		
D2335	Resin-Based Composite Four or More Surfaces or Involving Incisal Angle, (Anterior)	21-999	1 per 1 calendar year per tooth, per surface, per location	N		
D2391	Resin-Based Composite One Surface, Posterior	21-999	1 per 1 calendar year per tooth, per surface, per location	N		
D2392	Resin-Based Composite Two Surfaces, Posterior	21-999	1 per 1 calendar year per tooth, per surface, per location	N		
D2393	Resin-Based Composite Three Surfaces, Posterior	21-999	1 per 1 calendar year per tooth, per surface, per location	N		
D2394	Resin-Based Composite Four or More Surfaces or Involving Incisal Angle, (Posterior)	21-999	1 per 1 calendar year per tooth, per surface, per location	N		
D2710	Crown- Resin Based Composite (Indirect)	21-999	1 per 5 calendar years	Y	Radiographs Narrative of necessity	• Anterior- 50% incisal edge or 4+ surfaces involved • Premolar- 1 cusp or 3+ surfaces involved • Must have minimum 50% bone support • No periodontal furcation • No subcrestal caries • Clinically-acceptable root canal therapy (if applicable)
D2722	Crown-Resin with Noble Metal	21-999	1 per 5 calendar years	Y	Radiographs Narrative of necessity	• Anterior- 50% incisal edge or 4+ surfaces involved • Premolar- 1 cusp or 3+ surfaces involved • Must have minimum 50% bone support • No periodontal furcation • No subcrestal caries • Clinically-acceptable root canal therapy (if applicable)
D2750	Crown Porcelain Fused to High Noble Metal	21-999	1 per 5 calendar years	Y	Radiographs Narrative of necessity	• Anterior- 50% incisal edge or 4+ surfaces involved • Premolar- 1 cusp or 3+ surfaces involved • Must have minimum 50% bone support • No periodontal furcation • No subcrestal caries • Clinically-acceptable root canal therapy (if applicable)

Code	Description	Age limits	Frequency limits	Auth required	Required docs	Clinical criteria
D2751	Crown Porcelain Fused to Predominantly Base Metal	21-999	1 per 5 calendar years	Y	Radiographs Narrative of necessity	• Anterior- 50% incisal edge or 4+ surfaces involved • Premolar- 1 cusp or 3+ surfaces involved • Must have minimum 50% bone support • No periodontal furcation • No subcrestal caries • Clinically-acceptable root canal therapy (if applicable)
D2753	Crown Porcelain Fused to Titanium and Titanium Alloys	21-999	1 per 5 calendar years	Y	Radiographs Narrative of necessity	• Anterior- 50% incisal edge or 4+ surfaces involved • Premolar- 1 cusp or 3+ surfaces involved • Must have minimum 50% bone support • No periodontal furcation • No subcrestal caries • Clinically-acceptable root canal therapy (if applicable)
D2790	Crown- Full Cast High Noble Metal	21-999	1 per 5 calendar years	Y	Radiographs Narrative of necessity	• Anterior- 50% incisal edge or 4+ surfaces involved • Premolar- 1 cusp or 3+ surfaces involved • Must have minimum 50% bone support • No periodontal furcation • No subcrestal caries • Clinically-acceptable root canal therapy (if applicable)
D2799	Interim Crown- Further Treatment or Completion of Diagnosis Necessary Prior to Final Impression	21-999	1 per lifetime	Y	Radiographs Narrative of necessity	• Documentation describes medical necessity and provisional crown need for a minimum of 6 months. • Not to be used as a temporary crown for a routine prosthetic restoration
D2920	Re-cement or Re-bond Crown	21-999		N		
D2928	Prefabricated Porcelain/ Ceramic Crown- Permanent Tooth	21-999	1 per 5 calendar years	N		
D2930	Prefabricated Stainless Steel Crown-Primary Tooth	21-999	1 per 5 calendar years	N		
D2931	Prefabricated Stainless Steel Crown-Permanent Tooth	21-999	1 per lifetime	N		
D2934	Prefabricated Esthetic Coated Stainless Steel Crown-Primary Tooth	21-999	1 per 5 calendar years	N		
D2941	Interim Therapeutic Restoration-Primary Dentition	21-999	1 per 1 calendar year	N		
D2952	Post and Core in Addition to Crown, Indirectly Fabricated	21-999	1 per 5 calendar years	Y	Radiographs showing tooth after root canal therapy Narrative of necessity	• Endodontically-treated tooth with insufficient coronal tooth structure remaining (<50%) to support a core or crown.
D2954	Prefabricated Post and Core in Addition to Crown Fabricated	21-999	1 per 5 calendar years	Y	Radiographs showing tooth after root canal therapy Narrative of necessity	• Endodontically-treated tooth with insufficient coronal tooth structure remaining (<50%) to support a core or crown.
D3110	Pulp Cap Direct Excluding Final Restoration	21-999		N		
D3220	Therapeutic Pulpotomy (Excluding Final Restoration)	21-999	1 per lifetime	N		
D3310	Endodontic therapy, anterior tooth (Excluding Final Restoration)	21-999	1 per lifetime	Y	Radiograph Narrative of necessity	• Permanent or primary tooth with irreversible pulpitis, necrotic pulp or frank vital pulpal exposure • Teeth with radiographic periapical pathology • Primary teeth without a permanent successor • Teeth must have a completely developed root, a good long-term prognosis, and have at least 50% bone support.

Code	Description	Age limits	Frequency limits	Auth required	Required docs	Clinical criteria
D3320	Endodontic therapy, bicuspid tooth (Excluding Final Restoration)	21-999	1 per lifetime	Y	Radiograph Narrative of necessity	• Permanent or primary tooth with irreversible pulpitis, necrotic pulp or frank vital pulpal exposure • Teeth with radiographic periapical pathology • Primary teeth without a permanent successor • Teeth must have a completely developed root, a good long-term prognosis, and have at least 50% bone support.
D3330	Endodontic therapy, posterior tooth (Excluding Final Restoration)	21-999	1 per lifetime	Y	Radiograph Narrative of necessity	• Permanent or primary tooth with irreversible pulpitis, necrotic pulp or frank vital pulpal exposure • Teeth with radiographic periapical pathology • Primary teeth without a permanent successor • Teeth must have a completely developed root, a good long-term prognosis, and have at least 50% bone support with no furcation involvement
D3346	Retreatment of Previous Root canal therapy (Anterior)	21-999	1 per lifetime	Y	Radiograph Narrative of necessity	• Previously root canal-treated tooth that is sensitive to percussion/temperature • Previously root canal-treated tooth that shows evidence of periapical pathology/fistula • Teeth must have a completely developed root, a good long-term prognosis, and have at least 50% bone support with no furcation involvement
D3347	Retreatment of Previous Root canal therapy (Bicuspid)	21-999	1 per lifetime	Y	Radiograph Narrative of necessity	• Previously root canal-treated tooth that is sensitive to percussion/temperature • Previously root canal-treated tooth that shows evidence of periapical pathology/fistula • Teeth must have a completely developed root, a good long-term prognosis, and have at least 50% bone support with no furcation involvement
D3348	Retreatment of Previous Root canal therapy (Posterior)	21-999	1 per lifetime	Y	Radiograph Narrative of necessity	• Previously root canal-treated tooth that is sensitive to percussion/temperature • Previously root canal-treated tooth that shows evidence of periapical pathology/fistula • Teeth must have a completely developed root, a good long-term prognosis, and have at least 50% bone support with no furcation involvement
D3351	Apexification/recalcification-initial visit (apical closure/ calcific repair of perforations, root resorption, etc.)	21-999	1 per lifetime	Y	Radiograph Narrative of necessity	• Incomplete apical closure in a permanent tooth root • External root resorption or when the possibility of external root resorption exists • Perforations or root fractures that do not communicate with oral cavity • Not for a tooth with a completely closed apex
D3410	Apicoectomy-anterior	21-999	1 per lifetime	Y	Radiograph Narrative of necessity	Covered in the following scenarios: • Failed retreatment of endodontic therapy • When the apex of tooth cannot be accessed due to calcification or another anomaly • When a biopsy of periradicular tissue is Necessary • Where visualization of the periradicular tissues and tooth root is required when perforation or root fracture is suspected • Further diagnosis when post endodontic therapy symptoms persist • A marked over extension of obturating materials interfering with healing Not covered in the following situations: • Unusual bony or root configurations resulting in lack of surgical access • The possible involvement of neurovascular structures • Teeth with a hopeless prognosis

Code	Description	Age limits	Frequency limits	Auth required	Required docs	Clinical criteria
D3421	Apicoectomy-bicuspid (first root)	21-999	1 per lifetime	Y	Radiograph Narrative of necessity	Covered in the following scenarios: • Failed retreatment of endodontic therapy • When the apex of tooth cannot be accessed due to calcification or another anomaly • When a biopsy of periradicular tissue is Necessary • Where visualization of the periradicular tissues and tooth root is required when perforation or root fracture is suspected • Further diagnosis when post endodontic therapy symptoms persist • A marked over extension of obturating materials interfering with healing Not covered in the following situations: • Unusual bony or root configurations resulting in lack of surgical access • The possible involvement of neurovascular structures • Teeth with a hopeless prognosis
D3425	Apicoectomy-molar (first root)	21-999	1 per lifetime	Y	Radiograph Narrative of necessity	Covered in the following scenarios: • Failed retreatment of endodontic therapy • When the apex of tooth cannot be accessed due to calcification or another anomaly • When a biopsy of periradicular tissue is Necessary • Where visualization of the periradicular tissues and tooth root is required when perforation or root fracture is suspected • Further diagnosis when post endodontic therapy symptoms persist • A marked over extension of obturating materials interfering with healing Not covered in the following situations: • Unusual bony or root configurations resulting in lack of surgical access • The possible involvement of neurovascular structures • Teeth with a hopeless prognosis
D3426	Apicoectomy-each additional root	21-999	1 per lifetime	Y	Radiograph Narrative of necessity	Covered in the following scenarios: • Failed retreatment of endodontic therapy • When the apex of tooth cannot be accessed due to calcification or another anomaly • When a biopsy of periradicular tissue is Necessary • Where visualization of the periradicular tissues and tooth root is required when perforation or root fracture is suspected • Further diagnosis when post endodontic therapy symptoms persist • A marked over extension of obturating materials interfering with healing Not covered in the following situations: • Unusual bony or root configurations resulting in lack of surgical access • The possible involvement of neurovascular structures • Teeth with a hopeless prognosis
D3428	Bone Graft in Conjunction with Periradicular Surgery-Per Tooth, Single Site	21-999		Y	Radiograph Narrative of necessity	• Documentation shows medical necessity
D3429	Bone Graft in Conjunction with Periradicular Surgery- Each Additional Contiguous Tooth in the Same Surgical Site	21-999		Y	Radiograph Narrative of necessity	• Documentation describes medical necessity

Code	Description	Age limits	Frequency limits	Auth required	Required docs	Clinical criteria
D3430	Retrograde filling- per root	21-999	1 per lifetime	Y	Radiograph Narrative of necessity	• Periradicular pathosis and a blockage of the root canal system that could not be obturated by nonsurgical root canal treatment • Persistent periradicular pathosis resulting from an inadequate apical seal that cannot be corrected non-surgically • Root perforations • Resorptive defects
D3432	Guided Tissue Regeneration Resorbable Barrier Site in Conjunction with Periradicular Surgery	21-999	1 per lifetime	Y	Radiograph Narrative of necessity	• Documentation describes medical necessity
D3450	Root Amputation	21-999	1 per lifetime	Y	Radiograph Narrative of necessity	• Class III furcation involvement • Untreatable bony defect of one root • Root fracture, root caries, root resorption • Persistent sinus tract or recurrent periapical pathology • Must have at least 75% bone supporting the remaining root(s) • Must have had successful endodontic treatment
D3471	Surgical repair of root resorption- Anterior	21-999	1 per lifetime	Y	Radiograph Narrative of necessity	• Documentation describes medical necessity • Tooth must show a good prognosis with at least 50% bone support • Tooth must be free of active decay and periodontal disease.
D3472	Surgical repair of root resorption- Premolar	21-999	1 per lifetime	Y	Radiograph Narrative of necessity	• Documentation describes medical necessity • Tooth must show a good prognosis with at least 50% bone support • Tooth must be free of active decay and periodontal disease.
D3473	Surgical repair of root resorption- Molar	21-999	1 per lifetime	Y	Radiograph Narrative of necessity	• Documentation describes medical necessity • Tooth must show a good prognosis with at least 50% bone support • Tooth must be free of active decay and periodontal disease.
D4210	Gingivectomy or Gingivoplasty-Four or More Contiguous Teeth or Tooth Bounded Spaces per Quadrant	21-999	1 per 24 months	Y	Radiograph Narrative of necessity 6 point periodontal chart	• Hyperplasia or hypertrophy from drug therapy, hormonal disturbances or congenital defects • Generalized probe depths of 5 mm or more
D4211	Gingivectomy or Gingivoplasty- One to Three Contiguous Teeth or Tooth Bounded Spaces per Quadrant	21-999	1 per 24 months	Y	Radiograph Narrative of necessity 6 point periodontal chart	• Hyperplasia or hypertrophy from drug therapy, hormonal disturbances or congenital defects • Generalized probe depths of 5 mm or more
D4212	Gingivectomy or Gingivoplasty to allow access for restorative procedure, per tooth	21-999		Y	Radiograph Narrative of necessity 6 point periodontal chart	• To restore root surface decay or fracture when non-surgical gingival retraction techniques are insufficient.
D4240	Gingival Flap Procedure, Including Root Planing- Four or More Contiguous Teeth or Tooth Bounded Spaces per Quadrant	21-999	1 per 24 months	Y	Radiograph Narrative of necessity 6 point periodontal chart	Gingival Flap and apically positioned Flap procedures are indicated for the following: • The presence of moderate to deep probing depths Moderate/severe gingival enlargement or extensive areas of overgrowth • Loss of attachment • The need for increased access to root surface and/or alveolar bone when previous non-surgical attempts have been unsuccessful • The need for increased access to root surface and/or alveolar bone when previous non-surgical attempts have been unsuccessful • The diagnosis of a cracked tooth, fractured root or external root resorption when this cannot be accomplished by noninvasive methods • To preserve keratinized tissue in conjunction with Osseous Surgery

Code	Description	Age limits	Frequency limits	Auth required	Required docs	Clinical criteria
D4241	Gingival Flap Procedure, Including Root Planing- One to Three Contiguous Teeth or Tooth Bounded Spaces per Quadrant	21-999	1 per 24 months per quadrant	Y	Radiograph Narrative of necessity 6 point periodontal chart	Gingival Flap and apically positioned Flap procedures are indicated for the following: • The presence of moderate to deep probing depths Moderate/severe gingival enlargement or extensive areas of overgrowth • Loss of attachment • The need for increased access to root surface and/or alveolar bone when previous non-surgical attempts have been unsuccessful • The need for increased access to root surface and/or alveolar bone when previous non-surgical attempts have been unsuccessful • The diagnosis of a cracked tooth, fractured root or external root resorption when this cannot be accomplished by noninvasive methods • To preserve keratinized tissue in conjunction with Osseous Surgery
D4249	Clinical Crown Lengthening Hard Tissue	21-999	1 per lifetime per tooth	Y	Radiograph Narrative of necessity 6-point periodontal chart	• In an otherwise periodontally healthy area to allow a restorative procedure on a tooth with little to no crown exposure • To allow preservation of the biological width for restorative procedures
D4263	Bone Replacement Graft - Retained Natural Tooth First Site in Quadrant	21-999	1 per 24 months	Y	Radiograph Narrative of necessity 6-point periodontal chart	• Infrabony / Intrabony vertical defects • Class II Furcation involvements
D4264	Bone Replacement Graft - Retained Natural Tooth Each Additional Site in Quadrant	21-999	1 per 24 months	Y	Radiograph Narrative of necessity 6-point periodontal chart	• Infrabony / Intrabony vertical defects • Class II Furcation involvements
D4341	Periodontal scaling and root planning, 4 or more teeth per quadrant	21-999	1 per 12 months	Y	Panoramic x-ray or full series 6- point periodontal charting	• Probe depths exceeding 5 mm in conjunction with radiographic evidence of bone loss
D4342	Periodontal scaling and root planning, One to Three teeth per quadrant	21-999	1 per 12 months	Y	Panoramic x-ray or full series 6- point periodontal charting	• Probe depths exceeding 5 mm in conjunction with radiographic evidence of bone loss
D4346	Scaling in presence of generalized moderate or severe gingival inflammation-Full Mouth after oral evaluation	21-999	1 per 12 months	Y	Panoramic x-ray or full series 6- point periodontal charting	• Moderate or severe inflammation and increased sulcus depths in the absence of attachment loss.
D4355	Full mouth debridement to enable comprehensive	21-999	1 per 36 months	N		
D4910	Periodontal Maintenance	21-999	1 per 6 months	N		
D5110	Complete Denture-maxillary	21-999	1 per 60 months unless prior auth is obtained	N		
D5120	Complete Denture-mandibular	21-999	1 per 60 months unless prior auth is obtained	N		
D5211	Upper partial denture- resin base (including any conventional clasps, rests, and teeth	21-999	1 per 60 months unless prior auth is obtained	Y	Panoramic x-ray or full series	• Replacing one or more anterior teeth • Replacing three or more posterior teeth (excluding 3rd molars) • Existing partial denture greater than 5 years old and unserviceable • Abutment teeth have greater than 50% bone support and are restorable

Code	Description	Age limits	Frequency limits	Auth required	Required docs	Clinical criteria
D5212	Lower partial denture- resin base (including any conventional clasps, rests, and teeth	21-999	1 per 60 months unless prior auth is obtained	Y	Panoramic x-ray or full series	• Replacing one or more anterior teeth • Replacing three or more posterior teeth (excluding 3rd molars) • Existing partial denture greater than 5 years old and unserviceable • Abutment teeth have greater than 50% bone support and are restorable
D5213	Maxillary partial dentures-cast metal framework with resin denture bases (including any conventional clasps, rests, and teeth.	21-999	1 per 60 months unless prior auth is obtained	Y	Panoramic x-ray or full series	• Replacing one or more anterior teeth • Replacing three or more posterior teeth (excluding 3rd molars) • Existing partial denture greater than 5 years old and unserviceable • Abutment teeth have greater than 50% bone support and are restorable
D5214	Mandibular partial denture, cast metal framework with resin denture bases (including any conventional clasps, rests, and teeth	21-999	1 per 60 months unless prior auth is obtained	Y	Panoramic x-ray or full series	• Replacing one or more anterior teeth • Replacing three or more posterior teeth (excluding 3rd molars) • Existing partial denture greater than 5 years old and unserviceable • Abutment teeth have greater than 50% bone support and are restorable
D5221	Immediate Maxillary Partial Denture - Resin Base (Including Retentive/Clasping Materials Rests and Teeth)	21-999	1 per lifetime	Y	Panoramic x-ray or full series	• Replacing one or more anterior teeth • Replacing three or more posterior teeth (excluding 3rd molars) • Existing partial denture greater than 5 years old and unserviceable • Abutment teeth have greater than 50% bone support and are restorable
D5222	Immediate Mandibular Partial Denture - Resin Base (Including Retentive/Clasping Materials Rests and Teeth)	21-999	1 per lifetime	Y	Panoramic x-ray or full series	• Replacing one or more anterior teeth • Replacing three or more posterior teeth (excluding 3rd molars) • Existing partial denture greater than 5 years old and unserviceable • Abutment teeth have greater than 50% bone support and are restorable
D5223	Immediate Maxillary Partial Denture - Cast Metal Framework with Resin Denture Bases (Including Retentive/ Clasping Materials Rests	21-999	1 per lifetime	Y	Panoramic x-ray or full series	• Replacing one or more anterior teeth • Replacing three or more posterior teeth (excluding 3rd molars) • Existing partial denture greater than 5 years old and unserviceable • Abutment teeth have greater than 50% bone support and are restorable
D5224	Immediate Mandibular Partial Denture - Cast Metal Framework with Resin Denture Bases	21-999	1 per lifetime	Y	Panoramic x-ray or full series	• Replacing one or more anterior teeth • Replacing three or more posterior teeth (excluding 3rd molars) • Existing partial denture greater than 5 years old and unserviceable • Abutment teeth have greater than 50% bone support and are restorable
D5225	Mandibular partial denture-flexible base (including retentive /clasping materials, rests, and teeth)	21-999	1 per 60 months	Y	Panoramic x-ray or full series	• Replacing one or more anterior teeth • Replacing three or more posterior teeth (excluding 3rd molars) • Existing partial denture greater than 5 years old and unserviceable • Abutment teeth have greater than 50% bone support and are restorable
D5226	Maxillary partial denture-flexible base (including retentive /clasping materials, rests, and teeth)	21-999	1 per 60 months	Y	Panoramic x-ray or full series	• Replacing one or more anterior teeth • Replacing three or more posterior teeth (excluding 3rd molars) • Existing partial denture greater than 5 years old and unserviceable • Abutment teeth have greater than 50% bone support and are restorable

Code	Description	Age limits	Frequency limits	Auth required	Required docs	Clinical criteria
D5227	Immediate Maxillary Partial Denture-Flexible Base (Including any clasps, rests, and teeth)	21-999	1 per 60 months	Y	Panoramic x-ray or full series	• Replacing one or more anterior teeth • Replacing three or more posterior teeth (excluding 3rd molars) • Existing partial denture greater than 5 years old and unserviceable • Abutment teeth have greater than 50% bone support and are restorable
D5228	Immediate Mandibular Partial Denture-Flexible Base (Including any clasps, rests, and teeth)	21-999	1 per 60 months	Y	Panoramic x-ray or full series	• Replacing one or more anterior teeth • Replacing three or more posterior teeth (excluding 3rd molars) • Existing partial denture greater than 5 years old and unserviceable • Abutment teeth have greater than 50% bone support and are restorable
D5511	Repair broken complete denture base – Mandibular	21-999	1 per 12 months	N		
D5512	Repair broken complete denture base – Maxillary	21-999	1 per 12 months	N		
D5520	Replace missing or broken teeth	21-999		N		
D5611	Repair resin denture base – Mandibular	21-999	1 per 12 months	N		
D5612	Repair resin denture base – Maxillary	21-999	1 per 12 months	N		
D5621	Repair cast framework – Mandibular	21-999	1 per 12 months	N		
D5622	Repair cast framework – Maxillary	21-999	1 per 12 months	N		
D5630	Repair or replace broken clasp	21-999		N		
D5640	Replace broken teeth – per tooth	21-999		N		
D5650	Add tooth to existing partial denture	21-999		N		
D5660	Add clasp to existing partial denture	21-999		N		
D5710	Rebase complete maxillary denture	21-999	1 per 60 months unless prior auth is obtained	N		
D5711	Rebase complete mandibular denture	21-999	1 per 60 months unless prior auth is obtained	N		
D5720	Rebase maxillary partial denture	21-999	1 per 60 months unless prior auth is obtained	N		
D5721	Rebase mandibular partial denture	21-999	1 per 60 months unless prior auth is obtained	N		
D5725	Rebase Hybrid Prosthesis	21-999	1 per 60 months	N		
D5730	Reline complete maxillary denture (chairside)	21-999	1 per 60 months unless prior auth is obtained	N		
D5731	Reline complete mandibular denture (chairside)	21-999	1 per 60 months unless prior auth is obtained	N		
D5740	Reline maxillary partial denture (chairside)	21-999	1 per 60 months unless prior auth is obtained	N		

Code	Description	Age limits	Frequency limits	Auth required	Required docs	Clinical criteria
D5741	Reline mandibular partial denture (chairside)	21-999	1 per 60 months unless prior auth is obtained	N		
D5765	Soft Liner for complete or partial removable denture (indirect)	21-999	1 per 60 months	N		
D6010	Surgical Placement of Implant Body: Endosteal Implant	21-999	4 dental implants per arch will be authorized for the partially edentulous patient. For the completely edentulous patient, 4 in the maxilla and 2 in the mandibular area. 1 per 60 months per Implant site	Y	Panoramic or full mouth series x-rays	• Documentation shows adequate bone and periodontium (from master C&S criteria) • Documentation shows that implants will support single crowns or full denture (interpreted from frequency limitation descriptions in DC manual)
D6056	Prefabricated Abutment-includes modification and placement	21-999	1 per 60 months	Y	Radiographs of implant in place and osseointegrated	• Documentation shows fully integrated surgical implant with good crown / root ratio (from master C&S criteria) • Healthy bone and periodontium surrounding surgical implant (from master C&S criteria) • Documentation shows that implants will support single crowns or full denture (interpreted from frequency limitation descriptions in DC manual)
D6058	Abutment Supported Porcelain/Ceramic Crown	21-999	1 per 60 months	Y	Radiographs of implant in place and osseointegrated	• Documentation shows fully integrated surgical implant with good crown / root ratio (from master C&S criteria) • Healthy bone and periodontium surrounding surgical implant (from master C&S criteria)
D6081	Scaling and Debridement in the presence of inflammation or mucositis of a single implant including cleaning of the implant surfaces without flap entry and closure	21-999	The dental provider cannot bill for D6081 on the same date of service for the following scenarios: 1) D1110 and D4910 are billed. 2) D4341, D4342, D4240, D4241, are billed for the same quadrant. 1 per 12 months per implant site	Y	Radiographs of area Complete 6-point periodontal charting Narrative of necessity	• Documentation describes medical necessity (from master C&S criteria)
D6082	Implant Supported Crown-Porcelain Fused to Predominantly Base Alloys	21-999	1 per 60 months	Y	Radiographs of implant in place and osseointegrated	• Documentation shows fully integrated surgical implant with good crown / root ratio (from master C&S criteria) • Healthy bone and periodontium surrounding surgical implant (from master C&S criteria)

Code	Description	Age limits	Frequency limits	Auth required	Required docs	Clinical criteria
D6083	Implant Supported Crown-Porcelain Fused to Noble Alloys	21-999	1 per 60 months	Y	Radiographs of implant in place and osseointegrated	• Documentation shows fully integrated surgical implant with good crown / root ratio (from master C&S criteria) • Healthy bone and periodontium surrounding surgical implant (from master C&S criteria)
D6084	Implant Supported Crown-Porcelain Fused to Titanium and Titanium Alloys	21-999	1 per 60 months	Y	Radiographs of implant in place and osseointegrated	• Documentation shows fully integrated surgical implant with good crown / root ratio (from master C&S criteria) • Healthy bone and periodontium surrounding surgical implant (from master C&S criteria)
D6085	Provisional Implant Crown	21-999	1 per lifetime	Y	Radiographs of implant in place.	• Documentation describes medical necessity (from master C&S criteria)
D6089	Accessing and Retorquing Loose Implant Screw	21-999	1 per 12 months	N		
D6096	Remove Broken Implant Retaining Screw	21-999	1 per lifetime	Y	Narrative of necessity	• Documentation describes medical necessity (from master C&S criteria)
D6097	Abutment Supported Crown-Porcelain Fused to Titanium and Titanium Alloys	21-999	1 per 60 months	Y	Radiographs of implant in place and osseointegrated	• Documentation shows fully integrated surgical implant with good crown / root ratio (from master C&S criteria) • Healthy bone and periodontium surrounding surgical implant (from master C&S criteria)
D6100	Surgical Removal of Implant body	21-999	1 per lifetime per implant site	Y	Current dated radiographs, narrative of necessity	• Implant Failure
D6101	Debridement of a peri-implant defect or defects surrounding a single implant and surface cleaning of the exposed implant surfaces including flap entry and closure	21-999		Y	Radiographs of area Complete 6-point periodontal charting Narrative of necessity	• Documentation supports need for debridement at implant site (from master C&S criteria)
D6102	Debridement and osseous contouring of a peri- implant defect or defects surrounding a single implant and surface cleaning of the exposed implant surfaces including flap entry and closure	21-999		Y	Radiographs of area Complete 6-point periodontal charting Narrative of necessity	• Documentation supports need for debridement at implant site (from master C&S criteria)
D6103	Bone graft for repair of peri-implant defect- does not include flap entry and closure	21-999		Y	Radiographs of area Complete 6-point periodontal charting Narrative of necessity	• Documentation supports need for bone graft at implant site (from master C&S criteria)
D6104	Bone graft at time of implant placement	21-999		Y	Radiographs of area Narrative of necessity	• Documentation supports need for bone graft at implant site (from master C&S criteria)
D6110	Implant/Abutment Supported Removable Denture for Edentulous Arch - Maxillary	21-999	1 per 60 months	Y	Radiographs of implant in place and osseointegrated	• Documentation shows fully integrated surgical implant with good crown / root ratio (from master C&S criteria) • Healthy bone and periodontium surrounding surgical implant (from master C&S criteria)
D6111	Implant/Abutment Supported Removable Denture for Edentulous Arch - Mandibular	21-999	1 per 60 months	Y	Radiographs of implant in place and osseointegrated	• Documentation shows fully integrated surgical implant with good crown / root ratio (from master C&S criteria) • Healthy bone and periodontium surrounding surgical implant (from master C&S criteria)
D6112	Implant/Abutment Supported Removable Denture for Partially Edentulous Arch - Maxillary	21-999	1 per 60 months	Y	Radiographs of implant in place and osseointegrated	• Documentation shows fully integrated surgical implant with good crown / root ratio (from master C&S criteria) • Healthy bone and periodontium surrounding surgical implant (from master C&S criteria)

Code	Description	Age limits	Frequency limits	Auth required	Required docs	Clinical criteria
D6113	Partially Edentulous Arch - Mandibular	21-999	1 per 60 months	Y	Radiographs of implant in place and osseointegrated	• Documentation shows fully integrated surgical implant with good crown / root ratio (from master C&S criteria) • Healthy bone and periodontium surrounding surgical implant (from master C&S criteria)
D6190	Radiographic/Surgical Implant Index by Report	21-999		Y	Current dated radiographs, narrative of necessity	• Complex implant cases, multiple implant placements, or when anatomical structures require careful navigation.
D6191	Semi-precision Abutment - Placement	21-999	1 per 60 months	Y	Radiographs of implant in place and osseointegrated	• Documentation shows fully integrated surgical implant with good crown / root ratio (from master C&S criteria) • Healthy bone and periodontium surrounding surgical implant (from master C&S criteria)
D6192	Semi-precision Attachment - Placement	21-999	1 per 60 months	Y	Radiographs of implant in place and osseointegrated	• Documentation shows fully integrated surgical implant with good crown / root ratio (from master C&S criteria) • Healthy bone and periodontium surrounding surgical implant (from master C&S criteria)
D6193	Replacement of an Implant Screw	21-999	1 per dental implant every 24 months If performed within 6 months of the initial prosthesis placement by the same provider, the fees are included in the delivery of the prosthesis.	N		
D7111	Extraction, Coronal Remnants – Primary Tooth	21-999	1 per lifetime per tooth	N		
D7140	Extraction Erupted Tooth Extraction, Single Tooth	21-999	1 per lifetime per tooth	N		
D7210	Extraction erupted tooth requiring removal of bone and/or sectioning of tooth and including elevation of mucoperiosteal flap if indicated	21-999	1 per lifetime per tooth	N		
D7220	Removal of Impacted Tooth-Soft Tissue	21-999	1 per lifetime per tooth	Y	Panoramic radiograph Narrative of necessity	• Recurrent Infection and/or pathology (abscess, cellulitis, pericoronitis that does not respond to conservative treatment) • Non restorable caries, pulpal or periapical lesions or pulpal exposure • Tumor resection • Ectopic position/impinges on the root of an adjacent tooth/horizontal impacted, jeopardizing another molar Not Covered in the following scenarios: • Asymptomatic tooth lacking demonstrative pathology • For pain or discomfort related to normal tooth eruption • For prophylactic reasons other than an underlying medical condition

Code	Description	Age limits	Frequency limits	Auth required	Required docs	Clinical criteria
D7230	Removal of Impacted Tooth Partially Bony	21-999	1 per lifetime per tooth	Y	Panoramic radiograph Narrative of necessity	• Recurrent Infection and/or pathology (abscess, cellulitis, pericoronitis that does not respond to conservative treatment) • Non restorable caries, pulpal or periapical lesions or pulpal exposure • Tumor resection • Ectopic position/impinges on the root of an adjacent tooth/horizontal impacted, jeopardizing another molar Not Covered in the following scenarios: • Asymptomatic tooth lacking demonstrative pathology • For pain or discomfort related to normal tooth eruption • For prophylactic reasons other than an underlying medical condition
D7240	Removal of Impacted Tooth-Completely Bony	21-999	1 per lifetime per tooth	Y	Panoramic radiograph Narrative of necessity	• Recurrent Infection and/or pathology (abscess, cellulitis, pericoronitis that does not respond to conservative treatment) • Non restorable caries, pulpal or periapical lesions or pulpal exposure • Tumor resection • Ectopic position/impinges on the root of an adjacent tooth/horizontal impacted, jeopardizing another molar Not Covered in the following scenarios: • Asymptomatic tooth lacking demonstrative pathology • For pain or discomfort related to normal tooth eruption • For prophylactic reasons other than an underlying medical condition
D7241	Removal of Impacted Tooth Completely Bony, unusual surgical	21-999	1 per lifetime per tooth	Y	Panoramic radiograph Narrative of necessity	• Recurrent Infection and/or pathology (abscess, cellulitis, pericoronitis that does not respond to conservative treatment) • Non restorable caries, pulpal or periapical lesions or pulpal exposure • Tumor resection • Ectopic position/impinges on the root of an adjacent tooth/horizontal impacted, jeopardizing another molar Not Covered in the following scenarios: • Asymptomatic tooth lacking demonstrative pathology • For pain or discomfort related to normal tooth eruption • For prophylactic reasons other than an underlying medical condition
D7250	Surgical removal of residual tooth roots (cutting	21-999	1 per lifetime per tooth	Y	Panoramic radiograph	• Portion of tooth root remaining following a previous incomplete extraction by a different provider • Not considered for supraerupted root tips secondary to carious loss of tooth structure
D7251	Coronectomy-Intentional Partial Tooth Removal	21-999	1 per lifetime per tooth	Y	Panoramic radiograph Narrative of necessity	• When clinical criteria for extraction of impacted teeth is met • When the removal of complete tooth would likely result in damage to the neurovascular bundle
D7270	Tooth Reimplantation and/or stabilization of accidentally evulsed or displaced tooth	21-999	1 per lifetime per tooth	N		
D7280	Exposure of an unerupted tooth	21-999	1 per lifetime per tooth	Y	Panoramic radiograph Narrative of necessity	• When a normally developing permanent tooth is unable to erupt into a functional position
D7282	Mobilization of Erupted or Malpositioned Tooth to aid eruption	21-999	1 per lifetime per tooth	Y	Radiograph Narrative of necessity	• Indicated for the treatment of ankylosed permanent teeth

Code	Description	Age limits	Frequency limits	Auth required	Required docs	Clinical criteria
D7284	Excisional Biopsy of Minor Salivary Glands	21-999		N		
D7285	Incisional biopsy of oral tissue-Hard (bone, tooth)	21-999		N		
D7286	Incisional biopsy of oral tissue-Soft	21-999		N		
D7310	Alveoloplasty in conjunction with extractions- Four or more teeth or tooth spaces, per quadrant	21-999	1 per lifetime	N		
D7320	Four or more teeth or tooth spaces, per quadrant	21-999	1 per lifetime	N		
D7340	Vestibuloplasty-ridge extension (secondary epithelialization)	21-999		Y	Narrative of necessity	• Ridge extension, or lowering or altering submucous displacing attachments prior to prosthetic construction • To complement and complete osseous procedure when reconstructing edentulous bone • To correct inadequate or inappropriate soft tissue drape where a resection has been previously performed and prosthetic restoration requires improvement • For overall stability of a dental implant and the maintenance of bone health around an implant
D7350	Vestibuloplasty-ridge extension	21-999		Y	Narrative of necessity	• Ridge extension, or lowering or altering submucous displacing attachments prior to prosthetic construction • To complement and complete osseous procedure when reconstructing edentulous bone • To correct inadequate or inappropriate soft tissue drape where a resection has been previously performed and prosthetic restoration requires improvement • For overall stability of a dental implant and the maintenance of bone health around an implant
D7410	Excision of Benign Lesion up to 1.25 cm	21-999		N		
D7411	Excision of Benign Lesion Greater than 1.25 cm	21-999		N		
D7412	Excision of Benign Lesion Complicated	21-999		N		
D7413	Excision of Malignant Lesion up to 1.25 cm	21-999		N		
D7414	Excision of Malignant Lesion greater than 1.25 cm	21-999		N		
D7415	Excision of Malignant Lesion Complicated	21-999		N		
D7451	Removal of odontogenic cyst or tumor-lesion greater than 1.25 cm	21-999		N		
D7460	Removal of odontogenic cyst or tumor-lesion diameter up to 1.25 cm	21-999		N		

Code	Description	Age limits	Frequency limits	Auth required	Required docs	Clinical criteria
D7471	Removal of lateral exostosis (Maxilla or Mandible)	21-999	1 per lifetime per site	Y	Narrative of necessity	• When the presence of exostosis interferes with the fit of a dental prosthesis and it cannot be adapted successfully • When causing soft tissue trauma with existing removable appliances • For unusually large tori/exostosis that are prone to recurrent traumatic injury • When there is a functional disturbance, including, but not limited to normal tongue movement, mastication, swallowing and speech
D7472	Removal of Torus Palatinus	21-999	1 per lifetime	Y	Narrative of necessity	• When the presence of exostosis interferes with the fit of a dental prosthesis and it cannot be adapted successfully • When causing soft tissue trauma with existing removable appliances • For unusually large tori/exostosis that are prone to recurrent traumatic injury • When there is a functional disturbance, including, but not limited to normal tongue movement, mastication, swallowing and speech
D7473	Removal of Torus Mandibularis	21-999		Y	Narrative of necessity	• When the presence of exostosis interferes with the fit of a dental prosthesis and it cannot be adapted successfully • When causing soft tissue trauma with existing removable appliances • For unusually large tori/exostosis that are prone to recurrent traumatic injury • When there is a functional disturbance, including, but not limited to normal tongue movement, mastication, swallowing and speech
D7509	Marsupialization of odontogenic cyst	21-999	1 per lifetime per tooth	Y	Current dated radiographs, narrative of necessity	• Surgical decompression of large cystic lesion. • Conforms to CDT descriptor
D7510	Incision Drainage Abscess-Intra-Oral Soft Tissue	21-999		N		
D7520	Incision Drainage Abscess-Extra-Oral Soft Tissue	21-999		N		
D7530	Removal of Foreign Body from Mucosa, Skin, or Subcutaneous Alveolar Tissue	21-999		N		
D7610	Maxilla-Open Reduction (Teeth Immobilized, If Present)	21-999		Y	Narrative of necessity	• Documentation describes accident, operative report and medical necessity
D7620	Maxilla-Closed Reduction (Teeth Immobilized, If Present)	21-999		Y	Narrative of necessity	• Documentation describes accident, operative report and medical necessity
D7630	Mandible- Open Reduction (Teeth Immobilized, If Present)	21-999		Y	Narrative of necessity	• Documentation describes accident, operative report and medical necessity
D7640	Mandible- Closed Reduction (Teeth Immobilized, If Present	21-999		Y	Narrative of necessity	• Documentation describes accident, operative report and medical necessity
D7650	Malar and/or Zygomatic Arch-Open Reduction	21-999		Y	Narrative of necessity	• Documentation describes accident, operative report and medical necessity
D7660	Malar and/or Zygomatic Arch-Closed Reduction	21-999		Y	Narrative of necessity	• Documentation describes accident, operative report and medical necessity
D7670	Alveolus-Closed Reduction, May include stabilization of teeth	21-999		Y	Narrative of necessity	• Documentation describes accident, operative report and medical necessity
D7820	Closed Reduction of Dislocation	21-999		Y	Narrative of necessity	Covered in the following Scenarios: • Narrative, x-rays, or photos support medical necessity for procedure • Documentation supports history of TMJ pain / treatment efforts Not Covered in the following scenarios: • For bruxism, grinding or other occlusal factors

Code	Description	Age limits	Frequency limits	Auth required	Required docs	Clinical criteria
D7840	Condylectomy	21-999		Y	Narrative of necessity	Covered in the following Scenarios: • Narrative, x-rays, or photos support medical necessity for procedure • Documentation supports history of TMJ pain / treatment efforts Not Covered in the following scenarios: • For bruxism, grinding or other occlusal factors
D7850	Meniscectomy	21-999		Y	Narrative of necessity	Covered in the following Scenarios: • Narrative, x-rays, or photos support medical necessity for procedure • Documentation supports history of TMJ pain / treatment efforts Not Covered in the following scenarios: • For bruxism, grinding or other occlusal factors
D7860	Arthrotomy	21-999		Y	Narrative of necessity	Covered in the following Scenarios: • Narrative, x-rays, or photos support medical necessity for procedure • Documentation supports history of TMJ pain / treatment efforts Not Covered in the following scenarios: • For bruxism, grinding or other occlusal factors
D7870	Arthrocentesis	21-999		Y	Narrative of necessity	Covered in the following Scenarios: • Narrative, x-rays, or photos support medical necessity for procedure • Documentation supports history of TMJ pain / treatment efforts Not Covered in the following scenarios: • For bruxism, grinding or other occlusal factors
D7910	Sutures small wounds up to 5cm	21-999		Y	Narrative of necessity and description of accident	• Documentation describes accident • Not for tooth extraction or to close surgical incision
D7911	Complicated Suture-Up to 5 cm	21-999		Y	Narrative of necessity and description of accident	• Documentation describes accident • Not for tooth extraction or to close surgical incision
D7940	Osteoplasty- For Orthognathic Deformities	21-999		Y	Narrative of necessity	• Correction of congenital, developmental, or acquired traumatic or surgical deformity
D7950	Osseous, Osteoperiosteal, or Cartilage Graft of the Mandible or Maxilla-Autogenous or Nonautogenous, By report	21-999		Y	Narrative of necessity	• Indicated to augment deficient alveolar bone needed to support a dental prosthesis
D7953	Bone Replacement Graft for Ridge Preservation-Per Site	21-999		Y	Narrative of necessity Type and date of planned prosthesis	• Bone replacement graft for ridge preservation is indicated to preserve the alveolar ridge needed to support a dental prosthesis. • not indicated as a routine procedure to fill extraction sites
D7956	Guided tissue regeneration, edentulous area - resorbable barrier, per site	21-999	1 per 24 months	Y	Current dated radiographs, narrative of necessity	• For the correction of extensive bony defects: ridge augmentation, sinus lift procedures for placement of implants to support maxillarydenture and after tooth extraction where defect compromises integrity of arch.
D7957	Guided tissue regeneration, edentulous area - non-resorbable barrier, per site	21-999	1 per 24 months	Y	Current dated radiographs, narrative of necessity	• For the correction of extensive bony defects: ridge augmentation, sinus lift procedures for placement of implants to support maxillarydenture and after tooth extraction where defect compromises integrity of arch.
D7961	Buccal/Labial Frenectomy (Frenulectomy)	21-999	1 per lifetime	N		
D7962	Lingual Frenectomy (Frenulectomy)	21-999	1 per lifetime	N		
D7970	Excision of Hyperplastic Tissue-Per Arch	21-999		N		

Code	Description	Age limits	Frequency limits	Auth required	Required docs	Clinical criteria
D7972	Surgical Reduction of Fibrous Tuberosity	21-999	1 per lifetime	N		
D7979	Non-Surgical Sialolithotomy	21-999		Y	Narrative of necessity	• Documentation demonstrates a sialolith that can be removed with non-surgical means
D7982	Sialodochoplasty	21-999		Y	Narrative of necessity	• Documentation demonstrates need
D9110	Palliative (Emergency) treatment of dental pain-minor procedure	21-999	Not to be billed if other definitive treatment procedures are rendered on the same date of service	N		
D9222	Deep sedation/general anesthesia, first 15 minutes	21-999	1 unit per procedure	Y	Narrative of necessity	• Clinical procedures of extensiveness or complexity or situations that require more than a local anesthetic • Uncooperative or unmanageable individuals for which other behavior management techniques are inappropriate or inadequate • Physical, cognitive or developmental disabilities • Significant underlying medical condition • Allergy or sensitivity to Local Anesthesia • Individuals with extreme anxiety or fear Severe infection that inhibits local anesthesia Not Covered for the following scenarios: • Electively requested by the enrollee
D9223	Deep sedation/general anesthesia, each additional 15 minutes	21-999	7 units per procedure	Y	Narrative of necessity	• Clinical procedures of extensiveness or complexity or situations that require more than a local anesthetic • Uncooperative or unmanageable individuals for which other behavior management techniques are inappropriate or inadequate • Physical, cognitive or developmental disabilities • Significant underlying medical condition • Allergy or sensitivity to Local Anesthesia • Individuals with extreme anxiety or fear Severe infection that inhibits local anesthesia Not Covered for the following scenarios: • Electively requested by the enrollee
D9230	Inhalation of nitrous oxide/ analgesia, anxiolysis	21-999		N		
D9310	Consultation-Diagnostic service provided by Dentist or Physician other than requesting Dentist or Physician	21-999		N		
D9420	Hospital or Ambulatory Surgical Call Center	21-999		N		
D9430	Office Visit for Observation (During Regularly Scheduled Hours) - No other services performed	21-999		N		

Code	Description	Age limits	Frequency limits	Auth required	Required docs	Clinical criteria
D9944	Occlusal Guard- Hard Appliance, Full Arch	21-999		Y	Panoramic radiograph Narrative of necessity	• Bruxism or clenching either as a nocturnal parasomnia or during waking hours, resulting in excessive wear or fractures of natural teeth or restorations • To protect natural teeth when the opposing dentition has the potential to cause enamel wear such as the presence of porcelain or ceramic restorations Not covered in the following scenarios: • For treatment of temporomandibular disorders or myofacial pain disfunction • As an appliance intended for orthodontic tooth movement
D9945	Occlusal Guard- Soft Appliance, Full Arch	21-999	1 per 24 months	Y	Panoramic radiograph Narrative of necessity	• Bruxism or clenching either as a nocturnal parasomnia or during waking hours, resulting in excessive wear or fractures of natural teeth or restorations • To protect natural teeth when the opposing dentition has the potential to cause enamel wear such as the presence of porcelain or ceramic restorations Not covered in the following scenarios: • For treatment of temporomandibular disorders or myofacial pain disfunction • As an appliance intended for orthodontic tooth movement
D9946	Occlusal Guard- Hard Appliance, Partial Arch	21-999	1 per 24 months	Y	Panoramic radiograph Narrative of necessity	• Bruxism or clenching either as a nocturnal parasomnia or during waking hours, resulting in excessive wear or fractures of natural teeth or restorations • To protect natural teeth when the opposing dentition has the potential to cause enamel wear such as the presence of porcelain or ceramic restorations Not covered in the following scenarios: • For treatment of temporomandibular disorders or myofacial pain disfunction • As an appliance intended for orthodontic tooth movement
D9951	Occlusal Adjustment-Limited	21-999	2 per 12 months	Y	Narrative of necessity	• Adjustment not done on same date as restorative, prosthetic or endodontic treatment
D9952	Occlusal Adjustment-Complete	21-999	1 per lifetime	Y	Narrative of necessity	• Documentation describes medical necessity for complex case need (facebow, interocclusal records, tracings, diagnostic wax-up, etc.)
D9953	Reline custom sleep apnea appliance (indirect)	21-999	1 every 60 months	Y	Narrative of necessity	• Restore function and retention by resurfacing.
D9955	Oral Appliance Therapy (OAT) Titration Visit	21-999	1 every 60 months	N		
D9959	Unspecified sleep apnea services procedure, by report	21-999		Y	Pulmonologist referral, FMX or Pan, Sleep Study and documented failure of CPAP	• For sleep apnea service related to appliance fabrication and placement not described by CDT code.
D9997	Dental Case Management- Patients with Special Health Care Needs	21-999		Y	Narrative of necessity	• Documentation describes medical necessity

Appendix C: Authorization for treatment

C.1 Dental treatment requiring authorization

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

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

For questions concerning prior authorization, dental claim procedures, or to request clinical criteria, please call the Provider Services Line.

You can submit your authorization request electronically, by paper through mail, or online at **UHCdental.com/medicaid**. 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 to the address referenced in the appendix of this manual.

C.2 Authorization timelines

The following timelines will apply to requests for authorization:

- We will make a determination on standard authorizations within 2 days of receipt of the request. Written notification of denied determinations will be sent within 14 calendar days of receipt of the request.
- We will make a determination on expedited authorizations within 24 hours of receipt of the request. Written notification denied determinations will be sent within 2 business days of receipt of the request.
- Authorization approvals will expire 180 days from the date of determination.

C.3 Appealing a denied authorization

Enrollees have the right to appeal any fully or partially denied authorization determination. Denied requests for authorization are also known as adverse benefit determinations. An appeal is a formal way to share dissatisfaction with an adverse benefit determination.

As a treating provider, you may advocate for your patient and assist with their appeal. If you wish to file an appeal on the enrollee's behalf, you will need their consent to do so.

You or the enrollee may call or mail the information relevant to the appeal within 60 calendar days from the date of the adverse benefit determination.

Enrollee Denied Authorization Appeal Mailing Address:

UnitedHealthcare Community
Attn: Appeals and Grievances Unit
P.O. Box 31364
Salt Lake City, UT 84131-0364
Toll-free: 866-242-7726 (TTY 711)

For standard appeals, if you appeal by phone, you must follow up in writing, ask the enrollee to sign the written appeal, and mail it to UnitedHealthcare Community Plan. Expedited appeals do not need to be in writing.

The enrollee has the right to:

- Receive a copy of the rule used to make the decision.
- Ask someone (a family member, friend, lawyer, health care provider, etc.) to help. The enrollee may present evidence, and allegations of fact or law, in person and in writing.
- Review the case file before and during the appeal process. The file includes medical records and any other documents.
- Send written comments or documents considered for the appeal.
- Ask for an expedited appeal if waiting for this health service could harm the enrollee's health.
- Ask for continuation of services during the appeal. However, the enrollee may have to pay for the health service if it is continued or if the enrollee should not have received the service. As the provider, you cannot ask for a continuation. Only the enrollee may do so.

C.4 Appeal determination timeframe:

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

C.5 Peer-to-Peer Review

- The treating provider can request a peer-to-peer review with the dental consultant within 60 calendar days of adverse benefit determination. The dental consultant conducting the peer-to-peer consultation will clearly identify what documentation the provider must provide to obtain approval of the specific item, procedure, or service; or a more appropriate course of action based upon accepted clinical guidelines. To make the request, call Provider Services at 1-866-321-2789 8 a.m. - 6 p.m. (ET) Monday-Friday.

Note:

- Peer-to-peer review is only for prior authorizations. You must file an appeal for post authorization as the services have already been rendered and are not eligible for peer-to-peer.
- Peer-to-peer review is only valid within 60 days of issuance of denial. Providers who have appealed services are not eligible for a peer-to-peer request.
- UnitedHealthcare will offer a peer-to-peer consultation within a mutually agreed upon time within 24 business hours of a provider's request for a peer-to-peer consultation.

C.6 Credentialing and Recredentialing Appeals

Appeals for credentialing / re-credentialing for disciplinary action is not applicable in the District.

Appendix D: Enrollee rights and responsibilities

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

D.1 Enrollee rights

Enrollees have the right to:

- Request information on advance directives
- Be treated with respect and recognition of their dignity and right to privacy
- Receive courteous and prompt treatment
- Receive culturally competent assistance, including having an interpreter during appointments and procedures
- Receive information about the organization, its services, its practitioners and care providers and enrollee rights and responsibilities
- Know the qualifications of their health care provider
- Give their consent for treatment unless unable to do so because life or health is in immediate danger
- Discuss any and all treatment options with you
- Refuse treatment directly or through an advance directive
- Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation, as specified in other Federal regulations on the use of restraints and seclusion
- Be free to exercise their rights and that the exercise of those rights does not adversely affect the way UnitedHealthcare or our network providers or the state agency treat the enrollee
- Receive medically necessary services covered by their benefit plan
- Receive information about in-network care providers and practitioners, and choose a care provider from our network
- Change care providers at any time for any reason
- Tell us if they are not satisfied with their treatment or with us; they can expect a prompt response
- Tell us their opinions and concerns about services and care received
- Voice complaints or appeals about the organization or the care it provides
- Appeal any payment or benefit decision we make
- Request and receive a copy of their medical records, and request that they be amended or corrected
- A candid discussion of appropriate or medically necessary treatment options for their conditions, regardless of cost or benefit coverage
- Get a second opinion with an in-network care provider
- Participate with practitioners in making decisions about their health care
- Make recommendations regarding the organization's enrollee rights and responsibilities policy
- Get more information upon request, such as on how our health plan works and a care provider's incentive plan, if they apply

UnitedHealthcare may not prohibit or otherwise restrict a provider acting within the lawful scope of practice from advising or advocating on behalf of an Enrollee who is their patient for the following:

- The enrollee's health status, medical care or treatment options including any alternative care that may be self-administered.
- Any information the enrollee needs to decide among all relevant treatment options.
- The risks, benefits, and consequences of treatment or non-treatment.
- The enrollee's right to participate in decisions regarding their health care including the right to refuse treatment and to express preferences about future treatment decisions.

Enrollee has the right to be furnished health care services in accordance with §§438.206 through 438.210. These standards cover access and availability of services, coordination of care, and authorization of services.D.2 Enrollee responsibilities

D.2 Enrollee responsibilities

Enrollees should:

- Understand their benefits so they can get the most value from them
- Show you their Medicaid enrollee ID card
- Prevent others from using their ID card
- Understand their health problems and give you true and complete information
- Ask questions about treatment
- Work with you to set treatment goals
- A responsibility to follow plans and instructions for care that they have agreed to with their practitioners
- Get to know you before they are sick
- Keep appointments or tell you when they cannot keep them
- Treat your staff and our staff with respect and courtesy
- Get any approvals needed before receiving treatment
- Use the ER only during a serious threat to life or health
- Notify us of any change in address or family status
- Make sure you are in-network
- A responsibility to follow plans and instructions for care that they have agreed to with their practitioners
- Give you and us information that could help improve their health

Our enrollee rights and responsibilities help uphold the quality of care and services they receive from you. The 3 primary enrollee responsibilities as required by the National Committee of Quality Assurance (NCQA) are to:

- Supply information (to the extent possible) to UnitedHealthcare District Dual Choice Plan and to you that is needed for you to provide care
- A responsibility to follow plans and instructions for care that they have agreed to with their practitioners
- A responsibility to understand their health problems and participate in developing mutually agreed-upon treatment goals, to the degree possible

Dental Benefit Providers®