Dental Provider Manual

UnitedHealthcare Community Plan
NJ FamilyCare

Provider Services: 1-800-508-4881

Revised 1/10/2025

United Healthcare® | Dental Benefit Providers®

Contents

Section 1: Introduction - who we are

Welcome to UnitedHealthcare®

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

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/NJ FamilyCare, as well as Commercial products such as Preferred Provider Organization (PPO) plans.

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

Our Commercial program plan requirements are contained in a separate Provider Manual. If you support one of our Commercial plans and need that Manual, please contact Provider Services at **1-800-822-5353** (Note: All other concerns should be directed to **1-800-508-4881**).

If you have any questions or concerns about the information contained within this Manual, please contact the UnitedHealthcare Provider Services team at **1-800-508-4881**.

Unless otherwise specified herein, this Manual is effective on January 1, 2024 for dental providers currently participating in the UnitedHealthcare network, and effective immediately for newly contracted dental providers.

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

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

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

Section 2: Resources and services – how we help you

2.1 Quick reference guides — how we help you

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

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

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

You want to:	Provider Services Line– dedicated service representatives Phone: 1-800-508-4881 Hours: 9 a.m.-6 p.m. (ET) Monday – Friday	Online UHCdental.com/medicaid	Interactive Voice Response (IVR) System Phone: 1-800-508-4881 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	✓		

Need:	Resource				
Claim submission (initial)	**Claims:** UnitedHealthcare P.O. Box 2180 Milwaukee, WI 53201 Or submission via the Provider Web Portal at **UHCdental.com/medicaid**	**1-800-508-4881**	GP133	Within 180 calendar days from the date of service for Medicaid and FamilyCare claims	ADA Claim Form, 2019 version or later
Prior authorization requests (initial and resubmission for missing information)	**Prior authorizations:** UnitedHealthcare P.O. Box 2073 Milwaukee, WI 53201 Or submission via the Provider Web Portal at **UHCdental.com/medicaid**	**1-800-508-4881**	GP133		ADA Claim Form – check the box titled: Request for Predetermination/ Preauthorization section of the ADA Dental Claim Form
Provider administrative appeals	**Adjustments/resubmissions:** UnitedHealthcare P.O. Box 1266 Milwaukee, WI 53201	**1-800-508-4881**	GP133	Within 90 days from receipt of payment	ADA Claim Form - Provider narrative supporting appeal
Claim payment disputes	**Provider disputes:** UnitedHealthcare P. O. Box 1266 Milwaukee, WI 53201	**1-800-508-4881**	N/A	Within 90 days from receipt of payment	ADA Claim Form - Reason for requesting adjustment or resubmission
Internal utilization management appeal (with the member's written permission)	UnitedHealthcare Grievance and Appeals: ATT: Appeals P.O. Box 31364 Salt Lake City, UT 84131-0364 Or fax: 1-801-994-1082	Medicaid: **1-888-362-3368**	N/A	60 days from the date of the denial letter	N/A

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

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

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

2.2.b Provider web portal registration and instruction

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

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

Section 3: Patient eligibility verification procedures

3.1 Member eligibility

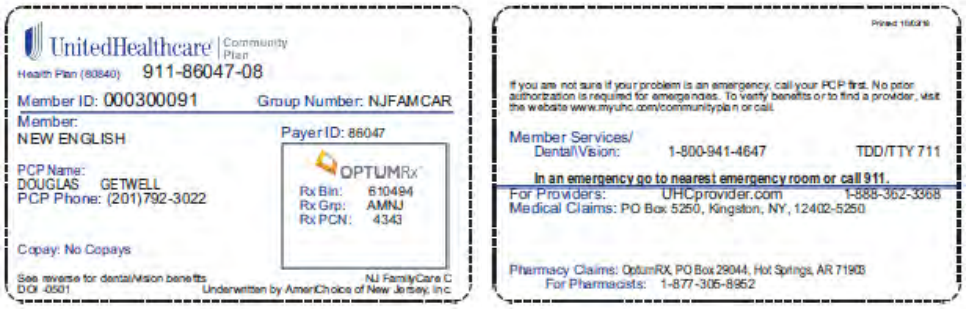
Member eligibility or dental benefits may be verified online or via phone.

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

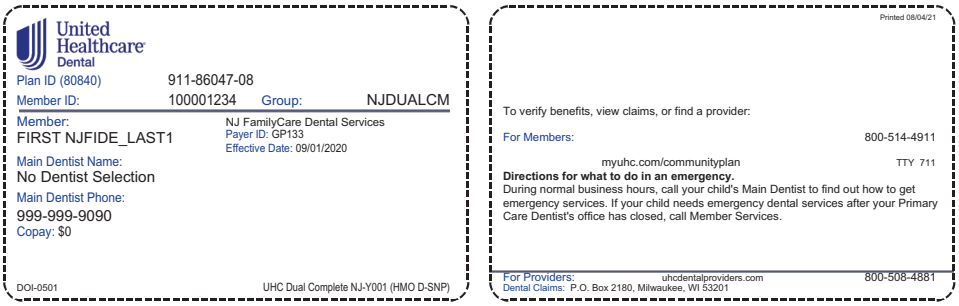
Important Note: Eligibility should be verified on the date of service. Verification of eligibility is not a guarantee of payment. Payment can only be made after the claim has been received and reviewed considering eligibility, dental necessity and other limitations and/or exclusions. **Additional rules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

3.2 Member identification card

Members are issued an identification (ID) card by UnitedHealthcare Community Plan. The ID cards are customized with the UnitedHealthcare Community Plan logo and include the toll-free customer service number for the health plan.



All members age 1-20 are assigned to a PCD. We notify members of their assigned dental home and send them a separate dental ID card with the PCD information. Members can change dental homes and visit a participating dentist of their choice at any time, regardless of where we assign them. A sample dental ID card is provided below. The member's actual dental ID card may look slightly different.



An ID card is not a guarantee of payment**.** It is the responsibility of the provider to verify eligibility at the time of service**.** To verify a member's dental coverage, go to **UHCdental.com/medicaid** or contact the dental Provider Services line at the telephone number listed on the cover of this document**.**

3.3 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, you can verify your patients' eligibility online with just a few clicks.

The username and password that are established during the registration process will be used to access the website. One username and password are granted for each payee ID number.

UnitedHealthcare Community Plan also offers an Interactive Voice Response (IVR) system for eligibility verification; please see Section 2.2.a of this manual to see details of the IVR system. The IVR is available 24 hours a day, 7 days a week.

3.4 Covered services for NJ FamilyCare A, B, C, D, Special Needs, MLTSS, and FIDE SNP

All NJ FamilyCare members: Plans A, B, C, D, ABP, MLTSS and FIDE SNP (dual eligible Medicare/Medicaid) have the same comprehensive dental benefit package which include diagnostic, preventive, restorative, endodontic, periodontal, prosthetic, oral and maxillofacial surgical and other adjunctive general services. Some procedures require prior authorization with documentation of medical necessity. Orthodontic services are age restricted and only approved with adequate documentation of medical necessity and/or handicapping malocclusion.

Claim payment is based on Plan Benefits and Patient Eligibility on the date of service. It is required that eligibility and benefits be verified prior to the delivery of services.

Consideration for prior authorization of services should consider the overall general health, patient compliance and dental history, condition of the oral cavity and complete treatment plan that is both judicious in the use of program funds and provides a clinically acceptable treatment outcome. In situations where a complex treatment plan is being considered, the provider may sequentially submit several prior authorization requests, one for each of the various stages of the treatment.

Please note: Family Care C and Family Care D have a $5 copay for non-diagnostic and non-preventive services.

Additional diagnostic, preventive and periodontal services shall be available beyond the frequency limitations of every six months and be allowed every three months to enrollees with special needs when medical necessity for these services without the need for preauthorization.

Documentation shall include the expected prognosis and improvement in the oral condition associated with the increased frequency for the requested service.

For procedures that may be considered either medical or dental such as maxillofacial prosthetics, surgical procedures for fractured jaw or removal of cysts the plan accepts prior authorization and payment requests from either qualified participating physicians or qualified participating oral surgeons and prosthodontists. Physician requests have to be made through the physician portal (**uhcprovider.com**) utilizing medical codes and dentist requests have to be made through the dental portal (**UHCdental.com/medicaid**) utilizing dental codes.

The following medical services can be performed by either provider type, within the scope of their license:

1. Repair of cleft palate
2. Cysts removal

3. Fractured jaw
4. Oral and maxillofacial surgery
5. Anesthesia services

3.5 Covered benefits

Based on EPSDT regulations, medically necessary services cannot be denied to children based on frequency. Documentation of medical necessity may be required.

Medically necessary orthodontic services are covered for children, based on the following age limits for eligibility:

- Plan A, APB, MLTSS and DDD members under the age of 21 are eligible for orthodontic treatment
- Plan B, C or D members under the age of 19 are eligible for orthodontic treatment Benefits for members in FamilyCare Plans B, C, and D terminate at age 19.

A list of covered benefits can be found on the **NJ FamilyCare Dental Services Clinical Criteria Grid**. This link will have the latest updates and includes additional guidance on covered benefits.

Claim payment is based on Plan Benefits and Patient Eligibility on the date of service. Services included in the Clinical Criteria Grid are Plan benefits.

For procedures that may be considered either medical or dental such as maxillofacial prosthetics, surgical procedures for fractured jaw or removal of cysts the plan accepts prior authorization and payment requests from either qualified participating physicians or qualified participating oral surgeons and prosthodontists. Physician requests must be made through the physician portal utilizing medical codes and dentist requests have to be made through the dental portal utilizing dental codes.

3.6 Exclusions & limitations

Please refer to the Clinical Criteria 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 Clinical Criteria Grid is excluded. Please call Provider Services if you have any questions regarding frequency limitations.

Additional exclusions

1. Dental services that are not medically necessary
2. Hospitalization or other facility charges. These may be covered through the patient's medical plan. To be sure, please contact Provider Services.
3. Reconstructive surgery, regardless of whether 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. These may be covered through the patient's medical plan. To be sure, please contact Provider Services.
4. Any procedure not performed in a dental setting that has not been prior authorized.
    - In situations where dental services are rendered in a school setting, health fair or a dental van the following services may be provided: oral assessment/screening, prophylaxis, fluoride treatment, emergency care and referral to the member's dental home when known.

5. 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.
6. Service for injuries or conditions covered by workers' compensation or employer liability laws, and services that are provided without cost to the covered persons by any municipality, county or other political subdivision. This exclusion does not apply to any services covered by Medicaid.
7. If a member loses eligibility, dental services which were approved and started duing a period of enrollment shall be covered for ninety (90) days folloing the loss of eligibility.
8. Services rendered by a provider with the same legal residence as a covered person or who is a member of a covered person's family, including a spouse, brother, sister, parent or child.

3.7 Member appeals & inquiries

Providers may have members that want to file a grievance, internal appeal, external appeal or request a State Fair Hearing. Providers may assist or instruct members on how to do so. These processes are explained in detail in the Member Handbook and in chapter 15 of the New Jersey FamilyCare Provider Manual.

Excerpts from the Member Handbook are provided below for your reference. Please note that the Member Handbook may be updated periodically, so for the most current information, please refer to the Member Handbook, which may be accessed at **uhccommunityplan.com**.

UnitedHealthcare reviews all the care you receive to make sure it's covered by UnitedHealthcare, FFS or the NJ FamilyCare program and is medically necessary. Any decision to deny or limit dental care will be made by a dental consultant at UnitedHealthcare. The dental consultant making the decision may talk to your dentist.

If you ever think that UnitedHealthcare has denied a service that should be covered, you, or your provider with your written consent, have the right to appeal that decision within 60 days of the date of your denial letter. This is called a Stage 1 Appeal. You can do this by calling Member Services at 1-800-941-4647, TTY: 711, and asking to have the decision reviewed. If you call, we recommend that you follow your call with a written request for each stage of an appeal. We will review your appeal as soon as possible, and always within 10 calendar days of your request. Your dentist can speak to the UnitedHealthcare Dental Director or the dental consultant who made the decision to discuss the reason for the decision.

UnitedHealthcare will write back to you within 10 business days to say we received your appeal. Dentists who have not been involved in the decision to deny the services will review your appeal. If necessary, dentist trained in the dental specialty that concerns your care will be part of the review. The panel will review your appeal as soon as possible, and always within 30 business days of getting your letter. You will get a letter telling you what UnitedHealthcare has decided. The letter will also tell you how to ask for an external appeal.

You or your provider (acting with your written consent) have 60 calendar days, from the date on the appeal letter to ask an Independent Utilization Review Organization (IURO) to do another review of the case. You can also request a Medicaid Fair Hearing at any time within 120 calendar days on the internal appeals notification letter if you are eligible for a Medicaid Fair Hearing.

You can appeal to the IURO before you request a Medicaid Fair Hearing and wait for the IURO's decision, or you can appeal to the IURO at the same time that you request a Medicaid Fair Hearing. This option is for FamilyCare Plan Types A /ABP only.

You or your provider must mail the completed form to the following address within 60 calendar days of the date on your Internal Appeal outcome letter:

Maximus Federal – NJ IHCAP
3750 Monroe Avenue, Suite 705
Pittsford, New York 14534

Fax: 1-585-425-5296

Online: **https://njihcap.maximus.com**

If a copy of the External Appeal Application is not included with your Internal Appeal outcome letter, please call Member Services at 1-800-941-4647, TTY 711 to request a copy.

External (IURO) Appeals are not conducted by the plan. These appeals are reviewed by an Independent Utilization Review Organization (IURO), which is an impartial third-party review organization that is not directly affiliated with either the plan or the State of New Jersey. The IURO will assign your case to an independent physician, who will review your case and make a decision. If the IURO decides to accept your case for review, they will make their decision within 45 calendar days (or sooner, if your medical condition makes it necessary).

The decision of the IURO panel is binding. That means that neither you nor UnitedHealthcare may appeal their decision. If the IURO panel decides you should get the care, UnitedHealthcare will provide it. UnitedHealthcare will never penalize you or your provider for filing an appeal.

If you have a problem

A grievance is a problem you have with UnitedHealthcare or an in-network provider that can be solved within 5 business days. The easiest way to get answers to your questions or to file a grievance is to call Member Services at 1-800-941-4647, TTY: 711. You can also write to:

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

After 5 business days, you'll get a letter acknowledging your grievance. UnitedHealthcare will look into your grievance and work hard to answer it within 30 calendar days. We'll send you a letter with our answer written in your primary language informing you of your right to file grievances and appeal decisions.

If you are not satisfied with our answer, you have the right to appeal our decision by calling Member Services at 1-800-941-4647, TTY: 711, within 90 calendar days of our response to you. When you call, we will help you file your appeal.

If you still are not satisfied with our answer, you can file a formal appeal by calling Member Services at 1-800-941-4647, TTY: 711, within 90 calendar days of our response. You can send us more information that may help us decide your case. You will receive an acknowledgment letter within 10 business days. We will get back to you with a decision within 20 calendar days.

If you are still not satisfied with our response and you are a NJ FamilyCare A or NJ FamilyCare ABC member, you may ask for a Medicaid Fair Hearing with the New Jersey Department of Human Services,

Division of Medical Assistance and Health Services, within 20 calendar days of when we sent you our denial letter. You may ask for a Fair Hearing by writing to:

Fair Hearing Section
Division of Medical Assistance and Health Services
P. O. Box 712
Trenton, New Jersey 08625-0712

If your grievance is about a medical issue, qualified medical staff will make our decision on the matter. If you want, you can ask your doctor or someone else to represent you when you file a grievance. When we make a decision, we will tell you why we decided the way we did and what rights you have to appeal our decision.

All UnitedHealthcare members also have the right to call the New Jersey Division of Medical Assistance and Health Services at 1-800-356-1561 to ask for assistance.

Neither UnitedHealthcare, nor any of its providers, will ever penalize you or your provider for filing a grievance or a request for a Fair Hearing. You may call Member Services at 1-800-941-4647, TTY: 711, if you have any questions about your rights.

3.8 Specialist referral process

If a member needs specialty care, any PCP or dentist may recommend a network specialty dentist, or the member can self- select a participating network specialist. There shall be no arbitrary number of visits by the PCD to allow a referral. Referrals must be made to qualified specialists who are participating within the provider network. No written referrals are needed for Specialty dental care. Dental services referred to any out-of-network providers will need an approved prior authorization.

- For administrative services or a list of participating network specialists go to our website at **UHCdental.com/medicaid** or contact Provider Services at **1-800-508-4881**.
- NJ Directory of Dentists Seeing Children under Six **https://www.uhccommunityplan.com/content/dam/uhccp/plandocuments/findadentist/NJ-Smiles-Directory.pdf**
- NJ Directory of Dentists seeing **NJ-Dental-IDD-Children-Directory** and **NJ-Dental-IDD-Adult-Directory**.
- To obtain additional information please visit UnitedHealthcare Community Plan at **https://www.uhcprovider.com/en/health-plans-by-state/new-jersey-health-plans/nj-comm-plan-home.html**

All dental specialists are either NJ Board Eligible or NJ Board certified for their specialty and have a valid specialty permit. A dentist with certification in the following specialties: Endodontics, Oral Surgery/OMFS, Periodontics, and Prosthodontics must have, or have confirmation of application submission, of valid DEA and CDS certificates.

Dental services shall be provided in accordance with N.J.A.C. 10:56 and the NJ FamilyCare Clinical Criteria Grid for Dental Services and its accompanying Policy document (found on www.njmmis.com (Rate and Code Information)) and shall include diagnostic, preventive, restorative, endodontic, periodontic, prosthodontics (fixed and removable), surgical, orthodontic and adjunctive services in the NJFC dental benefit provided by or under the supervision of a licensed New Jersey dentist including but not limited to the treatment of: the teeth and associated structures of the oral cavity; and disease, injury, or impairment that may affect the oral or general health of the Member. These services can be provided in New Jersey by or under the supervision of a licensed New Jersey dentist or if out of state provided by or under the

supervision of a dentist licensed in that state. The licensed out of state dentist must enroll in the NJ Medicaid/NJFC program and be credentialed by the contractor.

Referrals for children and individuals with special health care needs

Dental services may not be limited to emergency services. Dental screening by the licensed medical staff is an EPSDT requirement and means, at a minimum, observation of tooth eruption, occlusion pattern, presence of caries, or oral infection.

- A referral to a dentist by one year of age or soon after the eruption of the first primary tooth is mandatory and at a minimum a dental visit twice a year with follow up during well child visits to ensure that all needed dental preventive and treatment services are provided thereafter through the age of twenty (20).
- A referral to a dental specialist or dentist that provides dental treatment to patients with special needs shall be allowed when a PCD requires a consultation for services by that specialty provider.
- Any referring dentist is not obligated to supply diagnostic documentation like that required for a prior authorization request for treatment services as part of the referral request. The dentist receiving a referral is obligated to prepare and submit diagnostic materials to approve or reimburse for the referral.
- Referral to a dentist treating children 0-6refer years old can be found on myuhc.com > Find A Dentist > NJ > NJ Community Plan Medicaid > Pediatric Dentist. **https://www.uhccommunityplan.com/content/dam/uhccp/plandocuments/findadentist/NJ-Smiles-Directory.pdf**
- Referral to a dentist treating adults or children with intellectual or developmental disabilities can be found on **https://www.uhccommunityplan.com/content/dam/uhccp/plandocuments/findadentist/NJ-Dental-SNP-Directory.pdf** Special needs members may utilize hospital operating rooms (ORs) or an ambulatory surgical center for dental care when medically necessary

American Academy of Pediatrics (AAP) Oral Health Risk Assessment Tool

Developed by the American Academy of Pediatrics (AAP) and endorsed by the National Interprofessional Initiative on Oral Health, the Oral Health Risk Assessment (OHRA) Tool is easy to incorporate into any practice. The tool, available below, will help medical providers to understand the risk factors, protective factors, and clinical findings that demonstrate risk of dental caries in young children.

The AAP caries risk assessment form is for use of PCPs

Oral Health Risk Assessment Tool

The American Academy of Pediatrics (AAP) has developed this tool to aid in the implementation of oral health risk assessment during health supervision visits. This tool has been subsequently reviewed and endorsed by the National Interprofessional Initiative on Oral Health.

Instructions for Use

This tool is intended for documenting caries risk of the child, however, two risk factors are based on the mother or primary caregiver's oral health. All other factors and findings should be documented based on the child.

The child is at an absolute high risk for caries if any risk factors or clinical findings, marked with a ⚠ sign, are documented yes. In the absence of ⚠ risk factors or clinical findings, the clinician may determine the child is at high risk of caries based on one or more positive responses to other risk factors or clinical findings. Answering yes to protective factors should be taken into account with risk factors/clinical findings in determining low versus high risk.

Patient Name:_____ Date of Birth:_____ Date:_____

Visit: ☐6 month ☐9 month ☐12 month ☐15 month ☐18 month ☐24 month ☐30 month ☐3 year ☐4 year ☐5 year ☐6 year ☐Other_____

RISK FACTORS	PROTECTIVE FACTORS	CLINICAL FINDINGS
⚠ Mother or primary caregiver had active decay in the past 12 months ☐Yes ☐No	• Existing dental home ☐Yes ☐No	⚠ White spots or visible decalcifications in the past 12 months ☐Yes ☐No
• Mother or primary caregiver does not have a dentist ☐Yes ☐No	• Drinks fluoridated water or takes fluoride supplements ☐Yes ☐No	⚠ Obvious decay ☐Yes ☐No
• Continual bottle/sippy cup use with fluid other than water ☐Yes ☐No	• Fluoride varnish in the last 6 months ☐Yes ☐No	⚠ Restorations (fillings) present ☐Yes ☐No
• Frequent snacking ☐Yes ☐No	• Has teeth brushed twice daily ☐Yes ☐No	• Visible plaque accumulation ☐Yes ☐No
• Special health care needs ☐Yes ☐No		• Gingivitis (swollen/bleeding gums) ☐Yes ☐No
• Medicaid eligible ☐Yes ☐No		• Teeth present ☐Yes ☐No
		• Healthy teeth ☐Yes ☐No

ASSESSMENT/PLAN

Caries Risk:
☐Low ☐High

Completed:
☐Anticipatory Guidance
☐Fluoride Varnish
☐Dental Referral

Self Management Goals:

☐Regular dental visits	☐Wean off bottle	☐Healthy snacks
☐Dental treatment for parents	☐Less/No juice	☐Less/No junk food or candy
☐Brush twice daily	☐Only water in sippy cup	☐No soda
☐Use fluoride toothpaste	☐Drink tap water	☐Xylitol

Treatment of High Risk Children

If appropriate, high-risk children should receive professionally applied fluoride varnish and have their teeth brushed twice daily with an age-appropriate amount of fluoridated toothpaste. Referral to a pediatric dentist or a dentist comfortable caring for children should be made with follow-up to ensure that the child is being cared for in the dental home.

Adapted from Ramos-Gomez FJ, Crystal YO, Ng MW, Crall JJ, Featherstone JD. Pediatric dental care: prevention and management protocols based on caries risk assessment. *J Calif Dent Assoc* 2010;38(10):745–761; American Academy of Pediatrics Section on Pediatric Dentistry and Oral Health. Preventive oral health intervention for pediatricians. *Pediatrics*. 2008; 122(6):1387–1394; and American Academy of Pediatrics Section of Pediatric Dentistry. Oral health risk assessment timing and establishment of the dental home. *Pediatrics*. 2003;111(5):1113–1116.

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN™

Bright Futures.

National Interprofessional Initiative on Oral Health

Oral Health Risk Assessment Tool Guidance

Timing of Risk Assessment

The Bright Futures/AAP "Recommendations for Preventive Pediatric Health Care," (ie, Periodicity Schedule) recommends all children receive a risk assessment at the 6- and 9-month visits. For the 12-, 18-, 24-, 30-month, and the 3- and 6-year visits, risk assessment should continue if a dental home has not been established. View the Bright Futures/AAP Periodicity Schedule—http://brightfutures.aap.org/clinical_practice.html.

Risk Factors

⚠ Maternal Oral Health

Studies have shown that children with mothers or primary caregivers who have had active decay in the past 12 months are at greater risk to develop caries. **This child is high risk.**

Maternal Access to Dental Care

Studies have shown that children with mothers or primary caregivers who do not have a regular source of dental care are at a greater risk to develop caries. A follow-up question may be if the child has a dentist.

Continual Bottle/Sippy Cup Use

Children who drink juice, soda, and other liquids that are not water, from a bottle or sippy cup continually throughout the day or at night are at an increased risk of caries. The frequent intake of sugar does not allow for the acid it produces to be neutralized or washed away by saliva. Parents of children with this risk factor need to be counseled on how to reduce the frequency of sugar-containing beverages in the child's diet.

Frequent Snacking

Children who snack frequently are at an increased risk of caries. The frequent intake of sugar/refined carbohydrates does not allow for the acid it produces to be neutralized or washed away by saliva. Parents of children with this risk factor need to be counseled on how to reduce frequent snacking and choose healthy snacks such as cheese, vegetables, and fruit.

Special Health Care Needs

Children with special health care needs are at an increased risk for caries due to their diet, xerostomia (dryness of the mouth, sometimes due to asthma or allergy medication use), difficulty performing oral hygiene, seizures, gastroesophageal reflux disease and vomiting, attention deficit hyperactivity disorder, and gingival hyperplasia or overcrowding of teeth. Premature babies also may experience enamel hypoplasia.

Protective Factors

Dental Home

According to the American Academy of Pediatric Dentistry (AAPD), the dental home is oral health care for the child that is delivered in a comprehensive, continuously accessible, coordinated and family-centered way by a licensed dentist. The AAP and the AAPD recommend that a dental home be established by age 1. Communication between the dental and medical homes should be ongoing to appropriately coordinate care for the child. If a dental home is not available, the primary care clinician should continue to do oral health risk assessment at every well-child visit.

Fluoridated Water/Supplements

Drinking fluoridated water provides a child with systemic and topical fluoride exposure, a proven caries reduction intervention. Fluoride supplements may be prescribed by the primary care clinician or dentist if needed. View fluoride resources on the Oral Health Practice Tools Web Page http://aap.org/oralhealth/PracticeTools.html.

Fluoride Varnish in the Last 6 Months

Applying fluoride varnish provides a child with highly concentrated fluoride to protect against caries. Fluoride varnish may be professionally applied and is now recommended by the United States Preventive Services Task Force as a preventive service in the primary care setting for all children through age 5 http://www.uspreventiveservicestaskforce.org/Page/Topic/recommendation-summary/dental-caries-in-children-from-birth-through-age-5-years-screening. For online fluoride varnish training, access the Caries Risk Assessment, Fluoride Varnish, and Counseling Module in the Smiles for Life National Oral Health Curriculum, www.smilesforlifeoralhealth.org.

Tooth Brushing and Oral Hygiene

Primary care clinicians can reinforce good oral hygiene by teaching parents and children simple practices. Infants should have their mouths cleaned after feedings with a wet soft washcloth. Once teeth erupt it is recommended that children have their teeth brushed twice a day. For children under the age of 3 (until 3rd birthday) it is appropriate to recommend brushing with a smear (grain of rice amount) of fluoridated toothpaste twice per day. Children 3 years of age and older should use a pea-sized amount of fluoridated toothpaste twice a day. View the AAP Clinical Report on the use of fluoride in the primary care setting for more information http://pediatrics.aappublications.org/content/early/2014/08/19/peds.2014-1699.

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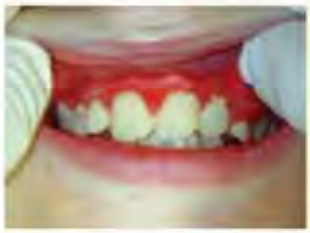
Clinical Findings

White Spots/Decalcifications
This child is high risk.
White spot decalcifications present—immediately place the child in the high-risk category.

Obvious Decay
This child is high risk.
Obvious decay present—immediately place the child in the high-risk category.

Restorations (Fillings) Present
This child is high risk.
Restorations (Fillings) present—immediately place the child in the high-risk category.

Visible Plaque Accumulation
Plaque is the soft and sticky substance that accumulates on the teeth from food debris and bacteria. Primary care clinicians can teach parents how to remove plaque from the child's teeth by brushing and flossing.



Gingivitis
Gingivitis is the inflamation of the gums. Primary care clinicians can teach parents good oral hygiene skills to reduce the inflammation.

Healthy Teeth
Children with healthy teeth have no signs of early childhood caries and no other clinical findings. They are also experiencing normal tooth and mouth development and spacing.

For more information about the AAP's oral health activities email oralhealth@aap.org or visit www.aap.org/oralhealth.

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American Dental Association (ADA) Caries Risk Assessment Form Ages 0-6

Developed by the American Dental Association, the ADA Caries Risk Assessment tool is intended for use by dentists in the identification of Caries. A separate form is provided for patient ages 0-6 and patients ages 6 and older.

ADA American Dental Association®
America's leading advocate for oral health

Caries Risk Assessment Form (Age 0-6)

Patient Name:				
Birth Date:			**Date:**	
Age:			**Initials:**	
		Low Risk	**Moderate Risk**	**High Risk**
Contributing Conditions		**Check or Circle the conditions that apply**		
I.	**Fluoride Exposure** (through drinking water, supplements, professional applications, toothpaste)	☐ Yes	☐ No	
II.	**Sugary Foods or Drinks** (including juice, carbonated or non-carbonated soft drinks, energy drinks, medicinal syrups)	Primarily at mealtimes ☐	Frequent or prolonged between meal exposures/day ☐	Bottle or sippy cup with anything other than water at bed time ☐
III.	**Eligible for Government Programs** (WIC, Head Start, Medicaid or SCHIP)	☐ No		☐ Yes
IV.	**Caries Experience of Mother, Caregiver and/or other Siblings**	No carious lesions in last 24 months ☐	Carious lesions in last 7-23 months ☐	Carious lesions in last 6 months ☐
V.	**Dental Home**: established patient of record in a dental office	☐ Yes	☐ No	
General Health Conditions		**Check or Circle the conditions that apply**		
I.	**Special Health Care Needs** (developmental, physical, medical or mental disabilities that prevent or limit performance of adequate oral health care by themselves or caregivers)	☐ No		☐ Yes
Clinical Conditions		**Check or Circle the conditions that apply**		
I.	**Visual or Radiographically Evident Restorations/ Cavitated Carious Lesions**	No new carious lesions or restorations in last 24 months ☐		Carious lesions or restorations in last 24 months ☐
II.	**Non-cavitated** (incipient) **Carious Lesions**	No new lesions in last 24 months ☐		New lesions in last 24 months ☐
III.	**Teeth Missing Due to Caries**	☐ No		☐ Yes
IV.	**Visible Plaque**	☐ No	☐ Yes	
V.	**Dental/Orthodontic Appliances Present** (fixed or removable)	☐ No	☐ Yes	
VI.	**Salivary Flow**	Visually adequate ☐		Visually inadequate ☐

Overall assessment of dental caries risk: ☐ Low ☐ Moderate ☐ High

Instructions for Caregiver:

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Caries Risk Assessment Form (Age 0-6)

Circle or check the boxes of the conditions that apply. Low Risk = only conditions in "Low Risk" column present; Moderate Risk = only conditions in "Low" and/or "Moderate Risk" columns present; High Risk = one or more conditions in the "High Risk" column present.

The clinical judgment of the dentist may justify a change of the patient's risk level (increased or decreased) based on review of this form and other pertinent information. For example, missing teeth may not be regarded as high risk for a follow up patient; or other risk factors not listed may be present.

The assessment cannot address every aspect of a patient's health, and should not be used as a replacement for the dentist's inquiry and judgment. Additional or more focused assessment may be appropriate for patients with specific health concerns. As with other forms, this assessment may be only a starting point for evaluating the patient's health status.

This is a tool provided for the use of ADA members. It is based on the opinion of experts who utilized the most up-to-date scientific information available. The ADA plans to periodically update this tool based on: 1) member feedback regarding its usefulness, and; 2) advances in science. ADA member-users are encouraged to share their opinions regarding this tool with the Council on Dental Practice.

American Dental Association (ADA) Caries Risk Assessment Form Ages 6+

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Caries Risk Assessment Form (Age >6)

Patient Name:				
Birth Date:			Date:	
Age:			Initials:	
		Low Risk	Moderate Risk	High Risk
Contributing Conditions		Check or Circle the conditions that apply		
I.	**Fluoride Exposure** (through drinking water, supplements, professional applications, toothpaste)	☐Yes	☐No	
II.	**Sugary Foods or Drinks** (including juice, carbonated or non-carbonated soft drinks, energy drinks, medicinal syrups)	Primarily at mealtimes ☐		Frequent or prolonged between meal exposures/day ☐
III.	**Caries Experience of Mother, Caregiver and/or other Siblings** (for patients ages 6-14)	No carious lesions in last 24 months ☐	Carious lesions in last 7-23 months ☐	Carious lesions in last 6 months ☐
IV.	**Dental Home**: established patient of record, receiving regular dental care in a dental office	☐Yes	☐No	
General Health Conditions		Check or Circle the conditions that apply		
I.	**Special Health Care Needs** (developmental, physical, medical or mental disabilities that prevent or limit performance of adequate oral health care by themselves or caregivers)	☐No	Yes (over age 14) ☐	Yes (ages 6-14) ☐
II.	**Chemo/Radiation Therapy**	☐No		☐Yes
III.	**Eating Disorders**	☐No	☐Yes	
IV.	**Medications that Reduce Salivary Flow**	☐No	☐Yes	
V.	**Drug/Alcohol Abuse**	☐No	☐Yes	
Clinical Conditions		Check or Circle the conditions that apply		
I.	**Cavitated or Non-Cavitated** (incipient) **Carious Lesions or Restorations** (visually or radiographically evident)	No new carious lesions or restorations in last 36 months ☐	1 or 2 new carious lesions or restorations in last 36 months ☐	3 or more carious lesions or restorations in last 36 months ☐
II.	**Teeth Missing Due to Caries in past 36 months**	☐No		☐Yes
III.	**Visible Plaque**	☐No	☐Yes	
IV.	**Unusual Tooth Morphology** that compromises oral hygiene	☐No	☐Yes	
V.	**Interproximal Restorations - 1 or more**	☐No	☐Yes	
VI.	**Exposed Root Surfaces** Present	☐No	☐Yes	
VII.	**Restorations with Overhangs** and/or **Open Margins**; **Open Contacts** with Food Impaction	☐No	☐Yes	
VIII.	**Dental/Orthodontic Appliances** (fixed or removable)	☐No	☐Yes	
IX.	**Severe Dry Mouth (Xerostomia)**	☐No		☐Yes

Overall assessment of dental caries risk: ☐ Low ☐ Moderate ☐ High

Patient Instructions:

ADA American Dental Association®
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Caries Risk Assessment Form (Age >6)

Circle or check the boxes of the conditions that apply. Low Risk = only conditions in "Low Risk" column present; Moderate Risk = only conditions in "Low" and/or "Moderate Risk" columns present; High Risk = one or more conditions in the "High Risk" column present.

The clinical judgment of the dentist may justify a change of the patient's risk level (increased or decreased) based on review of this form and other pertinent information. For example, missing teeth may not be regarded as high risk for a follow up patient; or other risk factors not listed may be present.

The assessment cannot address every aspect of a patient's health, and should not be used as a replacement for the dentist's inquiry and judgment. Additional or more focused assessment may be appropriate for patients with specific health concerns. As with other forms, this assessment may be only a starting point for evaluating the patient's health status.

This is a tool provided for the use of ADA members. It is based on the opinion of experts who utilized the most up-to-date scientific information available. The ADA plans to periodically update this tool based on: 1) member feedback regarding its usefulness, and; 2) advances in science. ADA member-users are encouraged to share their opinions regarding this tool with the Council on Dental Practice.

3.9 Mobile practice/dental van

- Mobile Dental Practice: Provider traveling to various locations and utilizing portable dental equipment to provide dental services to facilities, schools and residences. These providers are expected to provide on-site comprehensive dental care, necessary dental referrals to general dentist or specialists and emergency dental care in accordance with all New Jersey State Board of Dentistry regulations and the NJ FamilyCare MCO Contract. The sites served by the Mobile Dental Practice must allow Member access to treatment and allow for continuity of care. The MCO is responsible for assisting the member and facility in locating a dentist when referrals are issued. Patient records must be maintained at the facility when this is a long-term care facility or skilled nursing facility and duplicates may also be maintained in a central and secure area in accordance with State Board of Dentistry regulations. The MCO must maintain documentation for all locations that the mobile van will serve to include schedule with time and days.
- Mobile Dental Van: A vehicle specifically equipped with stationary dental equipment and is used to provide dental services within the van. A mobile dental van is not to be considered a dental practice. Providers using a mobile dental van to render dental services must also be associated with a dental practice that is in a brick-and-mortar facility located in New Jersey, that serves as a dental home offering comprehensive care, emergency care and appropriate dental specialty referrals to the mobile dental van's patients of record (Members).

  Patient records are to be maintained in the brick-and-mortar location in accordance with State Board of Dentistry regulations. The distance between the dental practice and the sites and locations served by the mobile dental van must not be a deterrent to the Member accessing treatment and allow for continuity of care by meeting the network standards for distance in miles. When a mobile dental van's use is associated with health fairs or other one-time events, services will be limited to oral screenings, exams, fluoride varnish, prophylaxis and palliative care to treat an acute condition. State Board regulations must still be followed. The MCO must maintain documentation for all locations served to include schedule of time and days.

Section 4: Orthodontics

4.1 Orthodontic eligibility

To qualify for orthodontic services, medical necessity must be met by demonstrating one or more of the following pathologies:

- Severe functional difficulties
- Developmental anomalies of facial bones and/or oral structures
- Facial trauma resulting in severe functional difficulties and/or
- Demonstration that long term psychological health requires orthodontic correction

The provider and UnitedHealthcare Community Plan should work together to ensure the anticipated treatment completion date will occur prior to the loss of benefit eligibility due to age. The dental office must provide an Informed Consent Form which must be signed after the patient and parent/guardian are advised of the following:

- The age limit for orthodontic coverage
- Expected length of treatment
- Consequences of excessive breakage of appliance(s) and/or other behavior that is not conducive to completing treatment in a timely manner
- Their responsibilities should coverage be lost

Orthodontic Consultation (D9310) – must include a visual examination and may also include a completed HLD (NJ-Mod3) Assessment Tool by the attending provider or a provider in the same group. This consultation does not require prior authorization, can be provided once a year and will be linked to the provider and not the patient (which allows for a second opinion with a different provider).

Pre-orthodontic Treatment Visit (D8660) – includes the diagnostic workup, clinical evaluation, orthodontic treatment plan and completion of HLD (NJ-Mod3) assessment tool.

The HLD (NJ-Mod3) is only required for consideration of comprehensive orthodontic treatment. The HLD (NJ Mod3) is completed by the dentist that will be rendering the orthodontic treatment.

4.2 Orthodontic treatment

The new HLD (NJ-Mod3) Assessment Tool and instructions begin on page 25.

If the HLD (NJ-Mod3) Assessment Tool has an "X" and correctly documented clinical criteria found in sections 1-6A and 15 of the assessment tool or a total score that is equal to or greater than 26, the pre-orthodontic treatment work-up can proceed. A total score of less than 26 points on the HLD (NJ-Mod3) Assessment Tool required documentation of the extenuating circumstances, functional difficulties and/or medical anomaly be included in the submission.

- The visit does not require prior authorization and should occur with the expectation that the case will be completed prior to the client exceeding the age of eligibility for the benefit;
- This service can be provided once a year and will be linked to the provider and not to the patient;
- The orthodontic work-up includes the consultation; therefore, consultation will not be reimbursed separately.

Minor treatment to control harmful habits

Minor treatment can be used for the correction or oral habits in any dentition. Approval for treatment to control harmful habits when not part of a limited or comprehensive case will include appliances, removable or fixed, insertion, all adjustments, repairs, removal, retention and treatment visits to the provider of placement. Replacement of appliances due to loss or damage beyond repair is allowed once and thereafter requires prior authorization and can be considered with documentation of incident and documentation of medical necessity.

For prior authorization, a narrative of the clinical findings, treatment plan, estimated treatment time with prognosis and diagnostic photographs and/or models shall be submitted and maintained in the treatment records.

Upon completion of the case pre-treatment and post-treatment photographs must be submitted.

Orthodontic treatment services

Limited and comprehensive orthodontic services must be prior authorized and will be considered for the treatment of the primary dentition, permanent dentition or mixed dentition for treatment of the permanent teeth.

Prior authorization determinations shall be made and notice sent to the provider within ten (10) days of receipt of necessary information sufficient for a dental consultant to make an informed decision.

In cases where prior authorization is denied, the denial decision must be made by an orthodontist. The denial letter must contain a detailed explanation of the reason(s) for denial; indicate whether additional information is needed and the process for reconsideration. It must also include the name and contact information of the orthodontic consultant that reviewed and denied the treatment request which will allow the treating provider an opportunity to discuss the case.

An approved case must be started within six (6) months of receiving the approval.

Limited orthodontic treatment

Limited orthodontic treatment can be considered for treatment not involving the entire dentition and can be used for corrections in any dentition. Any therapeutic modality (to include palatal expansion) with a limited objective or scale of treatment may be utilized. The objective may be limited by: not involving the entire dentition; not attempting to address the full scope of the existing or developing orthodontic problem; mitigating an aspect of a greater malocclusion or a decision to defer or forego comprehensive treatment

Additionally, this may also include treatment for localized tooth movement, for redirection of ectopic eruptions, correction of dental crossbites or recovery of space in the primary, transitional or adult dentition for children.

For prior authorization, the following shall be submitted:

- Narrative of clinical findings, treatment plan and estimated treatment time
- Diagnostic photographs
- Diagnostic x-rays or digital films
- Diagnostic study models or diagnostic digital study case images

- The referring primary care dentist must provide attestation that all needed preventive and dental treatment services have been completed. A copy must be submitted with the orthodontic treatment request.

In the Medicaid Fee for Service program, the billing date for the service is the date of insertion of the appliance.

When the Medicaid/NJ FamilyCare beneficiary is enrolled in a managed care organization (MCO), the provider shall consult the MCO in which the beneficiary is enrolled for additional information regarding billing procedures.

The reimbursement for the service includes the appliance, insertion, all adjustments, repairs, removal, retention and treatment visits to the provider of placement. Therefore, the case shall be completed even if eligibility is terminated at no additional charge to the member. Replacement of retainers or removable appliances due to loss or damage beyond repair required prior authorization and can be considered with documentation of medical necessity.

If it is determined that limited orthodontic treatment is part of a comprehensive treatment plan which will occur within less than 12 months, it will be considered part of the comprehensive case and will not be reimbursed separately. In this case, the prior authorization should be submitted for comprehensive orthodontic treatment with an attached treatment plan that indicates the limited treatment phase including the expected time frame for this and the expected initiation (month/year) of the comprehensive treatment.

Upon completion of the case pre-treatment and post-treatment photographs must be submitted.

Comprehensive orthodontic treatment

For prior authorization, the following shall be submitted:

- The completed HLD (NJ-Mod3) assessment tool for comprehensive orthodontic treatment
- Narrative of clinical findings for dysfunction and dental diagnosis
- The comprehensive orthodontic treatment plan and estimate treatment time
- Attestation from the referring primary care dentist that all needed preventive and dental treatment services have been completed
- Diagnostic study models or diagnostic digital study models
- Diagnostic photographs (which may suffice in place of models)
- Diagnostic x-rays, digital x-rays or cephalometric film with tracing (when applicable)
- When applicable:
  - Medical diagnosis and surgical treatment plan
  - Detailed documentation of extenuating circumstances
  - Detailed documentation from a mental health professional as described in the managed care contract indication the psychological or psychiatric diagnosis, treatment history and prognosis and an attestation stating and substantiating that orthodontic correction will result in a favorable prognosis of the mental/psychological condition

4.3 Prior Authorization

Eligibility should be checked prior to each visit.

The Medicaid/NJ FamilyCare Fee-for-Service (FFS) program reimburses for periodic treatment visits (D8670) which are billed for the date of services. A maximum of 24 unites for D8670 are allowed for each comprehensive orthodontic case, which is expected to last no longer than 36 months from the date of banding.

The reimbursement for comprehensive treatment is required using the date the appliances are placed and billed as D8080. The date of each periodic visit (D8670) is billed separately on the date of service. Services reimbursed through these codes will include all appliances, their insertions, adjustments, repairs and removal as well as the retention phase of treatment to the provider of placement.

Initial retainer(s) are included with the services; however replacement of retainers or removable applicated due to loss or damage beyond repair is allowed once. If additional replacements are needed, the service requires prior authorization and can be considered with documentation of the incident and medically necessity.

Reimbursement for orthodontic services includes the placement and removal of all appliances and brackets; therefore should it become necessary to remove the bands following or due to loss of eligibility, non-compliance or elective discontinuation of treatment by the parent, guardian or patient the appliance shall be removed with no additional reimbursement to the provider of placement because reimbursement for comprehensive orthodontics includes this service. In cases where treatment is discontinued, a "Release from Treatment" letter must be provided by the dental office which documents the reason for discontinuing case and releases the dentist from the responsibility of completing the case. The release form must be reviewed and signed by the parent/guardian and patient, and a copy maintained in the patient's records.

Requesting prior authorization

Prior authorization for comprehensive orthodontic treatment will only be considered for the late mixed and permanent dentitions. Comprehensive orthodontic treatment will be considered at two points of care: the beginning of treatment through the mid-point and the continuation of treatment to completion. This will allow the consultant to evaluate the progress of treatment.

Beginning treatment

- In addition to submission requirements already noted, the prior authorization form to request the beginning phase of treatment should be completed for procedure code D8080 and the treatment visits with the maximum number of units for treatment visits to be considered on any one prior authorization being twelve (12)
- The case start date is considered to be the banding date which must occur within six (6) months of approval
- If the prior authorization expires before all approved units are used, a prior authorization may be submitted for the remaining units along with an explanation that includes the original prior authorization number and why treatment did not occur within the active time of the prior authorization

Continuing treatment

- Prior authorization for the continuation of treatment visits for the continuation of the case she be submitted after completing the first twelve (12) united of treatment visits or at the mid-point of treatment
- The maximum number of additional treatment visits allowed to continue the case is twelve (12)
- If the prior authorization expired before all approved units were used, a prior authorization may be submitted for the remaining units along with an explanation that includes the original prior authorization number and why treatment did not occur withing the active time of the prior authorization
- The following shall be included with the prior authorization to continue treatment:
  - A copy of the treatment notes
  - Documentation of any problems with compliance
  - Attestation from the current primary care dentist that recall visits occurred and that all needed preventative and dental treatment services have been completed
  - Pre-treatment and current treatment diagnostic photographs and/or diagnostic panoramic radiographs to show status and to demonstrate case progression
  - A copy of the initial approval if the case was started under a different NJ FamilyCare Medicaid MCO or FFS program

Prior authorization for orthodontic services transferred or started outside of the Medicaid/NJ FamilyCare Program

For continuation of care for transfer cases whether they were or were not started by another Medicaid/ NJ FamilyCare provider, a prior authorization must be submitted to request the remaining treatment visits to continue a case with a maximum of twelve (12) per prior authorization to be considered. The following must be submitted with the prior authorization:

- A copy of the initial orthodontic case approval (if applicable)
- Attestation from the referring or treating primary care dentist that preventive and dental treatment services have been completed
- A copy of the orthodontic treatment notes from provider that started the case (if available)
- Recent diagnostic photographs and/or panoramic radiographs and if available pre-treatment images
- The date when active treatment was started
- The expected number of months to complete the case along with the number of units for treatment visits with maximum number of 24 units allowed
- If applicable a new treatment plan and documentation to support the treatment change if re-banding is planned

A case in treatment cannot be denied if the patient is eligible for orthodontic coverage based on age.

Orthognathic surgical cases with comprehensive orthodontic treatment

- The surgical consult, treatment plan and approval for surgical case must be included with the request for prior authorization of the orthodontic services

- Prior authorization and documentation requirements are the same as those for comprehensive treatment and shall be submitted by the treating orthodontist
- The parent/guardian and patient should understand that loss of eligibility at any time during treatment will result in the loss of all benefits and payment by the Medicaid/NJ FamilyCare program

Conclusion of active treatment

- Attestation of case completion must be submitted to comment that active treatment had a favorable outcome and that the case is ready for retention
- Procedure code D8680, orthodontic retention, shall be submitted for prior authorization along with recent panorex and photographs when the active phase of orthodontic treatment is completed
- Once approved, the bands can be removed and the case placed in retention
- If denied, a detailed explanation including what is required to end active treatment must be included with the name of the reviewing consultant

Documentation for completion of comprehensive cases – final records

After the appliances have been removed, the following must be submitted to document the completion of comprehensive cases:

- Final diagnostic photographs and/or panoramic radiograph
- Final diagnostic study models or diagnostic digital study models must be taken and be available upon request

If this is not received, reimbursement provided may be recovered until required documentation is submitted.

Behavior not conducive to favorable treatment outcomes

It is the expectation that the case selection process for orthodontic treatment takes into consideration the patient's ability, over the course of treatment to:

- Tolerate the treatment
- Keep multiple appointments over several years
- Maintain an oral hygiene regimen
- Be cooperative and complete all needed preventive and treatment visits

If it is determined that treatment is not progressing because the patient is exhibiting non-compliant behavior which may include any of the following: multiple missed orthodontic or general dental appointments, continued poor oral hygiene, failure to maintain the appliances or untreated dental disease, orthodontic care management should be considered. A member will be placed in case management subsequent to provider notification to the Contractor of compliance concerns. The Contractor's case manager shall discuss the situation with the member and parent/guardian to encourage behavioral changes that will allow completion of the case, or facilitate preventive services and completion of needed dental treatment.

If the case is discontinued for reasons other than the completion of treatment (D8695), the "Release from Treatment" letter should be signed by parent/guardian and/or patient. For members not enrolled in a NJ FamilyCare MCO, a copy of the signed form and the patient treatment records must be sent to the Bureau of Dental Services along with the request to remove the appliance for reasons other than

case completion. For members enrolled in an MCO, a copy of the signed form and the patient treatment records must be sent to the NJ FamilyCare MCO of enrollment. The reimbursement for appliance placement includes their removal, however, prior authorization to allow reimbursement can be considered when removal is performed by a provider that did not start the case.

For questions regarding patients not enrolled in a NJ FamilyCare MCO, please contact the Bureau of Dental Services at 609-588-7137. If the patient is enrolled in a NJ FamilyCare MCO, please refer to the MCO's Provider Manual for guidance, or contact the MCO's Provider Services Unit for assistance.

Updated Instructions for Completing the New Jersey Orthodontic Evaluation HLD (NJ-Mod3) Index Form

The intent of the HLD (NJ-Mod3) Index is to measure the presence or absence and the degree of the handicap caused by the components to be scored with the index and NOT to diagnose Malocclusion. Presence of any of the conditions sections 1 through 6A and 15, or a score total equal to or greater than 26 (when scored correctly) qualifies for medical necessity exception. Total scores less than 26 with extenuating circumstances must include appropriate documentation.

General information

- Only cases with late missed and permanent dentition will be considered (see Pre-orthodontic Treatment Visit (D8660) for exception)
- A Boley Gauge or disposable ruler scaled in millimeters should be used
- The patient's teeth are positioned in centric occlusion
- All measurements are recorded and rounded off to the nearest millimeter (mm)
- For sections 1 to 6A and 15 an X is placed if the condition exists and scoring is completed, as needed
- For sections 6B to 14, indicate the measurement or if a condition is absent, a 0 score is entered
- Diagnostic models are required with the submission of prior authorization. Casts must be properly poured, adequately trimmed without voids or bubbles and marked for centric occlusion; or
- Diagnostic Digital models may be submitted to show right and left lateral, frontal and posterior and maxillary and mandibular occlusal views
- Diagnostic quality photographs to show facial, frontal and profile, intra-oral front, left and right side, maxillary and mandibular occlusal views (minimum of seven views). Photographs shall include views with a millimeter ruler in place to demonstrate measurement for the following condition(s) when present as found in sections 6A, 6B, 7, 8, 9 and 13

Instructions for form completion

1. **Cleft Plate Deformity** – acceptable documentation must include at least one of the following: intraoral photographs of the palate, written consultation report be a qualified specialist or craniofacial panel. Score an X if present.
2. **Canio-facial Anomaly** – acceptable documentation must include written report by qualified specialist or craniofacial panel and photographs. Score an X if present.
3. **Impacted Permanent Anterior Teeth** – demonstrate that anterior tooth or teeth (incisors and cuspids) is or are impacted (soft or hard tissue); not indicated for extraction and treatment planned to be brought into occlusion. Arch space available for correction. Score an X if present.

4. **Crossbite of Individual Anterior teeth** – Score an X if present. – demonstrate that anterior tooth or teeth (incisors and cuspids) is or are in crossbite resulting in occlusal trauma with excessive wear, significant mobility or soft tissue damage. A narrative to include the class of mobility for the involved teeth and photographs of all areas with soft tissue damage. Score X as noted. If these conditions do not exist, it is to be considered an ectopic eruption and scored in section 10.
5. **Severe Traumatic Deviation** – damage to skeletal and or soft tissue as a result of trauma or other gross pathology. Include written report and intraoral photographs. Score an X if present.
6. **A. Overjet greater than 9mm or mandibular protrusion (reverse overjet) greater than 3.5** – Overjet is recorded with the patient's teeth in centric occlusion and is measured from the labial of the lower incisors to the labial of the corresponding upper central incisors. This measurement should record the greatest distance between any one upper central incisor and its corresponding lower central or lateral incisor. If the overjet is greater than 9mm or mandibular protrusion (reverse overjet) is greater than 3.5mm, score an X if present.
   B. Overjet equal to or less than 9mm – Overjet is recorded as in condition in section 6A. The measurement is rounded to the nearest millimeter and entered on the score form.
7. **Overbite** – A pencil mark on the tooth indicating the extent of the overlap facilitates the measurement. It is measured and rounded off the nearest millimeter and entered on the score form.
8. **Mandibular protrusion (reverse overjet) equal to or less than 3.5 mm** – Mandibular protrusion (reverse overjet) is recorded as a condition and rounded to the nearest millimeter. Enter the score on the form and multiply the measurement by five (5).
9. **Open Bite in millimeters** – This condition is defined as the absence of occlusal contact in the anterior region. It is measured from the incisal edge of a maxillary central incisor to the incisal edge of a corresponding mandibular incisor, in millimeters. Enter the measurement on the score form and multiply the measurement by four (4). If measurement is not possible, measurement can usually be estimated.
10. **Ectopic Eruption** – Count each tooth, excluding third molars. Each qualifying tooth must be more than 50% blocked out of the arch. Enter the number of qualifying teeth on the score form and multiply by three (3). If anterior crowding (see condition 12) also exists in the same arch, score the condition that produces the most points. DO NOT COUNT BOTH CONDITIONS. The exception to this rule is: (a) posterior ectopic eruptions in the same arch (b) if ectopic eruption score is transferred due to anterior crossbite without trauma, excessive wear of mobility. In these two exceptions, count ectopic eruption PLUS the crowding.
11. **Deep Impinging Overbite** – This occurs when either destruction of soft tissue on palate, gingival recession and mobility and/or abrasion of teeth are present. Submit intraoral photographs of tissue damage/impingement. The presence of deep impinging overbite is indicated by a total score of three (3) on the score form.
12. **Anterior Crowding** – Arch length insufficiency must exceed 3.5 mm. Mild rotations are not to be scored as crowded. Score one (1) crowding per arch. Enter the total on score form and multiply the measurement by five (5). If ectopic eruption is scored in section 10 (not from crossbite in section 4) this crowding cannot be scored in addition. However if ectopic eruption is due to a transfer of score from section 4 to section 10, because crossbite did not result in damage, both ectopic and crowding can be counted.

13. **Labio-Lingual Spread** – A Boley Gauge (or disposable ruler) is used to determine the extent of deviation from a normal arch. Where there is only a protruded or lingually displaced anterior tooth, the measurement should be made from the incisal edge of that tooth to the normal arch line. Otherwise, the total distance between the most protruded anterior tooth and the most lingually displaced adjacent anterior tooth is measured. In the event that multiple anterior crowding of teeth is observed, all deviations from the normal arch should be measured for the labio-lingual spread, but only the most severe individual measurement should be entered on the score form.
14. **Posterior Unilateral Crossbite** – This condition involves two or more adjacent teeth, one of which must be a molar. The crossbite must be one in which the maxillary posterior teeth involved may either be both palatal or both completely buccal in relation to the mandibular posterior teeth. The presence of posterior unilateral crossbite is indicated by a total score of four (4) on the score form. THERE IS NO ADDITIONAL SCORE FOR BI- LATERAL CROSSBITE.
15. **Psychological factors affecting child's development** – This condition requires detailed documentation by a mental health provider as described in the Medicaid/NJ FamilyCare managed care contract that contains the psychological or psychiatric diagnosis, treatment history and prognosis. An attestation from the mental health provider must state and substantiate that orthodontic correction will result in a favorable prognosis of the mental/psychological condition.

NJ Orthodontic Assessment Tool for Comprehensive Treatment
HLD (NJ-Mod3)

****Attach attestation that all needed preventive and dental treatment was completed ****

Date _____
Name: _____NJFC ID #_____
DOB: _____ Sex: M / F Class/Type of Case_____
Name of Orthodontist: _____

The instructions for completing this form begin on page 7. Sections 1-6A and 15 automatically qualify. Score with an X when these conditions are present. Sections 6B-14 scores must total 26 or more, or when less than 26 must include documentation of medically necessity.

	Condition	Score
1.	**Cleft palate deformity** (attach description from credentialed specialist)	
2.	**Cranio-facial Anomaly** (attach description from credentialed specialist)	
3.	**Impacted permanent anteriors** where extraction is not indicated Note the number of teeth_____	
4.	**Crossbite of individual anterior teeth with trauma, mobility and/or soft tissue damage must be present and documented**	
5.	**Severe traumatic deviations**	
6A.	**Overjet greater than 9 mm** with incompetent lips or **reverse overjet greater than 3.5 mm**	
6B.	**Overjet** (mm)	
7.	**Overbite** (mm)	
8.	**Mandibular protrusion** (mm) x 5	
9.	**Open bite** (mm) x 4	
10.	**Ectopic eruption or crossbite of individual anterior teeth without damage** (# of teeth x 3)	
11.	**Deep impinging overbite** (intra-oral photos showing palatal soft tissue impingement/destruction, gingival recession or attrition of teeth are required) Score 3 points if present	
12.	**Anterior crowding** MX_____ MD_____ Total_____ x 5 (score **1** per arch)	
13.	**Labiolingual spread** (mm)	
14.	**Posterior unilateral crossbite** (involving molar): Score 4 if present	
15.	**Psychological factors affecting development** (**"X"** requires detailed documentation by **mental health provider** as described per contract of psychological/psychiatric diagnosis, prognosis and that orthodontic correction will improve mental/psychological condition.)	
	TOTAL	

☐ Documentation of extenuating circumstances attached for score total less than 26 (independent of conditions described in #s1-6A and 15).

Section 5: Authorization for treatment

5.1 Dental treatment requiring authorization

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

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

Prior authorization means the practitioner must submit those procedures for approval with clinical documentation supporting necessity before initiating treatment. For questions concerning prior authorization, dental claim procedures, or to request clinical criteria, please call the Provider Services Line (**1-800-508-4881**).

Consideration for prior authorization of services should consider the overall general health, patient compliance and dental history, condition of the oral cavity and complete treatment plan that is both judicious in the use of program funds and provides a clinically acceptable treatment outcome. In situations where a complex treatment plan is being considered, the provider may sequentially submit several prior authorization requests, one for each of the various stages of the treatment.

All providers must comply with the Utilization Management program requirements. Failure to follow such requirements may result in delay or denial of payment for services rendered.

All final decisions regarding denials of referrals, PAs, treatment and treatment plans for non-emergency services shall be made by a physician and/or peer physician specialist or by a licensed New Jersey dentist/dental specialist in the case of dental services, or by a licensed mental health and/or behavioral health specialist in the case of behavioral health services. Prior authorization decisions for non-emergency services shall be made within fourteen (14) calendar days or sooner as required by the needs of the enrollee.

The name and contact information for the dentist, physician or other clinical peer that reviewed and denied the authorization shall be included with the denial, in accordance with requirements of the State Board of New Jersey.

Providers have the opportunity for a discussion with this clinical peer for a minimum of seven (7) business days after the date of the service denial. The peer-to-peer discussion will occur at a time mutually agreed upon by the parties. Dental Reviewers can be reached at **1-800-508-4881**.

Prior authorization requests may be submitted online at **UHCdental.com/medicaid**, or may be forwarded to the following address:

1. By mail: P.O. Box 2053
   Milwaukee, WI 53201
2. Electronically: Payor ID GP133
3. Online: **UHCdental.com/medicaid**

5.2 Prior authorization requirements

UnitedHealthcare NJ FamilyCare

For a complete list of covered services requiring prior authorization, please refer to the New Jersey Clinical Criteria Grid with Authorization Requirement on the provider portal at **UHCdental.com/medicaid**.

Code	Description	Prior authorization submission requirements	Prior authorization clinical criteria
**D0393 - D0395	Images	Narrative of medical necessity	Documentation describes why radiographic images would not be appropriate for endodontic retreatment, implant placement and complex OMFS services.
D2542-D2543 D2710 D2721 D2751 D2791 D6210-D6792	Onlays, Crowns, Bridges	Periapical X-ray(s) that includes views of adjacent and opposing teeth, pre and post op X-rays required for teeth that have had root canal treatment. Bitewings are not acceptable. X-rays must be dated within 30 days after the root canal has been filled.	• Teeth must have a minimum of 50% supporting structure healthy supporting structure and opposing occlusion • Member's caries index and overall oral health will be considered • Posts will be approved for endodontic treated teeth with no periapical pathology • Fixed bridges may also be allowed as direct replacements and for anterior tooth replacement in the absence of other missing teeth in the same arch. • Fixed bridges may also be allowed for Special Needs members who cannot function with a removable appliance.
D2950 D2952-D2954 D2957 D2981-D2983 D6970-D6973 D6976, D6977	Build-ups, Post and Cores	Periapical X-ray(s) must include views of adjacent and opposing teeth; pre and post op X-rays required for teeth that have had a root canal. Bitewings are not acceptable. X-rays must be dated within 30 days after the root canal has been filled.	• Build-ups must be necessary for retention of the crown or bridge retainer • Posts and cores are not necessarily indicated for teeth with minimal endodontic access opening • Posts must extend 1/2 or preferably 2/3 the length of the root
D3310-D3333 D3346-D3348 D3410-D3430 D3431-D3999	Endodontics	Periapical X-ray providing diagnostic view of the entire crown and root structure. Narrative if reason for treatment is not evident on the X-rays.	• Reimbursement for endodontics will include all associated pulp therapy and related radiographs • Emergency endodontic therapy requires prior authorization by telephone and is limited to one tooth • Post-operative radiographs are required to be submitted prior to reimbursement • All endodontic therapy must follow the guidelines for cast crown restoration and have a favorable prognosis to be considered for prior authorization Apicoectomy indications: • Overfilled canal • Excessive curvature or calcification • Broken instrument in canal • Perforation of the apical 1/3 of canal • Unresolved apical pathology • Post cannot be removed
D4210-D4285 D4320 D4321 D4341	Periodontics	Full mouth series and periodontal charting. Panorex or bitewings are not acceptable. Biologic materials / guided tissue regeneration Pre op radiographs of adjacent and opposing teeth. D4210-D4276: In addition to the above listed documents provider needs to submit – narrative of medical necessity, photo (optional). D4320-D4321: Narrative of medical necessity. D4341, D4342: Pre-operative radiographs and periodontal charting. D4381: Periodontal charting. D4910: Description of previous periodontal surgical or scaling and root planning service.	• Prior authorization considers the health of the member • Bone loss, missing teeth, caries index and member's overall oral health will be considered • Biologic Materials – No Caries below bone level – Repair of root perforation – Minimum 50% bone support – Exploratory curettage for root fractures

Code	Description	Prior authorization submission requirements	Prior authorization clinical criteria
D5110-D5120 D5211-D5214 D5225, D5226 D5863-D5866	Full and Partial Dentures Overdenture - complete or partial	Full mouth series or panoramic X-ray and periodontal state of remaining teeth.	• Prior authorization for removable partial dentures will be based on member having less than eight points of posterior contact (less than four posterior mandibular teeth in contact with four maxillary teeth). If one or more anterior max or mand tooth missing or will be extracted regardless of the number of permanent posterior teeth • Partial and full dentures include six months of post insertion adjustments • Remaining tooth roots supporting overdenture have healthy bone and periodontal support
D6010-D6053 D6055	Implant surgical services Implant, supporting structures	Pre-op x-ray, narrative of med necessity	• Prior authorization for implants will be limited to requests that demonstrate that a beneficiary has a facial anomaly, deformity or has been unable to function with a complete denture for at least 2 years and other oral surgical corrections have been unsuccessful in improving the retention of the denture. • Service is only considered with prior authorization for denture(s) for edentulous arch(es).
D7220, D7230, D7240, D7241, D7250	Extractions, including 3rd Molars	Removal of impacted third molars must be preauthorized. Submit X-rays, a description of the patient's symptoms, and the tooth numbers of the symptomatic teeth.	Teeth should be symptomatic or pathology present.
D7310-D7321, D7999	Other Oral Surgery	Periapical X-rays or panoramic film. For anesthesia: narrative with any other pertinent information such as patient, behavioral problems and underlying medical conditions.	Alveoloplasty Bone requires osteoplasty as preparation for prosthesis beyond that expected during healing
D8010, D8020, D8040, D8080, D8210, D8220, D8670, D8680, D8691, D8692, D8999	Orthodontia	Panorex or full mouth series, photos and cephalometric X-rays if available, and a comprehensive treatment plan. Case must meet handicapping malocclusion criteria. Please refer to the Modified HLD Index and submit with claims for comprehensive orthodontic care. This can be found in the Appendix Section of the manual.	• Up to and including age 20. • Orthodontic treatment will be approved on a selective basis for members with handicapping malocclusions. • Cases must meet the 26 points, unless the following extenuating circumstances are indicated: a. facial or oral clefts b. extreme anterior posterior relationships c. extreme mandibular prognathism d. a deep overbite where lower anterior teeth are in contact with the palate. e. extreme bi-maxillary protrusion

Code	Description	Prior authorization submission requirements	Prior authorization clinical criteria
D9222, D9223, D9239, D9243, D9248, D9612, D9630, D9910, D9911, D9944, D9945, D9974	Adjunctive/ Anesthesia	X-rays of the appropriate type to document the clinical problem and a narrative describing the necessity for the procedure. D9222, D9223, D9239, D9243, D9248: Documentation of medical necessity D9612, D9630: Description of drugs and parental administration with claim. D9910, D9911: Documentation of medical necessity D9944, D9945: Documentation of medical necessity. D9974: Endodontic fill x-ray, Documentation of medical necessity.	Anesthesia: Prior authorization will be limited to removal of impacted teeth, multiple extractions, complex OMFX procedures, situational anxiety, and dental care for members with Special Health needs.
D9999	Facility Cases	Treatment plan if available, narrative of medical necessity for the facility and anesthesia, name of the facility. X-rays may be required to document the request.	A hospital setting or surgery center facility may be authorized when required for dental procedures due to a mental or physical condition. Examples include: • Extensive dentistry for a child • History of age-inappropriate behavior • Physical disability • Underlying medical condition (special health care needs) The dental procedures are considered for coverage under the dental component and the facility and anesthesia under the medical component.

5.3 Authorization decisions – turnaround times & filing limits

Services must be performed within 180 calendar days from the date that the approval notification is received by the practitioner.

Orthodontic services that require treatment prior to banding are reviewed on a case-by-case basis for determination as to whether the 180-calendar day limitation can be extended.

Providers will receive a faxed notification of the decision within 10 calendar days of receipt of the prior authorization request.

5.4 Authorization appeal & inquiry process

If you have additional information that you believe may impact any authorization decisions, you may contact our Appeals Department at 1-888-362-3368.

Appeals may be submitted verbally or in writing and must be received by UnitedHealthcare no later than 60 calendar days from the date on the initial denial letter. The appeal should contain the following information:

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

Mail or fax the appeal to:

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

Fax: 801-994-1082

Phone: 1-888-362-3368

5.5 Payment for non-covered services

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

- That the member was informed and given written acknowledgment regarding proposed treatment plan and associated costs in advance of rendering treatment. Member should receive a utilization or administrative denial and be made aware of all options to appeal by the Plan.
- That those specific services are not covered under the member's plan and that the member is financially liable for such services rendered. Members may not be balance billed for covered services.

Please note: It is recommended that benefits and eligibility be confirmed by the provider before treatment is rendered.

5.6 After hours emergency

Dental Emergencies - Emergency dental services are covered by the plan. In network dental providers should be contacted for emergencies, unless the member is experiencing facial trauma including broken bones and dislocated jaw or severe swelling/ infection or uncontrolled bleeding which may require an emergency room visit. Out-of-network providers may be used if an in-network provider is not available.

For additional information, Members may contact Member Services at 1-800-941-4647, TTY 711.

When a provider treats a patient outside of the normal business hours of 8:00 am to 6:00 pm, Monday through Friday, providers should:

- Confirm patient eligibility on the date of service through our website, or our Interactive Voice Response system.
- Consult the benefit guide included in this Manual to determine if services are covered under the plan and if prior authorization is required for the service.
- Covered services that do not require prior authorization can be rendered.
- If prior authorization is required for a needed service, the provider should relieve the patient's immediate pain with covered services that do not require prior authorization. (e.g., palliative treatment or sedative filling or pulpectomy). The provider will submit a written request for prior authorization and may call the provider call center on the next business day to request information for submitting an expedited prior authorization request.

Note: Prior authorization requirements are not waived for emergency appointments. Prior authorization requests and supporting documents must be received in writing via paper, electronic or website

submission, and the request must be approved prior or post to rendering service. Prior authorizations may be needed post treatment if definitive treatment was provided during emergent care.

5.7 Dental services provided in an operating room (OR)

If dental services must be provided in an operating room setting or ambulatory surgery center due to patient medical necessity, a prior authorization must be obtained.

- The treating dental provider should submit an authorization for any dental services that require authorization through the standard prior authorization process.
- The treating dental provider should submit an authorization for use of the Operating Room under CDT Code D9999. The authorization request should include the name of the facility being utilized. The request should also include a narrative explaining why the use of an OR is necessary.
- The authorization for the dental treatment and the use of the facility will be reviewed by Dental Consultants licensed in the state of New Jersey:
  - Medical Necessity will be evaluated by dental consultants and each case will be reviewed individually.
  - Use of the OR is intended for members with special needs, children, or patients with limited tolerance for dental services.
  - UnitedHealthcare maintains separate lists of providers equipped to treat children and adult members with intellectual and developmental disabilities ; these providers may have OR privileges. Link to these listings is located here: **Specialty Dental Providers**
  - Authorization determinations will be communicated via writing and electronically.
- A daily report of approved OR facility authorizations is sent from the dental administration vendor to the medical plan to ensure the appropriate facility authorization is available for OR billing.
  - Facility services should be billed using the appropriate CPT/medical codes.
  - Professional services should be billed using the appropriate CDT/dental codes.
- In the event additional dental needs are discovered while the patient is under general anesthesia, providers may use their judgment to treat provide the needed treatment regardless of the prior authorization. Post-Authorization documentation and treatment notes may be provided during the claim process.
- Providers will be reimbursed for costs of pre-op and post-op costs related to OR services, prior authorization will not be required for restorative care, informed consent will be obtained, OR procedures to be subject to post-payment review.
- Members with special health care needs may need assistance with scheduling and coordination of dental treatment to have their dental care provided in an operating room or ambulatory surgical center. Members may contact their care manager or Member Services at 1-800-941-4647, TTY 711 for assistance. Providers have the option to appeal denied prior authorizations. See Section 5.1.c Authorization Appeal & Inquiry Process for more details.
- All claims with dates of service of October 1, 2015 or later must be submitted with a valid ICD-10 code. A valid ICD-10-CM diagnosis code is composed of 3, 4, 5, 6 or 7 characters. Codes with three characters are included in ICD-10-CM as the heading of a category of codes that may be further subdivided by the use of fourth, fifth, sixth or seventh characters to provide greater specificity. A three-character code is to be used only if it is not further subdivided.
  - E75 – E756 Disorders of Sphingolipid Metabolism and Other Lipid Storage Disorders

- F03 – F0391 Unspecified Dementia
- F06 – F068 Other Mental Disorders Due to Known Physiological Condition
- F07 – F079 Personality and Behavioral Disorders Due to Known Physiological Condition
- F09 – Unspecified Mental Disorder Due to Known Physiological Condition
- F48 – F489 Nonpsychotic Mental Disorders
- F53 – Puerperal Psychosis
- F60 – F609 Specific Personality Disorders
- F70 – Mild Intellectual Disabilities (IQ 50-55 to ~70))
- F71 – Moderate Intellectual Disabilities (IQ 35-40 to 50-55)
- F72 – Severe Intellectual Disabilities (IQ 20-25 to 35-40)
- F73 – Profound Intellectual Disabilities (IQ level below 20-25)
- F78 – Other Intellectual Disabilities
- F79 – Unspecified Intellectual Disabilities
- F84 – F849 Pervasive Developmental Disorders
- F88 – Other Disorders of Psychological Development
- F89 – Unspecified Disorder of Psychological Development
- F90 – F909 Attention-Deficit Hyperactivity Disorder
- F91 – F919 Conduct Disorders
- G10 – Huntington's Disease
- G25 – G259 Other Extrapyramidal and Movement Disorders
- G31 – G319 Other Degenerative Diseases of Nervous System, Not Otherwise Classified
- G40 – G409 Epilepsy and Recurrent Seizures
- G71 – G719 Primary Disorders of Muscles
- G72 – G729 Other and Unspecified Myopathies
- G73 – G737 Disorders of Myoneural Junction and Muscle in Diseases Classified Elsewhere
- G80 – G809 Cerebral Palsy
- G93 – G939 Other Disorders of Brain
- P04 – P049 Newborn (Suspected to be) Affected by Noxious Substances Transmitted via Placenta or Breast Milk (Does Not Include P042 (Maternal Use of Tobacco)
- Q86 – Congenital Malformation Syndromes Due to Known Exogenous Causes, Not Elsewhere Classified
- Q90 – Q99 Down Syndrome
- R56 – R569 Convulsions, Not Otherwise Classified
- S06 – S069X9 Intracranial Injury
- F819 – Developmental Disorder of Scholastic Skills, Unspecified
- I6783 – Posterior Reversible Encephalopathy Syndrome (PRES)
- P154 – Birth Injury to Face (Facial Congestion Due to Birth Injury)
- P158 – Other Specified Birth Injuries
- P159 – Birth Injury, Unspecified

5.8 Additional dental services

In the event oral hygiene instruction needs to be provided to members or their family to assist the patient in maintaining oral health or specialized hygiene equipment is needed for members, an authorization must be requested. Providers should use the appropriate miscellaneous procedure code (i.e. D1999) for the authorization request. The request should include a narrative indicating the patient's medical necessity for these services or products. The requests will be reviewed by a New Jersey licensed Dental Consultants who will make determinations based on the information presented and the patient's medical necessity. UnitedHealthcare Care Managers are available to design and implement "dental management" plans to better oversee patient oral health.

Section 6: Radiology requirements

To learn what Prior Authorization requests would require radiographs, refer to Section 5.1.a of the Manual (Prior Authorization Submission Criteria).

Guidelines for providing radiographs are as follows:

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

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

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

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

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

Section 7: Claim submission procedures

7.1 Claim submission best practices and required elements

Dental claim form

The Dental ADA claim form (2019 or later) must be submitted for payment of services rendered.

Claim submission options

Electronic claims

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

Payor ID is GP133

Effective Oct. 1, 2015, ICD-10 codes are required for oral surgery and anesthesia services.

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.)	34. Diagnosis Code List Qualifier ☐☐ (ICD-10 = AB)	31a. Other Fee(s)	
1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16	34a. Diagnosis Code(s) A _____ C _____		
32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17	(Primary diagnosis in "A") B _____ D _____	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, 2015)

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.

Paper claims

Due to periodic revisions and varying practice management systems, dental insurance claim forms exist in various formats. Use of the 2019 or later American Dental Association (ADA) form is required.

Dental claim form required information

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

Header information

Indicate the type of transaction by checking the appropriate box: Statement of Actual Services or Request for Pre-Treatment Estimate.

Subscriber information

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

Patient information

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

Primary payer information

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

Other coverage

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

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

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

- Name of subscriber/policy holder (last, first and middle initial)
- Date of birth and gender

- Subscriber ID number
- Relationship to the member

Billing dentist or dental entity

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

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

Treating dentist and treatment location

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

- 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, City, State, ZIP Code)
- Phone number
- National provider identifier (NPI)

Record of services provided

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

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

Missing teeth information

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

Prorated reimbursement

The plan will pay on a prorated basis for dental services that have a dental lab component, including cast crowns, fixed and removable prosthetics, retainers, and habit appliances based on stage of completion, if an enrollee expires or does not return to complete these services within three months from the

last office visit for that service. For cast restorative and fixed prosthodontics, the prorate shall be 10 percent of the total payment for preparation of tooth with or without temporary, 85 percent of the total payment for impression and 95 percent of the total payment for completed not inserted. For removable prosthodontics, the prorate shall be 10 percent of the total payment for impression, 55 percent of the total payment for bite registration, 75 percent of the total payment for "try-in" stage and 85 percent of the total payment for completed not inserted. For appliances and retainers, the prorate shall be 10 percent of the total payment for impression and 85 percent of the total payment for completed and not inserted.

Remarks section

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

Paper claims

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

Timely submission

All NJ FamilyCare claims should be submitted within 180 days of the date of service.

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**.

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 "whiteout," pre-or post-dating claim forms, and insurance billing before completion of service. Incorrect charges and codes include billing for services not performed, billing for more expensive services than performed, or adding unnecessary charges or services.

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

7.2 Electronic payment

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**.

7.3 Paper claims submission

To receive payment for services, practices must submit claims via paper or electronically. Network dentists are recommended to submit an American Dental Association (ADA) Dental Claim Form (2019 or version or later). If an incorrect claim form is used, the claim cannot be processed and will be returned.

Please refer to the Claims Submission Best Practices Section for more information on claims submission best practices and required information.

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

7.4 Coordination of benefits (COB)

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

The practitioner office is required to identify when a patient has coverage through multiple carriers and to inform UnitedHealthcare of such on each impacted claim form.

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

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

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

7.5 Dental claim filing limits & adjustments

All Dental Claims should be submitted within One Hundred and Eighty (180) days from the date of service.

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

7.6 Claim adjudication & periodic overview

Claim processing standards:

- 90% of all claims (the totality of claims received whether contested or uncontested) submitted electronically will be processed within 30 days of receipt
- 90% of all claims filed manually will be processed within 40 days of receipt
- 99% of all claims, whether submitted electronically or manually, will be processed within 60 days of receipt
- 99.5% of all claims will be processed within 90 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.

Invalid or incomplete claims:

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

7.7 Explanation of dental plan reimbursement

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

Below is a list and description of each field:

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

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

AMOUNT BILLED - Amount submitted by provider

AMOUNT PAYABLE - Amount payable after benefits have been applied

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

OTHER INSURANCE - Amount payable by another carrier

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

NET AMOUNT (Summary Page) - Total amount paid

PATIENT NAME

SUBSCRIBER/MEMBER NO - Identifying number on the subscriber's ID card

PATIENT DOB

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

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

ENCOUNTER NUMBER - Claim reference number

BENEFIT LEVEL - In our out-of-network coverage

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

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

CDTCODE - Current Dental Terminology - Procedure code of service performed

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

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

PLACE OF SERVICE - Treating location (office, hospital, other)

QTY OR NO. OF UNITS

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

PAYABLE AMOUNT - Contracted amount

COPAY AMOUNT - Member responsibility

COINSURANCE AMOUNT - Member responsibility of total payment amount

DEDUCTIBLE AMOUNT - Member responsibility before benefits begin

PATIENT PAY - Amount to be paid by the member

OTHER INSURANCE AMOUNT - Amount paid by other carriers

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

EXCEPTION CODES - Codes that explain how the claim was adjudicated

7.8 Provider grievances and appeals

A Provider may file an appeal or grievance for items related to claims payment, UnitedHealthcare determinations or decisions, or UnitedHealthcare policies and procedures. UnitedHealthcare appeals and grievance process is intended to resolve billing, payment, and other administrative disputes between providers and UnitedHealthcare, including but not limited to the following: lost or incomplete claim forms or electronic submissions, requests for additional explanation as to services or treatment rendered by a health care provider, inappropriate or unapproved referrals initiated by the provider, or any other reason for billing disputes. This procedure is not applicable to any disputes that may arise between the Contractor and any provider regarding the terms, conditions or termination or any other matter arising under contract between the provider and Contractor. A provider appeal must be submitted within 90 days after the receipt of the Provider Remittance Advice and/or decision. Instances where a provider is pursuing an appeal on behalf of a member are subject to the Member Appeal process in this Manual.

There are two types of provider appeals:

Claims payment dispute

Claim issues include overpayment, underpayment, denial, or an original or corrected claim determination you do not agree with.A claim reconsideration request is the quickest way to address your concern about

whether the claim was paid correctly. When you send a claims payment dispute, please send additional supporting information.

Administrative appeal

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

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

Appeals will be responded to in writing within 30 days from receipt. Provider Appeals and Grievances will be resolved directly between the provider and UnitedHealthcare, without involving the member.

Section 8: Quality management

8.1 Quality improvement program (QIP) description

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

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

The QIP description is reviewed and updated annually.

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

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

A complete copy of our QIP policy and procedure is available upon request by contacting Provider Services.

8.2 Credentialing

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

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

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

Dental Benefit Providers Credentialing Committee reviews adverse incidents based on the information provided by the applicant. Dental Benefit Providers will request a resolution of any discrepancy in credentialing forms submitted. Providers have the right to review and correct erroneous information and to be informed of the status of their application. Credentialing criteria is reviewed/ approved by the Credentialing Committee, which include input from practicing network providers to make sure that criteria are within generally accepted guidelines.

Dental Benefit Providers contracts with an external Credentialing Verification Organization (CVO) to assist with collecting the data required for the recredentialing process. The CVO will occasionally contact our contracted providers to collect outstanding credentialing information.

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

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

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

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

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

Initial credentialing

- Completed application
- Signed and dated Attestation
- Current copy of their state license
- Current copy of their Drug Enforcement Agency (DEA) certificate
- Current copy of their Controlled Dangerous Substance (CDS) certificate, if applicable
- Current copy of their Sedation and/or General Anesthesia certificates, if applicable
- Copy of their Sedation and/or General Anesthesia training certificate/diploma, if applicable
- Signed and dated Sedation and/or General Anesthesia Attestation, if applicable
- Malpractice face sheet which shows their name on the certificate, expiration dates and limits – limits $1/3m

- Explanation of any adverse information, if applicable
- Five years' work in month/date format with no gaps of 6 months or more; if there are, an explanation of the gap should be submitted
- Education (which is incorporated in the application)
- Current Medicaid ID (as required by state)
- Disclosure of Ownership form (as required by the Federal Government), only if applicable

Recredentialing

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

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

8.3 Site visits

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

The site visit focuses primarily on: dental record keeping, patient accessibility, infectious disease control, and emergency preparedness and radiation safety. Results of site reviews will be shared with the dental office. Any significant failures may result in a review by the 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.

8.4 Preventive health guidelines

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

UnitedHealthcare's National Clinical Policy and Technology Committee reviews current professional guidelines and processes while consulting the latest literature, including but not limited to ADAs

CDT-2011/2012 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 with an enhanced frequency for special needs members.
- Preventive interventions – Interventions to prevent caries should be 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 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.
- NJ Smiles Program provides caries risk assessment, anticipatory guidance a dental referral and fluoride varnish by a trained medical provider to be provided up to four times annually for children through age five (5) with a moderate or high risk for caries.

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

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

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

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

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

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

8.5 Cultural competency

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

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

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

8.6 Addressing the opioid epidemic

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

Brief summary of framework

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

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

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

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

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

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

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

Increasing education & awareness of opioids

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

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

Section 9: Utilization management program

9.1 Utilization management introduction

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

By identifying and correcting aberrant provider practice patterns such as over-utilization of multiple restorations at a single office visit, we can not only reduce the overall impact of such behavior on the cost of care, but also improve the quality of dental care delivered.

9.2 Community practice patterns

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

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

9.3 Evaluation of utilization management data

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

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

9.4 Utilization review data results

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

Feedback and recommended follow-up may also be communicated to the provider 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

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

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

9.5 Fraud and abuse

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

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

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

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

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

Section 10: Evidence-Based Dentistry and the Dental Clinical Policy and Technology Committee (DCPTC)

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

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

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

- Problem or Population
- Intervention under Investigation
- How it is being compared
- The expected outcome

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

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

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

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

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

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

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

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

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

- Define a clinical problem or question
- Search for the best evidence
- Evaluate the evidence
- Determine how it would apply to the patient
- Determine treatment

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

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

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

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

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

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

Recommendations can result in new products or enhanced benefits for members. Recent examples include: our current medical-dental outreach program which focuses in identifying those with medical conditions thought to be impacted by dental health, early childhood caries programs, oral cancer screening benefit, implant benefit, enhanced benefits for periodontal maintenance and pregnant members, and delivery of locally placed antibiotics.

Evidence-based dentistry is a methodology to help reduce variation and determine “what works.” It can be used on the individual patient, practice, plan or population levels, and helps to ensure that our clinical programs and policies are grounded in science.

Section 11: Governing administrative policies

11.1 Appointment scheduling standards

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

- **Emergency dental treatment care**
  Emergency dental care, which is the immediate care, treatment and/or referral for emergent dental conditions, and defined as serious orofacial conditions which require immediate medical intervention, to avoid placing the health of the individual in jeopardy.
- **Urgent care appointments**
  Urgent dental care, which is defined as oral and/or dental conditions which require timely treatment to alleviate pain, address infection risk and avoid additional degradation of the teeth and/or other oral structures, within forty-eight (48) hours of member request.
- **Routine non-symptomatic care appointments and/or specialist referrals**
  Within twenty-eight (28) days of member request

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

- Emergency Care appointments would be needed if a patient is experiencing excessive bleeding, pain or trauma.
- Providers are encouraged to schedule members appropriately to avoid inconveniencing the members with long wait times of more than forty-five (45) minutes. Members should be notified of anticipated wait times and given the option to reschedule their appointment.

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

11.2 After hours coverage

Dental providers must be available to members by phone 24 hours a day, seven days a week. Or they must have arrangements for phone coverage by another network dental provider.

Dental providers are expected to respond to after-hour patient calls within 30-45 minutes for non-emergent symptomatic conditions and within 15 minutes for crisis situations.

We track and follow up on all instances of dental provider unavailability.

The following are examples of acceptable and unacceptable responses as defined by UnitedHealthcare Community Plan of New Jersey, per state requirements.

Acceptable:

- Your phone is answered by care provider, office staff, answering service or voice mail permitting immediate contact.
- The answering service you use either: Connects the caller directly to the care provider.
- Contacts the care provider on behalf of the caller and the provider returns the call.
- Provides a phone number where the care provider or covering provider can be reached.
- Your answering machine message provides a phone number to contact the care provider responsible for maintaining care provider coverage.
- Your answering machine instructs the caller to dial 911 for life-threatening emergencies at the beginning of the call, or to go to the ER if needed.

Unacceptable:

- Office/Answering service hangs up.
- The care provider's answering machine message: Instructs the caller to go to the ER for non-emergent situations.
- Instructs the caller to leave a message for the care provider for any urgent situation.
- There is no answer.
- The caller is placed on hold for longer than 5 minutes.
- The phone lines are persistently busy despite multiple attempts to contact the care provider.

11.3 Missed appointments

Members are not to be charged for any missed appointment under any circumstances but may be informed of non- financial consequences which may result from missed appointments.

11.4 Emergency coverage

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

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

11.5 New associates

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

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

If you have any questions or need to receive a copy of our Provider Application packet, please contact Provider Services.

11.6 Change of address, phone number, email, fax or tax identification number (TIN)

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

Changes should be submitted to:

UnitedHealthcare – RMO
ATTN: 224-Prov Misc Mail WPN
P.O. 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

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

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

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

If you have any questions, don't hesitate to contact Provider Services for guidance.

11.7 Office conditions

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

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

11.8 Sterilization and asepsis-control fees

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

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

11.9 Recall system

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

11.10 Transfer of dental records

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

Members will be allowed a second opinion when a general or specialty dentist recommends a treatment other than what the member believes is necessary, or if the member believes they have a condition that the dentist failed to diagnose. The member may receive the second opinion within the UnitedHealthcare dental network. In addition, UnitedHealthcare may arrange for the member to obtain a second opinion outside the network at no cost to the member.

11.11 Nondiscrimination

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

Section 12: Dental record review

Dental record review documentation information

The following chart question table is used annually by UnitedHealthcare Community Plan during provider audit visits to review samples of medical records from dental offices. It is included for reference purposes only to help you and your practice align with these requirements.

Below you will find the Dental Audit Questions and the tool.

Confidentiality & record organization & office (completed by quality nurse)

1. Do you have an electronic record system? (If yes proceed to question 2)
   If no electronic record system, please answer the following :
   - **a.** Is there is an identified order to the chart assembly
   - **b.** Are pages are fastened in the medical record
   - **c.** Does each patient has a separate medical record
   - **d.** Is the chart legible?
2. Staff are trained in medical record confidentiality
3. The office uses a Release of Information form that requires patient signature
4. There is a policy for timely transfer of medical records to other locations/providers
5. Medical records are stored in an organized fashion for easy retrieval
6. Medical records are available to the treating practitioner where the member generally receives care
7. Medical records are released to entities as designated consistent with federal regulations
8. Records are stored in a secure location only accessible by authorized personnel
9. There is a mechanism to monitor and handle missed appointments
10. The office has a policy regarding medical record confidentiality that addresses office staff training on confidentiality; release of information; record retention; and availability of medical records housed in a different office location (as applicable).

Additional elements required

Does the office provide:

1. ADA / handicap parking?
2. Working elevator if office is not located at street level? (Note: if office is located at street level you my select N/A)
3. Office that is wheel chair accessible?
4. Exam rooms that are wheel chair accessible?

Will this office provide care for a patient who:

1. Has been diagnosed with HIV/AIDS?
2. Is aged (elderly) ? (NOTE: If this is a Pediatric only office, please indicate N/A)

3. Is developmentally disabled (mentally challenged, cerebral palsy, etc)?

Front end /office administrative elements (completed by quality nurse)

1. Is there patient biographical/demographic information in the chart?
2. Do all pages of the record contain patient name or ID#?
3. Are all entries dated?
4. Are all practitioner entries signed?
5. Is there a medical history in the chart?
6. The presence/absence of allergies or adverse reactions clearly displayed?
7. Is there screening of high risk behaviors- drug, alcohol & tobacco use? (Age 12 and older)
8. Are cultural/linguistic needs met?
9. Is there an updated dental history?
10. Is there an updated medication list?

Dental procedural elements

1. Do notes document patient complaint, dental findings, diagnosis & tx plan?
2. For patients under age 21, was a carries risk assessment noted?
3. Was head and neck exam documented?
4. Soft tissue exam documented?
5. Oral cancer screening?
6. Treatment plan documented?
7. Was oral hygiene status noted?
8. Was oral hygiene instruction noted?
9. Is the treatment plan consistent with medical necessity?
10. Are problems from previous visits addressed?
11. Date of service notes?
12. Tooth, teeth or quadrant (s) notes?
13. Is the Procedure/ procedures described?
14. Is the Anesthetic utilized documented (as indicated)?
15. Are the Materials utilized documented (as indicated) ?
16. Post Op instructions/ medications indicated?
17. Chart signed by dentist/hygienist?

Section 13: Appendix

13.1 NJ FamilyCare

NJ FamilyCare is a federal and state funded health insurance program created to help qualified New Jersey residents of any age access to affordable health insurance. NJ FamilyCare is for people who do not have employer insurance.

13.2 NJ FamilyCare overview

NJ FamilyCare has four plans (A, B, C & D). Enrollment in the plan is based on the family's income and household size. If applicable, premiums and copays associated with each plan are shown on the member's UnitedHealthcare Community Plan ID card.

Eligibility groups include:

- NJ FamilyCare A:
  - Uninsured children younger than age 19 with family incomes up to and including 142% of the federal poverty level
  - Pregnant women up to 200% of the federal poverty level
  - Beneficiaries eligible for MLTSS services.
  - This group may access certain other services which are paid fee-for-service (FFS) by the state.
- NJ FamilyCare B:
  - Uninsured children younger than 19 years with family incomes above 142% and up to and including 150% of the federal poverty level. This group may access certain other services which are FFS and not covered under this contract.
- NJ FamilyCare C:
  - Uninsured children younger than 19 years with family incomes above 150% and up to and including 200% of the federal poverty level.
  - Eligibles must take part in cost-sharing in the form of a personal contribution to care for most services. However, Eskimos and Native American Indians younger than 19 years old, identified by Race Code 3, do not take part in cost-sharing and do not have to pay a personal contribution to care.
  - This group also has access to certain other services, which are paid FFS.
- NJ FamilyCare D:
  - Uninsured children younger than age 19 with family incomes between 201% and up to and including 350% of the federal poverty level (FPL). Eligibles with incomes above 150% FPL must pay monthly premiums and/or copayments for most services except for both Eskimos and Native American Indians younger than 19 years. These groups are identified by Program Status Codes (PSCs) or Race Code on the eligibility system.
- NJ FamilyCare Alternative Benefit Plan (ABP):
  - Parents between ages 19-64 with income up to and including 133% FPL
  - Childless adults between 19-64 with income up to and including 133% FPL.

- These members may also access certain other services, which are paid FFS by the state.

Individuals under age 21

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

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) is a Title XIX mandated program that covers screening and diagnostic services to determine physical and mental defects in enrollees under the age of 21, and health care, treatment, and other measures to correct or ameliorate any defects and chronic conditions discovered, pursuant to Federal Regulations found in Title XIX of the Social Security Act.

All Medicaid covered beneficiaries under the age of twenty-one (21), including those receiving Managed Long Term Services and Supports, shall be entitled to receive any medically necessary service including physician and hospital services, home care services (including personal care and private duty nursing), medical equipment and supplies, rehabilitative services, vision care, hearing services, dental care and any other type of remedial care recognized under state law or specified by the Secretary of the Department of Health and Human Services.

The need for these services shall be based upon medical necessity and shall not be limited in volume, scope or duration, regardless of established state plan or regulatory limitations. While approval for these services is determined by medical necessity, the volume, scope and duration of approved services may take the availability of other medically appropriate, cost effective alternatives into consideration. When a Medicaid covered beneficiary under the age of twenty-one (21) requires a medically necessary service that is not listed in the state plan, the beneficiary or their legally responsible representative should contact their health plan by calling the number on their health plan member identification card so this service can be appropriately delivered and coordinated.

The Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit provides comprehensive and preventive health care services for children under age 21 who are enrolled in Medicaid. EPSDT is key to ensuring that children and adolescents receive appropriate preventive, dental, mental health, and developmental, and specialty services.

Dental services

NJ FamilyCare members have a comprehensive dental benefit package. Dental services may not be limited to emergency services. Each state is required to develop a dental periodicity schedule in consultation with recognized dental organizations involved in child health. A copy of the NJ FamilyCare Dental Periodicity Schedule can be found here:
https://www.nj.gov/humanservices/dmahs/clients/periodicity_of_dental_services.pdf

Dental services may not be limited to emergency services. Dental screening by the licensed medical staff in this context means, at a minimum, observation of tooth eruption, occlusion pattern, presence of caries, or oral infection.

- A referral to a dentist by one year of age or soon after the eruption of the first primary tooth is mandatory and at a minimum a dental visit twice a year with follow up during well child visits to ensure

that all needed dental preventive and treatment services are provided thereafter through the age of twenty (20).

- A referral to a dental specialist or dentist that provides dental treatment to patients with special needs shall be allowed when a PCD requires a consultation for services by that specialty provider. Pedodontists or general dentists may be PCDs.

Periodicity of Dental Services for Children in NJ FamilyCare/Medicaid

Dental service	0-12 months	13-24 months	2-6 years	7-20 years
Oral Evaluation	●	●	●	●
Caries/Cavities Risk Assessment	●	●	●	●
Fluoride Supplements	●	●	●	●
Fluoride Varnish		●	●	
Prophy with Fluoride		●	●	●
Sealants (Permanent Teeth)			●	●
Radiographs (non-emergency)			●	●
Oral Hygiene Instructions	●	●	●	●
Dental Treatment	●	●	●	●

- **Oral evaluations:** Oral evaluation should occur as early as one year of age. It should include risk assessment and can be provided twice a year or more frequently for Children with Special Health Care Needs (CSHCN).
- **Caries/cavities risk assessment:** The visit includes an oral evaluation, instructions on brushing, oral health, safety and nutritional counseling to parents/caregivers and children. This should be done once a year to determine your child's risk of developing cavities.
- **Fluoride supplements:** This is based on level of water fluoridation in child's community
- **Fluoride varnish:** Fluoride varnish can be applied twice by a dental provider in a rolling calendar year.
- **Prophy with fluoride:** Prophylaxis with fluoride can be provided twice a year or up to four times a year for CSHCN members
- **Sealants:** Sealants can be placed on primary molars, and permanent molars and premolars
- **Radiographs (non-emergency):** Routine diagnostic radiographs can be taken as well as additional films needed to treat or diagnose a problem. Films on younger patients (0-12 & 13-24 months) can be taken as needed for treatment and diagnostic purposes.
- **Oral hygiene instructions:** Oral hygiene instructions (OHI) and education on dental disease and prevention should be provided to parents/guardians/caregivers. OHI to children can begin at age 2.
- **Dental treatment:** Providers can explain and discuss any of the services noted here or treatment needed.

We are required to provide each PCD, which can be a general or pediatric dentist, on a quarterly basis, a list of the PCD's enrollees who have not had a dental visit/encounter by twelve (12) months of age, who have not complied with NJFC periodicity for dental services, or who have not had a subsequent dental visit for oral evaluation or preventive service within six (6) months. PCD or primary care dental site shall be required to contact these enrollees to arrange an appointment. Documentation of the outreach efforts and responses is required.

NJ Smiles

We will allow non-dental providers to provide dental risk assessment, anticipatory guidance, fluoride varnish application and dental referral for children through the age of five (5)

- Fluoride varnish may be applied by any trained medical staff. The physician must be trained and submit attestation that all staff providing this service have been trained and will be supervised.
- Fluoride varnish application will be combined with risk assessment and referral to a dentist that treats children under the age of six (6) and will be linked to well child visits for children through the age of five (5).
- These three services will be reimbursed as an all-inclusive service billed using a CPT code and can be provided up to four (4) times a year. This frequency does not affect the frequency of this service by the dentist.
- UHCCP provides training to all PCPs on the requirement of referral to a dentist for a dental visit by twelve (12) months of age
- UHCCP notifies PCPs and PCD on their referral process and required communications between these provider groups.
- UHCCP provides training to all PCD and PCPs on prescribing fluoride supplements (based on access & use to fluoridated public water) and their responsibility in counseling parents and guardians of young children on oral health and age appropriate oral habits and safety to include what dental emergencies are and use of the emergency room for dental services.
- The caries risk assessment service shall also be allowed by the PCD and is billed using a CDT procedure code. The reimbursement will be the same regardless of the determined risk level. The risk assessment must be provided at least once per year in conjunction with an oral evaluation service by a PCD and is linked to the provider not the member. It may be provided a second time with prior authorization and documentation of medical necessity.

To better enable the referral process, a complete listing of UnitedHealthcare dental providers who treat members under age six can be found on **myuhc.com** > Find a Dentist >NJ > NJ Community Plan Medicaid > Pediatric Dentist.

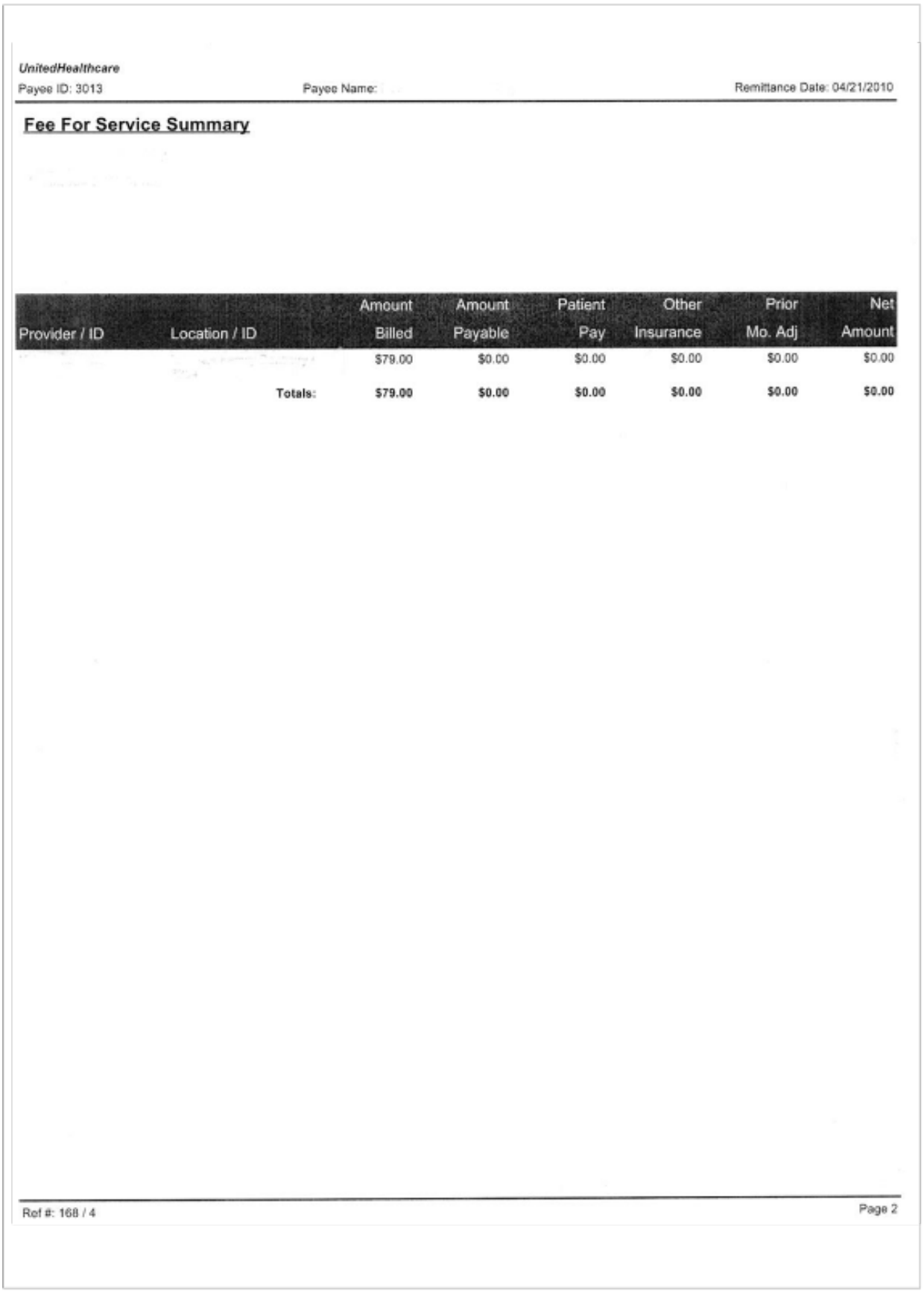
https://www.uhccommunityplan.com/nj/medicaid/familycare/find-a-provider-or-pharmacy

https://www.uhccommunityplan.com/content/dam/uhccp/plandocuments/findadentist/NJ-Smiles-Directory.pdf

Water fluoridation and emergency dental procedures

As a dental provider in NJ, we are certain that you are concerned about the possibility that your patient's municipal water supply may not be fluoridated. Please ask this question to your patients and, in the event that their water supply is not fluoridated, please discuss the advantages of prescription fluoride supplements and make a prescription for them available if deemed appropriate.

13.3 Example provider remittance advice



UnitedHealthcare

Payee ID: 3013 Payee Name: Remittance Date: 04/21/2010

Fee For Service Summary

Provider / ID	Location / ID	Amount Billed	Amount Payable	Patient Pay	Other Insurance	Prior Mo. Adj	Net Amount
		$79.00	$0.00	$0.00	$0.00	$0.00	$0.00
	Totals:	**$79.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**

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UnitedHealthcare

Payee ID: 3013 Payee Name: Remittance Date: 04/21/2010

Services Detail

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

Patient Name:
Subscriber/Member:
DOB:
Office Reference No:

Provider Name:
Provider NPI:
Plan: AmeriChoice
Product:

Encounter #: 20100420000100
Referral #:
Referral Date:
Benefit Level: In Network

ITM	DOS	CODE	BILLED QTY	BILLED AMOUNT	ALLOWED QTY	ALLOWED AMOUNT	PAYABLE AMOUNT	COPAY AMOUNT	COINS AMOUNT	DEDUCT AMOUNT	OVER MAX AMOUNT	PATIENT PAY	OTHER INSUR	NET AMOUNT	PAY CODE
1	04/10/10	D0210 00	1	$79.00	1	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	FFS
				$79.00		$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	

ITEM: 1 Exception Code: 1040 Service Exceeds Maximum Count Per Period.

Ref #: 168 / 5 Page 3

13.4 Fraud, waste & abuse training

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

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

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

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

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

13.5 Practitioner rights bulletin

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

To review your information

This is specific to the information the Plan has utilized to evaluate your credentialing application and includes information received from any outside source (e.g., malpractice insurance carriers; state license boards) apart from 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 fifteen (15) business days of receipt of the information. You will have an additional fifteen (15) business days to submit your reply in writing; within two (2) business days will send a written notification acknowledging receipt of the information.

To be informed of status of your application

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

To appeal adverse committee decisions

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

   Credentialing Supervisor
   Credentialing Department
   2300 Clayton Road Suite 1000
   Concord, CA 94520

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

Article One: Definitions

The following terms shall have the meaning stated, unless the context clearly indicates otherwise.

Alternative Benefit Plan (ABP) – Benefit package for individuals in the new adult group (Medicaid Expansion) under the Affordable Care Act (ACA). Section 1937 Medicaid Benchmark or Benchmark Equivalent Plans are now called Alternative Benefit Plans (ABPs). ABPs must cover the 10 Essential Health Benefits (EHB) as described in section 1302(b) of the ACA.

Adjudicate – the point in the claims/encounter processing at which a final decision is reached to pay or deny a claim, or accept or deny an encounter.

Administrative Service(s) – the contractual obligations of the Contractor that include but may not be limited to utilization management, credentialing providers, network management, quality improvement, marketing, enrollment, member services, claims payment, management information systems, financial management, and reporting.

Affordable Care Act (ACA) – Federal health reform statute signed into law in March 2010, also known as the Patient Protection and Affordable Care Act.

Appeal – a request for review of an action.

Benefits Package – dental services set forth in this contract, for which the Contractor has agreed to provide, arrange, and be held fiscally responsible.

Centers for Medicare and Medicaid Services (CMS) – formerly the Health Care Financing Administration (HCFA) within the U.S. Department of Health and Human Services.

Children with Special Health Care Needs – those children who have or are at increased risk for chronic physical, developmental, behavioral, or emotional conditions and who also require health and related services of a type and amount beyond that required by children generally. This includes all children who are MLTSS Members.

Comprehensive Orthodontic Treatment – the utilization of fixed orthodontic appliances (bands/brackets and arch wires) to improve the craniofacial dysfunction and/or dentofacial deformity of the patient. Active orthodontic treatment begins with banding of teeth or when tooth extractions are initiated as the result of and in conjunction with an authorized orthodontic treatment plan.

Condition – a disease, illness, injury, disorder, or biological or psychological condition or status for which treatment is indicated.

Consultation – A referral between different provider types or referral from a PCP or PCD to a specialist or in the case of dentistry, to a dentist that provides dental services to special needs patients. A member cannot be denied access to the consultation or when needed to medically necessary services provided by that specialty provider.

Contested Claim – a claim that is denied because the claim is an ineligible claim, the claim submission is incomplete, the coding or other required information to be submitted is incorrect, the amount claimed is in dispute, or the claim requires special treatment.

Continuity of Care – the plan of care for a particular enrollee that should assure progress without unreasonable interruption.

Copayment – the part of the cost-sharing requirement for which a fixed monetary amount is paid for certain services/items received from the Contractor's providers.

Covered Services – see "Benefits Package"

Credentialing – the Contractor's determination as to the qualifications and ascribed privileges of a specific provider to render specific health care services.

Dental Director – the Contractor's Director of dental services, who is required to be a Doctor of Dental Surgery or a Doctor of Dental Medicine and licensed by the New Jersey Board of Dentistry, with experience in the practice of dentistry in New Jersey, and designated by the Contractor to exercise general supervision over the Contractor's provision of dental services.

Dental Home – is the ongoing relationship between the dentist and the patient, inclusive of all aspects of oral health care delivered in a comprehensive, continuously accessible, coordinated, and family-centered way. The dental home should be established no later than 12 months of age to help children and their families institute a lifetime of good oral health. A dental home addresses anticipatory guidance and preventive, acute, and comprehensive oral health care and includes referral to dental specialists when appropriate.

Dental records – the complete, comprehensive records of dental services, to include chief complaint, treatment needed and treatment planned to include charting of hard and soft tissue findings, diagnostic images to include radiographs and digital views and to be accessible on site of enrollees participating dentist and in the records of a facility for enrollees in a facility.

Dual Eligible – individual covered by both Medicaid and Medicare.

Early and Periodic Screening, Diagnostic and Treatment (EPSDT) – a Title XIX mandated program that covers screening and diagnostic services to determine physical and mental defects in enrollees under the age of 21, and health care, treatment, and other measures to correct or ameliorate any defects

and chronic conditions discovered, pursuant to Federal Regulations found in Title XIX of the Social Security Act.

Effective Date of Enrollment – the date on which an enrollee can begin to receive services under the Contractor's plan pursuant to Article Five of the Managed Care Contract.

Emergency Dental Condition – an orofacial condition manifesting itself by acute symptoms of sufficient severity which impair oral functions including: severe pain or infection of dental origin resulting in facial swelling and possible airway obstruction, uncontrolled bleeding due to tissue laceration, oral trauma to include fracture of the jaw or other facial bones and /or dislocation of the mandible. These serious conditions as well as other acute symptoms that occur outside of the normal office hours of a dental clinic or office require immediate medical attention to avoid placing the health of the individual in jeopardy.

Excluded Services – those services covered under the fee-for-service Medicaid program that are not included in the Contractor benefits package.

Fair Hearing – the appeal process available to all Medicaid Eligibles pursuant to N.J.S.A. 30:4D-7 and administered pursuant to N.J.A.C. 10:49-10.1 et seq.

Federally Qualified Health Center (FQHC) – an entity that provides outpatient health programs pursuant to 42 U.S.C. § 201 et seq.

Fee-for-Service or FFS – a method for reimbursement based on payment for specific services rendered to an enrollee.

Fraud – an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to him/herself or some other person. It includes any act that constitutes fraud under applicable federal or State law. (See 42 C.F.R. § 455.2)

Grievance – means an expression of dissatisfaction about any matter or a complaint that is submitted in writing.

Grievance System – means the overall system that includes grievances and appeals at the Contractor level and access to the State Fair Hearing process.

HIPAA – Health Insurance Portability and Accountability Act.

Managed Long Term Services and Supports (MLTSS) – A program that applies solely to individuals who meet MLTSS eligibility requirements and encompasses the NJ FamilyCare A benefit package, NJ FamilyCare ABP (excluding the ABP BH/SA benefit), HCBS and institutionalization for long term care in a nursing facility or special care nursing facility.

Medicaid – the joint federal/State program of medical assistance established by Title XIX of the Social Security Act, 42 U.S.C. § 1396 et seq., which in New Jersey is administered by DMAHS in DHS pursuant to N.J.S.A. 30:4D-1 et seq.

Medicaid Eligible – an individual eligible to receive services under the New Jersey Medicaid program.

Medicaid Expansion – ACA created an eligibility group effective January 1, 2014 for individuals between the ages of 19 - 64 with income up to and including 133% FPL. (NJ FamilyCare ABP) Member – an enrolled participant in the Contractor's plan; also means enrollee.

Mobile Dental Practice – provider traveling to various locations and utilizing portable dental equipment to provide dental services to facilities, schools and residences. These providers are expected to provide on-site comprehensive dental care, necessary dental referrals to general dentist or specialists and emergency dental care in accordance with all New Jersey State Board of Dentistry regulations and the NJ FamilyCare MCO Contract. The sites served by the Mobile Dental Practice must allow Member access to treatment

and allow for continuity of care. The MCO is responsible for assisting the member and facility in locating a dentist when referrals are issued. Patient records must be maintained at the facility when this is a long term care facility or skilled nursing facility and duplicates may also maintained in a central and secure area in accordance with State Board of Dentistry regulations. The MCO must maintain documentation for all locations that the mobile van will serve to include schedule with time and days.

Mobile Dental Van – is a vehicle specifically equipped with stationary dental equipment and is used to provide dental services within the van. A mobile dental van is not to be considered a dental practice. Providers using a mobile dental van to render dental services must also be associated with a dental practice that is in a "brick and mortar" facility located in New Jersey, that serves as a dental home offering comprehensive care, emergency care and appropriate dental specialty referrals to the mobile dental van's patients of record (Members). Patient records are to be maintained in the brick and mortar location in accordance with State Board of Dentistry regulations. The distance between the dental practice and the sites and locations served by the mobile dental van must not be a deterrent to the Member accessing treatment and allow for continuity of care by meeting the network standards for distance in miles. When a mobile dental van's use is associated with health fairs or other one-time events, services will be limited to oral screenings, exams, fluoride varnish, prophylaxis and palliative care to treat an acute condition. State Board regulations must still be followed. The MCO must maintain documentation for all locations served to include schedule of time and days.

N.J.A.C. – New Jersey Administrative Code.

Non-Covered Contractor Services – services that are not covered in the Contractor's benefits package included under the terms of this contract.

Non-Covered Medicaid Services – all services that are not covered by the New Jersey Medicaid State Plan.

Non-Participating Provider – a provider of service that does not have a contract or other arrangement in accordance with N.J.A.C. 11:24 et seq. with the Contractor.

Out of Area Services – all services covered under the Contractor's benefits package included under the terms of the Medicaid contract which are provided to enrollees outside the defined basic service area.

Outcomes – the results of the health care process, involving either the enrollee or provider of care, and may be measured at any specified point in time. Outcomes can be medical, dental, behavioral, economic, or societal in nature.

Participating Provider – a provider that has entered into a provider contract or other arrangement in accordance with N.J.A.C. 11:24 et seq. with the Contractor to provide services.

Patient – an individual who is receiving needed professional services that are directed by a licensed practitioner of the healing arts toward the maintenance, improvement, or protection of health, or lessening of illness, disability, or pain.

Payments – any amounts the Contractor pays physicians or physician groups or subcontractors for services they furnished directly, plus amounts paid for administration and amounts paid (in whole or in part) based on use and costs of referral services (such as withhold amounts, bonuses based on referral levels, and any other compensation to the physician or physician groups or subcontractor to influence the use of referral services). Bonuses and other compensation that are not based on referral levels (such as bonuses based solely on quality of care furnished, patient satisfaction, and participation on committees) are not considered payments for purposes of the requirements pertaining to physician incentive plans.

Peer Review – a mechanism in quality assurance and utilization review where care delivered by a physician, dentist, or nurse is reviewed by a panel of practitioners of the same specialty to determine levels of appropriateness, effectiveness, quality, and efficiency.

Primary Care Dentist (PCD) – a licensed dentist who is the health care provider responsible for supervising, coordinating, and providing initial and primary dental care to patients; for initiating referrals for specialty care; and for maintaining the continuity of patient care.

Prior Authorization (also known as "preauthorization" or "approval") – authorization granted in advance of the rendering of a service after appropriate medical/dental review.

Provider – means any dentist, facility, or other provider of enrollee services who is licensed or otherwise authorized to provide services in the state or jurisdiction in which they are furnished.

Provider Contract – any written contract between the Contractor and a provider that requires the provider to perform specific parts of the Contractor's obligations for the provision of services under this contract.

Reassignment – the process by which an enrollee's entitlement to receive services from a particular Primary Care Practitioner/Dentist is terminated and switched to another PCP/PCD.

Service Area – the geographic area or region comprised of those counties as designated in the contract. Service Authorization Request – a managed care enrollee's request for the provision of a service.

Service Location/Service Site – any location at which an enrollee obtains any service provided by the Contractor under the terms of the contract.

State Fiscal Year – the period between July 1 through the following June 30 of every year.

TDD – Telecommunication Device for the Deaf.

TT – Tech Telephone.

Third Party – any person, institution, corporation, insurance company, public, private or governmental entity who is or may be liable in contract, tort, or otherwise by law or equity to pay all or part of the medical cost of injury, disease or disability of an applicant for or recipient of medical assistance payable under the New Jersey Medical Assistance and Health Services Act N.J.S.A. 30:4D-1 et seq.

Third Party Liability – the liability of any individual or entity, including public or private insurance plans or programs, with a legal or contractual responsibility to provide or pay for medical/dental services. Third Party is defined in N.J.S.A. 30:4D-3m.

Uncontested Claim – a claim that can be processed without obtaining additional information from the provider of the service or third party.

Urgent dental care – treatment of an oral or dental condition to alleviate pain, the risk of infection and additional degradation of the teeth and/or other oral structures. Most urgent dental conditions are best treated in an office or clinic setting within 24 hours to prevent additional deterioration. These conditions may include but are not limited to: dental/pulpal infections, pain and/or localized swelling associated with third molars, traumatic fracture or luxation/avulsion of teeth, fractured or lost restoration, and loss and/or breakage of fixed or removable dental prosthetics.

Utilization Review – procedures used to monitor or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of health care services, procedures or settings, and includes ambulatory review, prospective review, concurrent review, second opinions, Care Management, discharge planning, or retrospective review.

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