Dental Provider Manual

UnitedHealthcare Community Plan of Pennsylvania

Provider Services: 1-800-508-4876

Revised 1/2/2025

UnitedHealthcare® | Dental Benefit Providers®

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Section 1: Introduction — who we are

Welcome to UnitedHealthcare Community Plan

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

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

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

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

Our Commercial program plan requirements are contained in a separate Provider Manual. If you support one of our Commercial plans and need that Manual, please contact Provider Services at **1-800-822-5353**.

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

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

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

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

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

Provider Online Academy

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

- Dental provider portal training guide and digital solutions

- Dental plans and products overview
- Up-to-date dental operational tools and processes
- State-specific training requirements

To access Provider Online Academy, visit **UHCdental.com** and go to Resources > Dental Provider Online Academy.

Section 2: Patient eligibility verification procedures

2.1 Member eligibility

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

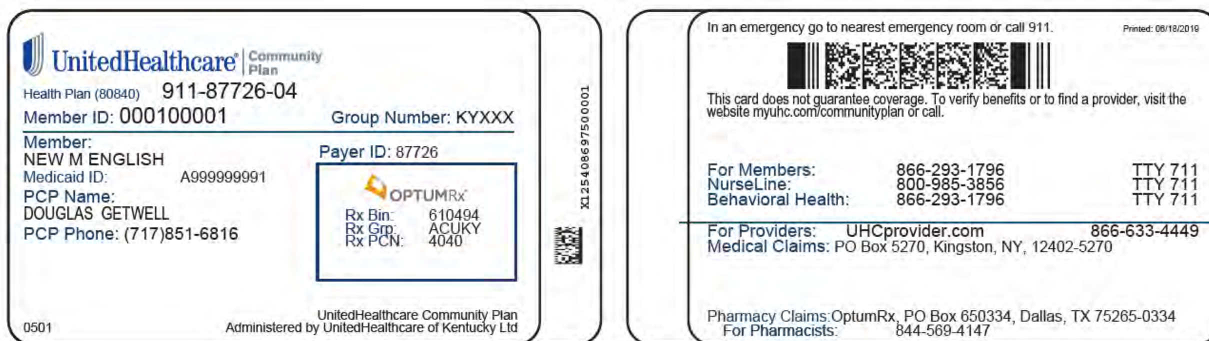
We receive daily updates on member eligibility and can provide the most up-to-date information available.

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

2.2 Identification card

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

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



2.3 Eligibility verification

Eligibility can be verified on our website at **UHCdental.com/medicaid** 24 hours a day, 7 days a week. In addition to current eligibility verification, our website offers other functionality for your convenience, such as claim status. Once you have registered on our provider website, 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. The IVR is available 24 hours a day, 7 days a week.

2.4 Quick reference guide

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

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

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

You want to:	Provider Services Line– Dedicated Service Representatives Phone: 1-800-508-4876 Hours: 8 a.m.-6 p.m. (EST) Monday-Friday	Online UHCdental.com/medicaid	Interactive Voice Response (IVR) System and Voicemail Phone: 1-800-508-4876 Hours: 24 hours a day, 7 days a week
Ask a Benefit/Plan Question (including prior authorization requirements)	✓	✓	
Ask a question about your contract	✓		
Changes to practice information (e.g., associate updates, address changes, adding or deleting addresses, Tax Identification Number change, specialty designation)	✓	✓	
Inquire about a claim	✓	✓	✓
Inquire about eligibility	✓	✓	✓
Inquire about the In-Network Practitioner Listing	✓	✓	✓
Nominate a provider for participation	✓	✓	
Request a copy of your contract	✓		
Request a Fee Schedule	✓	✓	
Request an EOB	✓	✓	
Request an office visit (e.g., staff training)	✓		
Request benefit information	✓	✓	
Request documents	✓	✓	
Request participation status change	✓		

2.5 Provider Portal / Dental Hub

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

To use the website, go to **UHCdental.com/medicaid** and register or log-in for Dental Hub as a participating user. Online access requires only an internet browser, a valid user ID, and a password once registered.There is no need to download or purchase software.

To register on the site, you will need information on a prior paid claim or a Registration code. To receive your Registration code and for other Dental Hub assistance, call Provider Services.

2.6 Integrated Voice Response (IVR) system — 1-800-508-4876

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).

Section 3: Office administration

3.1 Office site quality

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

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

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

3.2 Office conditions

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

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

3.3 Sterilization and infection control fees

Dental office infection control programs must meet the minimum requirements based on the Centers for Disease Control & Prevention's (CDC) guiding principles of infection control. All instruments should be sterilized where possible. Masks and eye protection should be worn by clinical staff where indicated; gloves should be worn during every clinical procedure. The dental office should have a sharps container for proper disposal of sharps. Disposal of medical waste should be handled per OSHA and state guidelines.

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

3.4 Recall system

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

3.5 Transfer of dental records

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

3.6 Office hours

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

3.7 Protect confidentiality of member data

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

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

3.8 Provide access to your records

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

3.9 Inform members of advance directives

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

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

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

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

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

3.10 Participate in quality initiatives

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

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

3.11 New associates

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

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

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

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

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

Changes should be submitted to:

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

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 at the telephone number listed on the cover of this document for guidance.

Section 4: Patient access

4.1 Appointment scheduling standards

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

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

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

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

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

4.2 Emergency coverage

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

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

4.3 Specialist referral process

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

To obtain a list of participating dental network specialists, go to our website at **UHCdental.com**. Click "Find a Dentist" on the top right and then choose "Medicaid Plans" to search by location. You may also contact Provider Services on the telephone number listed on the cover of the manual.

4.4 Missed appointments

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

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

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

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

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

4.5 Nondiscrimination

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

Section 5: Utilization Management program

5.1 Utilization Management

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

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

5.2 Community practice patterns

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

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

5.3 Evaluation of utilization management data

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

5.4 Utilization Management analysis results

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

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

- Provider Manual/Standards of Care
- Provider Training

- Continuing Education
- Provider News Bulletins

5.5 Utilization review

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

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

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

Utilization review is completed based on the following:

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

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

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

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

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

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

- Case series
- Case studies

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

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

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

Section 6: Quality management

6.1 Quality Improvement Program (QIP) description

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

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

The QIP description is reviewed and updated annually:

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

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

6.2 Credentialing

To become a participating provider 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 of both the provider agreement and continued participation with UnitedHealthcare Community Plan. Any failure to comply with the recredentialing process constitutes termination for cause under your provider agreement.

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

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

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

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

Initial credentialing

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

6.3 Site visits

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

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

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

6.4 Preventive health guideline

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

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

current ADA Current Dental Terminology (CDT), and specialty guidelines as suggested by organizations such as the American Academy of Pediatric Dentistry, American Academy of Periodontology, American Association of Endodontists, American Association of Oral and Maxillofacial Surgeons, and the American Association of Dental Consultants. Additional resources include publications such as the Journal of Evidence-Based Dental Practice, online resources obtained via the Library of Medicine, and evidence-based clearinghouses such as the Cochrane Oral Health Group and Centre for Evidence Based Dentistry as well as respected public health benchmarks such as the Surgeon General's Report on Oral Health in America. Preventive health focuses primarily on the prevention, assessment for risk, and early treatment of caries and periodontal diseases, but also encompasses areas including prevention of malocclusion, oral cancer prevention and detection, injury prevention, avoidance of harmful habits and the impact of oral disease on overall health. Preventive health recommendations for children are intended to be consistent with American Academy of Pediatric Dentistry periodicity recommendations.

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

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

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

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

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

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

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

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

6.5 Addressing the opioid epidemic

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

Brief summary of framework

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

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

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

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

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

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

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

Increasing education & awareness of opioids

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

such as, “The Role of the Health Care Team in Solving the Opioid Epidemic,” and “The Fight Against the Prescription Opioid Abuse Epidemic.” While resources are available, we also 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**. Choose Tools and resources > Resource library > Pharmacy resources > 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 7: Fraud, waste, and abuse training

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

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

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

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

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

Section 8: Governance

8.1 Practitioner rights bulletin

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

To review your information

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

To correct erroneous information

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

To be informed of status of your application

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

To appeal adverse committee decisions

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

UnitedHealthcare Dental
Credentialing Department
2300 Clayton Road, Suite 1000
Concord, CA 94520

Phone: **1-855-918-2265**
Fax: **1-844-881-4963**

8.2 Quality of care issues

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

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

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

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

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

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

8.3 Appeals process

You have the right to appeal any credentialing decision if your practice is in a state that allows for credentialing Appeals which is based on information received during the credentialing process. If you practice in a state that allows for Appeals, to initiate an appeal of a recredentialing decision, follow the instructions provided in the determination letter received from the Credentialing Committee Coordinator.

- Providers are notified in writing of their appeal rights within fifteen (15) calendar days of the Committee's determination. The letter will include the reason for denial/termination; notice that the provider has the right to request a hearing or review, at the provider's discretion, before a panel appointed by UnitedHealthcare; notice of a thirty (30)-day time frame for the request; and, a time limit for the hearing date, which must be held within thirty (30) days after the receipt of a request for a hearing.
- The Hearing will be scheduled within thirty (30) days of the request for a hearing.
- The Hearing Committee includes at least three members appointed by UnitedHealthcare, who are not in direct economic competition with the provider, and who have not acted as accuser, investigator, fact-finder, or initial decision-maker in the matter. At least one person on the panel will be the same discipline or same specialty as the person under review. The panel can consist of more than three members, provided the number of clinical peers constitute one-third or more of the total membership.
- The Hearing Committee may uphold, overturn, or modify the original determination. Modifications may include, but are not limited to, placing the provider on probation, requiring completion of specific continuing education courses, requiring site or chart audits, or other corrective actions.

- The decision of the Hearing Committee is sent to the provider by certified letter within thirty (30) calendar days.
- Decisions of terminations shall be effective not less than thirty (30) days after the receipt by the provider of the Hearing Panel's decision.
- In no event shall determination be effective earlier than sixty (60) days from receipt of the notice of termination.

Note: A provider terminated due to a case involving imminent harm to patient care, a determination of fraud, or a final disciplinary action by a state licensing board or other governmental agency that impairs the health care professional's ability to practice is not eligible for a hearing or review.

8.4 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.

Section 9: Claim submission procedures

9.1 Claim submission options

9.1.a Paper claims

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

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

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

9.1b Electronic claims

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

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

9.1.c Electronic payments

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

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

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

ePayment Center allows you to:

- Improve cash flow with faster primary payments and speed up secondary filing/patient collections
- Access your electronic remittance advice (ERA) remotely and securely 24/7

- Streamline reconciliation with automated payment posting capabilities
- Download remittances in various formats (835, CSV, XLS, PDF)
- Search payments history up to 7 years

To register:

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

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

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

The Zelis Payments advantage:

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

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

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

9.2 Claim submission requirements and best practices

9.2.a Dental claim form required information

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

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

Header information

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

Subscriber information

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

Patient Information

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

Primary Payer Information

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

Other coverage

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

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

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

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

Billing dentist or dental entity

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

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

- National provider identifier (NPI)

Treating dentist and treatment location

List the following information regarding the dentist that provided treatment:

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

Record of services provided

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

Missing teeth information

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

Remarks section

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

ICD-10 instructions

RECORD OF SERVICES PROVIDED

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

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

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17

34. Diagnosis Code List Qualifier (ICD-9 = B; ICD-10 = AB)
34a. Diagnosis Code(s) (Primary diagnosis in "A") A ____ B ____ C ____ D ____
31a. Other Fee(s)
32. Total Fee
35. Remarks

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

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

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

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

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

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

By Report procedures

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

Using current ADA codes

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

Supernumerary teeth

UnitedHealthcare recognizes tooth letters "A" through "T" for primary teeth and tooth numbers "1" to "32" for permanent teeth. Supernumerary teeth should be designated by using codes AS through TS or 51 through 82. Designation of the tooth can be determined by using the nearest erupted tooth. If the tooth closest to the supernumerary tooth is # 1 then the supernumerary tooth should be charted as #51, likewise if the nearest tooth is A the supernumerary tooth should be charted as. These procedure codes must be referenced in the patient's file for record retention and review. Patient records must be kept for a minimum of six (6) years or longer if required by applicable statutes or regulations.

Insurance fraud

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

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

Invalid or incomplete claims:

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

9.2.b Coordination of Benefits (COB)

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

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

9.2.c Timely submission (Timely filing)

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

All adjustments or requests for reprocessing must be made within 180 days from date of service, or date of eligibility posting, only if the initial submission time period has been met. An adjustment can be requested in writing or telephonically.

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

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

9.3 Timely payment

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

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

9.4 Provider remittance advice

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

The Provider Remittance Advice is a claim detail of each patient and each procedure considered for payment. Use these as a guide to reconcile 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 or 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

CDT CODE - 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

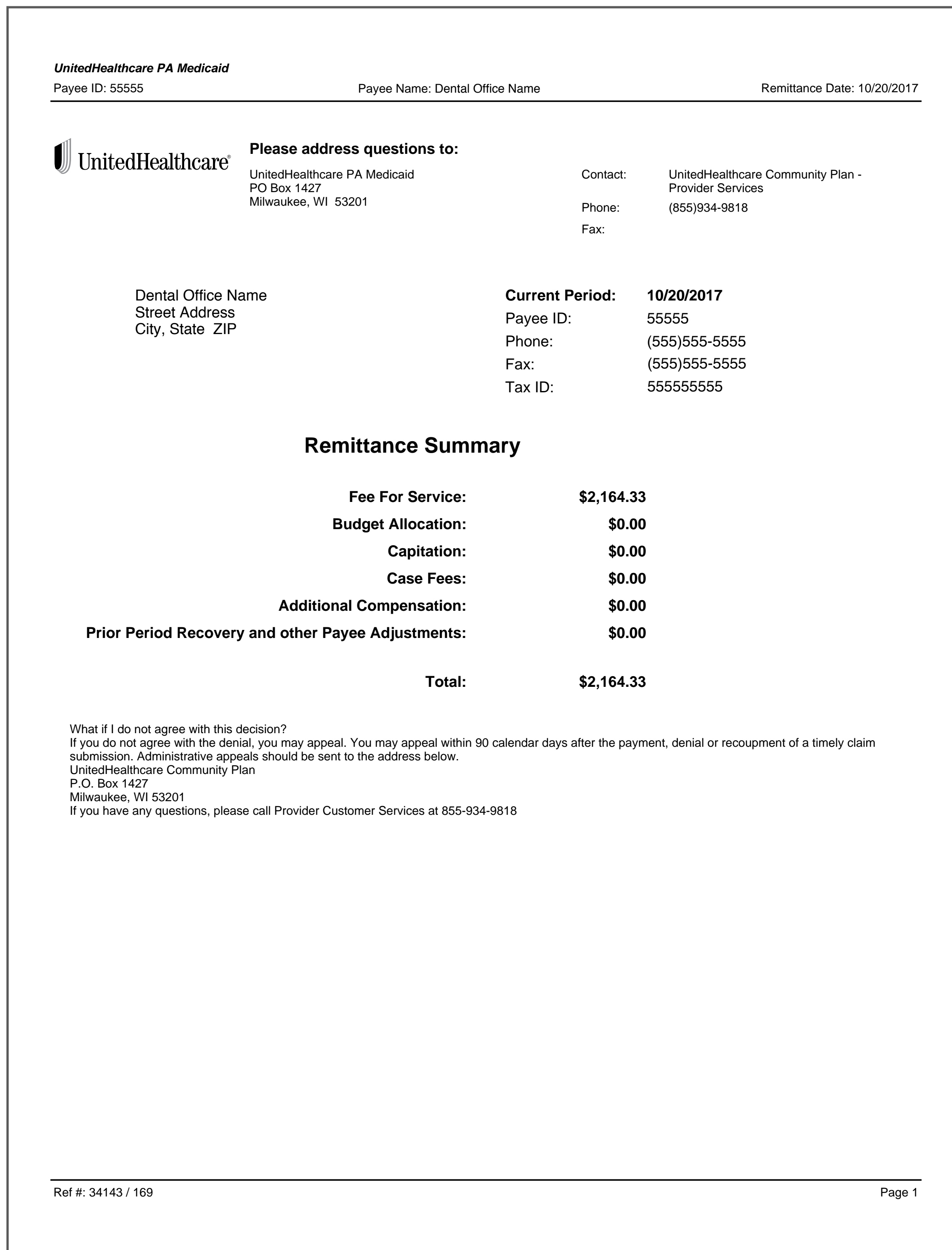
PATIENT PAY - Amount to be paid by the member

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

9.4.b Provider Remittance Advice sample (page 1)



UnitedHealthcare PA Medicaid

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

UnitedHealthcare

Please address questions to:

UnitedHealthcare PA Medicaid
PO Box 1427
Milwaukee, WI 53201

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

Dental Office Name
Street Address
City, State ZIP

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

Remittance Summary

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

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

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9.4.c Provider Remittance Advice sample (page 2)

UnitedHealthcare PA Medicaid

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

Fee For Service Summary

Dental Office Name
Street Address
City, State ZIP

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

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9.4.d Provider Remittance Advice sample (page 3)

UnitedHealthcare PA Medicaid

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

Services Detail

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

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

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

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

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

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

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

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

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

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

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

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9.5 Overpayment

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

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

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

Overpayment
P.O. Box 481
Milwaukee, WI 53201

Include the following information with the Overpayment Return Check:

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

9.6 Tips for successful claims resolution

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

9.7 Payment for non-covered services

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

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

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

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

9.8 Radiology requirements

Guidelines for providing radiographs are as follows:

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

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

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

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

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

9.9 Corrected claim submission guidelines

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

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

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

A corrected claim may be submitted using the methods below:

- Electronically through Clearing House

- Electronically through the Dental Hub if original claim was submitted on the Dental Hub. If original claim was not submitted on the Dental Hub, another method should be utilized.
- Paper to the mailing address below

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

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

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

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

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

9.10 Appealing a denied claim payment

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

Appeals for denied claims payment
UnitedHealthcare Specialty Benefits
Attn: Provider Appeals
PO BOX 1091
Milwaukee WI 53201

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

Appendices for the State of Pennsylvania

Appendix A: Resources and services — how we help you

Addresses and phone numbers

Need:	Address:	Phone Number:	Payer ID:	Submission Guidelines:	Form(s) Required:
Claim Submission (initial)	Claims: UnitedHealthcare PO Box 2173 Milwaukee, WI 53201	**1-800-508-4876**	GP133	Within 365 calendar days from the date of service For secondary claims, within 30 days from the primary payer determination	ADA* Claim Form, 2019 version or later
Corrected Claims	Corrected Claims: UnitedHealthcare PO Box 481 Milwaukee, WI 53201	**1-800-508-4876**	N/A	Within 365 days from date of service.	ADA Claim Form Reason for requesting adjustment or resubmission
Claim Appeals (Appeal of a denied or reduced payment)	Claim Appeals: UnitedHealthcare PO Box 1091 Milwaukee, WI 53201	**1-800-508-4876**	N/A	Within 60 days after the claim determination	Supporting documentation, including claim number is required for processing.
Prior Authorization Requests	Pre-authorizations: UnitedHealthcare PO Box 779 Milwaukee, WI 53201	**1-800-508-4876**	GP133	N/A	ADA Claim Form – check the box titled: Request for Predetermination / Pre-authorization section of the ADA Dental Claim Form
Member Benefit Appeal for Service Authorization (Appeal of a denied or reduced service)	UnitedHealthcare Community Attn: Appeals and Grievances Unit P.O. Box 31364 Salt Lake City, UT 84131-0364	**1-866-293-1796**	N/A	Within 60 calendar days from the date of the adverse benefit determination	N/A

Appendix B: Member benefits/exclusions and limitations

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

If you are prohibited from billing the member or choose never to bill the member for the services that are the subject of the grievance, you may drop the grievance with notice to the member or the member's legal representative.

Any member can ask another person to act as his or her representative in the appeals process ("member's representative"). If this representative is a health care provider, the provider must obtain the member's written consent to pursue a grievance.

The member's, or the member's legal representative's, if the member is a minor or is legally incompetent, consent to a health care provider to pursue a grievance must be in writing and is automatically rescinded upon the failure of the health care provider to file or pursue a grievance. The consent document giving the health care provider authority to pursue a grievance on behalf of a member must include each of the following elements:

1. The name and address of the member, the member's date of birth and the member's identification number.
2. If the member is a minor, or is legally incompetent, the name, address, and relationship to the member of the person who signs the consent for the member.
3. The name, address, and identification number of the health care provider to whom the member is providing the consent.
4. The name and address of the plan to which the grievance will be submitted.
5. An explanation of the specific service for which coverage was provided or denied to the member to which the consent will apply.

The following statements must be in the consent document:

1. The member or the member's representative may not submit a grievance concerning the services listed in this consent form unless the member or the member's legal representative rescinds consent in writing. The member or the member's legal representative has the right to rescind consent at any time during the grievance process.
2. The consent of the member or the member's legal representative is automatically rescinded if the provider fails to file a grievance or fails to continue to prosecute the grievance through the second level review process.
3. The member or the member's legal representative, if the member is a minor or is legally incompetent, has read, or has been read, this consent form, and has had it explained to his or her satisfaction.

The member or the member's legal representative understands the information in the member's consent form. The consent document must also have the dated signature of the member, or the member's legal representative if the member is a minor or is legally incompetent, and the dated signature of a witness. The member may rescind consent at any time during the grievance process. If the member rescinds consent, the member may continue with the grievance at the point at which consent was rescinded. The

member may not file a separate grievance. A member who has filed a grievance may, at any time during the grievance process, choose to provide consent to a health care provider to continue with the grievance instead of the member. The member's legal representative may exercise the rights conferred upon the member.

B.1 Exclusions & limitations

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

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

Please call Provider Services at 1-800-508-4876 if you have any questions regarding frequency limitations.

General exclusions

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

B.2 Benefit grid

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

Pennsylvania Medicaid

Code	Description	Age limits	Frequency limits	Other limits
D0120	Periodic Oral Evaluation - Established Patient	0-999	1 per 180 DAYS	D0120, D0145, D0150: 1 per 180 DAYS
D0140	Limited Oral Evaluation - Problem Focused	0-999	No limits	None
D0145	Oral Evaluation, Patient Under Three	0-2	1 per 180 DAYS	D0120, D0145, D0150: 1 per 180 DAYS
D0150	Comprehensive Oral Evaluation - New Or Established Patient	0-999	1 per 180 DAYS	D0120, D0145, D0150: 1 per 180 DAYS
D0160	Detailed And Extensive Oral Evaluation - Problem Focused, By Report	0-999	No limits	None
D0170	Re-Evaluation - Limited, Problem Focused	0-999	No limits	None
D0190	Screening of a Patient	0-999	1 per 1 YEAR	
D0191	Assessment of a Patient	0-999	1 per 1 YEAR	
D0210	Intraoral - Complete Series of Radiographic Images	0-999	1 per 5 FLOATING YEARS	None
D0220	Intraoral - Periapical First Radiographic Image	0-999	1 per 1 DAY	None
D0230	Intraoral - Periapical Each Additional Image	0-999	10 per 1 DAY	None
D0240	Intraoral - Occlusal Radiographic Image	0-999	2 per 1 DAY	None
D0250	Extraoral - 2D Projection Radiographic image	0-999	1 per 1 DAY	None
D0251	Extra-Oral Posterior Dental Radiographic Image	0-999	10 per 1 DAY	None
D0270	Bitewing - Single Radiographic Image	0-999	1 per 1 DAY	None
D0272	Bitewings - Two Radiographic Images	0-999	1 per 1 DAY	None
D0273	Bitewings - Three Radiographic Images	0-999	1 per 1 DAY	None
D0274	Bitewings - Four Radiographic Images	0-999	1 per 1 DAY	None
D0330	Panoramic Radiographic Image	0-999	1 per 5 FLOATING YEARS	None
D0340	2D Cephalometric Radiographic Image	0-21	1 per 1 DAY	None
D0372	intraoral tomosynthesis - comprehensive series of radiographic images; A radiographic survey of the whole mouth intended to display the crowns and roots of all teeth, periapical areas, interproximal areas and alveolar bone including edentulous areas	0-999	1 per 5 YEARS	None
D0373	intraoral tomosynthesis - bitewing radiographic image	0-999	4 per 1 day	None
D0374	intraoral tomosynthesis - periapical radiographic image	0-999	11 per 1 day	None
D1110	Prophylaxis - Adult	12-999	1 per 180 DAYS	D1110, D1120, D4910, D4346: 3 per 1 FLOATING YEAR

Code	Description	Age limits	Frequency limits	Other limits
D1120	Prophylaxis - Child	0-11	1 per 180 DAYS	D1110, D1120, D4910, D4346: 3 per 1 FLOATING YEAR
D1206	Topical Application Of Fluoride Varnish	0-20	6 per 1 YEAR	None
D1208	Topical Application of Fluoride	0-20	1 per 180 DAYS	None
D1310	Nutritional Counseling For Control Of Dental Disease	0-999	1 per 180 DAYS	None
D1320	Tobacco Counseling For The Control And Prevention Of Oral Disease	0-20	1 per 1 DAY	Tobacco Cessation Counseling: 70 per 1 ACCUM YEAR
D1330	Oral Hygiene Instructions	0-999	1 per 180 DAYS	None
D1351	Sealant - Per Tooth	0-20	1 per LIFETIME	None
D1354	Interim Caries Arresting Medicament Application - per tooth	0-999	1 Per tooth per day, maximum of 10 teeth per day, 4 times per tooth per year, 6 times per tooth per lifetime	D1354: 1 per 6 MONTH
D1354	Interim Caries Arresting Medicament Application - per tooth	0-20	1 per 6 MONTHS	D1354 Additional Limit: 10 per DAY PER MEMBER
D1510	Space Maintainer - Fixed - Unilateral - per quadrant	0-20	4 per 1 LIFETIME	None
D1516	Space Maintainer - Fixed - Bilateral, maxillary	0-20	4 per 1 LIFETIME	None
D1517	Space Maintainer - Fixed - Bilateral, mandibular	0-20	4 per 1 LIFETIME	None
D1550	Re-Cement Or Re-Bond Space Maintainer	0-20	1 per 1 DAY	None
D1555	Removal Of Fixed Space Maintainer	0-20	4 per 1 DAY	None
D1558	Removal of fixed bilateral space maintainer – mandibular	0-20	1 per 1 day	None
D1999	Unspecified Preventive Procedure, By Report	0-999	No limits	None
D2140	Amalgam - One Surface, Primary Or Permanent	0-999	1 per 1 DAY	None
D2150	Amalgam - Two Surfaces, Primary Or Permanent	0-999	1 per 1 DAY	None
D2160	Amalgam - Three Surfaces, Primary Or Permanent	0-999	1 per 1 DAY	None
D2161	Amalgam - Four Or More Surfaces, Primary Or Permanent	0-999	1 per 1 DAY	None
D2330	Resin-Based Composite - One Surface, Anterior	0-999	1 per 1 DAY	None
D2331	Resin-Based Composite - Two Surfaces, Anterior	0-999	1 per 1 DAY	None
D2332	Resin-Based Composite - Three Surfaces, Anterior	0-999	1 per 1 DAY	None
D2335	Resin-Based Composite - Four Or More Surfaces Or Involving Incisal Angle	0-999	1 per 1 DAY	None
D2390	Resin-Based Composite Crown, Anterior	0-20	1 per 1 DAY	None
D2391	Resin-Based Composite - One Surface, Posterior	0-999	1 per 1 DAY	None
D2392	Resin-Based Composite - Two Surfaces, Posterior	0-999	1 per 1 DAY	None
D2393	Resin-Based Composite - Three Surfaces, Posterior	0-999	1 per 1 DAY	None
D2394	Resin-Based Composite - Four Or More Surfaces, Posterior	0-999	1 per 1 DAY	None
D2710	Crown - Resin-Based Composite (Indirect)	0-20	1 per 3 FLOATING YEARS	None

Code	Description	Age limits	Frequency limits	Other limits
D2721	Crown - Resin With Predominantly Base Metal	0-20	1 per 5 FLOATING YEARS	None
D2740	Crown - Porcelain/Ceramic	0-20	1 per 5 FLOATING YEARS	None
D2751	Crown - Porcelain Fused To Predominantly Base Metal	0-20	1 per 5 FLOATING YEARS	None
D2791	Crown - Full Cast Predominantly Base Metal	0-20	1 per 5 FLOATING YEARS	None
D2910	Re-Cement Or Re-Bond Inlay, Onlay, Veneer Or Partial Coverage Restoration	0-999	1 per 1 DAY	None
D2915	Re-Cement or Re-Bond Cast Indirectly Fabricated Or Pre-Fabricated Post and Core	0-999	1 per 1 DAY	None
D2920	Re-Cement or Re-Bond Crown	0-999	1 per 1 DAY	None
D2930	Prefabricated Stainless Steel Crown - Primary Tooth	0-20	1 per 1 DAY	None
D2931	Prefabricated Stainless Steel Crown - Permanent Tooth	0-20	1 per 1 DAY	None
D2932	Prefabricated Resin Crown	0-20	1 per 1 DAY	None
D2933	Prefabricated Stainless Steel Crown With Resin Window	0-20	1 per 1 DAY	None
D2934	Prefabricated Esthetic Coated Stainless Steel Crown - Primary Tooth	0-20	1 per 1 DAY	None
D2952	Post And Core In Addition To Crown, Indirectly Fabricated	0-20	1 per 1 DAY	None
D2954	Prefabricated Post And Core In Addition To Crown	0-20	1 per 1 DAY	None
D2980	Crown Repair	0-999	1 per 1 DAY	None
D2991	Application of hydroxyapatite regeneration medicament - per tooth	0-999	No limits	
D2999	Unspecified Restorative Procedure, By Report	0-999	No limits	None
D3220	Therapeutic Pulpotomy	0-20	6 per 1 DAY	None
D3230	Pulpal Therapy (Resorbable Filling) - Anterior, Primary Tooth	0-20	1 per 1 DAY	None
D3240	Pulpal Therapy (Resorbable Filling) - Posterior, Primary Tooth	0-20	1 per 1 DAY	None
D3310	Endodontic Therapy, Anterior Tooth (Excluding Final Restoration)	0-20	1 per LIFETIME	None
D3320	Endodontic Therapy Premolar Tooth (Excluding Final Restoration)	0-20	1 per LIFETIME	None
D3330	Endodontic Therapy, Molar tooth (Excluding Final Restoration)	0-20	1 per LIFETIME	None
D3410	Apicoectomy - Anterior	0-20	2 per 1 DAY	None
D3421	Apicoectomy - Premolar (First Root)	0-20	2 per 1 DAY	None
D3425	Apicoectomy - Molar (First Root)	0-20	2 per 1 DAY	None
D3426	Apicoectomy - Each Additional Root)	0-20	2 per 1 DAY	None
D3921	Decoronation or submergence of an erupted tooth	0-20	1 tooth per 1 day	
D3999	Unspecified Endodontic Procedure, By Report	0-999	No limits	None
D4210	Gingivectomy Or Gingivoplasty - Four Or More Contiguous Teeth	0-20	4 per 24 MONTH	None

Code	Description	Age limits	Frequency limits	Other limits
D4341	Periodontal Scaling And Root Planing - Four Or More Teeth Per Quadrant	0-20	1-2 quad per day up to 4 different quads in 24 months	None
D4342	periodontal scaling and root planing - one to three teeth per quadrant	0-999	1 quad per day up to 4 differ quads in 24 months	
D4346	Scaling in moderate or severe gingival inflammation	0-20	1 per 180 days	D1110, D1120, D4910 D4346: 3 per 1 YEAR
D4355	Full Mouth Debridement	0-20	1 per 1 FLOATING YEAR	None
D4910	Periodontal Maintenance	0-20	1 per 90 days	D1110, D1120, D4910, D4346: 3 per 1 YEAR
D5110	Complete Denture - Maxillary	0-999	1 per LIFETIME	Dentures-Upper (D5110, D5130, D5211, D5213): 1 per 1 LIFETIME
D5120	Complete Denture - Mandibular	0-999	1 per LIFETIME	Dentures-Lower (D5120, D5140, D5212, D5214): 1 per 1 LIFETIME
D5130	Immediate Denture - Maxillary	0-999	1 per LIFETIME	Dentures-Upper (D5110, D5130, D5211, D5213): 1 per 1 LIFETIME
D5140	Immediate Denture - Mandibular	0-999	1 per LIFETIME	Dentures-Lower (D5120, D5140, D5212, D5214): 1 per 1 LIFETIME
D5211	Maxillary Partial Denture - Resin Base	0-999	1 per LIFETIME	Dentures-Upper (D5110, D5130, D5211, D5213): 1 per 1 LIFETIME
D5212	Mandibular Partial Denture - Resin Base	0-999	1 per LIFETIME	Dentures-Lower (D5120, D5140, D5212, D5214): 1 per 1 LIFETIME
D5213	maxillary partial denture - cast metal framework with resin denture bases	6-999	1 per LIFETIME	Dentures-Upper (D5110, D5130, D5211, D5213): 1 per 1 LIFETIME
D5214	mandibular partial denture - cast metal framework with resin denture bases	6-999	1 per LIFETIME	Dentures-Lower (D5120, D5140, D5212, D5214): 1 per 1 LIFETIME
D5410	Adjust Complete Denture - Maxillary	0-999	1 per 1 DAY	None
D5411	Adjust Complete Denture - Mandibular	0-999	1 per 1 DAY	None
D5421	Adjust Partial Denture - Maxillary	0-999	1 per 1 DAY	None
D5422	Adjust Partial Denture - Mandibular	0-999	1 per 1 DAY	None
D5511	Repair Broken Complete Denture Base - Mandibular	6-120	1 per 1 DAY	None
D5512	Repair Broken Complete Denture Base - Maxillary	6-120	1 per 1 DAY	None
D5520	Replace Missing Or Broken Teeth - Complete Denture (Each Tooth)	0-999	3 per 1 DAY	None
D5611	Repair Resin Partial Denture Base - Mandibular	0-999	1 per 1 DAY	None
D5612	Repair Resin Partial Denture Base - Maxillary	0-999	1 per 1 DAY	None

Code	Description	Age limits	Frequency limits	Other limits
D5621	Repair Cast Partial Framework - Mandibular	0-999	1 per 1 DAY	None
D5622	Repair Cast Partial Framework - Maxillary	0-999	1 per 1 DAY	None
D5630	Repair Or Replace Broken Retentive / Clasping Materials - Per Tooth	0-999	4 per 1 YEAR	None
D5640	Replace Broken Teeth - Per Tooth	0-999	3 per 1 DAY	None
D5650	Add Tooth To Existing Partial Denture	0-999	2 per 1 DAY	None
D5660	Add Clasp To Existing Partial Denture - Per Tooth	0-999	1 per lifetime per tooth	None
D5730	reline complete maxillary denture (direct)	0-999	1 per 1 DAY	None
D5731	reline complete mandibular denture (direct)	0-999	1 per 1 DAY	None
D5740	reline maxillary partial denture (direct)	0-999	1 per 1 DAY	None
D5741	reline mandibular partial denture (direct)	0-999	1 per 1 DAY	None
D5750	reline complete maxillary denture (indirect)	0-999	1 per 1 DAY	None
D5751	reline complete mandibular denture (indirect)	0-999	1 per 1 DAY	None
D5760	reline maxillary partial denture (indirect)	0-999	1 per 1 DAY	None
D5761	reline mandibular partial denture (indirect)	0-999	1 per 1 DAY	None
D5899	Unspecified Removable Prosthodontic Procedure, By Report	0-999	No limits	None
D5999	Unspecified Maxillofacial Prosthesis, By Report	0-999	No limits	None
D6930	Re-Cement Or Re-Bond Fixed Partial Denture	0-999	1 per 1 DAY	None
D6980	Fixed Partial Denture Repair	0-999	1 per 1 DAY	None
D7140	Extraction, Erupted Tooth Or Exposed Root	0-999	1 per LIFETIME	Extractions (D7111, D7140 - D7241): 1 per 1 LIFETIME
D7210	Extraction, Erupted Tooth	0-999	1 per LIFETIME	Extractions (D7111, D7140 - D7241): 1 per 1 LIFETIME
D7220	Removal Of Impacted Tooth - Soft Tissue	0-999	1 per LIFETIME	Extractions (D7111, D7140 - D7241): 1 per 1 LIFETIME
D7230	Removal Of Impacted Tooth - Partially Bony	0-999	1 per LIFETIME	Extractions (D7111, D7140 - D7241): 1 per 1 LIFETIME
D7240	Removal Of Impacted Tooth - Completely Bony	0-999	1 per LIFETIME	Extractions (D7111, D7140 - D7241): 1 per 1 LIFETIME
D7250	Removal Of Residual Tooth (Cutting Procedure)	0-999	1 per LIFETIME	None
D7260	Oroantral Fistula Closure	0-999	1 per 1 DAY	None
D7270	Reimplantation And/Or Stabilization Of Accidentally Evulsed / Displaced Tooth	0-20	1 per 1 DAY	None
D7280	Exposure of an Unerupted Tooth	0-23	1 per LIFETIME	None
D7283	Placement Of Device To Facilitate Eruption Of Impacted Tooth	0-23	1 per LIFETIME	None
D7288	Brush Biopsy - Transepithelial Sample Collection	0-999	2 per 1 DAY	None
D7310	Alveoloplasty In Conjunction With Extractions - Four Or More Teeth	0-999	1 per 1 DAY	None

Code	Description	Age limits	Frequency limits	Other limits
D7320	Alveoloplasty Not In Conjunction With Extractions - Four Or More Teeth	0-999	1 per 1 DAY	None
D7450	Removal Of Benign Odontogenic Cyst Or Tumor - Dia Up To 1.25 Cm	0-999	2 per 1 DAY	None
D7451	Removal Of Benign Odontogenic Cyst Or Tumor - Dia Greater Than 1.25 Cm	0-999	2 per 1 DAY	None
D7460	Removal Of Benign Nonodontogenic Cyst Or Tumor - Dia Up To 1.25 Cm	0-999	2 per 1 DAY	None
D7461	Removal Of Benign Nonodontogenic Cyst Or Tumor - Dia Greater Than 1.25 Cm	0-999	2 per 1 DAY	None
D7471	Removal Of Lateral Exostosis (Maxilla Or Mandible)	0-999	2 per 1 DAY	None
D7472	Removal Of Torus Palatinus	0-999	2 per 1 DAY	None
D7473	Removal Of Torus Mandibularis	0-999	2 per 1 DAY	None
D7485	Reduction Of Osseous Tuberosity	0-999	2 per 1 DAY	None
D7509	marsupialization of odontogenic cyst; Surgical decompression of a large cystic lesion by creating a long-term open pocket or pouch.	0-999	2 lesions per day	None
D7510	Incision And Drainage Of Abscess - Intraoral Soft Tissue	0-999	2 per 1 DAY	None
D7511	Incision And Drainage Of Abscess - Intraoral Soft Tissue - Complicated	0-999	2 per 1 DAY	None
D7520	Incision And Drainage Of Abscess - Extraoral Soft Tissue	0-999	2 per 1 DAY	None
D7521	Incision And Drainage Of Abscess - Extraoral Soft Tissue - Complicated	0-999	2 per 1 DAY	None
D7871	Non-Arthroscopic Lysis And Lavage	0-999	1 per 1 DAY	None
D7961	buccal / labial frenectomy (frenulectomy)	0-999	2 per 1 LIFETIME	None
D7962	lingual frenectomy (frenulectomy)	0-999	1 per LIFETIME	None
D7970	Excision Of Hyperplastic Tissue - Per Arch	0-999	2 per 1 DAY	None
D7999	Unspecified Oral Surgery Procedure, By Report	0-999	1 per 1 DAY	None
D8080	Comprehensive Orthodontic Treatment Of The Adolescent Dentition	0-20	1 per LIFETIME	None
D8210	Removable Appliance Therapy	0-20	1 per LIFETIME	None
D8220	Fixed Appliance Therapy	0-20	1 per LIFETIME	None
D8660	Pre-Orthodontic Treatment Examination To Monitor Growth And Development	0-22	1 per 1 FLOATING YEAR	None
D8670	Periodic Orthodontic Treatment Visit	0-22	1 per 25 DAYS	D8670: 7 per 1 LIFETIME
D8670	Periodic Orthodontic Treatment Visit	0-22	1 per 25 DAYS	D8670: 29 per 1 LIFETIME
D8670	Periodic Orthodontic Treatment Visit	0-22	1 per 76 DAYS	D8670: 7 per 1 LIFETIME
D8670	Periodic Orthodontic Treatment Visit	0-22	1 per 76 DAYS	D8670: 29 per 1 LIFETIME
D8680	Orthodontic Retention (Removal Of Appliances, Place Retainers)	0-22	1 per LIFETIME	None
D8703	Replacement of lost or broken retainer – maxillary	0-22	1 per LIFETIME	None
D8704	Replacement of lost or broken retainer – mandibular	0-22	1 per LIFETIME	None
D9110	Palliative (Emergency) Treatment Of Dental Pain - Minor Procedure	0-999	1 per 1 DAY	None
D9222	Deep Sedation/General Anesthesia - First 15 Minutes	0-999	1 per 1 DAY	None
D9223	Deep Sedation / General Anesthesia - Each subsequent 15 Minute Increment	0-999	9 per 1 DAY	None
D9230	Inhalation Of Nitrous/Analgesia, Anxiolysis	0-20	No limits	None

Code	Description	Age limits	Frequency limits	Other limits
D9239	Intravenous Moderate (Conscious) Sedation/Analgesia - First 15 Minutes	0-999	1 per 1 DAY	None
D9243	Intravenous Moderate (Conscious) Sedation/Analgesia - Each Subsequent 15 Minute	0-999	9 per 1 DAY	None
D9248	Non-Intravenous Conscious Sedation	0-999	1 per 1 DAY	None
D9420	Hospital Or Ambulatory Surgical Center Call	0-999	No limits	None
D9920	Behavior Management, By Report	0-999	4 per 1 FLOATING YEAR	None
D9930	Treatment Of Complications (Post Surgical) - Unusual Circumstances, By Report	0-999	1 per 1 DAY	None
D9947		0-20	1 per 1 lifetime	
D9948	Adjustment of custom sleep apnea appliance	0-20	1 per 1 DAY	at least 180 days post placement
D9949	Repair of custom sleep apnea appliance	0-20	1 per 1 DAY	at least 180 days post placement
D9953	reline custom sleep apnea appliance (indirect); Resurface dentition side of appliance with new soft or hard base material as required to restore original form and function.	0-999	1 per 2 years per appliance	at least 180 days post placement
D9991	Dental Case Management - addressing appointment compliance barriers	2-20	1 per code every Accum Year	None
D9994	Dental Case Management - Patient education	0-999	1 per code every Accum Year	None
D9995	Teledentistry - Synchronous; Real-Time Encounter	0-999	1 per 1 DAY	None
D9996	Teledentistry - Asynchronous; Information Stored And Forwarded To Dentist	0-999	1 per 1 DAY	None
D9999	Unspecified Adjunctive Procedure, By Report	0-999	1 per 1 FLOATING YEAR	None

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Code	Description	Age limits	Frequency limits	Other limits
D0120	Periodic Oral Exam	0-999	1 per every 6 Months	
D0140	Limited Oral Evaluation - Problem Focused	0-999		
D0145	Oral Evaluation, Patient Under Three	0-3		
D0150	Comprehensive Oral Evaluation - New Or Established Patient	0-999	1 per every 6 Months	
D0160	Detailed And Extensive Oral Evaluation - Problem Focused, By Report	0-999	1 per every 6 Months	
D0170	Re-Evaluation - Limited, Problem Focused	0-999		
D0180	Comprehensive periodontal evaluation	0-999	1 per every 6 Months	
D0210	Intraoral - Comprehensive Series of Radiographic Images	0-999	1 per every 60 Months	1 per every 60 Months

Code	Description	Age limits	Frequency limits	Other limits
D0220	Intraoral - Periapical First Radiographic Image	0-999	10 per every 12 Months	
D0230	Intraoral - Periapical Each Additional Image	0-999	10 per every 12 Months	
D0240	Intraoral - Occlusal Radiographic Image	0-999		
D0250	Extraoral - 2D Projection Radiographic image	0-999		
D0251	Extra-Oral Posterior Dental Radiographic Image	0-999	10 per every Day	
D0270	Bitewing - Single Radiographic Image	0-999	1 per every 6 Months	
D0272	Bitewings - Two Radiographic Images	0-999	1 per every 6 Months	
D0273	Bitewings - Three Radiographic Images	0-999	1 per every 6 Months	
D0274	Bitewings - Four Radiographic Images	0-999	1 per every 6 Months	
D0277	Vertical Bitewings - 7 To 8 Radiographic Images	0-999	1 per every 12 Months	
D0330	Panoramic Radiographic Image	0-999	1 per every 60 Months	1 per every 60 Months
D0340	2D Cephalometric Radiographic Image	0-999		
D0350	Oral/Facial Photographic Images	0-999		
D0351	3D photographic image This procedure is for diagnostic purposes. Not applicable	0-999		
D0391	Interpretation Of Diagnostic Image	0-999		
D0415	Collection Of Microorganisms For Culture And Sensitivity	0-999		
D0422	Collection And Preparation Of Genetic Sample	0-999	1 per every Lifetime	
D0423	Genetic Test For Susceptibility To Diseases	0-999	1 per every Lifetime	
D0460	Pulp Vitality Tests	13-999	1 per every 30 Days	
D0470	Diagnostic Casts	0-999		
D1110	Prophylaxis - Adult	0-999	1 per every 6 Months	
D1120	Prophylaxis - Child	0-12 13-999	1 per every 6 Months	
D1206	Topical Application Of Fluoride Varnish	0-999	2 per every 12 Months	
D1208	Topical Application of Fluoride	0-999	2 per every 12 Months	
D1351	Sealant - Per Tooth	0-999	1 per tooth every 14 Days	
D1352	Preventive Resin Restoration	0-999	1 per tooth every 36 Months	

Code	Description	Age limits	Frequency limits	Other limits
D1353	Sealant Repair - Per Tooth	0-999	1 per tooth every 36 Months	
D1354	Interim Caries Arresting Medicament Application - per tooth	0-20	10 per every Day	2 per tooth every Accum Year
		21-999	1 per tooth every 36 Months	2 per tooth every Accum Year
D1510	Space Maintainer - Fixed - Unilateral - per quadrant	0-18		
D1516	Space Maintainer - Fixed - Bilateral, maxillary	0-18		
D1517	Space Maintainer - Fixed - Bilateral, mandibular	0-18		
D1520	Space Maintainer - Removable - Unilateral - per quadrant	0-18		
D1526	Space Maintainer - Removable - Bilateral, maxillary	0-18		
D1527	Space Maintainer - Removable - Bilateral, mandibular	0-18		
D1551	Re-Cement Or Re-Bond Bilateral Space Maintainer - maxillary	0-18		
D1552	Re-Cement Or Re-Bond Bilateral Space Maintainer - mandibular	0-18		
D1553	Re-Cement Or Re-Bond Unilateral Space Maintainer - Per quadrant	0-18		
D1556	Removal Of Fixed Unilateral Space Maintainer - Per quadrant	0-18		
D1557	Removal Of Fixed Bilateral Space Maintainer - maxillary	0-18		
D1558	Removal Of Fixed Bilateral Space Maintainer - mandibular	0-18		
D1999	Unspecified Preventive Procedure, By Report	0-999		
D2140	Amalgam - One Surface, Primary Or Permanent	0-999	1 per tooth every 24 Months	
D2150	Amalgam - Two Surfaces, Primary Or Permanent	0-999	1 per tooth every 24 Months	
D2160	Amalgam - Three Surfaces, Primary Or Permanent	0-999	1 per tooth every 24 Months	
D2161	Amalgam - Four Or More Surfaces, Primary Or Permanent	0-999	1 per tooth every 24 Months	
D2330	Resin-Based Composite - One Surface, Anterior	0-999	1 per tooth every 24 Months	
D2331	Resin-Based Composite - Two Surfaces, Anterior	0-999	1 per tooth every 24 Months	
D2332	Resin-Based Composite - Three Surfaces, Anterior	0-999	1 per tooth every 24 Months	
D2335	Resin-Based Composite - Four Or More Surfaces Or Involving Incisal Angle	0-999	1 per tooth every 24 Months	
D2390	Resin-Based Composite Crown, Anterior	0-999		
D2391	Resin-Based Composite - One Surface, Posterior	0-999		
D2392	Resin-Based Composite - Two Surfaces, Posterior	0-999		
D2393	Resin-Based Composite - Three Surfaces, Posterior	0-999		
D2394	Resin-Based Composite - Four Or More Surfaces, Posterior	0-999		
D2510	Inlay - Metallic - One Surface	0-999		
D2520	Inlay - Metallic - Two Surfaces	0-999		

Code	Description	Age limits	Frequency limits	Other limits
D2530	Inlay - Metallic - Three Surfaces	0-999		
D2542	Onlay - Metallic - Two Surfaces	0-999	1 per tooth every 60 Months	
D2543	Onlay - Metallic - Three Surfaces	0-999	1 per tooth every 60 Months	
D2544	Onlay - Metallic - Four Or More Surfaces	0-999	1 per tooth every 60 Months	
D2710	Crown - Resin-Based Composite (Indirect)	0-999	1 per tooth every 3 Years	1 per tooth every 5 Accum Years
D2721	Crown - Resin With Predominantly Base Metal	0-999	1 per tooth every 5 Years	1 per tooth every 5 Accum Years
D2740	Crown - Porcelain/Ceramic	0-999	1 per tooth every 60 Months	1 per tooth every 5 Accum Years
D2750	Crown - Porcelain Fused To High Noble Metal	0-999	1 per tooth every 60 Months	
D2751	Crown - Porcelain Fused To Predominantly Base Metal	0-999	1 per tooth every 60 Months	1 per tooth every 5 Accum Years
D2752	Crown - Porcelain Fused To Noble Metal	0-999	1 per tooth every 60 Months	1 per tooth every 5 Accum Years
D2780	Crown - 3/4 Cast High Noble Metal	0-999	1 per tooth every 60 Months	
D2781	Crown - 3/4 Cast Predominantly Base Metal	0-999	1 per tooth every 60 Months	
D2783	Crown - 3/4 Porcelain/Ceramic	0-999	1 per tooth every 60 Months	
D2790	Crown - Full Cast High Noble Metal	0-999	1 per tooth every 60 Months	
D2791	Crown - Full Cast Predominantly Base Metal	0-999	1 per tooth every 60 Months	1 per tooth every 5 Accum Years
D2792	Crown - Full Cast Noble Metal	0-999	1 per tooth every 60 Months	
D2794	crown - titanium and titanium alloys	0-999	1 per tooth every 60 Months	
D2910	Re-Cement Or Re-Bond Inlay, Onlay, Veneer Or Partial Coverage Restoration	0-999		
D2915	Re-Cement or Re-Bond Cast Indirectly Fabricated Or Pre-Fabricated Post and Core	0-999		
D2920	Re-Cement or Re-Bond Crown	0-999		
D2929	Prefabricated Porcelain / Ceramic Crown - Primary Tooth	0-14		
D2930	Prefabricated Stainless Steel Crown - Primary Tooth	0-999	1 per tooth every 60 Months	
D2931	prefabricated stainless steel crown - permanent tooth	0-999	1 per tooth every 60 Months	
D2932	Prefabricated Resin Crown	0-999		
D2933	Prefabricated Stainless Steel Crown With Resin Window	0-999		
D2934	Prefabricated Esthetic Coated Stainless Steel Crown - Primary Tooth	0-999		

Code	Description	Age limits	Frequency limits	Other limits
D2940	Protective Restoration	0-999		
D2950	Core Buildup, Including Any Pins When Required	0-999	1 per tooth every 60 Months	
D2951	Pin Retention - Per Tooth, In Addition To Restoration	0-999		
D2952	Post And Core In Addition To Crown, Indirectly Fabricated	0-999		
D2954	Prefabricated Post And Core In Addition To Crown	0-999	1 per tooth every Lifetime	
D2955	Post Removal	0-999		
D2971	Additional procedures to customize a crown to fit under an existing partial dent	0-999		
D2980	Crown Repair	0-999	1 per tooth every 12 Months	
D2981	Inlay Repair	0-999		
D2983	Veneer Repair	0-999		
D2990	Resin Infiltration of Incipient Smooth Surface Lesions	0-999	1 per tooth every 36 Months	
D2999	Unspecified Restorative Procedure, By Report	0-999		
D3110	Pulp Cap - Direct (Excluding Final Restoration)	0-999		
D3120	Pulp Cap - Indirect (Excluding Final Restoration)	0-999		
D3220	Therapeutic Pulpotomy	0-999		
D3221	Pulpal Debridement - Primary And Permanent Teeth	0-999	1 per tooth every Lifetime	
D3222	Partial Pulpotomy For Apexogenesis - Permanent Tooth	0-999	1 per tooth every Lifetime	
D3230	Pulpal Therapy (Resorbable Filling) - Anterior, Primary Tooth	0-6	1 per tooth every Lifetime	
		7-11	1 per tooth every Lifetime	
D3240	Pulpal Therapy (Resorbable Filling) - Posterior, Primary Tooth	7-11	1 per tooth every Lifetime	
D3310	Endodontic Therapy, Anterior Tooth (Excluding Final Restoration)	0-999		
D3320	Endodontic Therapy Premolar Tooth (Excluding Final Restoration)	0-999		
D3330	Endodontic Therapy, Molar tooth (Excluding Final Restoration)	0-999		
D3332	Incomplete Endodontic Therapy	0-999		
D3333	Internal Root Repair Of Perforation Defects	0-999		
D3346	Retreatment Of Previous Root Canal Therapy - Anterior	0-999		
D3347	Retreatment Of Previous Root Canal Therapy - Premolar	0-999		
D3348	Retreatment Of Previous Root Canal Therapy - Molar	0-999		
D3351	Apexification / Recalcification - Initial Visit	0-999		
D3352	Apexification / Recalcification - Interim	0-999		
D3353	Apexification / Recalcification - Final Visit	0-999		
D3354	Pulpal Regeneration	0-999		

Code	Description	Age limits	Frequency limits	Other limits
D3355	Pulpal Regeneration - Initial Visit	0-999		
D3356	Pulpal Regeneration - Interim Medication Replacement	0-999		
D3357	Pulpal Regeneration - Completion Of Treatment	0-999		
D3410	Apicoectomy - Anterior	0-999		
D3421	Apicoectomy - Premolar (First Root)	0-999		
D3425	Apicoectomy - Molar (First Root)	0-999		
D3426	Apicoectomy - Each Additional Root)	0-999		
D3430	Retrograde Filling - Per Root	0-999		
D3450	Root Amputation - Per Root	0-999		
D3501	surgical exposure of root surface without apicoectomy or repair of root resorpti	0-999		
D3502	surgical exposure of root surface without apicoectomy or repair of root resorpti	0-999		
D3503	surgical exposure of root surface without apicoectomy or repair of root resorpti	0-999		
D3920	Hemisection (Including Any Root Removal), Not Including Root Canal Therapy	0-999		
D3999	Unspecified Endodontic Procedure, By Report	0-999		
D4210	Gingivectomy Or Gingivoplasty - Four Or More Contiguous Teeth	0-999	1 per quadrant every 36 Months	
D4211	Gingivectomy Or Gingivoplasty - One To Three Contiguous Teeth	0-999	1 per quadrant every 36 Months	
D4212	Gingevectomy/Gingivoplasty To Allow Access For Restorative Procedure, Per Tooth	0-999	1 per tooth every 36 Months	
D4240	Gingival Flap Procedure, Including Root Planing - Four Or More Contiguous Teeth	0-999	1 per quadrant every 36 Months	
D4241	Gingival Flap Procedure, Including Root Planing - One To Three Contiguous Teeth	0-999	1 per quadrant every 36 Months	
D4249	Clinical Crown Lengthening - Hard Tissue	0-999	1 per tooth every Lifetime	
D4260	Osseous Surgery (Including Flap And Closure) - Four Or More Teeth	0-999	1 per quadrant every 36 Months	
D4261	Osseous Surgery (Including Flap And Closure) - One To Three Teeth	0-999	1 per quadrant every 36 Months	
D4263	Bone Replacement Graft - First Site In Quadrant	0-999	1 per tooth every 36 Months	
D4266	Guided Tissue Generation, Natural Teeth - Resorbable Barrier, Per Site	0-999		
D4267	Guided Tissue Regeneration, Natural Teeth - Nonresorbable Barrier, Per Site (Inc	0-999		
D4270	Pedicle Soft Tissue Graft Procedure	0-999	1 per tooth every 36 Months	
D4273	Autogenous Connective Tissue Graft Proc, First Tooth, Implant Or Tooth Position	0-999	1 per tooth every 36 Months	

Code	Description	Age limits	Frequency limits	Other limits
D4275	Non-Autogenous Connective Tissue Graft, First Tooth, Implant Or Tooth Position	0-999	1 per tooth every 36 Months	
D4277	Free Soft Tissue Graft Procedure (Including Donor Site Surgery) First	0-999		
D4278	Free Soft Tissue Graft Procedure (Including Donor Site Surgery) Each Additional	0-999		
D4283	Autogenous Connective Tissue Graft Procedures, Each Additional	0-999		
D4285	Non-Autogenous Connective Tissue Graft, Each Additional	0-999	1 per tooth every 36 Months	
D4341	Periodontal Scaling And Root Planing - Four Or More Teeth Per Quadrant	0-999	1 per quadrant every 24 Months	
D4342	Periodontal Scaling And Root Planing - One To Three Teeth Per Quadrant	0-999	1 per quadrant every 24 Months	
D4355	Full Mouth Debridement To Enable Comprehensive Periodontal Evaluation And Diagno	0-999	1 per every Lifetime	
D4910	Periodontal Maintenance	0-999	1 per every 4 Years	
D4920	Unscheduled Dressing Change (By Someone Other Than Treating Dentist Or Staff)	0-999		
D4921	Gingival Irrigation With a Medicinal Agent - Per Quadrant	0-999		
D5110	Complete Denture - Maxillary	0-999	1 per every 60 Months	
D5120	Complete Denture - Mandibular	0-999	1 per every 60 Months	
D5130	Immediate Denture - Maxillary	0-999	1 per every 60 Months	
D5140	Immediate Denture - Mandibular	0-999	1 per every 60 Months	
D5211	Maxillary Partial Denture - Resin Base	0-999	1 per every 60 Months	
D5212	Mandibular Partial Denture - Resin Base	0-999	1 per every 60 Months	
D5213	maxillary partial denture - cast metal framework with resin denture bases	0-999	1 per every 60 Months	
D5214	mandibular partial denture - cast metal framework with resin denture bases	0-999	1 per every 60 Months	
D5221	immediate maxillary partial denture – resin base	0-999	1 per every 60 Months	
D5222	immediate mandibular partial denture – resin base	0-999	1 per every 60 Months	
D5223	immediate maxillary partial denture – cast metal framework with resin base	0-999	1 per every 60 Months	
D5224	immediate mandibular partial denture – cast metal framework with resin base	0-999	1 per every 60 Months	
D5282	removable unilateral partial denture - one piece cast metal (including retentive	0-999	1 per every 60 Months	

Code	Description	Age limits	Frequency limits	Other limits
D5283	removable unilateral partial denture - one piece cast metal (including retentive	0-999	1 per every 60 Months	
D5410	Adjust Complete Denture - Maxillary	0-999		
D5411	Adjust Complete Denture - Mandibular	0-999		
D5421	Adjust Partial Denture - Maxillary	0-999		
D5422	Adjust Partial Denture - Mandibular	0-999		
D5511	Repair Broken Complete Denture Base - Mandibular	0-999		
D5512	Repair Broken Complete Denture Base - Maxillary	0-999		
D5520	Replace Missing Or Broken Teeth - Complete Denture (Each Tooth)	0-999		
D5611	Repair Resin Partial Denture Base - Mandibular	0-999		
D5612	Repair Resin Partial Denture Base - Maxillary	0-999		
D5621	Repair Cast Partial Framework - Mandibular	0-999		
D5622	Repair Cast Partial Framework - Maxillary	0-999		
D5630	Repair Or Replace Broken Retentive / Clasping Materials - Per Tooth	0-999		
D5640	Replace Broken Teeth - Per Tooth	0-999		
D5650	Add Tooth To Existing Partial Denture	0-999		
D5660	Add Clasp To Existing Partial Denture - Per Tooth	0-999		
D5670	Replace All Teeth And Acrylic On Cast Metal Framework (Maxillary)	0-999		
D5671	Replace All Teeth And Acrylic On Cast Metal Framework (Mandibular)	0-999		
D5710	Rebase Complete Maxillary Denture	0-999	1 per every 36 Months	
D5711	Rebase Complete Mandibular Denture	0-999	1 per every 36 Months	
D5720	Rebase Maxillary Partial Denture	0-999	1 per every 36 Months	
D5721	Rebase Mandibular Partial Denture	0-999	1 per every 36 Months	
D5730	reline complete maxillary denture (direct)	0-999	1 per every 36 Months	
D5731	reline complete mandibular denture (direct)	0-999	1 per every 36 Months	
D5740	reline maxillary partial denture (direct)	0-999	1 per every 36 Months	
D5741	reline mandibular partial denture (direct)	0-999	1 per every 36 Months	
D5750	reline complete maxillary denture (indirect)	0-999	1 per every 36 Months	
D5751	reline complete mandibular denture (indirect)	0-999	1 per every 36 Months	
D5760	reline maxillary partial denture (indirect)	0-999	1 per every 36 Months	
D5761	reline mandibular partial denture (indirect)	0-999	1 per every 36 Months	

Code	Description	Age limits	Frequency limits	Other limits
D5850	Tissue Conditioning, Maxillary	0-999		
D5851	Tissue Conditioning, Mandibular	0-999		
D5863	Overdenture - Complete Maxillary	0-999		
D5864	Overdenture - Partial Maxillary	0-999		
D5865	Overdenture - Complete Mandibular	0-999		
D5866	Overdenture - Partial Mandibular	0-999		
D5999	Unspecified Maxillofacial Prosthesis, By Report	0-999		
D6010	Surgical Placement Of Implant Body: Endosteal Implant	0-999	1 per tooth every 60 Months	
D6012	Surgical placement of interim implant body for transitional prosthesis: endostea	0-999	1 per tooth every 60 Months	
D6040	Surgical Placement: Eposteal Implant	0-999	1 per arch every 60 Months	
D6050	Surgical Placement: Transosteal Implant	0-999	1 per tooth every 60 Months	
D6055	Connecting Bar - Implant Supported Or Abutment Supported	0-999	1 per tooth every 60 Months	
D6056	Prefabricated Abutment - Includes Modification And Placement	0-999	1 per tooth every 60 Months	
D6057	Custom Fabricated Abutment - Includes Placement	0-999	1 per tooth every 60 Months	
D6058	Abutment Supported Porcelain/Ceramic Crown	0-999	1 per tooth every 60 Months	
D6059	Abutment Supported Porcelain Fused To Metal Crown (High Noble Metal)	0-999	1 per tooth every 60 Months	
D6060	Abutment Supported Porcelain Fused To Metal Crown (Predominantly Base Metal)	0-999	1 per tooth every 60 Months	
D6061	Abutment Supported Porcelain Fused To Metal Crown (Noble Metal)	0-999	1 per tooth every 60 Months	
D6062	Abutment Supported Cast Metal Crown (High Noble Metal)	0-999	1 per tooth every 60 Months	
D6063	Abutment Supported Cast Metal Crown (Predominantly Base Metal)	0-999	1 per tooth every 60 Months	
D6064	Abutment Supported Cast Metal Crown (Noble Metal)	0-999	1 per tooth every 60 Months	
D6065	Implant Supported Porcelain/Ceramic Crown	0-999	1 per tooth every 60 Months	
D6066	implant supported crown – porcelain fused to metal crown (titanium, titanium all	0-999	1 per tooth every 60 Months	
D6067	implant supported metal crown – (titanium, titanium alloy, high noble metals all	0-999	1 per tooth every 60 Months	
D6068	Abutment Supported Retainer For Porcelain/Ceramic Fpd	0-999	1 per tooth every 60 Months	
D6069	Abutment Supported Retainer For Porcelain Fused To Metal Fpd (High Noble Metal)	0-999	1 per tooth every 60 Months	

Code	Description	Age limits	Frequency limits	Other limits
D6070	Abutment Supported Retainer For Porcelain Fused To Metal Fpd (Base Metal)	0-999	1 per tooth every 60 Months	
D6071	Abutment Supported Retainer For Porcelain Fused To Metal Fpd (Noble Metal)	0-999	1 per tooth every 60 Months	
D6072	Abutment Supported Retainer For Cast Metal Fpd (High Noble Metal)	0-999	1 per tooth every 60 Months	
D6073	Abutment Supported Retainer For Cast Metal Fpd (Base Metal)	0-999	1 per tooth every 60 Months	
D6074	Abutment Supported Retainer For Cast Metal Fpd (Noble Metal)	0-999	1 per tooth every 60 Months	
D6075	Implant Supported Retainer For Ceramic Fpd	0-999	1 per tooth every 60 Months	
D6076	implant supported retainer for porcelain fused to metal FPD – porcelain fused to	0-999	1 per tooth every 60 Months	
D6077	implant supported retainer for cast metal FPD – high noble alloys	0-999	1 per tooth every 60 Months	
D6080	Implant Maintenance Procedures, Including Removal And Reinsertion Of Prosthesis	0-999	1 per tooth every 60 Months	
D6090	Repair Implant Supported Prosthesis, By Report	0-999	1 per tooth every 60 Months	
D6091	Replacement Of Semi-Precision Or Precision Attachment	0-999	1 per tooth every 60 Months	
D6095	Repair Implant Abutment, By Report	0-999	1 per tooth every 60 Months	
D6100	Surgical removal of implant body removal, by report	0-999	1 per tooth every 60 Months	
D6101	Debridement Of A Peri-Implant Defect And Surface Cleaning	0-999	1 per tooth every 60 Months	
D6102	Debridement/Osseous Contouring Of Peri-Implant Defect; Includes Surface Cleaning	0-999	1 per tooth every 60 Months	
D6103	Bone Graft For Repair Of Peri-Implant Defect - Not Including Flap Entry/ Closure	0-999		
D6104	Bone Graft At Time Of Implant Placement	0-999		
D6110	Implant/Abutment Supported Removable Denture For Edentulous Maxillary Arch	0-999	1 per every 60 Months	
D6111	Implant/Abutment Supported Removable Denture For Edentulous Mandibular Arch	0-999	1 per every 60 Months	
D6112	Implant/Abutment Supported Removable Denture-Partially Edentulous Maxillary Arch	0-999	1 per every 60 Months	
D6113	Implant/Abutment Supported Removable Denture-Partially Edentulous Mand. Arch	0-999	1 per every 60 Months	
D6114	Implant/Abutment Supported Fixed Denture For Edentulous Maxillary Arch	0-999	1 per every 60 Months	
D6115	Implant/Abutment Supported Fixed Denture For Edentulous Mandibular Arch	0-999	1 per every 60 Months	

Code	Description	Age limits	Frequency limits	Other limits
D6116	Implant/Abutment Supported Fixed Denture-Partially Edentulous Maxillary Arch	0-999	1 per every 60 Months	
D6117	Implant/Abutment Supported Fixed Denture-Partially Edentulous Mandibular Arch	0-999	1 per every 60 Months	
D6190	Radiographic/Surgical Implant Index, By Report	0-999	1 per tooth every 60 Months	
D6210	Pontic - Cast High Noble Metal	0-999	1 per tooth every 60 Months	
D6211	Pontic - Cast Predominantly Base Metal	0-999	1 per tooth every 60 Months	
D6212	Pontic - Cast Noble Metal	0-999	1 per tooth every 60 Months	
D6214	pontic – titanium and titanium alloys	0-999	1 per tooth every 60 Months	
D6240	Pontic - Porcelain Fused To High Noble Metal	0-999	1 per tooth every 60 Months	
D6241	Pontic - Porcelain Fused To Predominantly Base Metal	0-999	1 per tooth every 60 Months	
D6242	Pontic - Porcelain Fused To Noble Metal	0-999	1 per tooth every 60 Months	
D6245	Pontic - Porcelain/Ceramic	0-999	1 per tooth every 60 Months	
D6545	Retainer - Cast Metal For Resin Bonded Fixed Prosthesis	0-999	1 per tooth every 60 Months	
D6548	Retainer - Porcelain/Ceramic For Resin Bonded Fixed Prosthesis	0-999	1 per tooth every 60 Months	
D6549	Resin Retainer - For Resin Bonded Fixed Prosthesis	0-999	1 per tooth every 60 Months	
D6740	Retainer Crown - Porcelain/Ceramic	0-999	1 per tooth every 60 Months	
D6750	Retainer Crown - Porcelain Fused To High Noble Metal	0-999	1 per tooth every 60 Months	
D6751	Retainer Crown - Porcelain Fused To Predominantly Base Metal	0-999	1 per tooth every 60 Months	
D6752	Retainer Crown - Porcelain Fused To Noble Metal	0-999	1 per tooth every 60 Months	
D6780	Retainer Crown - 3/4 Cast High Noble Metal	0-999	1 per tooth every 60 Months	
D6781	Retainer Crown - 3/4 Cast Predominantly Base Metal	0-999	1 per tooth every 60 Months	
D6782	Retainer Crown - 3/4 Cast Noble Metal	0-999	1 per tooth every 60 Months	
D6783	Retainer Crown - 3/4 Porcelain/Ceramic	0-999	1 per tooth every 60 Months	
D6790	Retainer Crown - Full Cast High Noble Metal	0-999	1 per tooth every 60 Months	

Code	Description	Age limits	Frequency limits	Other limits
D6791	Retainer Crown - Full Cast Predominantly Base Metal	0-999	1 per tooth every 60 Months	
D6792	Retainer Crown - Full Cast Noble Metal	0-999	1 per tooth every 60 Months	
D6930	Re-Cement Or Re-Bond Fixed Partial Denture	0-999		
D6980	Fixed Partial Denture Repair	0-999		
D7140	Extraction, Erupted Tooth Or Exposed Root	0-999		1 per tooth every Lifetime
D7210	Extraction, Erupted Tooth	0-999		1 per tooth every Lifetime
D7220	Removal Of Impacted Tooth - Soft Tissue	0-999		1 per tooth every Lifetime
D7230	Removal Of Impacted Tooth - Partially Bony	0-999		1 per tooth every Lifetime
D7240	Removal Of Impacted Tooth - Completely Bony	0-999		1 per tooth every Lifetime
D7241	Removal Of Impacted Tooth - Completely Bony, Unusual Surgical Complications	0-999		1 per tooth every Lifetime
D7250	Removal Of Residual Tooth (Cutting Procedure)	0-999		
D7251	Coronectomy - Intentional Partial Tooth Removal - Impacted Teeth Only	0-999		
D7260	Oroantral Fistula Closure	0-999		
D7261	Primary Closure Of Sinus Perforation	0-999		
D7270	Reimplantation And/Or Stabilization Of Accidentally Evulsed / Displaced Tooth	0-999		
D7280	Exposure of an Unerupted Tooth	0-999		
D7282	Mobilization Of Erupted Or Malpositioned Tooth To Aid Eruption	0-999		
D7283	Placement Of Device To Facilitate Eruption Of Impacted Tooth	0-999	1 per tooth every Lifetime	
D7285	Incisional Biopsy Of Oral Tissue - Hard (Bone, Tooth)	0-999		
D7286	Incisional Biopsy Of Oral Tissue - Soft	0-999		
D7288	Brush Biopsy - Transepithelial Sample Collection	0-999		
D7291	Transseptal Fiberotomy/Supra Crestal Fiberotomy, By Report	0-999		
D7310	Alveoloplasty In Conjunction With Extractions - Four Or More Teeth	0-999	1 per quadrant every Lifetime	
D7311	Alveoloplasty In Conjunction With Extractions - One To Three Teeth	0-999	1 per quadrant every Lifetime	
D7320	Alveoloplasty Not In Conjunction With Extractions - Four Or More Teeth	0-999	1 per quadrant every Lifetime	
D7321	Alveoloplasty Not In Conjunction With Extractions - One To Three Teeth	0-999	1 per quadrant every Lifetime	
D7471	Removal Of Lateral Exostosis (Maxilla Or Mandible)	0-999	1 per arch every Lifetime	
D7472	Removal Of Torus Palatinus	0-999		

Code	Description	Age limits	Frequency limits	Other limits
D7473	Removal Of Torus Mandibularis	0-999		
D7485	Reduction Of Osseous Tuberosity	0-999		
D7510	Incision And Drainage Of Abscess - Intraoral Soft Tissue	0-999		
D7511	Incision And Drainage Of Abscess - Intraoral Soft Tissue - Complicated	0-999		
D7520	Incision And Drainage Of Abscess - Extraoral Soft Tissue	0-999		
D7521	Incision And Drainage Of Abscess - Extraoral Soft Tissue - Complicated	0-999		
D7910	Suture Of Recent Small Wounds Up To 5 Cm	0-999		
D7921	Collection And Application Of Autologous Blood Concentrate Product	0-999	1 per every 36 Months	
D7953	Bone Replacement Graft For Ridge Preservation - Per Site	0-999		
D7961	buccal / labial frenectomy (frenulectomy)	0-999		
D7962	lingual frenectomy (frenulectomy)	0-999		
D7971	Excision Of Pericoronal Gingiva	0-999		
D7997	Appliance Removal (Not By Dentist Who Placed Appliance)	0-999		
D8010	Limited Orthodontic Treatment Of The Primary Dentition	0-18		
D8020	Limited Orthodontic Treatment Of The Transitional Dentition	0-18		
D8030	Limited Orthodontic Treatment Of The Adolescent Dentition	0-999		
D8040	Limited Orthodontic Treatment Of The Adult Dentition	0-999		
D8070	Comprehensive Orthodontic Treatment Of The Transitional Dentition	0-20	1 per every Lifetime	
D8080	Comprehensive Orthodontic Treatment Of The Adolescent Dentition	0-999	1 per every Lifetime	
D8090	Comprehensive Orthodontic Treatment Of The Adult Dentition	0-20	1 per every Lifetime	
D8210	Removable Appliance Therapy	0-20		
D8220	Fixed Appliance Therapy	0-999		
D8660	Pre-Orthodontic Treatment Examination To Monitor Growth And Development	0-20		
D8670	Periodic Orthodontic Treatment Visit	0-20	1 per every 76 Days (FQHC)	29 per every Lifetime
			1 per every 25 Days	29 per every Lifetime
D8680	Orthodontic Retention (Removal Of Appliances, Place Retainers)	0-999	1 per every Lifetime	
D9110	Palliative (Emergency) Treatment Of Dental Pain - Per Visit	0-999		
D9222	Deep Sedation/General Anesthesia - First 15 Minutes	0-999	1 per every Day	
D9223	Deep Sedation / General Anesthesia - Each subsequent 15 Minute Increment	0-999	9 per every Day	
D9230	Inhalation Of Nitrous/Analgesia, Anxiolysis	0-999		
D9239	Intravenous Moderate (Conscious) Sedation/Analgesia - First 15 Minutes	0-999	1 per every Day	
D9243	Intravenous Moderate (Conscious) Sedation/Analgesia - Each Subsequent 15 Minute	0-999	9 per every Day	

Code	Description	Age limits	Frequency limits	Other limits
D9248	Non-Intravenous Conscious Sedation	0-999		
D9310	Consultation - Diagnostic Service Provided By Dentist Or Physician	0-999		
D9610	Therapeutic Parenteral Drug, Single Administration	0-999		
D9930	Treatment Of Complications (Post Surgical) - Unusual Circumstances, By Report	0-999		
D9932	Cleaning And Inspection of Removable Complete Denture, Maxillary	0-999	1 per every 60 Months	
D9933	Cleaning And Inspection of Removable Complete Denture, Mandibular	0-999	1 per every 60 Months	
D9934	Cleaning And Inspection of Removable Partial Denture, Maxillary	0-999	1 per every 60 Months	
D9935	Cleaning And Inspection of Removable Partial Denture, Mandibular	0-999	1 per every 60 Months	
D9943	Occlusal Guard Adjustment	0-999	1 per every 24 Months	
D9944	Occlusal Guard-hard appliance, full arch	13-999	1 per every 12 Months	
D9945	Occlusal Guard-soft appliance, full arch	13-999	1 per every 12 Months	
D9946	Occlusal Guard-hard appliance, partial arch	13-999	1 per every 12 Months	
D9994	Dental Case Management - Patient education	0-999	1 per year	
D9995	Teledentistry - Synchronous; Real-Time Encounter	0-999	1 per every Day	
D9996	Teledentistry - Asynchronous; Information Stored And Forwarded To Dentist	0-999	1 per every Day	
D9999	Unspecified Adjunctive Procedure, By Report	0-999		

B.3 Pennsylvania Medicaid - Benefit Limit Exception (BLE) Process

Regulatory information

Section 6.8 of the Pennsylvania PROMISe™ Provider Handbook states that there are certain benefits offered to recipients age 21 and over outside of the standard benefit allowances. In order to access these additional benefits, providers must use the standard UHC BLE form and must follow the process below.

Members Eligible for BLE

Pennsylvania Medicaid Members age 21 and over.

Procedures Eligible for BLE

The BLE process will be required for the following procedures.

Code	Procedure	Frequency allowed without a BLE
D0120	periodic oral evaluation	1/180 Days
D1110	prophylaxis - adult	1/180 Days
D5110	complete denture - maxillary	1/1 Lifetime
D5130	immediate denture - maxillary	1/1 Lifetime
D5211	maxillary partial denture - resin base (including retentive/clasping materials, rests, and teeth)	1/1 Lifetime Regardless of Code*
D5213	maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and	1/1 Lifetime Regardless of Code*
D5120	complete denture - mandibular	1/1 Lifetime Regardless of Code*
D5140	immediate denture - mandibular	1/1 Lifetime Regardless of Code*
D5212	mandibular partial denture - resin base (including retentive/clasping materials, rests, and teeth)	1/1 Lifetime Regardless of Code*
D5214	mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and	1/1 Lifetime Regardless of Code*
D2710	crown, resin-based composite (indirect)	None
D2721	crown - resin with predominantly base metal	None
D2740	crown - porcelain/ceramic	None
D2751	crown - porcelain fused to predominantly base metal	None
D2791	crown - full cast predominantly base metal	None
D2910	recement or re-bond inlay, onlay, veneer or partial coverage restoration	None
D2915	recement or re-bond cast indirectlty fabricated or prefabricated post and core	None
D2920	recement or re-bond crown	None
D2952	cast post and core in addition to crown	None
D2954	prefabricated post and core in addition to crown	None
D2980	crown repair necessitated by restorative material failure	None
D4210	gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant	None
D4341	periodontal scaling and root planing - four or more teeth per quadrant	None

D4342	periodontal scaling and root planing for one to three teeth per quadrant,	None
D4355	full mouth debridement to enable a comprehensive oral evaluation and diagnosis on a subsequent visit	None
D4910	periodontal maintenance	None
D3310	endodontic therapy, anterior tooth (excluding final restoration)	None
D3320	endodontic therapy, premolar tooth (excluding final restoration)	None
D3330	endodontic therapy, molar tooth (excluding final restoration)	None
D3410	Apicoectomy - anterior	None
D3421	Apicoectomy - premolar (first root)	None
D3425	Apicoectomy - molar (first root)	None
D3426	Apicoectomy (each additional root)	None

*The lifetime limit for dentures will begin with claims payment history on and after dates of service April 27, 2015 due to Medicaid expansion. Additional dentures will require an approved BLE request.

BLE process

- **Authorization:** To access procedures that are eligible for BLE, providers must submit an authorization on the standard ADA form and attach the UnitedHealthcare BLE form. This may be an electronic or a paper authorization. Without an approved authorization, BLE claim will be denied.
  Note: It is not required to have a denied authorization before seeking a BLE service. BLE Services are initiated by the submission of an authorization along with a BLE form.
- **Diagnosis Code:** To request BLE services, providers must use diagnosis code Z98.818 in the diagnosis code field on the standard ADA form. This will enable the claim system to allow the additional BLE services. Without this diagnosis code, procedures will be subject to standard limitations.
  Note: The diagnosis code must be present on both the authorization request and the claim in order to be paid for BLE services.
- **UnitedHealthcare BLE Form:** Providers must attach the approved UHC BLE form to the authorization request. Providers will use this form to indicate the reason the BLE is necessary according to the state criteria. Providers must check the appropriate box and include a description of the medical needs that require the requested service(s) in the appropriate section. Without a complete UnitedHealthcare BLE form, the request will be denied.
  - A UnitedHealthcare Dental Consultant will review the authorization request along with the attached UnitedHealthcare BLE form and make a determination. The determination will be communicated in writing and on the online provider portal. See “Member and Provider Communication” section.
- **Claim:** If the BLE authorization request is approved, the provider will perform the requested treatment and submit the corresponding claim documentation.
  - **Diagnosis Code:** The same diagnosis code (Z98.818) must be documented in the diagnosis code field on the standard ADA claim form. This will enable the claim system to allow the additional BLE services. Without this diagnosis code, procedures will be subject to standard limitations.
    Note: The diagnosis code must be present on both the authorization request and the claim in order to be paid for BLE services.

Criteria for approval

Upon receipt of the BLE authorization request, UnitedHealthcare Dental Consultants will review the documentation submitted to determine if the BLE is approved. UnitedHealthcare Dental Consultants use the criteria defined by the State of Pennsylvania, as reflected on the UnitedHealthcare BLE Form.

The following qualifiers will be evaluated:

- The BLE request will be reviewed to determine if one of the criteria is met without requiring supporting medical record documentation of the condition.
  1. Diabetes
  2. Coronary Artery Disease
  3. Cancer of the Face, Neck, and Throat (does not include stage 0 or stage 1 noninvasive basal or sarcoma cell cancers of the skin)
  4. Intellectual Disability
  5. Current Pregnancy
- Does the patient have a serious chronic systemic illness or other serious health condition, and denial of the exception will jeopardize the life of the recipient?
- Does the patient have a serious chronic systemic illness or other serious health condition and denial of the exception will result in the serious deterioration of the health of the recipient?
- Would granting the exception be a cost-effective alternative for the MA Program
- Would granting the exception be necessary in order to comply with Federal law?

Along with checking the appropriate boxes, providers must include a description of the medical needs that require the requested services in the appropriate field and should include supplemental information to substantiate the selected qualifier.

Member and provider communication

UnitedHealthcare will communicate the determination of the BLE request in writing to both the member and the provider. The communication will be mailed to the member, faxed to the provider, and made available online via the provider portal.

BLE Request Form

SKYGEN/Pennsylvania Plans Dental Benefit Limit Exception (BLE) Request Form

Failure to complete this form in its entirety will result in this form being returned unprocessed. This form must be attached to a completed ADA dental claim form and mailed to:
SKYGEN Attention: UPMC Health Plan BLE Authorizations, *P.O. Box 351 Milwaukee WI 53201*

Member Last Name___________________________First Name______________

Member ID Number____________________________Member Date of Birth____

Provider Last Name____________________________First Name _____________

Provider NPI #_________________________________Provider Telephone (____)

Benefit Request Type ☐ Prospective ☐ Retrospective - Date(s) of Service ______________________

Benefit Limit Criteria to be reviewed (check all that apply):

☐ Member has a serious chronic systemic illness or other serious health condition and denial of the exception will jeopardize the life of the Member.

☐ Member has a serious chronic illness or other serious health condition and denial of the exception will result in the serious deterioration of the health of the Member.

☐ Granting the exception is a cost - effective alternative for Plan.

☐ Granting the exception is necessary in order to comply with Federal law.

This request must include documentation supporting the need for the service, including but not limited to chart documentation to include a treatment plan, radiographs (if applicable), and medical and dental history.

Explain why the Member meets criteria for a benefit limit exception in the space below. The explanation should be in narrative form and include a comprehensive justification (attach additional pages as necessary).

____

____

____

SKYGEN will notify the Provider and Member of its decision **within 2 business days of receiving the request or within 2 business days of receiving additional information if requested by Skygen.**

I attest that the information provided and statements made herein are true, accurate and complete, to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Provider Signature____Date____________________________

Appendix C: Authorization for treatment

C.1 Dental treatment requiring authorization

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

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

For questions concerning prior authorization, dental claim procedures, or to request clinical criteria, please call the Provider Services Line at 1-800-508-4876.

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

Authorization submission mailing address:

UnitedHealthcare Specialty Benefits
Attn: Authorizations
PO BOX 779
Milwaukee WI 53201

C.2 Authorization timelines

The following timelines will apply to requests for authorization:

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

C.3 Clinical criteria and documentation requirements for services requiring authorization

2021 Pennsylvania Medicaid clinical criteria

Prior authorization of treatment and emergency treatment

When submitting for prior authorization / retrospective review of these procedures, please note the documentation requirements when sending in the information to Skygen Dental. Skygen Dental criteria utilized for medical necessity determination were developed from information collected from American Dental Association's Code Manuals, clinical articles and guidelines, as well as dental schools, practicing dentists, insurance companies, other dental related organizations, and local state or health plan requirements. The criteria Skygen Dental reviewers will look for in order to approve the request is

listed below. Should the procedure need to be initiated under an emergency condition to relieve pain and suffering, you are to provide treatment to alleviate the patient's condition. However, to receive reimbursement for the treatment, Skygen Dental will require the same criteria / documentation be provided (with the claim for payment) and the same criteria be met to receive payment for the treatment.

When reviewing requests for services the following guidelines will be used: Treatment will not be routinely approved when functional replacement with less costly restorative materials, including prosthetic replacement, is possible. Dental work for cosmetic reasons or because of the personal preference of the member or provider is not within the scope of the Medicaid program.

Procedure	Procedure codes	Required documentation (simplified)	Criteria for approval	Prior or post
Crowns	D2710, D2721, D2740, D2751, D2791	Current x-rays Narrative of necessity if decay not evident on films	• Anterior - 50% incisal edge / 4+ surfaces involved • Bicuspid - 1 cusp / 3+ surfaces involved • Molar - 2 cusps / 4+ surfaces involved • Minimum 50% bone support • No periodontal furcation • No subcrestal caries • Clinically acceptable RCT (if performed)	Prior
Endodontic Therapy	D3310, D3320, D3330	treatment Pre-op x-rays (excluding BWX)	• Minimum 50% bone support • No periodontal furcation • No subcrestal caries • Evidence of apical pathology/fistula • Pain for percussion/temp • Closed apex	Prior
Gingivectomy or gingivoplasty - four or more contiguous teeth	D4210	Current x-rays Complete 6 point periodontal charting Narrative of necessity	• Hyperplasia or hypertrophy from drug therapy, hormonal disturbances or congenital defects • Generalized 5 mm or more pocketing indicated on the periodontal charting	Prior
Periodontal scaling and root planing - four or more teeth per quadrant	D4341	Current x-rays Complete 6 point periodontal charting	Covered in the following scenarios: • Four or more teeth in the quadrant • Probing depths of at least 5 mm or greater • Radiographic evidence of bone loss Not covered in the following situations: • For the removal of heavy deposits of calculus and plaque in the absence of clinical attachment loss • Gingivitis as defined by inflammation of the gingival tissue without loss of attachment (bone and tissue) • As a sole treatment for refractory chronic, aggressive or advanced Periodontal Diseases	Prior
Periodontal scaling and root planing - one to three teeth per quadrant	D4342	Current x-rays Complete 6 point periodontal charting	Covered in the following scenarios: • One to three teeth in the quadrant • Probing depths of at least 5 mm or greater • Radiographic evidence of bone loss Not covered in the following situations: • For the removal of heavy deposits of calculus and plaque in the absence of clinical attachment loss • Gingivitis as defined by inflammation of the gingival tissue without loss of attachment (bone and tissue) • As a sole treatment for refractory chronic, aggressive or advanced Periodontal Diseases	

Procedure	Procedure codes	Required documentation (simplified)	Criteria for approval	Prior or post
Full mouth debridement to enable a comprehensive oral evaluation	D4355	Narrative of necessity	• Indicated when, due to the amount of calculus, plaque and debris, a comprehensive examination and diagnosis is not possible.	Post
Periodontal maintenance	D4910	Current x-rays Complete 6 point periodontal charting	Covered in the following scenarios: • To maintain the results of surgical and non-surgical periodontal treatment • As an extension of active periodontal therapy at selected intervals Not covered in the following scenarios: • If no history of scaling and root planing (SRP) or surgical procedures	Prior
Complete dentures	D5110, D5120, D5130, D5140	Panoramic x-ray or FMX	• Remaining teeth do not have adequate bone support or are not restorable • Existing denture greater than 5 years old and unserviceable (narrative must explain why any existing denture is not serviceable or cannot be relined or rebased) Complete dentures for nursing facility beneficiaries - This procedure is to be used for requesting complete dentures only: • When a beneficiary is a resident of a nursing facility and the medical condition is such that the beneficiary cannot be moved from a room of the facility to obtain the needed radiographs, a Dental Services Certification form (available through the nursing facility) can be submitted, in lieu of radiographs, with the ADA Claim Form - Version 2019. • When submitting a request with a certification form, the treatment plan should contain sufficient detail for a thorough diagnostic review. The Dental Certification form must be completed and signed. Enter the statement "DENTAL CERTIFICATION FORM SUBMITTED IN LIEU OF RADIOGRAPHS" in the Remarks section of the ADA Claim Form - Version 2019.	Prior
Partial dentures	D5211, D5212, D5213, D5214	Panoramic x-ray or FMX	• Replacing one or more anterior teeth • Replacing three or more posterior teeth (excluding 3rd molars) • Existing partial denture greater than 5 years old and unserviceable • Abutment teeth have greater than 50% bone support and are restorable	Prior
Removal of impacted tooth	D7220, D7230, D7240	Current panoramic x-ray Narrative of necessity	Covered in the following scenarios: • Recurrent Infection and/or pathology (abscess, cellulitis, pericoronitis that does not respond to conservative treatment) • Non restorable caries, pulpal or periapical lesions or pulpal exposure • Tumor resection • Ectopic position/impinges on the root of an adjacent tooth/horizontal impacted, jeopardizing another molar • X-rays must match the type of impaction code described Not covered in the following scenarios: • Asymptomatic impactions (lack of demonstrative pathology) • For pain or discomfort related to normal tooth eruption • For prophylactic reasons other than an underlying medical condition	Prior
Removal of residual tooth roots	D7250	Current panoramic x-ray Narrative of necessity	• When tooth roots or fragments of tooth roots remain in the bone following a previous incomplete tooth extraction	Prior
Exposure of an unerupted tooth	D7280	Current panoramic x-ray Narrative of necessity	• Documentation supports this is needed for a normally developing permanent tooth that is unable to erupt into a functional position	Prior

Procedure	Procedure codes	Required documentation (simplified)	Criteria for approval	Prior or post
Placement of device to facilitate eruption of impacted tooth	D7283	Current panoramic x-ray Narrative of necessity	• Documentation supports this is needed following the surgical exposure of an un-erupted tooth to aid in its eruption	Prior
Comprehensive orthodontic treatment	D8080		• Documentation shows deep impinging overbite that shows palatal impingement of the majority of lower incisors • Documentation shows true anterior open bite (not including one or two teeth slightly out of occlusion or where the incisors have not fully erupted) • Documentation shows a large anterior – posterior discrepancy (Class II and Class III malocclusions that are virtually a full tooth Class II or Class III) • Documentation shows anterior cross bite (involves more than two teeth in cross bite) • Documentation shows posterior transverse discrepancies (involves several posterior teeth in cross bite, not a single tooth in cross bite) • Documentation shows significant posterior open bites (not involving partially erupted teeth or one or two teeth slightly out of occlusion) • Documentation shows impacted canines that will not erupt into the arch without orthodontic or surgical intervention (does not include cases where canines are going to erupt ectopically) • Documentation supports Salzmann Criteria Index Form score of 25+	Prior
Replacement of lost or broken retainer - Maxillary/ Mandibular	D8703, D8704	Narrative of Medical Necessity	• Narrative of Medical Necessity advising patient lost or broke retainer	Prior
Appliance therapy	D8210, D8220	Pano – Ceph Photos Treatment Plan	• Documentation of thumb sucking or tongue thrusting habit	Prior
Orthodontic retention (removal of appliances, place retainers)	D8680	Current photos		Prior

Procedure	Procedure codes	Required documentation (simplified)	Criteria for approval	Prior or post
Deep sedation / general anesthesia and intravenous moderate (conscious) sedation	D9223, D9243		• A statement must be included in the Remarks section of the invoice justifying the use of anesthesia/sedation on the basis of the beneficiary's condition and/or the nature of the oral surgery plus medical necessity. If the procedure performed is one of the surgical procedures identified in the MA Program Fee Schedule, medical necessity does not have to be documented. • What constitutes acceptable documentation for the condition of the beneficiary or the nature of the oral surgery to justify anesthesia/ sedation? – Child is under 7 years of age and more than one simple extraction or surgical extraction is performed. b. Beneficiary has medical conditions that preclude the use of local anesthesia. c. Severe infection at the injection site. d. Beneficiaries with intellectual disability, other mental health or physical conditions and who are unmanageable using local anesthesia. e. Multiple extractions in more than one quadrant. If the treatment is simple or surgical extractions, two or more quadrants must have had at least two teeth extracted per quadrant or three or more quadrants had at least one tooth extracted per quadrant. • What constitutes acceptable documentation to justify medical necessity? a. Severe infection at the injection site. b. Severe cerebral palsy, unmanageable. c. Severe intellectual disability, unmanageable. • Examples of unacceptable documentation: a. Beneficiary unable to tolerate the procedure. b. Beneficiary prefers or requests general anesthesia. c. Beneficiary wants to be asleep. d. Additional invoicing requirements – Dental practitioners who administer and bill DHS for anesthesia/ sedation when performing outpatient surgical procedures or tooth extractions dental provider handbook_ master_10-17-17. doc 82 October 17, 2017 (warranting anesthesia/ sedation) must bill for the surgical extractions and the anesthesia/sedation on the same invoice. Any substantiating documentation to justify payment for the anesthesia must be included in the Remarks section of the claim form.	Post
Unspecified procedures, by report	D5899, D7999	Description of procedure and narrative of medical necessity	• Procedure cannot be adequately described by an existing code • Documentation supports medical necessity	Prior
Custom sleep apnea appliance fabrication and placement	D9947	Narrative of medical necessity	• Copy of a documented sleep study (not done by dentist) and referral letter from physician with diagnosis and requested dental treatment	Prior
Unspecified adjunctive procedure, by report (Used for treatment done in an ASC/OR	D9999	Narrative of medical necessity Name of hospital/ outpatient facility	• Compromising medical condition • Age • Behavior/cognitive impairment • Complexity of care	Prior

2021 Pennsylvania CHIP Clinical Criteria

Prior Authorization of Treatment and Emergency Treatment

When submitting for prior authorization / retrospective review of these procedures, please note the documentation requirements when sending in the information to Skygen Dental. Skygen Dental criteria utilized for medical necessity determination were developed from information collected from American Dental Association's Code Manuals, clinical articles and guidelines, as well as dental schools, practicing dentists, insurance companies, other dental related organizations, and local state or health plan requirements. The criteria Skygen Dental reviewers will look for in order to approve the request is listed below. Should the procedure need to be initiated under an emergency condition to relieve pain and suffering, you are to provide treatment to alleviate the patient's condition. However, to receive reimbursement for the treatment, Skygen Dental will require the same criteria / documentation be provided (with the claim for payment) and the same criteria be met to receive payment for the treatment.

When reviewing requests for services the following guidelines will be used: Treatment will not be routinely approved when functional replacement with less costly restorative materials, including prosthetic replacement, is possible. Dental work for cosmetic reasons or because of the personal preference of the member or provider is not within the scope of the Medicaid program.

Procedure	Procedure codes	Required documentation (simplified)	Criteria for approval	Prior or post
Onlays and crowns	D2542, D2543, D2544, D2710, D2721, D2740, D2750, D2751, D2752, D2780, D2781, D2783, D2790, D2791, D2792, D2794	Current x-rays Narrative of necessity if decay not evident on films	• Anterior - 50% incisal edge / 4+ surfaces involved • Bicuspid - 1 cusp / 3+ surfaces involved • Molar - 2 cusps / 4+ surfaces involved • Minimum 50% bone support • No periodontal furcation • No subcrestal caries • Clinically acceptable RCT (if performed)	Prior
Prefabricated crowns	D2932, D2934	Current x-rays Narrative of necessity if decay not evident on films	• More than two surfaces affected with carious lesions, or where extensive one or two surface lesions are present • Extensive tooth surface loss due to attrition, abrasion or erosion • Cervical decalcification and/or developmental defects (hypoplasia, hypocalcification, enamel hypoplasia, amelogenesis imperfecta, dentinogenesis imperfecta, etc.) • Following pulpotomy or pulpectomy • Intermediate restoration of fractured teeth	Prior
Protective restoration	D2940	Current x-rays	Covered in the following scenarios: • To relieve pain • To promote healing • To prevent further deterioration • To retain tissue form Not a covered benefit in these situations: • As a liner or base for a definitive restoration • Not for endodontic access closure	Prior
Core buildup	D2950	Current x-rays Narrative of necessity if decay not evident on films	• Significant loss of coronal tooth structure due to caries or trauma in which insufficient tooth structure remains to adequately retain an indirect restoration.	Prior

Procedure	Procedure codes	Required documentation (simplified)	Criteria for approval	Prior or post
Prefabricated post and core in addition to crown	D2954	Current x-rays Narrative of necessity if decay not evident on films	• For teeth with significant loss of coronal tooth structure in endodontically treated teeth in which insufficient tooth structure remains to adequately retain an indirect restoration • For Posts: when there is inadequate remaining tooth structure to support a core	Prior
Post removal	D2955	Current x-rays	• When there has been loss of adequate retention • In the case of fracture of tooth and/or Post and core • When there is recurrent caries associated with Post and core • When access is needed to root canal system for non-surgical endodontics • When the tooth has a reasonable long-term prognosis for a new restoration	Prior
Additional procedures to construct new crown under existing partial	D2971	Panoramic or FMX Narrative of necessity	Documentation supports procedure, missing teeth on at least one side of requested crown	Prior
Endodontic therapy	D3310, D3320, D3330	Current x-rays	Covered in the following scenarios: • A restorable mature, completely developed permanent or primary tooth with irreversible pulpitis, necrotic pulp or frank vital pulpal exposure • Teeth with radiographic periapical pathology • Primary teeth without a permanent successor • Trauma • When needed for prosthetic rehabilitation Not covered in the following situations: • Teeth with a poor long-term prognosis • Teeth with inadequate bone support or advanced or untreated periodontal disease • Teeth with incompletely formed root apices • 3rd Molars (unless it is an abutment tooth)	Prior
Retreatment of previous root canal therapy	D3346, D3347, D3348	Current x-rays	• Tooth is sensitive to pressure and percussion or other subjective symptoms • Placement of a post has the potential to compromise the existing obturation or apical seal of the canal system • Minimum 50% bone support • No periodontal furcation • No subcrestal caries • Evidence of apical pathology/fistula • Pain from percussion / temp	Prior
Apexification / recalcification	D3351, D3352, D3353	Current x-rays Narrative of necessity	Covered in the following scenarios: • Incomplete apical closure in a permanent tooth root • External root resorption or when the possibility of external root resorption exists • Necrotic pulp, irreversible pulpitis or periapical lesion • For prevention or arrest of resorption • Perforations or root fractures that do not communicate with oral cavity Not covered in the following situations: • A tooth with a completely closed apex	Prior

Procedure	Procedure codes	Required documentation (simplified)	Criteria for approval	Prior or post
Apicoectomy	D3410, D3421, D3425, D3426	Current x-rays Narrative of necessity	Covered in the following scenarios: • Failed retreatment of endodontic therapy • When the apex of tooth cannot be accessed due to calcification or another anomaly • When a biopsy of periradicular tissue is Necessary • Where visualization of the periradicular tissues and tooth root is required when perforation or root fracture is suspected • Further diagnosis when post endodontic therapy symptoms persist • A marked over extension of obturating materials interfering with healing Not covered in the following situations: • Unusual bony or root configurations resulting in lack of surgical access • The possible involvement of neurovascular structures • Teeth with a hopeless prognosis	Prior
Retrograde filling - per root	D3430	Current x-rays Narrative of necessity	• Periradicular pathosis and a blockage of the root canal system that could not be obturated by nonsurgical root canal treatment • Persistent Periradicular pathosis resulting from an inadequate apical seal that cannot be corrected non-surgically • Root perforations • Resorptive defects	Prior
Root amputation - per root	D3450	Current x-rays Narrative of necessity	• Class III Furcation involvement • Untreatable bony defect (of one root) • Root fracture • Root caries • Root resorption • Persistent sinus tract or recurrent apical pathology • When there is greater than 75% bone supporting remaining root(s) • The tooth has had successful endodontic treatment	Prior
Surgical exposure of root surface	D3501, D3502, D3503	Current x-rays Narrative of necessity	• Failed retreatment of endodontic therapy • When the apex of tooth cannot be accessed due to calcification or another anomaly • When a biopsy of Periradicular tissue is Necessary • Where visualization of the Periradicular tissues and tooth root is required when perforation or root fracture is suspected • Further diagnosis when post endodontic therapy symptoms persist • A marked overextension of obturating materials interfering with healing	Prior
Gingivectomy or gingivoplasty	D4210, D4211	Current x-rays Complete 6 point periodontal charting Narrative of necessity	• Hyperplasia or hypertrophy from drug therapy, hormonal disturbances or congenital defects • Generalized 5 mm or more pocketing indicated on the periodontal charting	Prior
Gingival flap procedure, including root planing - four or more contiguous teeth	D4240	Current x-rays Complete 6 point periodontal charting Narrative of necessity	• The presence of moderate to deep probing depths • Moderate/severe gingival enlargement or extensive areas of overgrowth • Loss of attachment • The need for increased access to root surface and/or alveolar bone when previous non-surgical attempts have been unsuccessful • The diagnosis of a cracked tooth, fractured root or external root resorption when this cannot be accomplished by non-invasive methods • To preserve keratinized tissue in conjunction with osseous surgery	Prior

Procedure	Procedure codes	Required documentation (simplified)	Criteria for approval	Prior or post
Clinical crown lengthening - hard tissue	D4249	Current x-rays Complete 6 point periodontal charting Narrative of necessity	• In an otherwise periodontally healthy area to allow a restorative procedure on a tooth with little to no crown exposure • To allow preservation of the biological width for restorative procedures	Prior
Osseous surgery	D4260, D4261	Current x-rays Complete 6 point periodontal charting Narrative of necessity	• Patients with a diagnosis of moderate to advanced or Refractory periodontal disease • When less invasive therapy (i.e., non-surgical periodontal therapy, Flap procedures) has failed to eliminate disease	Prior
Guided tissue generation	D4266, D4267	Current x-rays Complete 6 point periodontal charting Narrative of necessity	• Intrabony/infrabony vertical defects • Class II Furcation involvements • To enhance periodontal tissue regeneration and healing for mucogingival defects in conjunction with mucogingival surgeries	Prior
Tissue graft procedure	D4270, D4273	Current x-rays Complete 6 point periodontal charting Narrative of necessity	• Areas with less than 2 mm of attached gingiva • Unresolved sensitivity in areas of Recession • Progressive Recession or chronic inflammation • Teeth with subgingival restorations where there is little or no attached gingiva to improve plaque control	Prior
Periodontal scaling and root planing	D4341, D4342	Current x-rays Complete 6 point periodontal charting	Covered in the following scenarios: • D4341 = Four or more teeth in the quadrant • D4342 = One to three teeth in the quadrant • Probing depths of at least 5 mm or greater • Radiographic evidence of bone loss Not covered in the following situations: • For the removal of heavy deposits of calculus and plaque in the absence of clinical attachment loss • Gingivitis as defined by inflammation of the gingival tissue without loss of attachment (bone and tissue) • As a sole treatment for refractory chronic, aggressive or advanced Periodontal Diseases	Prior
Periodontal maintenance	D4910	Current x-rays Complete 6 point periodontal charting	Covered in the following scenarios: • To maintain the results of surgical and non-surgical periodontal treatment • As an extension of active periodontal therapy at selected intervals Not covered in the following scenarios: • If no history of scaling and root planing (SRP) or surgical procedures	Prior
Gingival irrigation - per quadrant	D4921	Current x-rays Complete 6 point periodontal charting	• Documentation supports medical necessity for why this is needed as an extension of periodontal therapy.	Prior

Procedure	Procedure codes	Required documentation (simplified)	Criteria for approval	Prior or post
Complete dentures	D5110, D5120, D5130, D5140	Panoramic x-ray or FMX	• Remaining teeth do not have adequate bone support or are not restorable • Existing denture greater than 5 years old and unserviceable (narrative must explain why any existing denture is not serviceable or cannot be relined or rebased) Complete dentures for nursing facility beneficiaries - This procedure is to be used for requesting complete dentures only: • When a beneficiary is a resident of a nursing facility and the medical condition is such that the beneficiary cannot be moved from a room of the facility to obtain the needed radiographs, a Dental Services Certification form (available through the nursing facility) can be submitted, in lieu of radiographs, with the ADA Claim Form - Version 2019. • When submitting a request with a certification form, the treatment plan should contain sufficient detail for a thorough diagnostic review. The Dental Certification form must be completed and signed. Enter the statement "DENTAL CERTIFICATION FORM SUBMITTED IN LIEU OF RADIOGRAPHS" in the Remarks section of the ADA Claim Form - Version 2019.	Prior
Partial dentures	D5211, D5212, D5213, D5214	Panoramic x-ray or FMX	• Replacing one or more anterior teeth	Prior
Removable unilateral partial denture	D5282, D5283	Panoramic x-ray or FMX	• Replacing one or more missing teeth in one quadrant • Existing partial denture greater than 5 years old and unserviceable • Remaining teeth have greater than 50% bone support and are restorable	Prior
Overdentures	D5863, D5864, D5865, D5866	Panoramic x-ray or FMX Narrative of necessity	• To preserve the integrity of the edentulous ridge • When the teeth available as retainers have a good long-term prognosis	Prior
Surgical placement of implant body	D6010, D6012, D6040, D6050	Panoramic x-ray or FMX	• Documentation shows healthy bone and periodontium	Prior
Implant related services	D6055, D6056, D6058, D6059, D6060, D6061, D6062, D6063, D6064, D6065, D6066, D6067, D6068, D6069, D6070, D6071, D6072, D6073, D6074, D6075, D6076, D6077	At least 12 weeks post-operative x-rays of osseointegrated implant.	• Documentation shows fully integrated surgical implant with good crown / root ratio • Healthy bone and periodontium surrounding surgical implant	Prior
Bridges	D6210, D6211, D6212, D6214, D6240, D6242, D6245, D6545, D6548, D6740, D6750, D6751, D6752, D6780, D6781, D6782, D6783, D6790, D6791, D6792	Panoramic x-ray or FMX Dental charting indicating missing teeth	• Replacement of missing permanent teeth in which the Retainer/ Abutment teeth have a favorable long-term prognosis • Replacement of one to two missing teeth in a Tooth Bounded Space • Minimum 50% bone support on abutments • No periodontal furcation on abutments • No sub-crestal caries on abutments • Clinically acceptable RCT on abutments Replacement of existing fixed partial denture: • One of the abutment crowns is defective on existing bridge • One of the abutment crowns has recurrent decay on existing bridge • One of the abutment crowns needs root canal on existing bridge	Prior

Procedure	Procedure codes	Required documentation (simplified)	Criteria for approval	Prior or post
Bridge repair	D6980	Narrative of necessity	Documentation supports medical necessity and the appliance to be repaired is functional and has a favorable long-term prognosis.	Prior
Removal of impacted tooth	D7220, D7230, D7240, D7241,	Current panoramic x-ray Narrative of necessity	Covered in the following scenarios: • Recurrent Infection and/or pathology (abscess, cellulitis, pericoronitis that does not respond to conservative treatment) • Non restorable caries, pulpal or periapical lesions or pulpal exposure • Tumor resection • Ectopic position/impinges on the root of an adjacent tooth/horizontal impacted, jeopardizing another molar • X-rays must match the type of impaction code described Not covered in the following scenarios: • Asymptomatic impactions (lack of demonstrative pathology) • For pain or discomfort related to normal tooth eruption • For prophylactic reasons other than an underlying medical condition	Prior
Removal of residual tooth roots	D7250	Current panoramic x-ray Narrative of necessity	• When tooth roots or fragments of tooth roots remain in the bone following a previous incomplete tooth extraction	Prior
Coronectomy - intentional partial tooth removal	D7251	Current panoramic x-ray Narrative of necessity	• When clinical criteria for extraction of impacted teeth is met • When the removal of complete tooth would likely result in damage to the neurovascular bundle	Prior
Oroantral fistula closure	D7260	Current panoramic x-ray Narrative of necessity	• An oroantral fistula will not heal spontaneously and must be surgically repaired	Prior
Exposure of an unerupted tooth	D7280	Current panoramic x-ray Narrative of necessity	• Documentation supports this is needed for a normally developing permanent tooth that is unable to erupt into a functional position	Prior
Mobilization of erupted or malpositioned tooth to aid eruption	D7282	Current panoramic x-ray Narrative of necessity	• Indicated for the treatment of ankylosed permanent teeth	Prior
Placement of device to facilitate eruption of impacted tooth	D7283	Current panoramic x-ray Narrative of necessity	• Documentation supports this is needed following the surgical exposure of an un-erupted tooth to aid in its eruption	Prior
Transseptal fiberotomy/supra crestal fiberotomy, by report	D7291	Current panoramic x-ray Narrative of necessity	• Indicated to reduce rotational relapse of individual teeth following orthodontic treatment	Prior
Excision of bone tissue	D7471, D7472, D7473	Current panoramic x-ray Narrative of necessity	• When the presence of tori/exostosis interferes with the fit of a dental prosthesis and it cannot be adapted successfully • When causing soft tissue trauma with existing removable appliances • For unusually large tori/exostosis that are prone to recurrent traumatic injury • When there is a functional disturbance, including, but not limited to normal tongue movement, mastication, swallowing and speech	Prior

Procedure	Procedure codes	Required documentation (simplified)	Criteria for approval	Prior or post
Reduction of osseous tuberosity	D7485	Current panoramic x-ray Narrative of necessity	• Documentation describes problems that support medical necessity for reduction	Prior
Suture of recent small wounds up to 5 cm	D7910	Current x-rays Narrative of necessity	• Documentation describes accident • Not for tooth extraction or to close surgical incision	Prior
Appliance removal (not by dentist who placed appliance)	D7997	Current panoramic x-ray Narrative of necessity	• Documentation describes removal not by dentist who placed appliance	Prior
Interceptive orthodontic treatment	D8050, D8060		• Palatal expansion • Correction of skeletal disharmonies of the primary/transitional dentition • Correction of anterior crossbite • Severe cuspid crowding/correction of inadequate space for cuspid eruption	Prior
Limited and comprehensive orthodontic treatment	D8010, D8020, D8030, D8040, D8070, D8080, D8090		• Documentation shows deep impinging overbite that shows palatal impingement of the majority of lower incisors • Documentation shows true anterior open bite (not including one or two teeth slightly out of occlusion or where the incisors have not fully erupted) • Documentation shows a large anterior – posterior discrepancy (Class II and Class III malocclusions that are virtually a full tooth Class II or Class III) • Documentation shows anterior cross bite (involves more than two teeth in cross bite) • Documentation shows posterior transverse discrepancies (involves several posterior teeth in cross bite, not a single tooth in cross bite) • Documentation shows significant posterior open bites (not involving partially erupted teeth or one or two teeth slightly out of occlusion) • Documentation shows impacted canines that will not erupt into the arch without orthodontic or surgical intervention (does not include cases where canines are going to erupt ectopically) • Documentation supports Salzmann Criteria Index Form score of 25+	Prior
Appliance therapy	D8210, D8220	Current panoramic x-ray Cephalometric x-ray Photos Treatment plan	• Documentation of thumb sucking or tongue thrusting habit	Prior
Orthodontic retention (removal of appliances, place retainers)	D8680	Current photos		Prior

Procedure	Procedure codes	Required documentation (simplified)	Criteria for approval	Prior or post
Deep sedation / general anesthesia and intravenous moderate (conscious) sedation	D9223, D9243		• A statement must be included in the Remarks section of the invoice justifying the use of anesthesia/sedation on the basis of the beneficiary's condition and/or the nature of the oral surgery plus medical necessity. If the procedure performed is one of the surgical procedures identified in the MA Program Fee Schedule, medical necessity does not have to be documented. • What constitutes acceptable documentation for the condition of the beneficiary or the nature of the oral surgery to justify anesthesia/ sedation? a. Child is under 7 years of age and more than one simple extraction or surgical extraction is performed. b. Beneficiary has medical conditions that preclude the use of local anesthesia. c. Severe infection at the injection site. d. Beneficiaries with intellectual disability, other mental health or physical conditions and who are unmanageable using local anesthesia. e. Multiple extractions in more than one quadrant. If the treatment is simple or surgical extractions, two or more quadrants must have had at least two teeth extracted per quadrant or three or more quadrants had at least one tooth extracted per quadrant. • What constitutes acceptable documentation to justify medical necessity? a. Severe infection at the injection site. b. Severe cerebral palsy, unmanageable. c. Severe intellectual disability, unmanageable. • Examples of unacceptable documentation: a. Beneficiary unable to tolerate the procedure. b. Beneficiary prefers or requests general anesthesia. c. Beneficiary wants to be asleep. d. Additional invoicing requirements – Dental practitioners who administer and bill DHS for anesthesia/ sedation when performing outpatient surgical procedures or tooth extractions dental provider handbook_ master_10-17-17. doc 82 October 17, 2017 (warranting anesthesia/ sedation) must bill for the surgical extractions and the anesthesia/sedation on the same invoice. Any substantiating documentation to justify payment for the anesthesia must be included in the Remarks section of the claim form.	Prior
Occlusal guard	D9944, D9945, D9946	Narrarive of Medical Necessity	Covered in the following scenarios: • Bruxism or clenching either as a nocturnal parasomnia or during waking hours, resulting in excessive wear or fractures of natural teeth or restorations • To protect natural teeth when the opposing dentition has the potential to cause enamel wear such as the presence of porcelain or ceramic restorations Not Covered for the following scenarios: • For treatment of temporomandibular disorders or myofascial pain disfunction • As an appliance intended for orthodontic tooth movement	Prior
Unspecified procedures, by report	D2999, D5999	Description of procedure and narrative of medical necessity	• Procedure cannot be adequately described by an existing code • Documentation supports medical necessity	Prior

Procedure	Procedure codes	Required documentation (simplified)	Criteria for approval	Prior or post
Unspecified adjunctive procedure, by report (Used for treatment done in an ASC/OR	D9999	Narrative of medical necessity Name of hospital/ outpatient facility	• Compromising medical condition • Age • Behavior/cognitive impairment • Complexity of care	Prior

C.4 Appealing a denied authorization

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

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

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

Member Denied Authorization Appeal Mailing Address:

UnitedHealthcare Community
Attn: Appeals and Grievances Unit
P.O. Box 31364
Salt Lake City, UT 84131-0364
Toll-free: 866-293-1796 (TTY 711)

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

The member has the right to:

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

C.5 Appeal determination timeframe:

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

C.6 State Fair Hearing

A state fair hearing lets members share why they think Pennsylvania Medicaid services should not have been denied, reduced or terminated.

Members have 120 days from the date on UnitedHealthcare Community Plan's adverse appeal determination letter.

The UnitedHealthcare Community Plan member may ask for a state fair hearing by writing a letter to:

Department of Human Services
Office of Administration
Bureau of Program Integrity
HealthChoices Physical Health Agreement effective January 1, 2020 94
Division of Program and Provider Compliance Recipient Restriction Section
P.O. Box 2675
Harrisburg, Pennsylvania 17105-2675

Phone: 1-717-772-4627

The member may ask UnitedHealthcare Community Plan Customer Service for help writing the letter.

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

Processes related to reversal of our initial decision

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

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

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

C.7 Credentialing and Recredentialing Appeals

In the event you are denied participation or continued participation, you have the right to appeal the decision in writing within 30 calendar days of the date of receipt of the rejection/denial letter. Please note, appeals for credentialing / recredentialing for disciplinary action is not applicable in your state.

To appeal the decision, submit your request to the following address; you may also call 1-443-896-0754 with any questions you may have.

All written inquires must be sent to:

UnitedHealthcare
Attn: Credentialing Department
2300 Clayton Rd., Ste 1000
Concord, CA 94520

C.8 Medicaid member appeals and inquiries

Provider-initiated member grievance (Act 68 process)

Pennsylvania Act 68 gives you the right, with the written permission of the member, to pursue a grievance in lieu of the member. You may ask for a member's written consent in advance of treatment but may not require a member to sign a document allowing the filing of a grievance as a condition of treatment. The regulatory requirements for providers provide information relating to items that must be in the document giving you permission to pursue a grievance, along with the time frames for you to provide to the member notification of your intent to pursue or not pursue a grievance.

These are important because under this scenario you assume the grievance and appeal rights of the member. However, the member may rescind the consent at any time. The Act 68 Process applies to Medicaid members and CHIP members.

Provider responsibilities under provider-initiated member appeals (Act 68 process)

If you assume responsibility for filing a grievance, you may not bill the member for services that are the subject of the grievance until the external grievance review allowed by Act 68, and available through the PA Department of Insurance, has been completed or the member rescinds consent for you to pursue the grievance.

If you choose not to bill the enrollee or the enrollee's legal representative for the services provided that are the subject of the grievance, you may drop the grievance with notice to the enrollee and the enrollee's legal representative.

Provider-initiated member appeals (Act 68 process) – First level review

The member, member's representative, or health care provider with written consent of the member may file le a written grievance with UnitedHealthcare. A grievance is a request to have UnitedHealthcare Community Plan reconsider a decision solely concerning the medical necessity and appropriateness of a health care service.

A grievance may be filed led regarding a decision to:

1. Deny, in whole or in part, payment for a service (if based on lack of medical necessity or appropriateness)
2. Deny or issue a limited authorization of a requested service, including the type or level of service
3. Reduce, suspend, or terminate a previously authorized service 4. Deny the requested service but approve an alternate service

The member, member's representative, or health care provider with written consent of the member must file a grievance within 45 days of the utilization management decision or from the date of receipt of notification about the utilization management decision. The request must be submitted in writing to:

UnitedHealthcare Community Plan

Grievance and Appeals Department 1001 Brinton Road Pittsburgh, PA 15221

If the grievance (at fi rst or second levels) is filed within 10 days of the decision or receiving notice of the decision, and the grievance is about a currently authorized service, Medicaid members will continue to

receive service while the appeal is being considered. There is a similar right for Medicaid members if a member had filed a complaint to dispute a decision to discontinue, reduce, or change a service because it is not, or is no longer, a covered benefit. If this type of complaint is filed within 10 days of receiving the decision (first or second levels), the Medicaid member must continue to receive the disputed service/item at the previously authorized level pending resolution of the complaints. There is also an expedited grievance process detailed at the end of this section.

The provider, having obtained consent from the member or the member's legal representative to file a grievance, has 10 days from receipt of the standard written denial and any decision letter from a first level, second level or external review to notify the member or the member's legal representative of its intention not to pursue a grievance.

UnitedHealthcare Community Plan will send written confirmation of its receipt of the grievance to the member, the member's representative (if the member has designated one) and the health care provider, if the health care provider filed the grievance with member consent, upon receipt of the grievance. The notification will include the following information:

- That UnitedHealthcare Community Plan considers the matter to be a grievance (rather than a complaint). The member, the member's representative or health care provider may question the classification of complaints and grievances by contacting the Pennsylvania Department of Health
- That the member may appoint a representative to act on the member's behalf at any time during the internal grievance process
- That the member, the member's representative, or the health care provider that filed the grievance with member's consent, may review information related to the grievance upon request and submit additional material to be considered by UnitedHealthcare Community Plan
- That the member or the member's representative may request the aid of an UnitedHealthcare Community Plan employee who has not participated in the utilization management decision to assist in preparing the member's first level grievance at no charge

The first level grievance review shall be performed by a UnitedHealthcare Community Plan initial review committee. The members of the committee will not have been involved in any prior decision relating to the grievance. The committee will include a licensed physician or an approved licensed psychologist, practicing in the same or similar specialty, who would typically consult on the health care services in question. UnitedHealthcare Community Plan will provide the member, the member's representative, or a health care provider that filed a grievance with member consent access to all information relating to the matter being grieved and will allow the provision of written data or other material in support of the grievance. The member, the member's representative or the health care provider may specify the remedy or corrective action being sought.

UnitedHealthcare Community Plan will provide, at no charge, at the request of the member or the member's representative, an employee who has not participated in previous denial decisions regarding the issue in dispute, to aid the member or the member's representative in preparing the member's grievance.

UnitedHealthcare Community Plan will complete its review and investigation and arrive at a decision within 30 days of the receipt of the grievance. The member, the member's representative or the health care provider appealing with the written consent of the member, may request a 14-day extension. UnitedHealthcare Community Plan will notify the member, the member's representative and the health care provider of the decision of the internal review committee in writing within 5 business days of the

committee's decision. The notice to the member, the member's representative and the health care provider will include the basis for the decision and the procedures for the member or provider to file a request for a second level review of the decision of the initial review committee including:

- A statement of the issue reviewed by the first level review committee
- The specific reasons for the decision
- References to the specific UnitedHealthcare Community Plan provisions on which the decision is based and how to obtain these documents, if used
- An explanation of the scientific or clinical judgment for the decision
- An explanation of how to file a request for a second level review of the decision, which must be filed within 45 days of receipt of the first level decision

Provider-initiated member appeals (Act 68 process) — Second level review

Upon receipt of a second level grievance, UnitedHealthcare Community Plan will send the member, the member's representative and the health care provider an explanation of the procedures to be followed during the second level review. This explanation will include the following information:

- How to request the aid of a UnitedHealthcare Community Plan employee who has not participated in any discussion of the issue in dispute in preparing the member's second level grievance
- Notification that the member, the member's representative and the health care provider have the right to appear before the second level review committee, and that UnitedHealthcare Community Plan will provide the member, the member's representative and the health care provider with 15 days advance written notice of the time scheduled for the review

The second level review committee shall be made up of three or more individuals who did not previously participate in the decision to deny coverage or payment for the issue in dispute. The committee will include a licensed physician or a licensed psychologist, practicing in the same or similar specialty, who would typically consult on the health care services in question. The second level review allows the following:

- The member, the member's representative and the health care provider have the right to be present at the second level review, and to present a case.
- UnitedHealthcare Community Plan shall notify the member, the member's representative and the health care provider at least 15 days in advance of the date scheduled for the second level review

UnitedHealthcare Community Plan will make reasonable accommodation to facilitate the participation of the member, the member's representative, and the health care provider by conference call or in person. UnitedHealthcare Community Plan will take into account the member's access to transportation and any disabilities or language barriers. If the member, the member's representative or filing health care provider cannot appear in person at the second level review, UnitedHealthcare Community Plan will provide the member, the member's representative, or the provider the opportunity to communicate with the review committee by telephone or other appropriate means.

Attendance at the second level review is limited to

- Members of the review committee who are not employed by the plan
- Appropriate UnitedHealthcare Community Plan representatives
- The member, or the member's representatives, including any legal representative and/or attendant necessary for the member to participate in or understand the proceedings

- The health care provider who filed the grievance with the member's consent
- Applicable witnesses

The committee may not discuss the case to be reviewed prior to the second level review meeting. A committee member who does not personally attend the review meeting may not vote on the case unless that person actively participates in the review meeting by telephone or videoconference and base the opportunity to review any additional information introduced at the review meeting prior to the vote. UnitedHealthcare Community Plan may provide an attorney to represent the interests of the committee, but the attorney may not argue UnitedHealthcare Community Plan's position or represent UnitedHealthcare Community Plan or UnitedHealthcare Community Plan staff. The committee may question the member, the member's representative, the health care provider, and UnitedHealthcare Community Plan staff. The committee will base its decision solely upon the materials and testimony presented at the review. The proceedings will be recorded electronically and then summarized. The summary will be maintained as a part of the grievance record to be forwarded upon a request for an external grievance review.

UnitedHealthcare Community Plan will complete the second level grievance review and arrive at its decision within 45 days of receipt of the request for the review. UnitedHealthcare Community Plan will notify the member, the member's representative, and the health care provider of the decision of the second level review committee in writing within 5 business days of the committee's decision. UnitedHealthcare Community Plan will include the basis for the decision and the procedures and time frames for the member, the member's representative, or the health care provider, to file a request for an external grievance review including the following:

- A statement of the issue reviewed by the second level review committee
- The specific reasons for the decision
- References to the specific UnitedHealthcare Community Plan provisions on which the decision is based and how to obtain these documents, if used
- An explanation of the scientific or clinical judgment for the decision, applying the terms of the plan to the member's medical circumstances

Expedited grievances (Act 68 process)

The member, member's representative, or health care provider with written consent of the member can file at expedited grievance with UnitedHealthcare Community Plan by calling **1-800-414-9025.** The member, member's representative, or health care provider with written consent of the member may request an expedited review at any stage of the plan's review process if the member's life, health or ability to regain maximum function would be placed in jeopardy by delay occasioned by the review process in order to obtain an expedited review, the member, the member's representative, or the health care provider with written consent of the member must provide UnitedHealthcare Community Plan with a written certification from the member's physician that the member's life, health or ability to regain maximum function would be placed in jeopardy by delay. The certification must include the clinical rationale and facts to support the physician's opinion.

The expedited grievance will be put in writing for review. The expedited grievance process will follow the process described above in **Provider-Initiated Member Appeals (Act 68 Process) — Second Level Review,** with the following exceptions:

- Time frame is 48 hours for a decision.

- The hearing may be held telephonically if the member cannot be present in the short time frame. (All information presented at the hearing is read into the record
- If UnitedHealthcare Community Plan cannot provide a copy of the report of the same or similar specialist to the member prior to the expedited hearing, the plan may read the report into the record at the hearing and shall provide the member with a copy of the report at that time.
- It is the responsibility of the member, the member's representative or the health care provider to provide information to UnitedHealthcare Community Plan in an expedited manner to allow the plan to conform to the requirements of this section.
- An expedited internal review will be conducted within 48 hours of receipt of the request from the member, the member's representative, or health care provider with written consent of the member for an expedited review accompanied by a physician's certification. If the external grievance is being requested by a health care provider, UnitedHealthcare Community Plan and the health care provider must each establish escrow accounts in the amount of half the anticipated cost of the review. The notification to the member, member's representative or health care provider will state the basis for the decision, including any clinical rationale, and the procedure for obtaining an expedited external review and a DPW Fair Hearing (if applicable). The member, member's representative, or health care provider with written consent of the member has 2 business days from the receipt of the expedited grievance decision to request an expedited external review and a DPW Fair Hearing **If the Certified Review Entity's (CRE's) decision in an external grievance review filed by a health care provider is against the health care provider in full, the health care provider shall pay the fees and costs associated with the external grievance.**

Regardless of the identity of the grievant, if the CRE's decision is against UnitedHealthcare Community Plan in full or in part, UnitedHealthcare Community Plan will pay the fees and costs associated with the external grievance review. For expedited external review requests, UnitedHealthcare Community Plan will submit a request for an expedited external review to the Pennsylvania Department of Health by fax transmission and telephone within 24 hours of receipt of the request from the member, member's representative, or health care provider with written consent of the member. The Department of Health will assign a CRE within 1 business day of receiving the request for an expedited review. The CRE will have 2 business days following the receipt of the case file to make a decision.

External grievances (Act 68 process)

Pennsylvania Act 68 allows for an external grievance process by which a Medicaid or CHIP member, member's representative, or a health care provider with the written consent of the member, may request an external review of a denial of a second level grievance. The external grievance process shall adhere to the following standards:

A member, the member's representative or the health care provider who filed the grievance has 15 days from receipt of the second level grievance review decision to file with UnitedHealthcare Community Plan a request for an external review. If the request for an external grievance is being filed by a health care provider, the health care provider shall provide the name of the member involved and a copy of the member's written consent for the health care provider to file the external grievance.

Within 5 business days of receiving the external grievance from the member or a health care provider filing a grievance with member consent, UnitedHealthcare Community Plan will notify the Pennsylvania Department of Health, the member and the health care provider that a request for an external grievance

review has been filed. UnitedHealthcare Community Plan's notification to the Pennsylvania Department of Health by phone and fax shall include a request for assignment of a certified review entity (CRE). If the external grievance is being requested by a health care provider, UnitedHealthcare Community Plan and the health care provider must each establish escrow accounts in the amount of half the anticipated cost of the review. UnitedHealthcare Community Plan will notify the provider or the member of the name, address, and phone number of the assigned CRE within 2 business days.

UnitedHealthcare Community Plan will, within 15 days of request for an external review, forward the case file to the assigned CRE. UnitedHealthcare Community Plan will also send the provider or member a listing of all documents forwarded to the CRE. Once the CRE reaches its decision, UnitedHealthcare Community Plan will authorize a health care service and pay claim(s) determined to be medically necessary and appropriate by the CRE whether or not UnitedHealthcare Community Plan appeals the CRE's decision to a court of competent jurisdiction. If the CRE's decision in an external grievance review filed by a health care provider is against the health care provider in full, the health care provider shall pay the fees and costs associated with the external grievance. Regardless of the identity of the grievant, if the CRE's decision is against UnitedHealthcare Community Plan in full or in part, UnitedHealthcare Community Plan will pay the fees and costs associated with the external grievance review. The assigned CRE will review and issue a written decision within 60 days of the filing of the request for an external grievance review. The decision will be sent to the member and the member's representative, the health care provider, the plan and the Pennsylvania Department of Health.

Administrative waiver (program exception)

The Department, under extraordinary circumstances, will pay for a medical service or item that is not one for which the MA Program has an established fee, or will expand the limits for services or items that are listed on the MA Program Fee Schedule. If a provider concludes that lack of the service or item would impair the beneficiary's health, the provider may request an 1150 Administrative Waiver or Program Exception (PE). Refer to section 6.6 of PA PROMISe Manual for instructions.

Member Medicaid exception process

The following limitations and exclusions became applicable to Medicaid adult recipients 21 years of age and older effective 10/3/2011:

- Oral Examinations and Prophylaxis are limited to 1 per 180 days per recipient
- Endodontics, Periodontal Services, Crowns and adjunctive services are available only with an approved Benefit Limit Exception request for MA adult receipts 21 years of age and older. Please note the applicable ADA codes below:

Endodontic: D3310, D3320, D3330, D3410, D3421, D3425, D3426

Crowns: D2710, D2721, D2740, D2751, D2791, D2952, D2954, D2980

Periodontics: D4210, D4341, D4342, D4355, D4910

Dentures are limited to 1 unit per arch per lifetime

Upper arch: D5110, D5130, D5211, D5213
Lower arch: D5120, D5140, D5212, D5214

NOTE: The provider may not seek payment from the MA beneficiary for a service that is over a benefit limit unless:

1. The provider informed the beneficiary before providing the service that the service may be above the benefit limit, in which case it would not be covered unless the Department grants an exception;
2. The provider submitted a request for an exception to the benefit limit; and
3. The Department denied the BLE request.

To support a Benefit Limit Exception request, a narrative from the member's Primary Care Physician or Medical Specialist is necessary if the member has no previous history on file with UnitedHealthcare. This document should be submitted along with the BLE request form, ADA Claim Form, and all required documentation noted in the submission requirements with your request for exception. The request for exception should be forwarded to the following address:

UnitedHealthcare Community Plan PA Medicaid
Benefit Limit Exception
PO Box 1091
Milwaukee, WI 53201

Exception requests can be submitted prior to treatment or up to 60 days after the services were furnished. The provider can contact **1-800-508-4876** if they have any questions regarding Benefit Limit Exception request or status of a request.

The dental benefit changes noted above do not apply to children under 21 years of age or to adults who reside in a nursing facility, an intermediate care facility for persons with mental retardation (ICF/MR) or an intermediate care facility for person with other related conditions (ICF/ORC)

If the BLE request is received prior to dental treatment, the Provider and member will receive a response within 21 days of receipt of the request; if the request is received after dental services have been completed, the Provider and member will receive a response within 30 days of receipt of the request.

C.9 Orthodontia

C.9.a UnitedHealthcare Dental Pennsylvania CHIP orthodontia guidelines

Orthodontic coverage criteria

Pennsylvania CHIP orthodontic treatment is approved under the following conditions:

Members must have a fully erupted set of permanent teeth to be eligible for comprehensive orthodontic services.

All orthodontic services require prior approval, a written plan of care, and must be rendered by a participating provider.

Orthodontic treatment must be considered medically necessary and be the only method considered capable of:

1. Preventing irreversible damage to the member's teeth or their supporting structures.
2. Restoring the member's oral structure to health and function.

A medically necessary orthodontic service is an orthodontic procedure that addresses a harmful habit (e.g. tongue thrust) that is causing deformative changes to the teeth and/or jaw structure or is a limited, interceptive, or comprehensive orthodontic treatment that is intended to treat a severe dentofacial

abnormality or serious handicapping malocclusion. Orthodontic services for cosmetic purposes are not covered.

Orthodontia procedures will only be approved for dentofacial abnormalities that severely compromise the member's physical health or for serious handicapping malocclusions. Presence of a serious handicapping malocclusion is determined by the magnitude of the following variables: degree of malalignment, missing teeth, angle classification, overjet and overbite, open bite, and crossbite.

1. Dentofacial abnormalities that severely compromise the member's physical health may be manifested by:
   - Markedly protruding upper jaw and teeth, protruding lower jaw and teeth, or the protrusion of upper and lower teeth so that the lips cannot be brought together.
   - Under-developed lower jaw and receding chin.
   - Marked asymmetry of the lower face.
2. A "handicapping" malocclusion is a condition that constitutes a hazard to the maintenance of oral health and interferes with the well-being of the recipient by causing:
   - Obvious difficulty in eating because of the malocclusion, so as to require a liquid or semi-soft diet, cause pain in jaw joints during eating, or extreme grimacing or excessive motions of the orofacial muscles during eating because of necessary compensation for anatomic deviations.
   - Obvious severe breathing difficulties related to the malocclusion, such as unusually long lower face with downward rotation of the mandible in which lips cannot be brought together, or chronic mouth breathing and postural abnormalities relating to breathing difficulties.
   - Lisping or other speech articulation errors that are directly related to orofacial abnormalities and cannot be corrected by means other than orthodontic intervention.
3. Members who score 25 or higher on the Salzmann Evaluation Index upon examination and evaluation by an orthodontist are considered to meet the criteria required to substantiate the medical necessity for orthodontic treatment of a serious handicapping malocclusion.

Prior authorization and submission of documentation are required. The documentation required will be:

- 5 – 7 Diagnostic quality photos
- Completed Salzmann Form
- X-rays (Panoramic and Cephalometric)
- ADA form with procedure code D8080

Please submit a pre-authorization request for D8080 only. If the case meets all requirements and is approved, an ADA Claim form should be submitted for D8080 to receive the contracted full orthodontic case rate. The case rate payment will cover:

- Comprehensive orthodontic treatment of the adolescent dentition
- Periodic orthodontic treatment
- Orthodontic retention.

Subsequent ADA claims should be submitted quarterly with D8670 to receive quarterly payments over a 24 month period.

If a pre-authorization for PA CHIP enrollee is denied, providers should submit a claim with D8660 to receive payment for their records fee. D8660 is only covered as a separate service if the member is determined to be ineligible for other orthodontic services.

Orthodontic continuation of care

UnitedHealthcare will honor orthodontic approvals for from the following appropriate sources:

- Previous PA Managed Care Organization (MCO) Program
- Previous PA CHIP Program

Providers are instructed to submit in-process continuation of care requests such as these to the following address:

PA CHIP Dental Continuity of Care Requests
PO Box 779
Milwaukee, WI 53201

Documentation requirements

The following documentation must accompany all in-process continuation of care requests:

- Copy of original approval (Medicaid or CHIP)
- Evidence of banding date (usually copy of remit of paid D8080)
- Payment history
- ADA form with code D8670

If the Continuation of Care provider is a new provider, the new provider's contract case rate will be prorated based upon the documentation supplied subject to a members remaining month of treatment. Orthodontic treatment maximum is 24 months.

The initial provider may be subject to a partial recoupment of the contracted case rate should it be determined that there is a moderate amount of treatment time remaining that will be assumed by the new provider.

If the Continuation of Care provider is the same provider and there is only a change from one MCO to another, the provider will not receive additional payment as payment was received from the previous MCO for the orthodontic treatment.

Orthodontic retention

Orthodontic retention when not associated with comprehensive orthodontic services:

- D8680 – This procedure code may be submitted when not associated with comprehensive orthodontic treatment by the same provider and is limited to once per lifetime.

It is UnitedHealthcare Dental contractual policy for all providers to complete treatment of orthodontic cases within the allotted 24 months following the original banding date. Any provider, for any reason, requesting continuity of care beyond 36 months will be denied.

C.9.b UnitedHealthcare Dental Pennsylvania Medicaid orthodontia guidelines

Orthodontic coverage criteria

Per the Pennsylvania Code § 1149.55, orthodontic treatment is approved under the following conditions

- They are necessary to prevent irreversible damage to the teeth or their supporting structures.
- They are necessary to treat acute dental problems as evidenced by the following factors:

1. Dentofacial abnormalities that severely compromise the client's physical health, as manifested by markedly protruding upper jaw and teeth, protruding lower jaw and teeth, the protrusion of upper and lower teeth so that the lips cannot be brought together, under- developed lower jaw and receding chin or marked asymmetry of the lower face.
2. Obvious difficulty in eating because of the malocclusion, to require liquid or semi-soft diet, or cause pain in jaw joints during eating, or extreme grimacing or excessive motions of the orofacial
3. Muscles during eating because of necessary compensation for anatomic deviations.
4. Obvious severe breathing difficulties related to the malocclusion, such as unusually long lower face with downward rotation of the mandible and with lips that cannot be brought together, chronic mouth breathing and postural abnormalities relating to breathing difficulties— for example, head forward and extended, round shouldered.
5. Lisping or other speech articulation errors that are directly related to orofacial abnormalities.
   - The recipient has a fully erupted set of permanent teeth.
   - The recipient is 20 years of age or younger
   - The recipient is 21 years of age or older but was receiving orthodontic services through the MA Program when the recipient turned 21 years of age.
   - The recipient scored 25 or higher on the Salzmann Evaluation Index upon examination and evaluation by the orthodontist.

Prior authorization and submission of documentation are required. The documentation required will be:

- 5 – 7 Diagnostic quality photos
- Completed Salzmann Form
- X-rays (Panoramic and Cephalometric)
- ADA form with procedure code D8080

Please submit a pre-authorization request for D8080 only. If the case meets all requirements and is approved an ADA Claim form should be initially submitted for D8080 to receive the contracted banding fee. This reimbursement will include the records fee. Subsequent ADA claims should be submitted quarterly with D8670 to receive quarterly payments over a 24-month period.

If a pre-authorization for PA Medicaid enrollee is denied, Providers should submit a claim with D8660 to receive payment for their records fee. D8660 is only covered as a separate service if the member is determined to be ineligible for other orthodontic services.

Orthodontic continuation of care

UnitedHealthcare will honor orthodontic approvals for from the following appropriate sources:

- Previous PA Managed Care Organization (MCO) Program
- Previous PA CHIP Program

Providers are instructed to submit in-process continuation of care requests such as these to the following address:

PA Medicaid Dental Continuity of Care Requests
PO Box 779
Milwaukee, WI 53201

Documentation requirements

The following documentation must accompany all in-process continuation of care requests:

- Copy of original approval (Medicaid or CHIP)
- Evidence of banding date (usually copy of remit of paid D8080)
- Payment history
- If Continuation of Care submission is for new MCO and treating provider is the same, ADA form with code D8670

Once continuation of care authorization is granted, claims may be mailed to standard claims address.

If the Continuation of Care provider is a new provider, the contract case rate will be prorated based upon the documentation supplied subject to the members remaining months of treatment.

If the Continuation of Care provider is the same provider and there is only a change from one MCO to another, the provider will be reimbursed per their current contract case rate.

The initial provider may be subject to a partial recoupment of the contracted case rate should it be determined there is a moderate amount of treatment time remaining that will be assumed by the new provider relative to the amounts paid to the initial provider.

It is UnitedHealthcare Dental contractual policy for all providers to complete treatment of orthodontic cases within the allotted 24 months following the original banding date. Any provider, for any reason, requesting continuity of care beyond 36 months will be denied.

C.9.c Instructions for completing the Salzmann Evaluation Index

Introduction

This assessment record is intended to disclose whether a handicapping malocclusion is present and to assess its severity according to the criteria and weights (point values) assigned to them. The weights are based on tested clinical orthodontic values from the standpoint of the effect of the malocclusion on dental health, function, and aesthetics. The assessment is not directed to ascertain the presence of occlusal deviations ordinarily included in epidemiological surveys of malocclusion. Etiology, diagnosis, planning, complexity of treatment, and prognosis are not factors in this assessment.

A. Intra-arch deviations

The casts are placed, teeth upward, in direct view. When the assessment is made directly in the mouth, a mouth mirror is used. The number of teeth affected is entered as indicated in the "Handicapping Malocclusion Assessment Record." The scoring can be entered later.

1. Anterior segment: A value of 2 points is scored for each tooth affected in the maxilla and 1 point in the mandible.
   - Missing teeth are assessed by actual count. A tooth with only the roots remaining is scored as missing.

- Crowded refers to tooth irregularities that interrupt the continuity of the dental arch when the space is insufficient for alignment without moving other teeth in the arch. Crowded teeth may or may not also be rotated. A tooth scored as crowded is not scored also as rotated.
- Rotated refers to tooth irregularities that interrupt the continuity of the dental arch but there is sufficient space for alignment. A tooth scored as rotated is not scored also as crowded or spaced.
- Spacing:
  - Open spacing refers to tooth separation that exposes to view the interdental papillac on the alveolar crest. Score the number of papillae visible (not teeth).
  - Closed spacing refers to partial space closure that will not permit a tooth to complete its eruption without moving other teeth in the same arch. Score the number of teeth affected.

2. Posterior segment: A value of 1 point is scored of each tooth affected.

- Missing teeth are assessed by actual count. A tooth with only the roots remaining is scored as missing.
- Crowded refers to tooth irregularities that interrupt the continuity of the dental arch when the space is insufficient for alignment. Crowded teeth may or may not also be rotated. A tooth scored as crowded is not scored also as rotated.
- Rotated refers to tooth irregularities that interrupt the continuity of the dental arch and all or part of the lingual or buccal surface faces some part or all of the adjacent proximal tooth surfaces. There is sufficient space for alignment. A tooth scored as rotated is not scored also as crowded.
- Spacing:
  - Open spacing refers to interproximal tooth separation that exposes to view the mesial and distal papillae of a tooth. Score the number of teeth affected (Not the spaces).
  - Closed spacing refers to partial space closure that will not permit a tooth to erupt without moving other teeth in the same arch. Score the number of teeth affected.

B. Interarch deviations

When casts are assessed for interarch deviations, they first are approximated in terminal occlusion. Each side assessed is held in direct view. When the assessment is made in the mouth, terminal occlusion is obtained by bending the head backward as far as possible while the mouth is held wide open. The tongue is bent upward and backward on the palate and the teeth are quickly brought to terminal occlusion before the head is again brought downward. A mouth mirror is used to obtain a more direct view in the mouth.

1. Anterior segment: A value of 2 points is scored for each affected maxillary tooth only.

- Overjet refers to labial axial inclination of the maxillary incisors in relation to the mandibular incisor, permitting the latter to occlude on or over the palatal mucosa. If the maxillary incisors are not in labial axial inclination, the condition is scored as overbite only.
- Overbite refers to the occlusion of the maxillary incisors on or over the labial gingival mucosa of the mandibular incisors, while the mandibular incisors themselves occlude on or over the palatal mucosa in back of the maxillary incisors. When the maxillary incisors are in labial axial inclination, the deviation is scored also as overjet.
- Cross-bite refers to maxillary incisors that occlude lingual to their opponents in the opposing jaw, when the teeth are in terminal occlusion.

- Open-bite refers to vertical interach dental separation between the upper and lower incisors when the posterior teeth are in terminal occlusion. Open-bite is scored in addition to overjet if the maxillary incisor teeth are above the incisal edges of the mandibular incisors when the posterior teeth are in terminal occlusion edge-to-edge occlusion in not assessed as open-bite.

2. Posterior segment: A value of 1 point is scored for each affected tooth.
   - Cross-bite refers to teeth in the buccal segment that are positioned lingually or buccally out of entire occlusal contact with the teeth in the opposing jaw when the dental arches are in terminal occlusion.
   - Open-bite refers to the vertical interdental separation between the upper and lower segments when the anterior teeth are in terminal occlusion. Cusp-to-cusp occlusion is not assessed as open-bite.
   - Anteroposterior deviation refers to the occlusion forward or rearward of the accepted normal of the mandibular canine, first and second premolars, and first molar in relation to the opposing maxillary teeth. The deviation is scored when it extends a full cusp or more in the molar and the premolars and canine occlude in the interproximal area mesial or distal to the accepted normal position.

Salzmann Evaluation Index, page 1

ORTHODONTIC SERVICE
SALZMANN EVALUATION INDEX

PATIENT'S NAME – LAST, FIRST, MIDDLE INITIAL	Member #	Date of Birth
REFERRING DENTIST		
ORTHODONTIST'S NAME	Tax ID	DATE OF ASSESSMENT

HANDICAPPING MALOCCLUSION ASSESSMENT RECORD

A. Intra-Arch Deviation

SCORE TEETH AFFECTED ONLY		MISSING	CROWDED	ROTATED	SPACING		NO.	POINT VALUE	SCORE
					Open	Closed			
MAXILLA	ANT.							X2	
	POST.							X1	
MANDIBLE	ANT.							X1	
	POST.							X1	
								TOTAL SCORE	

ANT = Anteriro Teeth (4 incisors)
POST = Posterior Teeth (include canine, premolars and first molars)
NO. = Number of teeth affected

B. Inter-Arch Deviation

1. Anterior Segment

SCORE MAXILLARY TEETH AFFECTED ONLY EXCEPT OVERBITE*	OVERJET	OVERBITE	CROSSBITE	OPENBITE	NO.	POINT VALUE	SCORE
						X2	
						TOTAL SCORE	

*Score Maxillary or Mandibular incisors
No. = Number of teeth affected

2. Posterior Segment

SCORE AFFECTED TEETH ONLY	RELATE MANDIBULAR TO MAXILLARY TEETH				SCORE AFFECTED MAXILLARY TEETH ONLY				NO.	POINT VALUE	SCORE
	DISTAL		MESIAL		CROSSBITE		OPENBITE				
	Right	Left	Right	Left	Right	Left	Right	Left			
CANINE										X1	
1ST PREMOLAR										X1	
2ND PREMOLAR										X1	
1ST MOLAR											
										TOTAL SCORE	

GRAND TOTAL ____

Salzmann Evaluation Index score of 25 points or more must be achieved to be eligible for comprehensive orthodontic treatment under the program

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PLEASE COMPLETE THE FOLLOWING IN DETAIL:

DESCRIPTION OF PATIENT'S CONDITION AND DIAGNOSIS:

DIAGNOSTIC PROCEDURES:

TREATMENT PLAN:

NAME OF PHYSICIAN/PEDIATRICIAN:

REMARKS:

PLEASE ATTACH A WRITTEN REPORT FROM THE ATTENDING PHYSICIAN/PEDIATRICIAN

Appendix D: Member rights and responsibilities

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

D.1 Member rights

Members of UnitedHealthcare Community Plan of Pennsylvania have a right to:

- Respect, dignity, privacy, confidentiality, accessibility and nondiscrimination.
- A reasonable opportunity to choose a PCP and to change to another provider in a reasonable manner.
- Consent for or refusal of treatment and active participation in decision choices.
- Ask questions and receive complete information relating to your medical condition and treatment options, including specialty care.
- Voice grievances and receive access to the grievance process, receive assistance in filing an appeal, and request a State Fair Hearing from UnitedHealthcare Community Plan of Pennsylvania and/or the Department.
- Timely access to care that does not have any communication or physical access barriers.
- Prepare Advance Medical Directives.
- Assistance with requesting and receiving a copy of your medical records.
- Timely referral and access to medically indicated specialty care.
- Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.
- Be furnished health care services in accordance with federal and state regulations.

D.2 Member responsibilities

Members of UnitedHealthcare Community Plan of Pennsylvania agree to:

- Work with their PCP to protect and improve their health.
- Find out how their health plan coverage works.
- Listen to their PCP's advice and ask questions when in doubt.
- Call or go back to their PCP if they do not get better or ask to see another provider.
- Treat health care staff with the respect they expect themselves.
- Tell us if they have problems with any health care staff by calling Member Services at 1-855-841-2989.
- Keep their appointments, calling as soon as they can if they must cancel.
- Use the emergency department only for real emergencies.
- Call their PCP when you need medical care, even if it is after hours.

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

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