Dental Provider Manual

UnitedHealthcare Community Plan of Wisconsin

Provider Services: 1-888-249-8833

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United Healthcare® | 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 of the cover of this document for dental providers currently participating in the UnitedHealthcare Community Plan's network, and effective immediately for newly contracted dental providers.

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

2.5 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

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 recordkeeping practices conform with our standards.

3.3 Sterilization and infection control fees

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

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
P.O. BOX 30567
SALT LAKE CITY, UT 84130

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

Credentialing updates should be sent to:

2300 Clayton Road
Suite 1000
Concord, CA 94520

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

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

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

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

4.4 Missed appointments

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

Section 6: Quality management

6.1 Quality Improvement Program (QIP) description

UnitedHealthcare Community Plan has established and continues to maintain an ongoing program of quality management and quality improvement to facilitate, enhance and improve 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 for your continued participation with UnitedHealthcare Community Plan. Any failure to comply with the recredentialing process constitutes termination for cause under your provider agreement.

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

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

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

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

Initial credentialing

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

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

Recredentialing

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

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

6.3 Site visits

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

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

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

6.4 Preventive health guideline

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

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

current ADA Current Dental Terminology (CDT), and specialty guidelines as suggested by organizations such as the American Academy of Pediatric Dentistry, American Academy of Periodontology, American Association of Endodontists, American Association of Oral and Maxillofacial Surgeons, and the American Association of Dental Consultants. Additional resources include publications such as the Journal of Evidence-Based Dental Practice, online resources obtained via the Library of Medicine, and evidence-based clearinghouses such as the Cochrane Oral Health Group and Centre for Evidence Based Dentistry as well as respected public health benchmarks such as the Surgeon General's Report on Oral Health in America. Preventive health focuses primarily on the prevention, assessment for risk, and early treatment of caries and periodontal diseases, but also encompasses areas including prevention of malocclusion, oral cancer prevention and detection, injury prevention, avoidance of harmful habits and the impact of oral disease on overall health. 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**. Click “Resources” on the top right. Then click “Drug Lists and Pharmacy”. There you will see an Opioid Programs and Resources - Community Plan (Medicaid) link which provides tools and education.

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 Provider rights bulletin

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

To review your information

You may review any information the plan has utilized to evaluate your credentialing application, including information received from any outside source (e.g., malpractice insurance carriers; 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 (2006 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.

9.1.b Electronic claims

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

If you wish to submit claims electronically, please contact your clearinghouse to initiate this process. If you do not currently work with a clearinghouse, you may either sign up with one to initiate this process. The UnitedHealthcare Community Plan website (**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 (2006 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 will need to indicate if the "other insurance" is the primary insurance. You may need to provide documentation from the primary insurance carrier, including amounts paid for specific services.

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

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

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

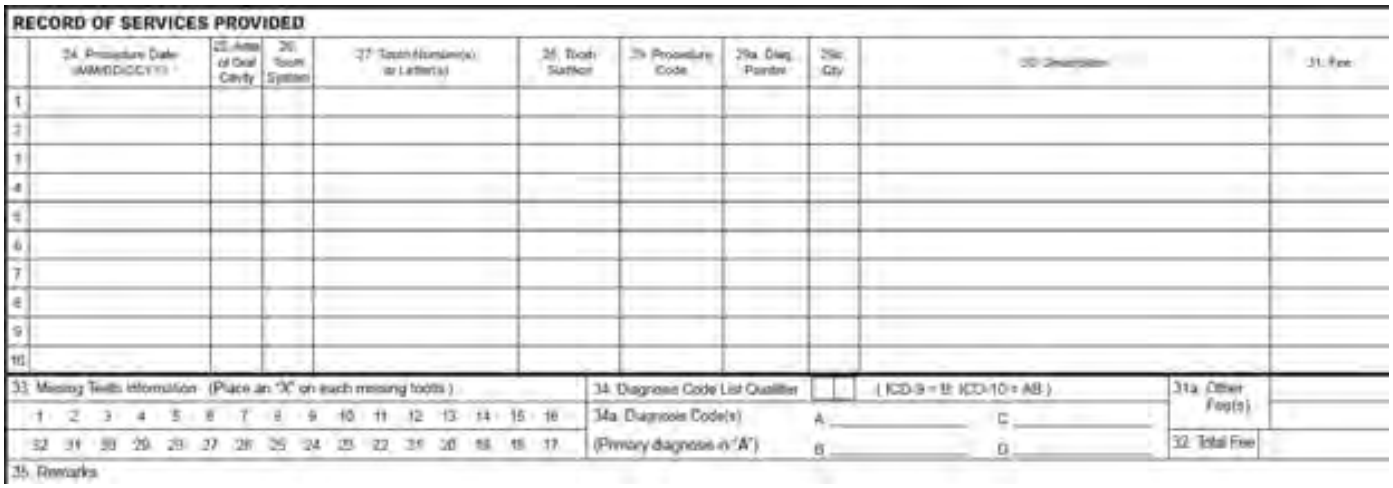
Missing teeth information

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 7 years.

Insurance fraud

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

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

Invalid or incomplete claims:

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

9.2.b Coordination of Benefits (COB)

Our benefits contracts are subject to coordination of benefits (COB) rules. We coordinate benefits based on the 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 90 calendar days from the date of service.

All adjustments or requests for reprocessing must be made within 365 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 180 calendar days of the primary payer's determination (see section 9.2.b).

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

9.3 Timely payment

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

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

9.4 Provider remittance advice

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

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

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 MO Medicaid

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

UnitedHealthcare®

Please address questions to:

UnitedHealthcare MO Medicaid
PO Box 1427
Milwaukee, WI 53201

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

Dental Office Name
Street Address
City, State ZIP

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

Remittance Summary

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

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

Ref #: 34143 / 169 Page 1

9.4.c Provider Remittance Advice sample (page 2)

UnitedHealthcare MO Medicaid

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

Fee For Service Summary

Dental Office Name
Street Address
City, State ZIP

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

Ref #: 34143 / 170 Page 2

9.4.d Provider Remittance Advice sample (page 3)

UnitedHealthcare MO Medicaid

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

Services Detail

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

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

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

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

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

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

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

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

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

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

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

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9.5 Overpayment

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

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

If you prefer to mail a refund, send an Overpayment Return Check 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 180 calendar days from the date of service, even if the primary carrier has not made payment.
- When submitting appeal or reconsiderations requests, provide the same information required for a clean claim. Explain the discrepancy, what should have been paid and why.

9.7 Payment for non-covered services

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

Please note: 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.

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.

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.

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

When should I submit a corrected claim?

A corrected claim should ONLY be submitted when an original claim or service was PAID based upon incorrect information.

A Corrected Claim must be submitted in order for the original claim to be adjusted with the correct information. As part of this process, the original claim will be recouped and a new claim processed in its place with any necessary changes.

On the other hand, if a claim or service originally denied due to incorrect or missing information, 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.

What scenarios are subject to the corrected claim process?

A corrected claim should only be submitted if the original service(s) PAID based on incorrect information.

Some examples of correction(s) that need to be made to 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

How do I submit a corrected claim?

- Electronically – Clearing House
- Electronically – Dental Hub (only if original claim was submitted on the Dental Hub. If original claim was not submitted on the Dental Hub, another method should be utilized)
- Provider Web Portal (PWP)
- Paper

Electronic submission are 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 PO 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.

What scenarios ARE NOT subject to the corrected claim process?

A corrected claim should not be submitted if the original claim or service(s) which are the subject of the correction denied or were not previously submitted.

Some examples of items that are not considered claim corrections are:

- Any request to “Reprocess” a claim with no changes being made. This includes requests to reprocess a claim based on a new authorization being obtained.
- Any changes being made to a claim or service that denied for any reason such as missing tooth, quad, or arch information, incorrect code, age inappropriate code being billed, missing primary EOB, incorrect provider, etc.
- Any request to recoup a denied service. You DO NOT need to recoup a denied service as denied services are invalid and have no impact on member service/tooth history or accumulators.

If you received a claim or service denial due to missing/incomplete/incorrect information or you have since obtained authorization for services, please 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 your provider handbook for the proper method for submitting an appeal or reprocess request.

What happens if I submit a corrected claim to the wrong PO box or don't include the required documentation?

Following the above guidelines will allow you to receive payment as expediently as possible. Failure to follow these guidelines may result in unnecessary delay and/or rejection of your submission. As a reminder the Corrected Claim mailing address is found below.

Submit to:

Corrected Claims
PO Box 481
Milwaukee, WI 53201

Appendices for the State of Wisconsin

Appendix A: Resources and services — how we help you

Addresses and phone numbers

Need:	Address:	Phone Number:	Payer I.D.:	Submission Guidelines:	Form(s) Required:
Claim Submission (initial)	Claims: UnitedHealthcare P.O. Box 583 Milwaukee, WI 53201	**1-888-249-8833**	GP133	Within 90 calendar days from the date of service For secondary claims, within 180 calendar days from the primary payer determination	ADA* Claim Form, 2006 version or later
Corrected Claims	Corrected Claims: UnitedHealthcare P.O. Box 481 Milwaukee, WI 53201	**1-888-249-8833**	GP133	Within 90 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: Appeals Coordinator P.O. Box 1698 Milwaukee, WI 53201	**1-888-249-8833**	GP133	Within 90 days after the claim determination	Supporting documentation, including claim number is required for processing.
Prior Authorization Requests	Pre-authorizations: UnitedHealthcare P.O. Box 363 Milwaukee, WI 53201	**1-888-249-8833**	GP133	N/A	ADA Claim Form - check the box titled: Request for Predetermination / Preauthorization section of the ADA Dental Claim Form
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	**1-800-504-9660**	N/A	Within 45 days of the action being appealed	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 your state's Medicaid and legislature included in your state's Medicaid Provider Billing Manual.

B.1 Exclusions & limitations

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

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

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

General exclusions

1. Unnecessary dental services.
2. Any dental procedure performed solely for cosmetic/aesthetic reasons.
3. Reconstructive surgery, regardless of whether or not the surgery is incidental to a dental disease, injury, or congenital anomaly when the primary purpose is to improve physiological functioning of the involved part of the body.
4. Any dental procedure not directly associated with dental disease.
5. Any procedure not performed in a dental setting that has not had prior authorization.
6. Procedures that are considered experimental, investigational or unproven. This includes pharmacological regimens not accepted by the American Dental Association Council on Dental Therapeutics. The fact that an experimental, investigational or unproven service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in coverage if the procedure is considered to be experimental, investigational or unproven in the treatment of that particular condition.
7. Service for injuries or conditions covered by workers' compensation or employer liability laws, and services that are provided without cost to the covered persons by any municipality, county or other political subdivision. This exclusion does not apply to any services covered by 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**.

Code	Description	Age	Limit	Other limits	Auth required?	Required documents
D0120	Periodic Oral Exam	0-20	1 per code every 6 Months		No	
D0120	Periodic Oral Exam	21-999	1 per code every 12 Months		No	
D0140	Limited Oral Evaluation - Problem Focused	0-999	1 per code every 6 Months		No	
D0150	Comprehensive Oral Evaluation - New Or Established Patient	0-999	1 per code every 3 Years		No	
D0160	Detailed And Extensive Oral Evaluation - Problem Focused, By Report	0-999	1 per code every 3 Years		No	
D0170	Re-Evaluation - Limited, Problem Focused	0-999	1 per code every 1 Year		No	
D0191	Assessment Of A Patient	0-999	1 per code every 6 Months		No	
D0210	Intraoral - Comprehensive Series of Radiographic Images	0-999	1 per code every 3 Years		No	
D0220	Intraoral - Periapical First Radiographic Image	0-999	1 per code every Day		No	
D0230	Intraoral - Periapical Each Additional Image	0-999	3 per code every Day		No	
D0240	Intraoral - Occlusal Radiographic Image	0-999	2 per code every Day		No	
D0250	Extraoral - 2D Projection Radiographic image	0-999	1 per code every Day		No	
D0251	Extra-Oral Posterior Dental Radiographic Image	0-999	1 per code every 6 Months		No	
D0270	Bitewing - Single Radiographic Image	0-999	2 per code every 6 Months		No	
D0272	Bitewings - Two Radiographic Images	0-999	1 per code every 6 Months		No	
D0273	Bitewings - Three Radiographic Images	0-999	1 per code every 6 Months		No	
D0274	Bitewings - Four Radiographic Images	0-999	1 per code every 6 Months		No	
D0277	Vertical Bitewings - 7 To 8 Radiographic Images	21-999	1 per code every 12 Months		No	
D0330	Panoramic Radiographic Image	0-999	1 per code every Day		No	
D0340	2D Cephalometric Radiographic Image	0-20			No	
D0350	Oral/Facial Photographic Images	0-20			No	
D0372	Intraoral tomosynthesis - comprehensive series of radiographic images	0-999	1 per code every 3 Years		No	
D0373	Intraoral tomosynthesis - bitewing radiographic image	0-999	1 per code every 3 Years		No	
D0374	Intraoral tomosynthesis - periapical radiographic image	0-999	1 per code every 3 Years		No	

Code	Description	Age	Limit	Other limits	Auth required?	Required documents
D0387	Intraoral tomosynthesis - comprehensive series of radiographic images - image capture only	0-999	1 per code every Day		No	
D0388	Intraoral tomosynthesis - bitewing radiographic image - image capture only	0-999	1 per code every Day		No	
D0389	Intraoral tomosynthesis - periapical radiographic image - image capture only	0-999	1 per code every Day		No	
D0391	Interpretation Of Diagnostic Image	0-999			No	
D0470	Diagnostic Casts	0-999			No	
D0486	Accession Of Transepithelial Cytologic Sample, Microscopic Examination	0-999			No	
D0701	Panoramic Radiographic Image - Image Capture Only	0-999	1 per code every Lifetime		No	
D0702	2-D Cephalometric Radiographic Image - Image Capture Only	0-999			No	
D0703	2-D Oral/Facial Photographic Image Obtained Intra-orally or Extra-orally - Image Capture Only	0-999			No	
D0705	Extra-Oral Posterior Dental Radiographic Image - Image Capture Only	0-999			No	
D0706	Intraoral - Occlusal Radiographic Image - Image Capture Only	0-999	2 per code every Day		No	
D0707	Intraoral - Periapical Radiographic Image - Image Capture Only	0-999	4 per code every Day		No	
D0708	Intraoral - Bitewing Radiographic Image - Image Capture Only	0-999	1 per code every 6 Months		No	
D0709	Intraoral - Comprehensive Series of Radiographic Images - Image Capture Only	0-999	1 per code every 3 Years		No	
D0999	Unspecified Diagnostic Procedures, By Report	13-20	2 per code every Year		Yes	Description of procedure and narrative of medical necessity
D1110	Prophylaxis - Adult	13-20	1 per code every 6 Months		No	
D1110	Prophylaxis - Adult	21-999	1 per code every 12 Months		No	
D1110	Prophylaxis - Adult	0-999	4 per code every Year	F84.9 Special Needs Member Frequency	No	
D1120	Prophylaxis - Child	0-12	1 per code every 6 Months		No	
D1120	Prophylaxis - Child		4 per code every Year	F84.9 Special Needs Member Frequency	No	
D1206	Topical Application Of Fluoride Varnish	0-20	2 per code every 12 Months		No	
D1206	Topical Application Of Fluoride Varnish	21-999	1 per code every 12 Months		No	
D1206	Topical Application Of Fluoride Varnish	0-999	4 per code every Year	F84.9 Special Needs Member Frequency	No	

Code	Description	Age	Limit	Other limits	Auth required?	Required documents
D1208	Topical Application of Fluoride - excluding varnish	0-20	2 per code every 12 Months		No	
D1208	Topical Application of Fluoride - excluding varnish	21-999	1 per code every 12 Months		No	
D1208	Topical Application of Fluoride - excluding varnish	0-999	4 per code every Year	F84.9 Special Needs Member Frequency	No	
D1351	Sealant - Per Tooth	0-20	1 per code per tooth every 3 Years	Tooth: 02-03, 04-05, 12-13, 14-15, 18-19, 20-21, 28-29, 30-31, A-B, I-L, S-T	No	
D1351	Sealant - Per Tooth	21-999	1 per code per tooth every 3 Years	Tooth: 2, 3, 14, 15, 18, 19, 30, and 31	Yes	Description of procedure and narrative of medical necessity
D1354	Interim Caries Arresting Medicament Application - per tooth	0-999	1 per code per tooth every 6 Months	Tooth: 01-32, A-T	No	
D1510	Space Maintainer - Fixed - Unilateral - per quadrant	0-20	1 per code per quadrant every Year	Quadrant: LL, LR, UL, UR	No	
D1516	Space Maintainer - Fixed - Bilateral, maxillary	0-20	1 per code per tooth every Year	Tooth: 02-15, 18-31, A-T	No	
D1517	Space Maintainer - Fixed - Bilateral, mandibular	0-20	1 per code per tooth every Year	Tooth: 02-15, 18-31, A-T	No	
D1551	Re-Cement Or Re-Bond Bilateral Space Maintainer - maxillary	0-20	2 per code every Day		No	
D1552	Re-Cement Or Re-Bond Bilateral Space Maintainer - mandibular	0-20	2 per code every Day		No	
D1553	Re-Cement Or Re-Bond Unilateral Space Maintainer - Per quadrant	0-20	2 per code per quadrant every Day	Quadrant: LL, LR, UL, UR	No	
D1556	Removal Of Fixed Unilateral Space Maintainer - Per quadrant	0-999		Quadrant: LL, LR, UL, UR	No	
D1557	Removal Of Fixed Bilateral Space Maintainer - maxillary	0-999			No	
D1558	Removal Of Fixed Bilateral Space Maintainer - mandibular	0-999			No	
D1575	Distal Shoe Space Maintainer - Fixed - Per Quadrant	0-20	1 per code per quadrant every Year	Quadrant: LL, LR, UL, UR	No	
D1999	Unspecified Preventive Procedure, by report	0-999			No	
D2140	Amalgam - One Surface, Primary Or Permanent	0-999	1 per code per tooth every 3 Years	Tooth: 01-32, A-T	No	
D2150	Amalgam - Two Surfaces, Primary Or Permanent	0-999	1 per code per tooth every 3 Years	Tooth: 01-32, A-T	No	
D2160	Amalgam - Three Surfaces, Primary Or Permanent	0-999	1 per code per tooth every 3 Years	Tooth: 01-32, A-T	No	

Code	Description	Age	Limit	Other limits	Auth required?	Required documents
D2161	Amalgam - Four Or More Surfaces, Primary Or Permanent	0-999	1 per code per tooth every 3 Years	Tooth: 01-32, A-T	No	
D2330	Resin-Based Composite - One Surface, Anterior	0-999	1 per code per tooth every 3 Years	Tooth: 06-11, 22-27, C-H, M-R	No	
D2331	Resin-Based Composite - Two Surfaces, Anterior	0-999	1 per code per tooth every 3 Years	Tooth: 06-11, 22-27, C-H, M-R	No	
D2332	Resin-Based Composite - Three Surfaces, Anterior	0-999	1 per code per tooth every 3 Years	Tooth: 06-11, 22-27, C-H, M-R	No	
D2335	resin-based composite - four or more surfaces (anterior)	0-999	1 per code per tooth every 3 Years	Tooth: 06-11, 22-27, C-H, M-R	No	
D2390	Resin-Based Composite Crown, Anterior	0-999	1 per code per tooth every 5 Years	Tooth: 06-11, 22-27, C-H, M-R	No	
D2391	Resin-Based Composite - One Surface, Posterior	0-999	1 per code per tooth every 3 Years	Tooth: 01-05, 12-21, 28-32, A-B, I-L, S-T	No	
D2392	Resin-Based Composite - Two Surfaces, Posterior	0-999	1 per code per tooth every 3 Years	Tooth: 01-05, 12-21, 28-32, A-B, I-L, S-T	No	
D2393	Resin-Based Composite - Three Surfaces, Posterior	0-999	1 per code per tooth every 3 Years	Tooth: 01-05, 12-21, 28-32, A-B, I-L, S-T	No	
D2394	Resin-Based Composite - Four Or More Surfaces, Posterior	0-999	1 per code per tooth every 3 Years	Tooth: 01-05, 12-21, 28-32, A-B, I-L, S-T	No	
D2791	Crown - Full Cast Predominantly Base Metal	0-999	1 per code per tooth every 5 Years	Tooth: 01-32	No	
D2910	Re-Cement Or Re-Bond Inlay, Onlay, Veneer Or Partial Coverage Restoration	0-999		Tooth: 01-32	No	
D2915	Re-Cement or Re-Bond Cast Indirectly Fabricated Or Pre-Fabricated Post and Core	0-999		Tooth: 01-32	No	
D2920	Re-Cement or Re-Bond Crown	0-999		Tooth: 01-32	No	
D2921	Reattachment of Tooth Fragment, Incisal Edge or Cusp	0-999			No	
D2928	Prefabricated Porcelain / Ceramic Crown - Permanent Tooth	0-999	1 per code per tooth every 5 Years	Tooth: 01-32	No	
D2929	Prefabricated Porcelain / Ceramic Crown - Primary Tooth	0-999	1 per code per tooth every Year	Tooth: A-T	No	
D2930	Prefabricated Stainless Steel Crown - Primary Tooth	0-999	1 per code per tooth every Year	Tooth: A-T	No	
D2931	Prefabricated Stainless Steel Crown - Permanent Tooth	0-999	1 per code per tooth every 5 Years	Tooth: 01-32	No	
D2932	Prefabricated Resin Crown	0-999	1 per code per tooth every 5 Years	Tooth: 06-11, 22-27, D-G	No	

Code	Description	Age	Limit	Other limits	Auth required?	Required documents
D2933	Prefabricated Stainless Steel Crown With Resin Window	0-999	1 per code per tooth every 5 Years	Tooth: D-G	No	
D2934	Prefabricated Esthetic Coated Stainless Steel Crown - Primary Tooth	0-20	1 per code per tooth every Year	Tooth: D-G	No	
D2940	Protective Restoration	0-999		Tooth: 01-32, A-T	No	
D2941	Interim Therapeutic Restoration - Primary Dentition	0-999			No	
D2951	Pin Retention - Per Tooth, In Addition To Restoration	0-999	1 per code per tooth every 3 Years	Tooth: 01-32	No	
D2952	Post And Core In Addition To Crown, Indirectly Fabricated	0-999	1 per code per tooth every Lifetime	Tooth: 02-15, 18-31	No	
D2954	Prefabricated Post And Core In Addition To Crown	0-999	1 per code per tooth every Lifetime	Tooth: 02-15, 18-31	No	
D2971	Additional procedures to customize a crown to fit under an existing partial dent	0-999		Tooth: 02-15, 18-31	No	
D2999	Unspecified Restorative Procedure, By Report	0-20			Yes	Description of procedure and narrative of medical necessity
D3220	Therapeutic Pulpotomy	0-999	1 per code per tooth every Lifetime	Tooth: A-T	No	
D3221	Pulpal Debridement - Primary And Permanent Teeth	0-999		Tooth: 02-15, 18-31	No	
D3222	Partial Pulpotomy For Apexogenesis - Permanent Tooth	0-12		Tooth: 01-32	No	
D3310	Endodontic Therapy, Anterior Tooth (Excluding Final Restoration)	0-999	1 per code per tooth every Lifetime	Tooth: 06-11, 22-27	No	Pre-op x-rays (excluding bitewings), 4 or more teeth
D3320	Endodontic Therapy Premolar Tooth (Excluding Final Restoration)	0-999	1 per code per tooth every Lifetime	Tooth: 04-05, 12-13, 20-21, 28-29	No	Pre-op x-rays (excluding bitewings), 4 or more teeth
D3330	Endodontic Therapy, Molar tooth (Excluding Final Restoration)	0-999	1 per code per tooth every Lifetime	Tooth: 02-03, 14-15, 18-19, 30-31	Yes 21-999	Pre-op x-rays (excluding bitewings), 4 or more teeth
D3351	Apexification / Recalcification - Initial Visit	0-20		Tooth: 02-15, 18-31	No	
D3352	Apexification / Recalcification - Interim	0-20	2 per code per tooth every Lifetime	Tooth: 02-15, 18-31	No	
D3353	Apexification / Recalcification - Final Visit	0-20	1 per code per tooth every Lifetime	Tooth: 02-15, 18-31	No	
D3410	Apicoectomy - Anterior	0-999		Tooth: 06-11, 22-27	No	
D3430	Retrograde Filling - Per Root	0-999		Tooth: 06-11, 22-27	No	
D4210	Gingivectomy Or Gingivoplasty - Four Or More Contiguous Teeth	0-999		Quadrant: LL, LR, UL, UR	Yes	Pre-op x-rays, perio charting, narrative of medical necessity, photo (optional)
D4211	Gingivectomy Or Gingivoplasty - One To Three Contiguous Teeth	0-999		Quadrant: LL, LR, UL, UR	Yes	Pre-op x-rays, perio charting, narrative of medical necessity, photo (optional

Code	Description	Age	Limit	Other limits	Auth required?	Required documents
D4322	Splint - Intra-Coronal; Natural Teeth or Prosthetic Crowns	0-999			No	
D4323	Splint - Extra-Coronal; Natural Teeth or Prosthetic Crowns	0-999			No	
D4341	Periodontal Scaling And Root Planing - Four Or More Teeth Per Quadrant	13-999	1 per code per quadrant every 3 Years	Quadrant: LL, LR, UL, UR	Yes	Periodontal charting and pre-op x-rays
D4342	Periodontal Scaling And Root Planing - One To Three Teeth Per Quadrant	13-999	1 per code per quadrant every 3 Years	Quadrant: LL, LR, UL, UR	Yes	Periodontal charting and pre-op x-rays
D4346	Scaling in moderate or severe gingival inflammation	0-999			No	
D4355	Full Mouth Debridement To Enable Comprehensive Periodontal Evaluation And Diagno	13-999	1 per code every 3 Years		Yes	Pre-op x-rays or photos
D4910	Periodontal Maintenance	13-999	1 per code every Year		Yes	Date of previous perio surgical or S&C service with claim
D4999	Unspecified Periodontal Procedure, By Report	0-20			Yes	Description of procedure and narrative of medical necessity
D5110	Complete Denture - Maxillary	0-999	2 per code every 5 Years		Yes	FMX or Panorex, or Administrator/ member statement on loss/theft
D5120	Complete Denture - Mandibular	0-999	2 per code every 5 Years		Yes	FMX or Panorex, or Administrator/ member statement on loss/theft
D5211	Maxillary Partial Denture - Resin Base	0-999	2 per code every 5 Years		Yes	FMX or Panorex, or Administrator/ member statement on loss/theft
D5212	Mandibular Partial Denture - Resin Base	0-999	2 per code every 5 Years		Yes	FMX or Panorex, or Administrator/ member statement on loss/theft
D5213	Maxillary Partial Denture - Cast Metal Framework With Resin Denture Bases	0-999	2 per code every 5 Years		Yes	FMX or Panorex, or Administrator/ member statement on loss/theft
D5214	Mandibular Partial Denture - Cast Metal Framework With Resin Denture Bases	0-999	2 per code every 5 Years		Yes	FMX or Panorex, or Administrator/ member statement on loss/theft
D5225	Maxillary Partial Denture - Flexible Base	0-999	2 per code every 5 Years		Yes	FMX or Panorex, or Administrator/ member statement on loss/theft
D5226	Mandibular Partial Denture - Flexible Base	0-999	2 per code every 5 Years		Yes	FMX or Panorex, or Administrator/ member statement on loss/theft
D5227	Immediate Maxillary Partial Denture - Flexible Base	0-999			No	
D5228	Immediate Mandibular Partial Denture - Flexible Base	0-999			No	
D5511	Repair Broken Complete Denture Base - Mandibular	0-999			No	
D5512	Repair Broken Complete Denture Base - Maxillary	0-999			No	
D5520	Replace Missing Or Broken Teeth - Complete Denture (Each Tooth)	0-999		Tooth: 01-32	No	
D5611	Repair Resin Partial Denture Base - Mandibular	0-999			No	
D5612	Repair Resin Partial Denture Base - Maxillary	0-999			No	
D5621	Repair Cast Partial Framework - Mandibular	0-999			No	
D5622	Repair Cast Partial Framework - Maxillary	0-999			No	
D5630	Repair Or Replace Broken Retentive / Clasping Materials - Per Tooth	0-999		Tooth: 01-32, A-T	No	

Code	Description	Age	Limit	Other limits	Auth required?	Required documents
D5640	Replace Broken Teeth - Per Tooth	0-999		Tooth: 01-32	No	
D5650	Add Tooth To Existing Partial Denture	0-999		Tooth: 01-32	No	
D5660	Add Clasp To Existing Partial Denture - Per Tooth	0-999		Tooth: 01-32	No	
D5670	Replace 0-999 Teeth And Acrylic On Cast Metal Framework (Maxillary)	0-999			Yes	Date of service with claim
D5671	Replace 0-999 Teeth And Acrylic On Cast Metal Framework (Mandibular)	0-999			Yes	Date of service with claim
D5750	Reline Complete Maxillary Denture (Indirect)	0-999	1 per code every 3 Years		No	
D5751	Reline Complete Mandibular Denture (Indirect)	0-999	1 per code every 3 Years		No	
D5760	Reline Maxillary Partial Denture (Indirect)	0-999	1 per code every 3 Years		No	
D5761	Reline Mandibular Partial Denture (Indirect)	0-999	1 per code every 3 Years		No	
D5922	Nasal Septal Prosthesis	0-999			No	
D5923	Interim Ocular Prosthesis	0-999			No	
D5925	Facial Augmentation Implant Prosthesis	0-999			No	
D5932	Obturator Prosthesis, Definitive	0-999	1 per code every 6 Months		No	
D5955	Palatal Lift Prosthesis, Definitive	0-999	1 per code every 6 Months		No	
D5991	Vesiculobullous Disease Medicament Carrier	0-999			No	
D5999	Unspecified Maxillofacial Prosthesis, By Report	0-999			Yes	Description of procedure and narrative of medical necessity
D6211	Pontic - Cast Predominantly Base Metal	0-999		Tooth: 01-32	Yes	Description of procedure and narrative of medical necessity
D6241	Pontic - Porcelain Fused To Predominantly Base Metal	0-999		Tooth: 01-32	Yes	Description of procedure and narrative of medical necessity
D6545	Retainer - Cast Metal For Resin Bonded Fixed Prosthesis	0-999		Tooth: 01-32	Yes	Description of procedure and narrative of medical necessity
D6751	Retainer Crown - Porcelain Fused To Predominantly Base Metal	0-999		Tooth: 01-32	Yes	Description of procedure and narrative of medical necessity
D6791	Retainer Crown - Full Cast Predominantly Base Metal	0-999		Tooth: 01-32	Yes	Description of procedure and narrative of medical necessity
D6930	Re-Cement Or Re-Bond Fixed Partial Denture	0-999		Tooth: 01-32	No	
D6940	Stress Breaker	0-999		Tooth: 01-32	Yes	Document describing type of device and narrative of medical necessity
D6980	Fixed Partial Denture Repair	0-999		Tooth: 01-32	Yes	Narrative of medical necessity with claim
D6985	Pediatric Partial Denture, Fixed	0-12		Arch: LA, UA	No	
D7111	Extraction, Coronal Remnants - PrimaryTooth	0-999	1 per code per tooth every Lifetime	Tooth: AS-TS, A-T	No	
D7140	Extraction, Erupted Tooth Or Exposed Root	0-999	1 per code per tooth every Lifetime	Tooth: 01-32, 51-82, A-TS	No	

Code	Description	Age	Limit	Other limits	Auth required?	Required documents
D7210	Extraction, Erupted Tooth	0-999	1 per code per tooth every Lifetime	Tooth: 01-32, 51-82, A-TS	No	
D7220	Removal Of Impacted Tooth - Soft Tissue	0-999	1 per code per tooth every Lifetime	Tooth: 01-32, 51-82, A-TS	No	
D7230	Removal Of Impacted Tooth - Parti0-999y Bony	0-999	1 per code per tooth every Lifetime	Tooth: 01-32, 51-82, A-TS	No	
D7240	Removal Of Impacted Tooth - Completely Bony	0-999	1 per code per tooth every Lifetime	Tooth: 01-32, 51-82, A-TS	No	
D7241	Removal Of Impacted Tooth - Completely Bony, Unusual Surgical Complications	0-999	1 per code per tooth every Lifetime	Tooth: 01-32, 51-82, A-TS	No	
D7250	Removal Of Residual Tooth (Cutting Procedure)	0-999	1 per code per tooth every Lifetime	Tooth: 01-32, 51-82, A-TS	No	
D7260	Oroantral Fistula Closure	0-999			No	
D7261	Primary Closure Of Sinus Perforation	0-999			No	
D7270	Reimplantation And/Or Stabilization Of Accident0-999y Evulsed / Displaced Tooth	0-999		Tooth: 01-32	No	
D7280	Exposure of an Unerupted Tooth	0-20		Tooth: 02-15, 18-31	No	
D7282	Mobilization Of Erupted Or Malpositioned Tooth To Aid Eruption	0-20		Tooth: 02-15, 18-31	No	
D7283	Placement Of Device To Facilitate Eruption Of Impacted Tooth	0-20		Tooth: 02-15, 18-31	No	
D7285	Incisional Biopsy Of Oral Tissue - Hard (Bone, Tooth)	0-999	1 per code every Day		No	
D7286	Incisional Biopsy Of Oral Tissue - Soft	0-999	1 per code every Day		No	
D7287	Exfoliative Cytological Sample Collection	0-999	1 per code every Day		No	
D7288	Brush Biopsy - Transepithelial Sample Collection	0-999	1 per code every Day		No	
D7310	Alveoloplasty In Conjunction With Extractions - Four Or More Teeth	0-999		Quadrant: LL, LR, UL, UR	Yes	Pre-operative x-rays (excluding bitewings) with claim
D7311	Alveoloplasty In Conjunction With Extractions - One To Three Teeth	0-999		Quadrant: LL, LR, UL, UR	Yes	Pre-operative x-rays (excluding bitewings) with claim
D7320	Alveoloplasty Not In Conjunction With Extractions - Four Or More Teeth	0-999		Quadrant: LL, LR, UL, UR	Yes	Pre-operative x-rays (excluding bitewings) with claim
D7321	Alveoloplasty Not In Conjunction With Extractions - One To Three Teeth	0-999		Quadrant: LL, LR, UL, UR	Yes	Pre-operative x-rays (excluding bitewings) with claim
D7410	Excision Of Benign Lesion Up To 1.25 Cm	0-999	1 per code every Day		No	
D7411	Excision Of Benign Lesion Greater Than 1.25 Cm	0-999	1 per code every Day		No	
D7412	Excision Of Benign Lesion, Complicated	0-999	1 per code every Day		No	
D7413	Excision Of Malignant Lesion Up To 1.25 Cm	0-999	1 per code every Day		No	

Code	Description	Age	Limit	Other limits	Auth required?	Required documents
D7414	Excision Of Malignant Lesion Greater Than 1.25 Cm	0-999	1 per code every Day		No	
D7415	Excision Of Malignant Lesion, Complicated	0-999	1 per code every Day		Yes	Copy of pathology report with claim
D7440	Excision Of Malignant Tumor - Lesion Diameter Up To 1.25 Cm	0-999	1 per code every Day		Yes	Copy of pathology report with claim
D7441	Excision Of Malignant Tumor - Lesion Diameter Greater Than 1.25 Cm	0-999	1 per code every Day		Yes	Copy of pathology report with claim
D7450	Removal Of Benign Odontogenic Cyst Or Tumor - Dia Up To 1.25 Cm	0-999	1 per code every Day		No	
D7451	Removal Of Benign Odontogenic Cyst Or Tumor - Dia Greater Than 1.25 Cm	0-999	1 per code every Day		No	
D7460	Removal Of Benign Nonodontogenic Cyst Or Tumor - Dia Up To 1.25 Cm	0-999	1 per code every Day		No	
D7461	Removal Of Benign Nonodontogenic Cyst Or Tumor - Dia Greater Than 1.25 Cm	0-999	1 per code every Day		No	
D7471	Removal Of Lateral Exostosis (Maxilla Or Mandible)	0-999		Arch: LA, UA	Yes	Narrative of medical necessity, xrays or photos optional
D7472	Removal Of Torus Palatinus	0-999			Yes	Narrative of medical necessity, xrays or photos optional
D7473	Removal Of Torus Mandibularis	0-999			Yes	Narrative of medical necessity, xrays or photos optional
D7485	Reduction Of Osseous Tuberosity	0-999			Yes	Narrative of medical necessity, xrays or photos optional
D7490	Radical Resection Of Maxilla Or Mandible	0-999			Yes	Narrative of medical necessity, xrays or photos optional
D7509	Marsupialization of odontogenic cyst	0-999			No	
D7510	Incision And Drainage Of Abscess - Intraoral Soft Tissue	0-999			No	
D7511	Incision And Drainage Of Abscess - Intraoral Soft Tissue - Complicated	0-999			No	
D7520	Incision And Drainage Of Abscess - Extraoral Soft Tissue	0-999			No	
D7521	Incision And Drainage Of Abscess - Extraoral Soft Tissue - Complicated	0-999			No	
D7530	Removal Of Foreign Body From Mucosa	0-999			No	
D7540	Removal Of Reaction Producing Foreign Bodies	0-999			No	
D7550	Partial Ostectomy/Sequestrectomy For Removal Of Non-Vital Bone	0-999		Quadrant: LL, LR, UL, UR	Yes	Narrative of medical necessity with claim, x-rays or photos optional
D7560	Maxillary Sinusotomy For Removal Of Tooth Fragment Or Foreign Body	0-999			Yes	Narrative of medical necessity with claim, x-rays or photos optional
D7610	Maxilla - Open Reduction (Teeth Immobilized, If Present)	0-999			Yes	Narrative of medical necessity with claim, x-rays or photos optional
D7620	Maxilla - Closed Reduction (Teeth Immobilized, If Present)	0-999			Yes	Narrative of medical necessity with claim, x-rays or photos optional
D7630	Mandible - Open Reduction (Teeth Immobilized, If Present)	0-999			Yes	Narrative of medical necessity with claim, x-rays or photos optional
D7640	Mandible - Closed Reduction (Teeth Immobilized, If Present)	0-999			Yes	Narrative of medical necessity with claim, x-rays or photos optional

Code	Description	Age	Limit	Other limits	Auth required?	Required documents
D7650	Malar And/Or Zygomatic Arch - Open Reduction	0-999			Yes	Narrative of medical necessity with claim, x-rays or photos optional
D7660	Malar And/Or Zygomatic Arch - Closed Reduction	0-999			Yes	Narrative of medical necessity with claim, x-rays or photos optional
D7670	Alveolus - Closed Reduction, May Include Stabilization Of Teeth	0-999			Yes	Narrative of medical necessity with claim, x-rays or photos optional
D7671	Alveolus - Open Reduction, May Include Stabilization Of Teeth	0-999			Yes	Narrative of medical necessity with claim, x-rays or photos optional
D7680	Facial Bones - Complicated Reduction With Fixation And Multiple Surgical	0-999			Yes	Narrative of medical necessity with claim, x-rays or photos optional
D7710	Maxilla - Open Reduction	0-999			Yes	Narrative of medical necessity with claim, x-rays or photos optional
D7720	Maxilla - Closed Reduction	0-999			Yes	Narrative of medical necessity with claim, x-rays or photos optional
D7730	Mandible - Open Reduction	0-999			Yes	Narrative of medical necessity with claim, x-rays or photos optional
D7740	Mandible - Closed Reduction	0-999			Yes	Narrative of medical necessity with claim, x-rays or photos optional
D7750	Malar And/Or Zygomatic Arch - Open Reduction	0-999			Yes	Narrative of medical necessity with claim, x-rays or photos optional
D7760	Malar And/Or Zygomatic Arch - Closed Reduction	0-999			Yes	Narrative of medical necessity with claim, x-rays or photos optional
D7770	Alveolus - Open Reduction Stabilization Of Teeth	0-999			Yes	Narrative of medical necessity with claim, x-rays or photos optional
D7771	Alveolus - Closed Reduction Stabilization Of Teeth	0-999			Yes	Narrative of medical necessity with claim, x-rays or photos optional
D7780	Facial Bones - Complicated Reduction With Fixation And Multiple Approaches	0-999			Yes	Narrative of medical necessity with claim, x-rays or photos optional
D7810	Open Reduction Of Dislocation	0-999			Yes	Narrative of medical necessity with claim, x-rays or photos optional
D7820	Closed Reduction Of Dislocation	0-999	1 per code every Day		Yes	Narrative of medical necessity with claim, x-rays or photos optional
D7830	Manipulation Under Anesthesia	0-999			Yes	Narrative of medical necessity with claim, x-rays or photos optional
D7840	Condylectomy	0-999			Yes	Narrative of medical necessity with claim, x-rays or photos optional
D7850	Surgical Discetomy, With/Without Implant	0-999			Yes	Narrative of medical necessity with claim, x-rays or photos optional
D7860	Arthrotomy	0-999			Yes	Narrative of medical necessity with claim, x-rays or photos optional
D7871	Non-Arthroscopic Lysis And Lavage	0-999	1 per code every 3 Years		Yes	Narrative of medical necessity with claim, x-rays or photos optional
D7899	Unspecified Tmd Therapy, By Report	0-999			Yes	Narrative of medical necessity with claim, x-rays or photos optional
D7910	Suture Of Recent Sm0-999 Wounds Up To 5 Cm	0-999	1 per code every Day		Yes	Narrative of medical necessity with claim, x-rays or photos optional
D7911	Complicated Suture - Up To 5 Cm	0-999	1 per code every Day		Yes	Narrative of medical necessity with claim, x-rays or photos optional
D7912	Complicated Suture - Greater Than 5 Cm	0-999	1 per code every Day		Yes	Narrative of medical necessity with claim, x-rays or photos optional
D7940	Osteoplasty - For Orthognathic Deformities	0-20			Yes	Narrative of medical necessity with claim, x-rays or photos optional

Code	Description	Age	Limit	Other limits	Auth required?	Required documents
D7950	Osseous, Osteoperiosteal, Or Cartilage Graft Of The Mandible Or Maxilla	0-999			Yes	Narrative of medical necessity with claim, x-rays or photos optional
D7951	Sinus Augmentation With Bone Or Bone Substitutes Via A Lateral Open Approach	0-999			No	
D7961	Buccal / Labial Frenectomy (frenulectomy)	0-999	1 per code per arch every Lifetime	Arch: LA, UA	Yes	Members must meet one of the following criteria: 1) The member's frenum creates a central incisor diastema. 2) The member's frenum creates ankyloglossia. 3) The member's frenum creates periodontal defects. 4) The member's frenum requires removal to complete orthodontic services. 5) The member's frenum interferes with denture stabilization, due to its high attachment on the ridge.
D7962	Lingual Frenectomy (frenulectomy)	0-999	1 per code every Lifetime		Yes	Members must meet one of the following criteria: 1) The member's frenum creates a central incisor diastema. 2) The member's frenum creates ankyloglossia. 3) The member's frenum creates periodontal defects. 4) The member's frenum requires removal to complete orthodontic services. 5) The member's frenum interferes with denture stabilization, due to its high attachment on the ridge
D7970	Excision Of Hyperplastic Tissue - Per Arch	0-999		Arch: LA, UA	Yes	Pre-op x-rays, narrative of medical necessity, photos optional
D7972	Surgical Reduction Of Fibrous Tuberosity	0-999			Yes	Pre-op x-rays,narr of medical nec with claim,photos optional
D7979	Non-Surgical Sialolithotomy	0-999			Yes	Narrative of medical necessity, xrays or photos optiona
D7980	Surgical Sialolithotomy	0-999			Yes	Narrative of medical necessity with claim, x-rays or photos optional
D7991	Coronoidectomy	0-999			Yes	Narrative of medical necessity with claim, x-rays or photos optional
D7997	Appliance Removal (Not By Dentist Who Placed Appliance)	0-999			No	
D7999	Unspecified Oral Surgery Procedure, By Report	0-999			Yes	Description of procedure and narrative of medical necessity
D8010	Limited Orthodontic Treatment Of The Primary Dentition	0-20			Yes	Panorex or full mouth x-rays, cephalometric x-ray, diagnostic quality photos
D8020	Limited Orthodontic Treatment Of The Transitional Dentition	0-20			Yes	Panorex or full mouth x-rays, cephalometric x-ray, diagnostic quality photos
D8030	Limited Orthodontic Treatment Of The Adolescent Dentition	0-20			Yes	Panorex or full mouth x-rays, cephalometric x-ray, diagnostic quality photos
D8040	Limited Orthodontic Treatment Of The Adult Dentition	0-20			Yes	Panorex or full mouth x-rays, cephalometric x-ray, diagnostic quality photos
D8070	Comprehensive Orthodontic Treatment Of The Transitional Dentition	0-20			Yes	Pan or FMX, ceph x-ray,diagnostic quality photos,salzmann score sheet
D8080	Comprehensive Orthodontic Treatment Of The Adolescent Dentition	0-20			Yes	Pan or FMX, ceph x-ray,diagnostic quality photos,salzmann score sheet
D8090	Comprehensive Orthodontic Treatment Of The Adult Dentition	0-20			Yes	Pan or FMX, ceph x-ray,diagnostic quality photos,salzmann score sheet

Code	Description	Age	Limit	Other limits	Auth required?	Required documents
D8210	Removable Appliance Therapy	0-20			Yes	Panorex and/or cephalometirc, narrative of medical necessity
D8220	Fixed Appliance Therapy	0-20			Yes	Panorex and/or cephalometirc, narrative of medical necessity
D8660	Pre-Orthodontic Treatment Examination To Monitor Growth And Development	0-20			No	
D8670	Periodic Orthodontic Treatment Visit	0-23	24 per code every Lifetime		No for initial 24 units requested	
					Yes for 25th unit or more	Yes for 25th unit or more, narrative of medical necessity and diagnostic quality photos
D8680	Orthodontic Retention (Removal Of Appliances, Place Retainers)	0-23			Yes	Diagnostic quality photos
D8695	Removal Of Fixed Orthodontic Appliances	0-20	1 per code every Lifetime		No	
D8698	Re-cement Or Re-bond Fixed Retainer - Maxillary	0-999			No	
D8699	Re-cement Or Re-bond Fixed Retainer - Mandibular	0-999			No	
D8703	Replacement Of Lost Or Broken Rertainer - Maxillary	0-20			No	
D8704	Replacement Of Lost Or Broken Rertainer - Mandibular	0-20			No	
D9110	P0-999iative (Emergency) Treatment Of Dental Pain - Per Visit	0-999			No	
D9222	Deep Sedation/General Anesthesia - First 15 Minutes	0-999	1 per code every Day		Yes	Narrative of medical necessity with claim
D9223	Deep Sedation / General Anesthesia - Each subsequent 15 Minute Increment	0-999	2 per code every Day		Yes	Narrative of medical necessity with claim
D9230	Inhalation Of Nitrous/Analgesia, Anxiolysis	0-999	1 per code every Day		No	
D9239	Intravenous Moderate (Conscious) Sedation/Analgesia - First 15 Minutes	0-999			Yes	Narrative of medical necessity with claim
D9243	Intravenous Moderate (Conscious) Sedation/Analgesia - Each Subsequent 15 Minute	0-999			Yes	Narrative of medical necessity with claim
D9248	Non-Intravenous Conscious Sedation	0-999			Yes	Narrative of medical necessity with claim
D9410	House/Extended Care Facility C0-999	0-999	1 per code every 333 Days		No	
D9420	Hospital Or Ambulatory Surgical Center C0-999	0-999			No	
D9610	Therapeutic Parenteral Drug, Single Administration	0-999			No	
D9612	Therapeutic Parenteral Drugs, Two Or More Administrations	0-999			No	
D9613	Infiltration of sustained release therapeutic drug, per quadrant	0-999		Quadrant: LL, LR, UL, UR	No	
D9910	Application Of Desensitizing Medicament	0-999			No	
D9944	Occlusal Guard-hard appliance, full arch	0-999			Yes	Narrative of medical necessity
D9945	Occlusal Guard-soft appliance, full arch	0-999			Yes	Narrative of medical necessity

Code	Description	Age	Limit	Other limits	Auth required?	Required documents
D9946	Occlusal Guard-hard appliance, partial arch	0-999			Yes	Narrative of medical necessity
D9995	Teledentistry - Synchronous; Real-Time Encounter	0-999			No	
D9999	Unspecified Adjunctive Procedure, By Report	0-999			Yes	Description of procedure and narrative of medical necessity
T1013	Sign language or oral interpretive services	0-999			No	
T1015	FQHC Encounter Payment-ADA	0-999			No	

Comprehensive orthodontic treatment

Pre authorization requirements

- Orthodontic records of the examination, consultation, and diagnostic casts (Casts must be securely packed, must be clearly labeled to identify the provider and the member, and must include a bite registration.)
- A completed **https://www.forwardhealth.wi.gov/kw/html/PADRF.html and https://www.forwardhealth.wi.gov/kw/html/PADA2.html**
- A specific orthodontic treatment plan that addresses appliance(s) to be used during the course of treatment

Orthodontic retention

Documentation of diagnostic quality photos to show completed comprehensive orthodontic treatment.

Orthodontic continuation of care

If the member needs to continue treatment with a new provider after banding has been started. The new provider does not need to send a new pre authorization, as long as the member has one on file with UHC. The new provider can continue treatment and bill (D8670) until the retention (D8680) appointment. The retention code (D8680) does require a pre authorization before it can be billed.

Appendix C: Authorization for treatment

C.1 Dental treatment requiring authorization

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

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

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

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

C.2 Authorization timelines

The following timelines will apply to requests for authorization:

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

C.3 Appealing a denied authorization

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.4 Appeal determination timeframe:

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

C.5 State Fair Hearing

When benefits are denied (Fair Hearings).

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

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

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

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

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

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

C.6 Credentialing and Recredentialing Appeals

Appeals for credentialing / re-credentialing for disciplinary action is not applicable in your state.

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 Wisconsin 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 Wisconsin 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 Wisconsin 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 1-800-504-9660.
- 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.

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