



# UnitedHealthcare Commercial Dental Provider Manual

Fall 2019



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# Section 1: Introduction – Who We Are

## Welcome to UnitedHealthcare®

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

UnitedHealthcare is committed to providing accessible, quality, comprehensive dental care 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.

UnitedHealthcare offers a portfolio of products to its members, your patients, as well as to its participating dental offices. Products include Preferred Provider Organization (PPO), Exclusive Provider Organization (EPO), In-Network Only (INO), Dental Health Maintenance Organization (DHMO), Discount Preferred Programs, Direct Compensation (DC) and various discounted Fee for Service (FFS) plans.

The products offered and how our plans are branded vary by market, based on how the products are licensed and the associated contracting entity.

This Provider Manual is designed as a comprehensive reference guide focusing on the PPO, EPO and INO plans referenced above. Here you will find the tools and information needed to successfully administer UnitedHealthcare plans. As changes and new information arise, we will send these updates to you. Please store these updates with this Provider Manual for future reference.

Our Medicaid, and many of our DHMO and Direct Compensation Plans, are summarized separately. If you support one of these plans and need a manual, please contact our Provider Services team at **1-800-822-5353**.

This manual is being provided in accordance with your executed agreement. If you have any questions or concerns about the information contained within this Provider Manual, please contact the UnitedHealthcare provider services team at **1-800-822-5353**.

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

Sincerely,

UnitedHealthcare, Professional Networks

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

UnitedHealthcare Dental® coverage provided by or through UnitedHealthcare Insurance Company, located in Hartford, Connecticut, or its affiliates. Administrative services provided by Dental Benefit Providers, Inc., Dental Benefit Administrative Services (CA only), United HealthCare Services, Inc. or their affiliates. Plans sold in Texas use policy form number DPOL.06.TX (11/15/2006) and associated COC form number DCOCCER.06.

## Section 2: Resources & Services

### 2.1. Quick Reference Guides – Addresses and Phone Numbers

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

Our Provider Servicing Team is available to assist you in plan administration. Call our toll-free number during normal business hours to speak with knowledgeable specialists. They are trained to address eligibility, claims, plan information and contract inquiries.

Refer to the table below for available resources based on type of inquiry.

| Resource                                                                                                                                                                                           |                                                                                                                                     |                          |                                                                                      |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------|--------------------------|--------------------------------------------------------------------------------------|
| You want to:                                                                                                                                                                                       | Provider Services Line –<br>Dedicated Service Representatives<br>Phone: 1-800-822-5353<br>Hours: 8 am–9 pm EST<br>or 7 am–10 pm CST | Online:<br>uhcdental.com | Interactive Voice<br>Response (IVR) System<br>Phone: 1-800-822-5353<br>Hours: 24 / 7 |
| Inquire about a claim                                                                                                                                                                              | ✓                                                                                                                                   | ✓                        | ✓                                                                                    |
| Ask a benefit / plan question (including<br>prior authorization requirements)                                                                                                                      | ✓                                                                                                                                   | ✓                        | ✓                                                                                    |
| Inquire about eligibility                                                                                                                                                                          | ✓                                                                                                                                   | ✓                        | ✓                                                                                    |
| Request an EOB                                                                                                                                                                                     | ✓                                                                                                                                   | ✓                        |                                                                                      |
| Request a Fee Schedule                                                                                                                                                                             | ✓                                                                                                                                   | ✓                        |                                                                                      |
| Request a copy of your contract                                                                                                                                                                    | ✓                                                                                                                                   |                          |                                                                                      |
| Ask a question about your contract                                                                                                                                                                 | ✓                                                                                                                                   |                          |                                                                                      |
| Inquire about the In-Network Practitioner<br>Listing                                                                                                                                               | ✓                                                                                                                                   | ✓                        | ✓                                                                                    |
| Nominate a provider for participation                                                                                                                                                              | ✓                                                                                                                                   | ✓                        |                                                                                      |
| Changes to Practice Information (e.g.,<br>associate updates, address changes,<br>adding or deleting addresses, Tax<br>Identification Number change, specialty<br>designation, demographic updates) | ✓                                                                                                                                   | ✓                        |                                                                                      |
| Request participation status change                                                                                                                                                                | ✓                                                                                                                                   |                          |                                                                                      |
| Request documents                                                                                                                                                                                  | ✓                                                                                                                                   | ✓                        |                                                                                      |
| Request benefit information                                                                                                                                                                        | ✓                                                                                                                                   | ✓                        |                                                                                      |

| Resource                                                     |                                                                                                   |                |                                          |                                              |                                                                                                                                                    |
|--------------------------------------------------------------|---------------------------------------------------------------------------------------------------|----------------|------------------------------------------|----------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------|
| Need:                                                        | Address                                                                                           | Phone Number   | Payer I.D.                               | Submission Guidelines                        | Form(s) Required                                                                                                                                   |
| <b>Claim Submission (initial)</b>                            | CLAIMS<br>UnitedHealthcare<br>P.O. Box 30567<br>Salt Lake City, UT 84130-0567                     | 1-800-822-5353 | 52133<br>Claim Filing<br>indicator: "CL" | Within 90 days<br>of the date of<br>service  | ADA Claim Form,<br>2012 version or later                                                                                                           |
| <b>Prior Authorization Requests*</b>                         | PTE/Preauthorizations<br>UnitedHealthcare<br>P.O. Box 30552<br>Salt Lake City, UT 84130-0567      | 1-800-822-5353 | 52133                                    |                                              | ADA Claim Form<br>– check the box<br>titled: Request for<br>Predetermination /<br>Preauthoriza-<br>tion<br>section of the ADA<br>Dental Claim Form |
| <b>Claim Adjustment Request or Requests for Reprocessing</b> | Adjustments/ Resubmissions<br>UnitedHealthcare<br>P.O. Box 30567<br>Salt Lake City, UT 84130-0567 | 1-800-822-5353 | 52133                                    | Within 60 days<br>from receipt of<br>payment | ADA Claim Form<br>Provider narrative<br>Reason for requesting<br>adjustment or<br>resubmission                                                     |
| <b>Claim Disputes</b>                                        | Provider Disputes<br>UnitedHealthcare<br>P.O. Box 30567<br>Salt Lake City, UT 84130-0567          | 1-800-822-5353 | N/A                                      | Within 60 days<br>from receipt of<br>payment | ADA Claim Form<br>Written summary of<br>appeal                                                                                                     |
| <b>Coordination of Benefits</b>                              | Claims<br>UnitedHealthcare<br>P.O. Box 30567<br>Salt Lake City, UT 84130-0567                     | 1-800-822-5353 | 52133                                    | Within 90 days<br>of the date of<br>service  | ADA Claim Form<br>Primary Payer's EOB<br>showing the amount<br>paid by the primary<br>payer                                                        |
| <b>Member Complaints and Appeals</b>                         | UnitedHealthcare<br>P.O. Box 30569<br>Salt Lake City, UT 84130-0567                               | 1-800-822-5353 | N/A                                      | N/A                                          | N/A                                                                                                                                                |

## 2.2.A Integrated Voice Response (IVR) System 1-800-822-5353

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

Through this system, network dental offices can obtain immediate eligibility information, check the status of claims and receive an explanation of benefits. The system also has the ability to fax eligibility confirmation directly to the caller.

## 2.2.B Web Site [uhcdental.com](http://uhcdental.com)

The UnitedHealthcare Web site, [uhcdental.com](http://uhcdental.com), offers many time-saving features including eligibility verification, claims status, claim receipt acknowledgement and network specialist locations. Through this site, you may also enroll in Electronic Payments and Statements, a free direct deposit service.

You can also verify eligibility on our Web site at [uhcdental.com](http://uhcdental.com) 24 hours a day, seven days a week. In addition to current eligibility verification, our Web site offers other functionality for your convenience such as claims status, procedure level pricing, fee schedules, benefit information and a provider search.

### We make it easy to get started

You can use our Online Guided Tour under the dentist site to take you through the registration process.

Once you have registered on our provider web site at [uhcdental.com](http://uhcdental.com), you can verify your patients' eligibility online with just a few clicks.

Please contact our Customer Service line if you have additional questions or need help registering on our Web site.

Note: Passwords are the responsibility of the dental office (see agreement during the registration process).

## 2.3. Electronic Payments and Statements

### What is Electronic Payments and Statements (EPS)?

Electronic Payments and Statements (EPS) is a no cost, practical solution to provide electronic delivery of payments and explanations of benefits (EOBs) to dental providers and other health care professionals.

EPS is fast, easy and secure. You will be notified by email the day deposits are made. No more time wasted on trips to the bank to make deposits. Claims payments will be made directly to your bank account, five to seven days faster than paper checks.

With Electronic Payments and Statements (EPS), your claim payments, explanations of benefits, and Pre-Treatment Estimates (PTEs) are delivered electronically, allowing your office faster payment, easier reconciliation, less paperwork and much greater efficiency.

EPS eliminates:

- Check clearing wait time
- Check processing fees
- Searching through files for claim and payment information
- Frustrating reconciliation tasks
- Endless piles of paper and mail

EPS provides:

- Secure, direct deposit
- Online payment and claim information
- Fast and easy information searches
- Simplified reconciliation
- Reduced paper usage and waste
- Update banking information

### How to Enroll:

Navigate to the Optum EPS website at [myservices.optumhealthpaymentservices.com](https://myservices.optumhealthpaymentservices.com). There you will find additional information, how to enroll and FAQs. Once enrolled select your TIN(s) from the drop-down box and then complete the required enrollment fields - the entire process should not take more than five minutes per TIN. Should you need any assistance with EPS enrollment or support after enrolled please call at **1-877-620-6194**.

## Section 3: Plan Eligibility

Eligibility may be verified one of three ways:

1. At our Web site (uhcdental.com)
2. Through our Interactive Voice Response (IVR) available through the Provider Services line
3. By speaking with a Provider Services Representative

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

### 3.1 Member Identification Card

Members are issued an identification (ID) card to all recipients enrolled in benefits. When members of a family enroll, separate cards may be issued to each family member. The ID cards are customized with the Plan logo and include the toll-free customer service number. For DHMO plans, the primary care dentist name and telephone number is also included. ID cards also include the member's group ID number.

The ID card has instructions for both members (how to access care) and providers (eligibility verification). ID cards should be presented by members when services are rendered.

Presentation by a person with an ID card is not a guarantee of payment. It is the responsibility of the provider to verify eligibility at the time of service.

### 3.2 Eligibility Verification

As outlined in your provider agreement, member eligibility must be verified prior to rendering services. This section contains helpful tips on how to establish eligibility through our Provider Servicing tools.

#### The Interactive Voice Response (IVR) system

Our Provider Services line provides IVR features that enable you to obtain up-to-the minute eligibility information with one quick telephone call. Eligibility may be verified for one or more members at a time by using either voice or touch-tone keypad, or a combination. This 24-hour-a-day, seven-day-a-week, toll-free access delivers immediate eligibility information directly by fax to your office.

**The IVR is never busy, there is never a wait and is available 24 hours a day, seven days a week.  
Provider services line: 1-800-822-5353**

**Important Note: A member's ID card is not proof of eligibility. 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.**

#### It's easy to get started.

All you need is the following:

- A touch-tone phone
- The member's name, subscriber ID number and date of birth
- Your dental office fax number

When calling the Provider Services line, here's what you'll receive:

- Confirmation of the member's name
- Dependent information
- Plan details

Upon your request, our IVR system will automatically fax to your office all the information needed to effectively and efficiently serve your patients.

Use the touch-tone option if you are encountering problems with speech recognition.

### 3.3 Specialty Care Referral Guidelines

No authorization is needed for participating dentists to refer members to a specialist.

If specialty care is necessary, please refer members to a participating specialist, whenever possible, as it will be less costly for the member. Members covered under an “in-network only” plan can only utilize their benefits when treated by a participating specialist.

You may obtain a listing of participating specialists in your area through our Web site, [uhcdental.com](http://uhcdental.com), or by calling **1-800-822-5353** and using the Interactive Voice Response (IVR) system. If you are unable to locate a participating specialist in your area, contact a provider services representative at **1-800-822-5353** for assistance.



## Section 4: Member Benefits/Exclusions & Limitations

### 4.1.A Diagnostic Services Guidelines

For the most recent and up to date clinical policy criteria and documentation requirements please follow <http://uhcdental.com>> RESOURCES> CLINICAL GUIDELINES, or you may use this [LINK](#).

| Code                                                               | Description                                                                                  | Age    | Frequencies and limitations                                                                                                                                                                                       | Clinical review req |
|--------------------------------------------------------------------|----------------------------------------------------------------------------------------------|--------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|
| <b>DIAGNOSTIC</b>                                                  |                                                                                              |        |                                                                                                                                                                                                                   |                     |
| <b>Clinical Oral Evaluations</b>                                   |                                                                                              |        |                                                                                                                                                                                                                   |                     |
| D0120                                                              | Periodic oral evaluation – established patient                                               | 0 - 99 | Limited to 2 times per consecutive 12 months.                                                                                                                                                                     | N                   |
| D0140                                                              | Limited oral evaluation – problem focused                                                    | 0 - 99 | Periodic Oral Evaluation - Limited to 2 times per consecutive 12 months.                                                                                                                                          | N                   |
| D0145                                                              | Oral evaluation for a patient under three years of age and counseling with primary caregiver | 0 - 2  | Limited to 2 times per consecutive 12 months. Not Covered if done in conjunction with other exams.                                                                                                                | N                   |
| D0150                                                              | Comprehensive oral evaluation – new or established patient                                   | 0 - 99 | Comprehensive Oral Evaluation - Limited to 2 times per consecutive 12 months. Not Covered if done in conjunction with other exams.                                                                                | N                   |
| D0160                                                              | Detailed and extensive oral evaluation – problem focused, by report                          | 0 - 99 | Limited to 2 times per consecutive 12 months. Only 1 exam is Covered per date of service.                                                                                                                         | N                   |
| D0170                                                              | Re-evaluation – limited, problem focused (established patient; not post-operative visit)     | 0 - 99 | Service Not Listed - Included in category for Limited or Detailed Oral Evaluation. Limited or Detailed Oral Evaluation. Limited to 2 times per consecutive 12 months. Only 1 exam is Covered per date of service. | N                   |
| D0180                                                              | Comprehensive periodontal evaluation – new or established patient                            | 0 - 99 | Comprehensive Periodontal Evaluation - new or established patient. Limited to 2 times per consecutive 12 months.                                                                                                  | N                   |
| <b>Radiographs / Diagnostic Imaging (Including Interpretation)</b> |                                                                                              |        |                                                                                                                                                                                                                   |                     |
| D0210                                                              | Intraoral – complete series of radiographic images                                           | 0 - 99 | Limited to 1 time per consecutive 36 months. Vertical bitewings can not be billed in conjunction with a complete series.                                                                                          | N                   |
| D0220                                                              | Intraoral – periapical first radiographic image                                              | 0 - 99 |                                                                                                                                                                                                                   | N                   |
| D0230                                                              | Intraoral – periapical each radiographic image                                               | 0 - 99 |                                                                                                                                                                                                                   | N                   |
| D0240                                                              | Intraoral – occlusal radiographic image                                                      | 0 - 99 |                                                                                                                                                                                                                   | N                   |
| D0250                                                              | Extraoral – first radiographic image                                                         | 0 - 99 | Limited to 2 films per calendar year.                                                                                                                                                                             | N                   |
| D0251                                                              | Extra-oral posterior dental radiographic image                                               | 0 - 99 | Limited to 2 films per calendar year.                                                                                                                                                                             | N                   |
| D0270                                                              | Bitewing – single radiographic image                                                         | 0 - 99 | Limited to 4 films per calendar year.                                                                                                                                                                             | N                   |
| D0272                                                              | Bitewings – two radiographic image                                                           | 0 - 99 | Limited to 1 series of films per calendar year.                                                                                                                                                                   | N                   |
| D0273                                                              | Bitewings – three radiographic image                                                         | 0 - 99 | Limited to 1 series of films per calendar year.                                                                                                                                                                   | N                   |
| D0274                                                              | Bitewings – four radiographic image                                                          | 0 - 99 | Limited to 1 series of films per calendar year.                                                                                                                                                                   | N                   |
| D0277                                                              | Vertical bitewings – 7 to 8 radiographic image                                               | 0 - 99 | Limited to 1 time per consecutive 36 months. Vertical bitewings can not be billed in conjunction with a complete series.                                                                                          | N                   |
| D0320                                                              | Temporomandibular joint arthrogram, including injection                                      | 0 - 99 | TMJ plans only; not generally covered on standard plans - Limited to 1 film per joint, total of 2 films per consecutive 12 months.                                                                                | N                   |

| Code                         | Description                                                                                                                                                               | Age    | Frequencies and limitations                                                                                                             | Clinical review req |
|------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------|-----------------------------------------------------------------------------------------------------------------------------------------|---------------------|
| <b>DIAGNOSTIC</b>            |                                                                                                                                                                           |        |                                                                                                                                         |                     |
| D0321                        | Other temporomandibular joint radiographic image                                                                                                                          | 0 - 99 | TMJ plans only; not generally covered on core standard plans - Limited to 1 film per joint, total of 2 films per consecutive 12 months. | N                   |
| D0322                        | Tomographic survey                                                                                                                                                        | 0 - 99 | TMJ plans only; not generally covered on standard plans - Limited to 1 film per joint, per consecutive 12 months.                       | N                   |
| D0330                        | Panoramic radiographic image                                                                                                                                              | 0 - 99 | Limited to 1 time per consecutive 36 months.                                                                                            | N                   |
| D0340                        | Cephalometric radiographic image                                                                                                                                          | 0 - 18 | Limited to 1 per consecutive 12 months. Can only be billed for orthodontics.                                                            | N                   |
| D0350                        | Oral/facial photographic images obtained intraorally or extraorally                                                                                                       | 0 - 99 | Limited to 1 time per consecutive 36 months.                                                                                            | N                   |
| D0351                        | 3D photographic image                                                                                                                                                     | 0 - 99 | Limited to 1 time per consecutive 36 months.                                                                                            | N                   |
| <b>Test and Examinations</b> |                                                                                                                                                                           |        |                                                                                                                                         |                     |
| D0414                        | Lab processing of microbial specimen to include culture and sensitivity studies.                                                                                          | 0 - 99 |                                                                                                                                         | N                   |
| D0415                        | Collection of microorganisms for culture and sensitivity                                                                                                                  | 0 - 99 |                                                                                                                                         | N                   |
| D0416                        | Viral culture                                                                                                                                                             | 0 - 99 |                                                                                                                                         | N                   |
| D0431                        | Adjunctive pre-diagnostic test that aids in detection of mucosal abnormalities including premalignant and malignant lesions, not to include cytology or biopsy procedures | 0 - 99 | Limited to 1 time per consecutive 12 months.                                                                                            | N                   |
| D0460                        | Pulp vitality tests                                                                                                                                                       | 0 - 99 | Limited to 1 charge per visit, regardless of how many teeth are tested.                                                                 | N                   |
| D0470                        | Diagnostic casts                                                                                                                                                          | 0 - 99 | Limited to 1 time per consecutive 24 months.                                                                                            | N                   |
| D0601                        | Caries risk assessment and documentation, with a finding of low risk                                                                                                      | 0 - 99 | Limited to 2 times per consecutive 12 months.                                                                                           | N                   |
| D0602                        | Caries risk assessment and documentation, with a finding of moderate risk                                                                                                 | 0 - 99 | Limited to 2 times per consecutive 12 months.                                                                                           | N                   |
| D0603                        | Caries risk assessment and documentation, with a finding of high risk                                                                                                     | 0 - 99 | Limited to 2 times per consecutive 12 months.                                                                                           | N                   |

## 4.1.B Preventive Services Guidelines

For the most recent and up to date clinical policy criteria and documentation requirements please follow <http://uhcdental.com>> RESOURCES> CLINICAL GUIDELINES, or you may use this [LINK](#).

| Code                                                 | Description                                                                              | Age     | Frequencies and limitations                                                                                                                             | Clinical review req |
|------------------------------------------------------|------------------------------------------------------------------------------------------|---------|---------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|
| <b>PREVENTATIVE</b>                                  |                                                                                          |         |                                                                                                                                                         |                     |
| <b>Dental Prophylaxis</b>                            |                                                                                          |         |                                                                                                                                                         |                     |
| D1110                                                | Prophylaxis – adult                                                                      | 13 - 99 | Limited to 2 times per consecutive 12 months.                                                                                                           | N                   |
| D1120                                                | Prophylaxis – child                                                                      | 2 - 12  | Limited to 2 times per consecutive 12 months.                                                                                                           | N                   |
| <b>Topical Fluoride Treatment (Office Procedure)</b> |                                                                                          |         |                                                                                                                                                         |                     |
| D1206                                                | Topical application of fluoride varnish                                                  | 0 - 15  | Limited to Covered Persons under the age of 16 years, and limited to 2 times per consecutive 12 months.                                                 | N                   |
| D1208                                                | Topical application of fluoride                                                          | 0 - 15  | Limited to Covered Persons under the age of 16 years, and limited to 2 times per consecutive 12 months.                                                 | N                   |
| <b>Other Preventive Services</b>                     |                                                                                          |         |                                                                                                                                                         |                     |
| D1351                                                | Sealant – per tooth                                                                      | 4 - 15  | Limited to Covered Persons under the age of 16 years and once per first or second permanent molar every consecutive 36 months.                          | N                   |
| D1352                                                | Preventive resin restoration in a moderate to high caries risk patient – permanent tooth | 0 - 15  | Limited to Covered Persons under the age of 16 years and once per first or second permanent molar every consecutive 36 months.                          | N                   |
| D1353                                                | Sealant repair – per tooth                                                               | 4 - 15  | Limited to Covered Persons under the age of 16 years and once per first or second permanent molar every consecutive 36 months.                          | N                   |
| <b>Space Maintenance (Passive Appliances)</b>        |                                                                                          |         |                                                                                                                                                         |                     |
| D1510                                                | Space maintainer – fixed – unilateral                                                    | 0 - 15  | 12 sites total, for refractory pockets.                                                                                                                 | N                   |
| D1516                                                | Space maintainer – fixed – bilateral, maxillary                                          | 0 - 15  | Limited to Covered Persons under the age of 16 years, once per consecutive 60 months. Benefit includes all adjustments within 6 months of installation. | N                   |
| D1517                                                | Space maintainer – fixed – bilateral, mandibular                                         | 0 - 15  | Limited to Covered Persons under the age of 16 years, once per consecutive 60 months. Benefit includes all adjustments within 6 months of installation. | N                   |
| D1520                                                | Space maintainer – removable – unilateral                                                | 0 - 15  | Limited to Covered Persons under the age of 16 years, once per consecutive 60 months. Benefit includes all adjustments within 6 months of installation. | N                   |
| D1526                                                | Space maintainer – removable – bilateral, maxillary                                      | 0 - 15  | Limited to Covered Persons under the age of 16 years, once per consecutive 60 months. Benefit includes all adjustments within 6 months of installation. | N                   |
| D1527                                                | Space maintainer – removable – bilateral, mandibular                                     | 0 - 15  | Limited to Covered Persons under the age of 16 years, once per consecutive 60 months. Benefit includes all adjustments within 6 months of installation. | N                   |
| D1550                                                | Re-cementation of space maintainer                                                       | 0 - 15  | Limited to 1 per consecutive 6 months after initial insertion.                                                                                          | N                   |
| D1555                                                | Removal of fixed space maintainer                                                        | 0 - 15  |                                                                                                                                                         | N                   |

| Code                | Description                                     | Age    | Frequencies and limitations                                                                                                                             | Clinical review req |
|---------------------|-------------------------------------------------|--------|---------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|
| <b>PREVENTATIVE</b> |                                                 |        |                                                                                                                                                         |                     |
| <b>D1575</b>        | Distal shoe space maintainer - fixed unilateral | 0 - 15 | Limited to Covered Persons under the age of 16 years, once per consecutive 60 months. Benefit includes all adjustments within 6 months of installation. | N                   |

### 4.1.C Restorative Services Guidelines

For the most recent and up to date clinical policy criteria and documentation requirements please follow <http://uhcdental.com>> RESOURCES> CLINICAL GUIDELINES, or you may use this [LINK](#).

| Code                                                 | Description                                                                         | Age    | Frequencies and limitations                                                                                                                                                                                                     | Clinical review req |
|------------------------------------------------------|-------------------------------------------------------------------------------------|--------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|
| <b>RESTORATIVE</b>                                   |                                                                                     |        |                                                                                                                                                                                                                                 |                     |
| <b>Amalgam Restorations (Including Polishing)</b>    |                                                                                     |        |                                                                                                                                                                                                                                 |                     |
| <b>D2140</b>                                         | Amalgam – one surface, primary or permanent                                         | 0 - 99 | Multiple restorations on one surface will be treated as a single filling.                                                                                                                                                       | N                   |
| <b>D2150</b>                                         | Amalgam – two surfaces, primary or permanent                                        | 0 - 99 | Multiple restorations on one surface will be treated as a single filling.                                                                                                                                                       | N                   |
| <b>D2160</b>                                         | Amalgam – three surfaces, primary or permanent                                      | 0 - 99 | Multiple restorations on one surface will be treated as a single filling.                                                                                                                                                       | N                   |
| <b>D2161</b>                                         | Amalgam – four or more surfaces, primary or permanent                               | 0 - 99 | Multiple restorations on one surface will be treated as a single filling.                                                                                                                                                       | N                   |
| <b>Resin - Based Composite Restorations – Direct</b> |                                                                                     |        |                                                                                                                                                                                                                                 |                     |
| <b>D2330</b>                                         | Resin-based composite – one surface, anterior                                       | 0 - 99 | Multiple restorations on one surface will be treated as a single filling.                                                                                                                                                       | N                   |
| <b>D2331</b>                                         | Resin-based composite – two surfaces, anterior                                      | 0 - 99 | Multiple restorations on one surface will be treated as a single filling.                                                                                                                                                       | N                   |
| <b>D2332</b>                                         | Resin-based composite – three surfaces, anterior                                    | 0 - 99 | Multiple restorations on one surface will be treated as a single filling.                                                                                                                                                       | N                   |
| <b>D2335</b>                                         | Resin-based composite – four or more surfaces or involving incisal angle (anterior) | 0 - 99 | Multiple restorations on one surface will be treated as a single filling.                                                                                                                                                       | N                   |
| <b>D2390</b>                                         | Resin-based composite crown, anterior                                               | 0 - 99 | Limited to 1 time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth. Not Covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes. | Y                   |
| <b>D2391</b>                                         | Resin-based composite – one surface, posterior                                      | 0 - 99 | Alternate benefit.<br>Enhanced Plans Only - Multiple restorations on one surface will be treated as a single filling.                                                                                                           | N                   |
| <b>D2392</b>                                         | Resin-based composite – two surfaces, posterior                                     | 0 - 99 | Alternate benefit.<br>Enhanced Plans Only - Multiple restorations on one surface will be treated as a single filling.                                                                                                           | N                   |
| <b>D2393</b>                                         | Resin-based composite – three surfaces, posterior                                   | 0 - 99 | Alternate benefit.<br>Enhanced Plans Only - Multiple restorations on one surface will be treated as a single filling.                                                                                                           | N                   |
| <b>D2394</b>                                         | Resin-based composite – four or more surfaces, posterior                            | 0 - 99 | Alternate benefit.<br>Enhanced Plans Only - Multiple restorations on one surface will be treated as a single filling.                                                                                                           | N                   |
| <b>Gold Foil Restorations</b>                        |                                                                                     |        |                                                                                                                                                                                                                                 |                     |
| <b>D2410</b>                                         | Gold foil – one surface                                                             | 0 - 99 | Gold Foil Restorations - Multiple restorations on one surface will be treated as a single filling.                                                                                                                              | N                   |
| <b>D2420</b>                                         | Gold foil – two surfaces                                                            | 0 - 99 | Gold Foil Restorations - Multiple restorations on one surface will be treated as a single filling.                                                                                                                              | N                   |

| Code                                                                                                                           | Description                                            | Age    | Frequencies and limitations                                                                                                                                                                                                     | Clinical review req |
|--------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|--------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|
| <b>RESTORATIVE</b>                                                                                                             |                                                        |        |                                                                                                                                                                                                                                 |                     |
| D2430                                                                                                                          | Gold foil – three surfaces                             | 0 - 99 | Gold Foil Restorations - Multiple restorations on one surface will be treated as a single filling.                                                                                                                              | N                   |
| <b>Inlay/Onlay Restorations</b>                                                                                                |                                                        |        |                                                                                                                                                                                                                                 |                     |
| D2510                                                                                                                          | Inlay – metallic – one surface                         | 0 - 99 | Limited to 1 time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth. Not Covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes. | N                   |
| D2520                                                                                                                          | Inlay – metallic – two surfaces                        | 0 - 99 | Limited to 1 time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth. Not Covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes. | N                   |
| D2530                                                                                                                          | Inlay – metallic – three or more surfaces              | 0 - 99 | Limited to 1 time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth. Not Covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes. | N                   |
| D2542                                                                                                                          | Onlay – metallic – two surfaces                        | 0 - 99 | Limited to 1 time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth. Not Covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes. | Y                   |
| D2543                                                                                                                          | Onlay – metallic – three surfaces                      | 0 - 99 | Limited to 1 time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth. Not Covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes. | Y                   |
| D2544                                                                                                                          | Onlay – metallic – four or more surfaces               | 0 - 99 | Limited to 1 time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth. Not Covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes. | Y                   |
| <b>Inlay/Onlay Restorations: Porcelain/Ceramic Inlays/Onlays Include All Indirect Ceramic and Porcelain Type Inlays/Onlays</b> |                                                        |        |                                                                                                                                                                                                                                 |                     |
| D2610                                                                                                                          | Inlay – porcelain/ceramic – one surface                | 0 - 99 | Limited to 1 time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth. Not Covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes. | N                   |
| D2620                                                                                                                          | Inlay – porcelain/ceramic – two surfaces               | 0 - 99 | Limited to 1 time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth. Not Covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes. | N                   |
| D2630                                                                                                                          | Inlay – porcelain/ceramic – three or more surfaces     | 0 - 99 | Limited to 1 time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth. Not Covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes. | N                   |
| D2642                                                                                                                          | Onlay – porcelain/ceramic – two surfaces               | 0 - 99 | Limited to 1 time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth. Not Covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes. | Y                   |
| D2643                                                                                                                          | Onlay – porcelain/ceramic – three surfaces             | 0 - 99 | Limited to 1 time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth. Not Covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes. | Y                   |
| D2644                                                                                                                          | Onlay – porcelain/ceramic – four or more surfaces      | 0 - 99 | Limited to 1 time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth. Not Covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes. | Y                   |
| <b>Inlay/Onlay Restorations: Resin - Based Composite Inlays/Onlays Must Utilize Indirect Technique</b>                         |                                                        |        |                                                                                                                                                                                                                                 |                     |
| D2650                                                                                                                          | Inlay – resin-based composite – one surface            | 0 - 99 | Limited to 1 time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth. Not Covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes. | N                   |
| D2651                                                                                                                          | Inlay – resin-based composite – two surfaces           | 0 - 99 | Limited to 1 time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth. Not Covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes. | N                   |
| D2652                                                                                                                          | Inlay – resin-based composite – three or more surfaces | 0 - 99 | Limited to 1 time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth. Not Covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes. | N                   |

| Code                                     | Description                                           | Age    | Frequencies and limitations                                                                                                                                                                                                     | Clinical review req |
|------------------------------------------|-------------------------------------------------------|--------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|
| <b>RESTORATIVE</b>                       |                                                       |        |                                                                                                                                                                                                                                 |                     |
| <b>D2662</b>                             | Onlay – resin-based composite – two surfaces          | 0 - 99 | Limited to 1 time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth. Not Covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes. | Y                   |
| <b>D2663</b>                             | Onlay – resin-based composite – three surfaces        | 0 - 99 | Limited to 1 time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth. Not Covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes. | Y                   |
| <b>D2664</b>                             | Onlay – resin-based composite – four or more surfaces | 0 - 99 | Limited to 1 time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth. Not Covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes. | Y                   |
| <b>Crowns – Single Restorations Only</b> |                                                       |        |                                                                                                                                                                                                                                 |                     |
| <b>D2710</b>                             | Crown – resin-based composite (indirect)              | 0 - 99 | Limited to 1 time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth. Not Covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes. | Y                   |
| <b>D2712</b>                             | Crown – 3/4 resin-based composite (indirect)          | 0 - 99 | Limited to 1 time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth. Not Covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes. | Y                   |
| <b>D2720</b>                             | Crown – resin with high noble metal                   | 0 - 99 | Limited to 1 time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth. Not Covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes. | Y                   |
| <b>D2721</b>                             | Crown – resin with predominantly base metal           | 0 - 99 | Limited to 1 time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth. Not Covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes. | Y                   |
| <b>D2722</b>                             | Crown – resin with noble metal                        | 0 - 99 | Limited to 1 time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth. Not Covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes. | Y                   |
| <b>D2740</b>                             | Crown – porcelain/ceramic substrate                   | 0 - 99 | Limited to 1 time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth. Not Covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes. | Y                   |
| <b>D2750</b>                             | Crown – porcelain fused to high noble metal           | 0 - 99 | Limited to 1 time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth. Not Covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes. | Y                   |
| <b>D2751</b>                             | Crown – porcelain fused to predominantly base metal   | 0 - 99 | Limited to 1 time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth. Not Covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes. | Y                   |
| <b>D2752</b>                             | Crown – porcelain fused to noble metal                | 0 - 99 | Limited to 1 time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth. Not Covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes. | Y                   |
| <b>D2780</b>                             | Crown – 3/4 cast high noble metal                     | 0 - 99 | Limited to 1 time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth. Not Covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes. | Y                   |
| <b>D2781</b>                             | Crown – 3/4 cast predominantly base metal             | 0 - 99 | Limited to 1 time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth. Not Covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes. | Y                   |
| <b>D2782</b>                             | Crown – 3/4 cast noble metal                          | 0 - 99 | Limited to 1 time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth. Not Covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes. | Y                   |
| <b>D2783</b>                             | Crown – 3/4 porcelain/ceramic                         | 0 - 99 | Limited to 1 time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth. Not Covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes. | Y                   |
| <b>D2790</b>                             | Crown – full cast high noble metal                    | 0 - 99 | Limited to 1 time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth. Not Covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes. | Y                   |

| Code                              | Description                                                                                         | Age    | Frequencies and limitations                                                                                                                                                                                                     | Clinical review req |
|-----------------------------------|-----------------------------------------------------------------------------------------------------|--------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|
| <b>RESTORATIVE</b>                |                                                                                                     |        |                                                                                                                                                                                                                                 |                     |
| <b>D2791</b>                      | Crown – full cast predominantly base metal                                                          | 0 - 99 | Limited to 1 time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth. Not Covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes. | Y                   |
| <b>D2792</b>                      | Crown – full cast noble metal                                                                       | 0 - 99 | Limited to 1 time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth. Not Covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes. | Y                   |
| <b>D2794</b>                      | Crown – titanium                                                                                    | 0 - 99 | Limited to 1 time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth. Not Covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes. | Y                   |
| <b>D2799</b>                      | Provisional crown– further treatment or completion of diagnosis necessary prior to final impression | 0 - 99 | Limited to 1 time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth. Not Covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes. | Y                   |
| <b>Other Restorative Services</b> |                                                                                                     |        |                                                                                                                                                                                                                                 |                     |
| <b>D2910</b>                      | Recement inlay, onlay, or partial coverage restoration                                              | 0 - 99 | Re-Cement Inlays/Onlays, Crowns, Bridges and Post and Core - Limited to those performed more than 12 months after the initial insertion.                                                                                        | N                   |
| <b>D2915</b>                      | Recement cast or prefabricated post and core                                                        | 0 - 99 | Re-Cement Inlays/Onlays, Crowns, Bridges and Post and Core - Limited to those performed more than 12 months after the initial insertion.                                                                                        | N                   |
| <b>D2920</b>                      | Recement crown                                                                                      | 0 - 99 | Re-Cement Inlays/Onlays, Crowns, Bridges and Post and Core - Limited to those performed more than 12 months after the initial insertion.                                                                                        | N                   |
| <b>D2921</b>                      | Reattachment of tooth fragment, incisal edge or cusp                                                | 0 - 99 | Repairs or Adjustments to Full Dentures, Partial Dentures, Bridges or Crowns - Limited to repairs or adjustments performed more than 12 months after the initial insertion. Limited to 1 per consecutive 6 months.              | N                   |
| <b>D2930</b>                      | Prefabricated stainless steel crown – primary tooth                                                 | 0 - 15 | Limited to 1 time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth. Prefabricated esthetic coated stainless steel crown - primary tooth, are limited to primary anterior teeth.        | N                   |
| <b>D2931</b>                      | Prefabricated stainless steel crown – permanent tooth                                               | 0 - 99 | Limited to 1 time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth. Prefabricated esthetic coated stainless steel crown - primary tooth, are limited to primary anterior teeth.        | N                   |
| <b>D2932</b>                      | Prefabricated resin crown                                                                           | 0 - 99 | Limited to 1 time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth. Prefabricated esthetic coated stainless steel crown - primary tooth, are limited to primary anterior teeth.        | N                   |
| <b>D2933</b>                      | Prefabricated stainless steel crown with resin window                                               | 0 - 99 | Limited to 1 time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth. Prefabricated esthetic coated stainless steel crown - primary tooth, are limited to primary anterior teeth.        | N                   |
| <b>D2934</b>                      | Prefabricated esthetic coated stainless steel crown – primary tooth                                 | 0 - 15 | Limited to 1 time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth. Prefabricated esthetic coated stainless steel crown - primary tooth, are limited to primary anterior teeth.        | N                   |
| <b>D2940</b>                      | Protective restoration                                                                              | 0 - 99 | Sedative Filling - Covered as a separate benefit only if no other service, other than x-rays and exam, were performed on the same tooth during the visit.                                                                       | N                   |
| <b>D2941</b>                      | Interim therapeutic restoration – primary dentition                                                 | 0 - 99 | Sedative Filling - Covered as a separate benefit only if no other service, other than x-rays and exam, were performed on the same tooth during the visit.                                                                       | N                   |
| <b>D2950</b>                      | Core buildup, including any pins when required                                                      | 0 - 99 | Post and Cores - Covered only for teeth that have had root canal therapy.                                                                                                                                                       | Y                   |
| <b>D2951</b>                      | Pin retention – per tooth, in addition to restoration                                               | 0 - 99 | Pin Retention - Limited to 2 pins per tooth; not covered in addition to cast restoration.                                                                                                                                       | N                   |



| Code               | Description                                               | Age    | Frequencies and limitations                                                                                                                                                                                        | Clinical review req |
|--------------------|-----------------------------------------------------------|--------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|
| <b>RESTORATIVE</b> |                                                           |        |                                                                                                                                                                                                                    |                     |
| <b>D2952</b>       | Post and core in addition to crown, indirectly fabricated | 0 - 99 | Post and Cores - Covered only for teeth that have had root canal therapy.                                                                                                                                          | Y                   |
| <b>D2953</b>       | Each additional indirectly fabricated post – same tooth   | 0 - 99 | Post and Cores - Covered only for teeth that have had root canal therapy.                                                                                                                                          | Y                   |
| <b>D2954</b>       | Prefabricated post and core in addition to crown          | 0 - 99 | Post and Cores - Covered only for teeth that have had root canal therapy.                                                                                                                                          | Y                   |
| <b>D2957</b>       | Each additional prefabricated post – same tooth           | 0 - 99 | Post and Cores - Covered only for teeth that have had root canal therapy.                                                                                                                                          | Y                   |
| <b>D2975</b>       | Coping                                                    | 0 - 99 | Limited to 1 per tooth per consecutive 60 months. Not covered if done at the same time as a crown on same tooth.                                                                                                   | Y                   |
| <b>D2980</b>       | Crown repair necessitated by restorative material failure | 0 - 99 | Repairs or Adjustments to Full Dentures, Partial Dentures, Bridges or Crowns - Limited to repairs or adjustments performed more than 12 months after the initial insertion. Limited to 1 per consecutive 6 months. | N                   |
| <b>D2981</b>       | Inlay repair necessitated by restorative material failure | 0 - 99 | Repairs or Adjustments to Full Dentures, Partial Dentures, Bridges or Crowns - Limited to repairs or adjustments performed more than 12 months after the initial insertion. Limited to 1 per consecutive 6 months. | N                   |
| <b>D2982</b>       | Onlay repair necessitated by restorative material failure | 0 - 99 | Repairs or Adjustments to Full Dentures, Partial Dentures, Bridges or Crowns - Limited to repairs or adjustments performed more than 12 months after the initial insertion. Limited to 1 per consecutive 6 months. | N                   |

## 4.1.D Endodontic Services Guidelines

For the most recent and up to date clinical policy criteria and documentation requirements please follow <http://uhcdental.com>> RESOURCES> CLINICAL GUIDELINES, or you may use this [LINK](#).

| Code                                                                                           | Description                                                                                                                                 | Age    | Frequencies and limitations                                                                                                                                   | Clinical review req |
|------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------|--------|---------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|
| <b>ENDODONTICS</b>                                                                             |                                                                                                                                             |        |                                                                                                                                                               |                     |
| <b>Pulp Capping</b>                                                                            |                                                                                                                                             |        |                                                                                                                                                               |                     |
| <b>D3110</b>                                                                                   | Pulp cap – direct (excluding final restoration)                                                                                             | 0 - 99 | Not Covered if utilized solely as a liner or base underneath a restoration.                                                                                   | N                   |
| <b>D3120</b>                                                                                   | Pulp cap – indirect (excluding final restoration)                                                                                           | 0 - 99 | Not Covered if utilized solely as a liner or base underneath a restoration.                                                                                   | N                   |
| <b>Pulpotomy</b>                                                                               |                                                                                                                                             |        |                                                                                                                                                               |                     |
| <b>D3220</b>                                                                                   | Therapeutic pulpotomy (excluding final restoration) – removal of pulp coronal to the dentinocemental junction and application of medicament | 0 - 99 | Limited to 1 time per primary or secondary tooth per lifetime.                                                                                                | N                   |
| <b>D3221</b>                                                                                   | Pulpal debridement, primary and permanent teeth                                                                                             | 0 - 99 | Limited to 1 time per tooth per lifetime. This procedure is not to be used when endodontic services are done on same date of service..                        | N                   |
| <b>D3222</b>                                                                                   | Partial pulpotomy for apexogenesis – permanent tooth with incomplete root development                                                       | 0 - 99 | Limited to 1 time per primary or secondary tooth per lifetime.                                                                                                | N                   |
| <b>Endodontic Therapy on Primary Teeth</b>                                                     |                                                                                                                                             |        |                                                                                                                                                               |                     |
| <b>D3230</b>                                                                                   | Pulpal therapy (resorbable filling) – anterior, primary tooth (excluding final restoration)                                                 | 0 - 15 | Limited to 1 time per tooth per lifetime. Covered for anterior teeth only.                                                                                    | N                   |
| <b>D3240</b>                                                                                   | Pulpal therapy (resorbable filling) – posterior, primary tooth (excluding final restoration)                                                | 0 - 15 | Limited to 1 time per tooth per lifetime. Covered for posterior teeth only.                                                                                   | N                   |
| <b>Endodontic Therapy (Including Treatment Plan, Clinical Procedures and Follow - Up Care)</b> |                                                                                                                                             |        |                                                                                                                                                               |                     |
| <b>D3310</b>                                                                                   | Endodontic therapy, anterior tooth (excluding final restoration)                                                                            | 0 - 99 | Limited to 1 time per tooth per lifetime. Dentist who performed the original root canal should not be reimbursed for the retreatment for the first 12 months. | N                   |
| <b>D3320</b>                                                                                   | Endodontic therapy, bicuspid tooth (excluding final restoration)                                                                            | 0 - 99 | Limited to 1 time per tooth per lifetime. Dentist who performed the original root canal should not be reimbursed for the retreatment for the first 12 months. | N                   |
| <b>D3330</b>                                                                                   | Endodontic therapy, molar (excluding final restoration)                                                                                     | 0 - 99 | Limited to 1 time per tooth per lifetime. Dentist who performed the original root canal should not be reimbursed for the retreatment for the first 12 months. | N                   |
| <b>D3331</b>                                                                                   | Treatment of root canal obstruction; non-surgical access                                                                                    | 0 - 99 | Limited to 1 time per tooth per lifetime.                                                                                                                     | N                   |
| <b>D3332</b>                                                                                   | Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth                                                                  | 0 - 99 | Limited to 1 time per tooth per lifetime.                                                                                                                     | N                   |
| <b>D3333</b>                                                                                   | Internal root repair of perforation defects                                                                                                 | 0 - 99 | Limited to 1 time per tooth per lifetime.                                                                                                                     | N                   |
| <b>Endodontic Retreatment</b>                                                                  |                                                                                                                                             |        |                                                                                                                                                               |                     |
| <b>D3346</b>                                                                                   | Retreatment of previous root canal therapy – anterior                                                                                       | 0 - 99 | Dentist who performed the original root canal should not be reimbursed for the retreatment for the first 12 months.                                           | Y                   |
| <b>D3347</b>                                                                                   | Retreatment of previous root canal therapy – bicuspid                                                                                       | 0 - 99 | Dentist who performed the original root canal should not be reimbursed for the retreatment for the first 12 months.                                           | Y                   |
| <b>D3348</b>                                                                                   | Retreatment of previous root canal therapy – molar                                                                                          | 0 - 99 | Dentist who performed the original root canal should not be reimbursed for the retreatment for the first 12 months.                                           | Y                   |

| Code                                      | Description                                                                                                                                                                | Age    | Frequencies and limitations               | Clinical review req |
|-------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------|-------------------------------------------|---------------------|
| <b>ENDODONTICS</b>                        |                                                                                                                                                                            |        |                                           |                     |
| <b>Apexification/Recalcification</b>      |                                                                                                                                                                            |        |                                           |                     |
| <b>D3351</b>                              | Apexification/recalcification/pupal regeneration initial visit (apical closure/calcific repair of perforations, root resorption, pulp space disinfection, etc.)            | 0 - 99 | Limited to 1 time per tooth per lifetime. | N                   |
| <b>D3352</b>                              | Apexification/recalcification/pupal regeneration interim medication visit (apical closure/calcific repair of perforations, root resorption, pulp space disinfection, etc.) | 0 - 99 | Limited to 1 time per tooth per lifetime. | N                   |
| <b>D3353</b>                              | Apexification/recalcification – final visit (includes completed root canal therapy – apical closure/calcific repair of perforations, root resorption, etc.)                | 0 - 99 | Limited to 1 time per tooth per lifetime. | N                   |
| <b>Pulpal Regeneration</b>                |                                                                                                                                                                            |        |                                           |                     |
| <b>D3355</b>                              | Pulpal regeneration - initial visit                                                                                                                                        | 0 - 99 | Limited to 1 time per tooth per lifetime. | N                   |
| <b>D3356</b>                              | Pulpal regeneration -interim medicament replacement                                                                                                                        | 0 - 99 | Limited to 1 time per tooth per lifetime. | N                   |
| <b>D3357</b>                              | Pulpal regeneration - completion of treatment                                                                                                                              | 0 - 99 | Limited to 1 time per tooth per lifetime. | N                   |
| <b>Apicoectomy/Periradicular Services</b> |                                                                                                                                                                            |        |                                           |                     |
| <b>D3410</b>                              | Apicoectomy/periradicular surgery – anterior                                                                                                                               | 0 - 99 | Limited to 1 time per tooth per lifetime. | Y                   |
| <b>D3421</b>                              | Apicoectomy/periradicular surgery – bicuspid (first root)                                                                                                                  | 0 - 99 | Limited to 1 time per tooth per lifetime. | Y                   |
| <b>D3425</b>                              | Apicoectomy/periradicular surgery – molar (first root)                                                                                                                     | 0 - 99 | Limited to 1 time per tooth per lifetime. | Y                   |
| <b>D3426</b>                              | Apicoectomy/periradicular surgery – (each additional root)                                                                                                                 | 0 - 99 | Limited to 1 time per tooth per lifetime. | Y                   |
| <b>D3427</b>                              | Periradicular surgery without apicoectomy                                                                                                                                  | 0 - 99 | Limited to 1 time per tooth per lifetime. | Y                   |
| <b>D3430</b>                              | Retrograde filling – per root                                                                                                                                              | 0 - 99 | Limited to 1 time per tooth per lifetime. | Y                   |
| <b>D3450</b>                              | Root amputation – per root                                                                                                                                                 | 0 - 99 |                                           | Y                   |
| <b>Other Endodontic Procedures</b>        |                                                                                                                                                                            |        |                                           |                     |

## 4.1.E Periodontal Services Guidelines

For the most recent and up to date clinical policy criteria and documentation requirements please follow <http://uhcdental.com>> RESOURCES> CLINICAL GUIDELINES, or you may use this [LINK](#).

| Code                                                          | Description                                                                                                                                            | Age     | Frequencies and limitations                                  | Clinical review req |
|---------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------|---------|--------------------------------------------------------------|---------------------|
| <b>PERIODONTICS</b>                                           |                                                                                                                                                        |         |                                                              |                     |
| <b>Surgical Services (Including Usual Postoperative Care)</b> |                                                                                                                                                        |         |                                                              |                     |
| <b>D4210</b>                                                  | Gingivectomy or gingivoplasty – four or more contiguous teeth or tooth bounded spaces per quadrant                                                     | 14 - 99 | Limited to 1 per quadrant or site per consecutive 36 months. | N                   |
| <b>D4211</b>                                                  | Gingivectomy or gingivoplasty – one to three contiguous teeth or tooth bounded spaces per quadrant                                                     | 14 - 99 | Limited to 1 per quadrant or site per consecutive 36 months. | N                   |
| <b>D4230</b>                                                  | Anatomical crown exposure – four or more contiguous teeth or tooth bounded spaces per quadrant                                                         | 18 - 99 | Limited to 1 per quadrant or site per consecutive 36 months. | Y                   |
| <b>D4231</b>                                                  | Anatomical crown exposure – one to three teeth or tooth bounded spaces per quadrant                                                                    | 18 - 99 | Limited to 1 per quadrant or site per consecutive 36 months. | Y                   |
| <b>D4240</b>                                                  | Gingival flap procedure, including root planing – four or more contiguous teeth or tooth bounded spaces per quadrant                                   | 18 - 99 | Limited to 1 per quadrant or site per consecutive 36 months. | N                   |
| <b>D4241</b>                                                  | Gingival flap procedure, including root planing – one to three contiguous teeth or tooth bounded spaces per quadrant                                   | 18 - 99 | Limited to 1 per quadrant or site per consecutive 36 months. | N                   |
| <b>D4245</b>                                                  | Apically positioned flap                                                                                                                               | 18 - 99 | Limited to 1 per quadrant or site per consecutive 36 months. | N                   |
| <b>D4249</b>                                                  | Clinical crown lengthening – hard tissue                                                                                                               | 18 - 99 | Limited to 1 per quadrant or site per consecutive 36 months. | Y                   |
| <b>D4260</b>                                                  | Osseous surgery (including flap entry and closure) – four or more contiguous teeth or tooth bounded spaces per quadrant                                | 18 - 99 | Limited to 1 per quadrant or site per consecutive 36 months. | Y                   |
| <b>D4261</b>                                                  | Osseous surgery (including flap entry and closure) – one to three contiguous teeth or tooth bounded spaces per quadrant                                | 18 - 99 | Limited to 1 per quadrant or site per consecutive 36 months. | Y                   |
| <b>D4263</b>                                                  | Bone replacement graft first site in quadrant                                                                                                          | 18 - 99 | Limited to 1 per quadrant or site per 36 months.             | Y                   |
| <b>D4264</b>                                                  | Bone replacement graft – each additional site in quadrant                                                                                              | 18 - 99 | Limited to 1 per quadrant or site per 36 months.             | Y                   |
| <b>D4265</b>                                                  | Biologic materials to aid in soft and osseous tissue regeneration                                                                                      | 18 - 99 | Limited to 1 per quadrant or site per consecutive 36 months. | Y                   |
| <b>D4266</b>                                                  | Guided tissue regeneration – resorbable barrier, per site                                                                                              | 18 - 99 | Limited to 1 per quadrant or site per consecutive 36 months. | Y                   |
| <b>D4267</b>                                                  | Guided tissue regeneration – nonresorbable barrier, per site (includes membrane removal)                                                               | 18 - 99 | Limited to 1 per quadrant or site per consecutive 36 months. | Y                   |
| <b>D4268</b>                                                  | Surgical revision procedure, per tooth                                                                                                                 | 18 - 99 | Limited to 1 per quadrant or site per consecutive 36 months. | Y                   |
| <b>D4270</b>                                                  | Pedicle soft tissue graft procedure                                                                                                                    | 18 - 99 | Limited to 1 per quadrant or site per consecutive 36 months. | Y                   |
| <b>D4273</b>                                                  | Autogenous connective tissue graft procedure (including donor and recipient surgical sites) first tooth, implant or edentulous tooth position in graft | 18 - 99 | Limited to 1 per quadrant or site per consecutive 36 months. | Y                   |

| Code                                    | Description                                                                                                                                                                                         | Age     | Frequencies and limitations                                                                                                                                                                                                                                     | Clinical review req |
|-----------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|
| <b>PERIODONTICS</b>                     |                                                                                                                                                                                                     |         |                                                                                                                                                                                                                                                                 |                     |
| D4274                                   | Mesial/distal wedge procedure, single tooth (when not performed in conjunction with surgical procedures in the same anatomical area)                                                                | 18 - 99 | Limited to 1 per quadrant or site per 36 months.                                                                                                                                                                                                                | Y                   |
| D4275                                   | Non-autogenous connective tissue graft (including recipient site and donor material) first tooth, implant, or edentulous tooth position in graft                                                    | 18 - 99 | Limited to 1 per quadrant or site per consecutive 36 months.                                                                                                                                                                                                    | Y                   |
| D4276                                   | Combined connective tissue and double pedicle graft, per tooth                                                                                                                                      | 18 - 99 | Limited to 1 per quadrant or site per consecutive 36 months.                                                                                                                                                                                                    | Y                   |
| D4277                                   | Free soft tissue graft procedure (including recipient and donor surgical sites) first tooth, implant, or edentulous tooth position in graft                                                         | 18 - 99 | Limited to 1 per quadrant or site per consecutive 36 months.                                                                                                                                                                                                    | Y                   |
| D4283                                   | Autogenous connective tissue graft procedure (including donor and recipient surgical sites) – each additional contiguous tooth, implant or edentulous tooth position in same graft site             | 18 - 99 | Limited to 1 per quadrant or site per consecutive 36 months.                                                                                                                                                                                                    | Y                   |
| D4285                                   | Non-autogenous connective tissue graft procedure (including recipient surgical site and donor material) – each additional contiguous tooth, implant or edentulous tooth position in same graft site | 18 - 99 | Limited to 1 per quadrant or site per consecutive 36 months.                                                                                                                                                                                                    | Y                   |
| <b>Non-Surgical Periodontal Service</b> |                                                                                                                                                                                                     |         |                                                                                                                                                                                                                                                                 |                     |
| D4320                                   | Provisional splinting – intracoronal                                                                                                                                                                | 0 - 99  | Cannot be used to restore vertical dimension or as part of full mouth rehabilitation, should not include use of laboratory based crowns and/or fixed partial dentures (bridges). Exclusion of laboratory based crowns or bridges for the purposes of provisiona | N                   |
| D4321                                   | Provisional splinting – extracoronal                                                                                                                                                                | 0 - 99  | Cannot be used to restore vertical dimension or as part of full mouth rehabilitation, should not include use of laboratory based crowns and/or fixed partial dentures (bridges). Exclusion of laboratory based crowns or bridges for the purposes of provisiona | N                   |
| D4341                                   | Periodontal scaling and root planing – four or more teeth per quadrant                                                                                                                              | 16 - 99 | Limited to 1 time per quadrant per consecutive 24 months.                                                                                                                                                                                                       | N                   |
| D4342                                   | Periodontal scaling and root planing – one to three teeth per quadrant                                                                                                                              | 16 - 99 | Limited to 1 time per quadrant per consecutive 24 months.                                                                                                                                                                                                       | N                   |
| D4346                                   | Scaling in presence of generalized moderate or severe gingival inflammation                                                                                                                         | 16 - 99 | Limited to 2 times per consecutive 12 months.                                                                                                                                                                                                                   | N                   |
| D4355                                   | Full mouth debridement to enable comprehensive evaluation and diagnosis                                                                                                                             | 16 - 99 | Limited to once per consecutive 36 months.                                                                                                                                                                                                                      | N                   |
| D4381                                   | Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth                                                                              | 16 - 99 | Limited to 3 sites per quadrant, or 12 sites total, for refractory pockets, or in conjunction with scaling or root planing, by report.                                                                                                                          | Y                   |
| <b>Other Periodontal Services</b>       |                                                                                                                                                                                                     |         |                                                                                                                                                                                                                                                                 |                     |
| D4910                                   | Periodontal maintenance                                                                                                                                                                             | 16 - 99 | Limited to 2 times per consecutive 12 months following active or adjunctive periodontal therapy, exclusive of gross debridement.                                                                                                                                | N                   |
| D4920                                   | Unscheduled dressing change (by someone other than treating dentist or their staff)                                                                                                                 | 0 - 99  |                                                                                                                                                                                                                                                                 | N                   |

## 4.1.F Removable Prosthodontic Services Guidelines

For the most recent and up to date clinical policy criteria and documentation requirements please follow <http://uhcdental.com>> RESOURCES> CLINICAL GUIDELINES, or you may use this [LINK](#).

| Code                                                              | Description                                                                                                                               | Age     | Frequencies and limitations                                                                                   | Clinical review req |
|-------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------|---------|---------------------------------------------------------------------------------------------------------------|---------------------|
| <b>REMOVABLE PROSTHODONTICS</b>                                   |                                                                                                                                           |         |                                                                                                               |                     |
| <b>Complete Dentures (Including Routine Post - Delivery Care)</b> |                                                                                                                                           |         |                                                                                                               |                     |
| D5110                                                             | Complete denture – maxillary                                                                                                              | 16 - 99 | Limited to 1 per consecutive 60 months. No additional allowances for precision or semi-precision attachments. | N                   |
| D5120                                                             | Complete denture – mandibular                                                                                                             | 16 - 99 | Limited to 1 per consecutive 60 months. No additional allowances for precision or semi-precision attachments. | N                   |
| D5130                                                             | Immediate denture – maxillary                                                                                                             | 16 - 99 | Limited to 1 per consecutive 60 months. No additional allowances for precision or semi-precision attachments. | N                   |
| D5140                                                             | Immediate denture – mandibular                                                                                                            | 16 - 99 | Limited to 1 per consecutive 60 months. No additional allowances for precision or semi-precision attachments. | N                   |
| <b>Partial Dentures (Including Routine Post - Delivery Care)</b>  |                                                                                                                                           |         |                                                                                                               |                     |
| D5211                                                             | Maxillary partial denture – resin base (including retentive/clasping materials, rests and teeth)                                          | 0 - 99  | Limited to 1 per consecutive 60 months. No additional allowances for precision or semi-precision attachments. | N                   |
| D5212                                                             | Mandibular partial denture – resin base (including retentive/clasping materials, rests and teeth)                                         | 0 - 99  | Limited to 1 per consecutive 60 months. No additional allowances for precision or semi-precision attachments. | N                   |
| D5213                                                             | Maxillary partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)            | 16 - 99 | Limited to 1 per consecutive 60 months. No additional allowances for precision or semi-precision attachments. | N                   |
| D5214                                                             | Mandibular partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)           | 16 - 99 | Limited to 1 per consecutive 60 months. No additional allowances for precision or semi-precision attachments. | N                   |
| D5221                                                             | Immediate maxillary partial denture – resin base (including any conventional clasps, rests and teeth)                                     | 0 - 99  | Limited to 1 per consecutive 60 months. No additional allowances for precision or semi-precision attachments. | N                   |
| D5222                                                             | Immediate mandibular partial denture – resin base (including any conventional clasps, rests and teeth)                                    | 0 - 99  | Limited to 1 per consecutive 60 months. No additional allowances for precision or semi-precision attachments. | N                   |
| D5223                                                             | Immediate maxillary partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)  | 0 - 99  | Limited to 1 per consecutive 60 months. No additional allowances for precision or semi-precision attachments. | N                   |
| D5224                                                             | Immediate mandibular partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth) | 0 - 99  | Limited to 1 per consecutive 60 months. No additional allowances for precision or semi-precision attachments. | N                   |
| D5225                                                             | Maxillary partial denture – flexible base (including any clasps, rests and teeth)                                                         | 0 - 99  | Limited to 1 per consecutive 60 months. No additional allowances for precision or semi-precision attachments. | N                   |
| D5226                                                             | Mandibular partial denture – flexible base (including any clasps, rests and teeth)                                                        | 0 - 99  | Limited to 1 per consecutive 60 months. No additional allowances for precision or semi-precision attachments. | N                   |
| D5282                                                             | Removable unilateral partial denture – one piece cast metal (including clasps and teeth), maxillary                                       | 16 - 99 | Limited to 1 per consecutive 60 months. No additional allowances for precision or semi-precision attachments. | N                   |

| Code                                | Description                                                                                          | Age     | Frequencies and limitations                                                                                                                                                                                        | Clinical review req |
|-------------------------------------|------------------------------------------------------------------------------------------------------|---------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|
| <b>REMOVABLE PROSTHODONTICS</b>     |                                                                                                      |         |                                                                                                                                                                                                                    |                     |
| <b>D5283</b>                        | Removable unilateral partial denture – one piece cast metal (including clasps and teeth), mandibular | 16 - 99 | Limited to 1 per consecutive 60 months. No additional allowances for precision or semi-precision attachments.                                                                                                      | N                   |
| <b>Adjustments to Dentures</b>      |                                                                                                      |         |                                                                                                                                                                                                                    |                     |
| <b>D5410</b>                        | Adjust complete denture – maxillary                                                                  | 16 - 99 | Limited to repairs or adjustments performed more than 12 months after the initial insertion. Limited to 1 per consecutive 6 months.                                                                                | N                   |
| <b>D5411</b>                        | Adjust complete denture – mandibular                                                                 | 16 - 99 | Limited to repairs or adjustments performed more than 12 months after the initial insertion. Limited to 1 per consecutive 6 months.                                                                                | N                   |
| <b>D5421</b>                        | Adjust partial denture – maxillary                                                                   | 0 - 99  | Limited to repairs or adjustments performed more than 12 months after the initial insertion. Limited to 1 per consecutive 6 months.                                                                                | N                   |
| <b>D5422</b>                        | Adjust partial denture – mandibular                                                                  | 0 - 99  | Limited to repairs or adjustments performed more than 12 months after the initial insertion. Limited to 1 per consecutive 6 months.                                                                                | N                   |
| <b>Repairs to Complete Dentures</b> |                                                                                                      |         |                                                                                                                                                                                                                    |                     |
| <b>D5511</b>                        | Repair broken complete denture base, mandibular                                                      | 16 - 99 | Limited to repairs or adjustments performed more than 12 months after the initial insertion. Limited to 1 per consecutive 6 months.                                                                                | N                   |
| <b>D5512</b>                        | Repair broken complete denture base, maxillary                                                       | 16 - 99 | Limited to repairs or adjustments performed more than 12 months after the initial insertion. Limited to 1 per consecutive 6 months.                                                                                | N                   |
| <b>D5520</b>                        | Replace missing or broken teeth – complete denture (each tooth)                                      | 16 - 99 | Repairs or Adjustments to Full Dentures, Partial Dentures, Bridges or Crowns - Limited to repairs or adjustments performed more than 12 months after the initial insertion. Limited to 1 per consecutive 6 months. | N                   |
| <b>Repairs to Partial Dentures</b>  |                                                                                                      |         |                                                                                                                                                                                                                    |                     |
| <b>D5611</b>                        | Repair resin partial denture base, mandibular                                                        | 16 - 99 | Limited to repairs or adjustments performed more than 12 months after the initial insertion. Limited to 1 per consecutive 6 months.                                                                                | N                   |
| <b>D5612</b>                        | Repair resin partial denture base, maxillary                                                         | 16 - 99 | Limited to repairs or adjustments performed more than 12 months after the initial insertion. Limited to 1 per consecutive 6 months.                                                                                | N                   |
| <b>D5621</b>                        | Repair cast partial framework, mandibular                                                            | 16 - 99 | Limited to repairs or adjustments performed more than 12 months after the initial insertion. Limited to 1 per consecutive 6 months.                                                                                | N                   |
| <b>D5622</b>                        | Repair cast partial framework, maxillary                                                             | 16 - 99 | Limited to repairs or adjustments performed more than 12 months after the initial insertion. Limited to 1 per consecutive 6 months.                                                                                | N                   |
| <b>D5630</b>                        | Repair or replace broken retentive/ clasp materials                                                  | 0 - 99  | Repairs or Adjustments to Full Dentures, Partial Dentures, Bridges or Crowns - Limited to repairs or adjustments performed more than 12 months after the initial insertion. Limited to 1 per consecutive 6 months. | N                   |
| <b>D5640</b>                        | Replace broken teeth – per tooth                                                                     | 0 - 99  | Repairs or Adjustments to Full Dentures, Partial Dentures, Bridges or Crowns - Limited to repairs or adjustments performed more than 12 months after the initial insertion. Limited to 1 per consecutive 6 months. | N                   |
| <b>D5650</b>                        | Add tooth to existing partial denture                                                                | 0 - 99  | Repairs or Adjustments to Full Dentures, Partial Dentures, Bridges or Crowns - Limited to repairs or adjustments performed more than 12 months after the initial insertion. Limited to 1 per consecutive 6 months. | N                   |

| Code                                       | Description                                                        | Age     | Frequencies and limitations                                                                                                                                                                                        | Clinical review req |
|--------------------------------------------|--------------------------------------------------------------------|---------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|
| <b>REMOVABLE PROSTHODONTICS</b>            |                                                                    |         |                                                                                                                                                                                                                    |                     |
| D5660                                      | Add clasp to existing partial denture                              | 0 - 99  | Repairs or Adjustments to Full Dentures, Partial Dentures, Bridges or Crowns - Limited to repairs or adjustments performed more than 12 months after the initial insertion. Limited to 1 per consecutive 6 months. | N                   |
| D5670                                      | Replace all teeth and acrylic on cast metal framework (maxillary)  | 16 - 99 | Repairs or Adjustments to Full Dentures, Partial Dentures, Bridges or Crowns - Limited to repairs or adjustments performed more than 12 months after the initial insertion. Limited to 1 per consecutive 6 months. | N                   |
| D5671                                      | Replace all teeth and acrylic on cast metal framework (mandibular) | 16 - 99 | Repairs or Adjustments to Full Dentures, Partial Dentures, Bridges or Crowns - Limited to repairs or adjustments performed more than 12 months after the initial insertion. Limited to 1 per consecutive 6 months. | N                   |
| <b>Denture Rebase Procedures</b>           |                                                                    |         |                                                                                                                                                                                                                    |                     |
| D5710                                      | Rebase complete maxillary denture                                  | 16 - 99 | Limited to rebasing performed more than 6 months after the initial insertion. Limited to 1 time per consecutive 12 months.                                                                                         | N                   |
| D5711                                      | Rebase complete mandibular denture                                 | 16 - 99 | Limited to rebasing performed more than 6 months after the initial insertion. Limited to 1 time per consecutive 12 months.                                                                                         | N                   |
| D5720                                      | Rebase maxillary partial denture                                   | 0 - 99  | Limited to rebasing performed more than 6 months after the initial insertion. Limited to 1 time per consecutive 12 months.                                                                                         | N                   |
| D5721                                      | Rebase mandibular partial denture                                  | 0 - 99  | Limited to rebasing performed more than 6 months after the initial insertion. Limited to 1 time per consecutive 12 months.                                                                                         | N                   |
| D5730                                      | Reline complete maxillary denture (chairside)                      | 16 - 99 | Limited to relining performed more than 6 months after the initial insertion. Limited to 1 time per consecutive 12 months.                                                                                         | N                   |
| D5731                                      | Reline complete mandibular denture (chairside)                     | 16 - 99 | Limited to relining performed more than 6 months after the initial insertion. Limited to 1 time per consecutive 12 months.                                                                                         | N                   |
| D5740                                      | Reline maxillary partial denture (chairside)                       | 0 - 99  | Limited to relining performed more than 6 months after the initial insertion. Limited to 1 time per consecutive 12 months.                                                                                         | N                   |
| D5741                                      | Reline mandibular partial denture (chairside)                      | 0 - 99  | Limited to relining performed more than 6 months after the initial insertion. Limited to 1 time per consecutive 12 months.                                                                                         | N                   |
| D5750                                      | Reline complete maxillary denture (laboratory)                     | 16 - 99 | Limited to relining performed more than 6 months after the initial insertion. Limited to 1 time per consecutive 12 months.                                                                                         | N                   |
| D5751                                      | Reline complete mandibular denture (laboratory)                    | 16 - 99 | Limited to relining performed more than 6 months after the initial insertion. Limited to 1 time per consecutive 12 months.                                                                                         | N                   |
| D5760                                      | Reline maxillary partial denture (laboratory)                      | 0 - 99  | Limited to relining performed more than 6 months after the initial insertion. Limited to 1 time per consecutive 12 months.                                                                                         | N                   |
| D5761                                      | Reline mandibular partial denture (laboratory)                     | 0 - 99  | Limited to relining performed more than 6 months after the initial insertion. Limited to 1 time per consecutive 12 months.                                                                                         | N                   |
| <b>Interim Prosthesis</b>                  |                                                                    |         |                                                                                                                                                                                                                    |                     |
| D5810                                      | Interim complete denture (maxillary)                               | 16 - 99 | Limited to 1 per consecutive 60 months. No additional allowances for precision or semi-precision attachments.                                                                                                      | N                   |
| D5811                                      | Interim complete denture (mandibular)                              | 16 - 99 | Limited to 1 per consecutive 60 months. No additional allowances for precision or semi-precision attachments.                                                                                                      | N                   |
| D5820                                      | Interim partial denture (maxillary)                                | 0 - 99  | Limited to 1 per consecutive 60 months. No additional allowances for precision or semi-precision attachments.                                                                                                      | N                   |
| D5821                                      | Interim partial denture (mandibular)                               | 0 - 99  | Limited to 1 per consecutive 60 months. No additional allowances for precision or semi-precision attachments.                                                                                                      | N                   |
| <b>Other Removable Prosthetic Services</b> |                                                                    |         |                                                                                                                                                                                                                    |                     |
| D5850                                      | Tissue conditioning, maxillary                                     | 0 - 99  | Limited to 1 time per consecutive 12 months.                                                                                                                                                                       | N                   |
| D5851                                      | Tissue conditioning, mandibular                                    | 0 - 99  | Limited to 1 time per consecutive 12 months.                                                                                                                                                                       | N                   |



| Code                            | Description                                               | Age     | Frequencies and limitations                                                                                                | Clinical review req |
|---------------------------------|-----------------------------------------------------------|---------|----------------------------------------------------------------------------------------------------------------------------|---------------------|
| <b>REMOVABLE PROSTHODONTICS</b> |                                                           |         |                                                                                                                            |                     |
| <b>D5863</b>                    | Overdenture - complete maxillary                          | 16 - 99 | Limited to 1 per consecutive 60 months. No additional allowances for precision or semi-precision attachments.              | N                   |
| <b>D5864</b>                    | Overdenture - complete mandibular                         | 16 - 99 | Limited to 1 per consecutive 60 months. No additional allowances for precision or semi-precision attachments.              | N                   |
| <b>D5865</b>                    | Overdenture - partial maxillary                           | 16 - 99 | Limited to 1 per consecutive 60 months. No additional allowances for precision or semi-precision attachments.              | N                   |
| <b>D5866</b>                    | Overdenture - partial mandibular                          | 16 - 99 | Limited to 1 per consecutive 60 months. No additional allowances for precision or semi-precision attachments.              | N                   |
| <b>D5876</b>                    | Add metal substructure to acrylic full denture (per arch) | 16 - 99 | Limited to rebasing performed more than 6 months after the initial insertion. Limited to 1 time per consecutive 12 months. | N                   |

## 4.1.G Implant and Fixed Prosthetic Services Guidelines

For the most recent and up to date clinical policy criteria and documentation requirements please follow <http://uhcdental.com>> RESOURCES> CLINICAL GUIDELINES, or you may use this [LINK](#).

| Code                                                                    | Description                                                                                   | Age    | Frequencies and limitations                                                     | Clinical review req |
|-------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------|--------|---------------------------------------------------------------------------------|---------------------|
| <b>IMPLANTS</b>                                                         |                                                                                               |        |                                                                                 |                     |
| <b>Surgical Services</b>                                                |                                                                                               |        |                                                                                 |                     |
| D6010                                                                   | Surgical placement of implant body: endosteal implant                                         | 0 - 99 | Buy-Up Only - Enhanced Plans Only: Limited to 1 time per consecutive 60 months. | Y                   |
| D6012                                                                   | Surgical placement of interim implant body for transitional prosthesis: endosteal implant     | 0 - 99 | Buy-Up Only - Enhanced Plans Only: Limited to 1 time per consecutive 60 months. | Y                   |
| D6013                                                                   | Surgical placement of a mini-implant                                                          | 0 - 99 | Buy-Up Only - Enhanced Plans Only: Limited to 1 time per consecutive 60 months. | Y                   |
| D6040                                                                   | Surgical placement: eposteal implant                                                          | 0 - 99 | Buy-Up Only - Enhanced Plans Only: Limited to 1 time per consecutive 60 months. | Y                   |
| D6050                                                                   | Surgical placement: transosteal implant                                                       | 0 - 99 | Buy-Up Only - Enhanced Plans Only: Limited to 1 time per consecutive 60 months. | Y                   |
| <b>Implant Supported Prosthetics: Supporting Structures</b>             |                                                                                               |        |                                                                                 |                     |
| D6051                                                                   | Interim abutment                                                                              | 0 - 99 | Buy-Up Only - Enhanced Plans Only: Limited to 1 time per consecutive 60 months. | Y                   |
| D6052                                                                   | Semi-precision attachment abutment                                                            | 0 - 99 | Buy-Up Only - Enhanced Plans Only: Limited to 1 time per consecutive 60 months. | Y                   |
| D6055                                                                   | Connecting bar – implant supported or abutment supported                                      | 0 - 99 | Buy-Up Only - Enhanced Plans Only: Limited to 1 time per consecutive 60 months. | Y                   |
| D6056                                                                   | Interceptive Orthodontic Treatment                                                            | 0 - 99 | Buy-Up Only - Enhanced Plans Only: Limited to 1 time per consecutive 60 months. | Y                   |
| D6057                                                                   | Custom abutment – includes placement                                                          | 0 - 99 | Buy-Up Only - Enhanced Plans Only: Limited to 1 time per consecutive 60 months. | Y                   |
| <b>Implant Supported Prosthetics: Single Crowns, Abutment Supported</b> |                                                                                               |        |                                                                                 |                     |
| D6058                                                                   | Abutment supported porcelain/ceramic crown                                                    | 0 - 99 | Buy-Up Only - Enhanced Plans Only: Limited to 1 time per consecutive 60 months. | Y                   |
| D6059                                                                   | Abutment supported porcelain fused to metal crown (high noble metal)                          | 0 - 99 | Buy-Up Only - Enhanced Plans Only: Limited to 1 time per consecutive 60 months. | Y                   |
| D6060                                                                   | Abutment supported porcelain fused to metal crown (predominantly base metal)                  | 0 - 99 | Buy-Up Only - Enhanced Plans Only: Limited to 1 time per consecutive 60 months. | Y                   |
| D6061                                                                   | Abutment supported porcelain fused to metal crown (noble metal)                               | 0 - 99 | Buy-Up Only - Enhanced Plans Only: Limited to 1 time per consecutive 60 months. | Y                   |
| D6062                                                                   | Abutment supported cast metal crown (high noble metal)                                        | 0 - 99 | Buy-Up Only - Enhanced Plans Only: Limited to 1 time per consecutive 60 months. | Y                   |
| D6063                                                                   | Abutment supported cast metal crown (predominantly base metal)                                | 0 - 99 | Buy-Up Only - Enhanced Plans Only: Limited to 1 time per consecutive 60 months. | Y                   |
| D6064                                                                   | Abutment supported cast metal crown (noble metal)                                             | 0 - 99 | Buy-Up Only - Enhanced Plans Only: Limited to 1 time per consecutive 60 months. | Y                   |
| D6094                                                                   | Abutment supported crown – (titanium)                                                         | 0 - 99 | Buy-Up Only - Enhanced Plans Only: Limited to 1 time per consecutive 60 months. | Y                   |
| <b>Implant Supported Prosthetics: Single Crowns, Implant Supported</b>  |                                                                                               |        |                                                                                 |                     |
| D6065                                                                   | Implant supported porcelain/ceramic crown                                                     | 0 - 99 | Buy-Up Only - Enhanced Plans Only: Limited to 1 time per consecutive 60 months. | Y                   |
| D6066                                                                   | Implant supported porcelain fused to metal crown (titanium, titanium alloy, high noble metal) | 0 - 99 | Buy-Up Only - Enhanced Plans Only: Limited to 1 time per consecutive 60 months. | Y                   |

| Code                                                                                     | Description                                                                                                                                                                                | Age    | Frequencies and limitations                                                                                                                                        | Clinical review req |
|------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|
| <b>IMPLANTS</b>                                                                          |                                                                                                                                                                                            |        |                                                                                                                                                                    |                     |
| <b>D6067</b>                                                                             | Implant supported metal crown (titanium, titanium alloy, high noble metal)                                                                                                                 | 0 - 99 | Buy-Up Only - Enhanced Plans Only: Limited to 1 time per consecutive 60 months.                                                                                    | Y                   |
| <b>Implant Supported Prosthetics: Fixed Partial Denture Retainer, Abutment Supported</b> |                                                                                                                                                                                            |        |                                                                                                                                                                    |                     |
| <b>D6068</b>                                                                             | Abutment supported retainer for porcelain/ceramic FPD                                                                                                                                      | 0 - 99 | Buy-Up Only - Enhanced Plans Only: Limited to 1 time per consecutive 60 months.                                                                                    | Y                   |
| <b>D6069</b>                                                                             | Abutment supported retainer for porcelain fused to metal FPD (high noble metal)                                                                                                            | 0 - 99 | Buy-Up Only - Enhanced Plans Only: Limited to 1 time per consecutive 60 months.                                                                                    | Y                   |
| <b>D6070</b>                                                                             | Abutment supported retainer for porcelain fused to metal FPD (predominantly base metal)                                                                                                    | 0 - 99 | Buy-Up Only - Enhanced Plans Only: Limited to 1 time per consecutive 60 months.                                                                                    | Y                   |
| <b>D6071</b>                                                                             | Abutment supported retainer for porcelain fused to metal FPD (noble metal)                                                                                                                 | 0 - 99 | Buy-Up Only - Enhanced Plans Only: Limited to 1 time per consecutive 60 months.                                                                                    | Y                   |
| <b>D6072</b>                                                                             | Abutment supported retainer for cast metal FPD (high noble metal)                                                                                                                          | 0 - 99 | Buy-Up Only - Enhanced Plans Only: Limited to 1 time per consecutive 60 months.                                                                                    | Y                   |
| <b>D6073</b>                                                                             | Abutment supported retainer for cast metal FPD (predominantly base metal)                                                                                                                  | 0 - 99 | Buy-Up Only - Enhanced Plans Only: Limited to 1 time per consecutive 60 months.                                                                                    | Y                   |
| <b>D6074</b>                                                                             | Abutment supported retainer for cast metal FPD (noble metal)                                                                                                                               | 0 - 99 | Buy-Up Only - Enhanced Plans Only: Limited to 1 time per consecutive 60 months.                                                                                    | Y                   |
| <b>D6194</b>                                                                             | Abutment supported retainer crown for FPD – (titanium)                                                                                                                                     | 0 - 99 | Buy-Up Only - Enhanced Plans Only: Limited to 1 time per consecutive 60 months.                                                                                    | Y                   |
| <b>Implant Supported Prosthetics: Fixed Partial Denture Retainer, Implant Supported</b>  |                                                                                                                                                                                            |        |                                                                                                                                                                    |                     |
| <b>D6075</b>                                                                             | Implant supported retainer for ceramic FPD                                                                                                                                                 | 0 - 99 | Buy-Up Only - Enhanced Plans Only: Limited to 1 time per consecutive 60 months.                                                                                    | Y                   |
| <b>D6076</b>                                                                             | Implant supported retainer for porcelain fused to metal FPD (titanium, titanium alloy, or high noble metal)                                                                                | 0 - 99 | Buy-Up Only - Enhanced Plans Only: Limited to 1 time per consecutive 60 months.                                                                                    | Y                   |
| <b>D6077</b>                                                                             | Implant supported retainer for cast metal FPD (titanium, titanium alloy, or high noble metal)                                                                                              | 0 - 99 | Buy-Up Only - Enhanced Plans Only: Limited to 1 time per consecutive 60 months.                                                                                    | Y                   |
| <b>Other Implant Services</b>                                                            |                                                                                                                                                                                            |        |                                                                                                                                                                    |                     |
| <b>D6080</b>                                                                             | Implant maintenance procedures, when prostheses are removed and reinserted, including cleansing removal of prostheses, cleansing of prosthesis and abutments and reinsertion of prosthesis | 0 - 99 | Buy-Up Only - Enhanced Plans Only: Limited to 1 time per consecutive 60 months.                                                                                    | N                   |
| <b>D6081</b>                                                                             | Scaling and debridement in the presence of inflammation or mucositis of a single implant                                                                                                   | 0 - 99 | Buy-Up Only - Enhanced Plans Only: Limited to 1 time per consecutive 60 months.                                                                                    | Y                   |
| <b>D6085</b>                                                                             | Provisional implant crown                                                                                                                                                                  | 0 - 99 | Buy-Up Only - Enhanced Plans Only: Limited to 1 time per consecutive 60 months.                                                                                    | Y                   |
| <b>D6090</b>                                                                             | Repair implant supported prosthesis, by report                                                                                                                                             | 0 - 99 | Buy-Up Only - Enhanced Plans Only: Limited to 1 time per consecutive 60 months.                                                                                    | Y                   |
| <b>D6091</b>                                                                             | Replacement of semi-precision or precision attachment (male or female component) of implant/abutment supported prosthesis, per attachment                                                  | 0 - 99 | Buy-Up Only - Enhanced Plans Only: Limited to 1 time per consecutive 60 months.                                                                                    | N                   |
| <b>D6092</b>                                                                             | Recement implant/abutment supported crown                                                                                                                                                  | 0 - 99 | Buy-Up Only - Enhanced Plans Only: Limited to 1 time per consecutive 60 months.                                                                                    | N                   |
| <b>D6093</b>                                                                             | Recement implant/abutment supported fixed partial denture                                                                                                                                  | 0 - 99 | Buy-Up Only - Enhanced Plans Only: Limited to 1 time per consecutive 60 months.                                                                                    | N                   |
| <b>D6095</b>                                                                             | Repair implant abutment, by report                                                                                                                                                         | 0 - 99 | Buy-Up Only - Enhanced Plans Only: Limited to repairs or adjustments performed more than 12 months after initial insertion. Limited to 1 per consecutive 6 months. | Y                   |

| Code                                                                                                | Description                                                                                                                                                                                 | Age    | Frequencies and limitations                                                                                                                                        | Clinical review req |
|-----------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|
| <b>IMPLANTS</b>                                                                                     |                                                                                                                                                                                             |        |                                                                                                                                                                    |                     |
| D6096                                                                                               | Remove broken implant retaining screw                                                                                                                                                       | 0 - 99 | Buy-Up Only - Enhanced Plans Only: Limited to repairs or adjustments performed more than 12 months after initial insertion. Limited to 1 per consecutive 6 months. | Y                   |
| D6118                                                                                               | Implant/abutment supported interim fixed denture for edentulous arch – mandibular                                                                                                           | 0 - 99 | Buy-Up Only - Enhanced Plans Only: Limited to 1 time per consecutive 60 months.                                                                                    | Y                   |
| D6119                                                                                               | Implant/abutment supported interim fixed denture for edentulous arch – maxillary                                                                                                            | 0 - 99 | Buy-Up Only - Enhanced Plans Only: Limited to 1 time per consecutive 60 months.                                                                                    | Y                   |
| D6100                                                                                               | Implant removal, by report                                                                                                                                                                  | 0 - 99 | Buy-Up Only - Enhanced Plans Only: Limited to 1 time per consecutive 60 months.                                                                                    | Y                   |
| D6101                                                                                               | Debridement of a periimplant defect and surface cleaning of exposed implant surfaces, including flap entry and closure                                                                      | 0 - 99 | Buy-Up Only - Enhanced Plans Only: Limited to 1 time per consecutive 60 months.                                                                                    | Y                   |
| D6102                                                                                               | Debridement of osseous contouring of a periimplant defect; includes surface cleaning of exposed implant surfaces and flap entry and closure                                                 | 0 - 99 | Buy-Up Only - Enhanced Plans Only: Limited to 1 time per consecutive 60 months.                                                                                    | Y                   |
| D6103                                                                                               | Bone graft for repair of periimplant defect – not including flap entry and closure or, when indicated, placement of a barrier membrane or biologic materials to aid in osseous regeneration | 0 - 99 | Buy-Up Only - Enhanced Plans Only: Limited to 1 time per consecutive 60 months.                                                                                    | Y                   |
| D6104                                                                                               | Bone graft at time of implant placement                                                                                                                                                     | 0 - 99 | Buy-Up Only - Enhanced Plans Only: Limited to 1 time per consecutive 60 months.                                                                                    | Y                   |
| <b>Implant Supported Prosthetics: Implant/Abutment Supported Removable Dentures</b>                 |                                                                                                                                                                                             |        |                                                                                                                                                                    |                     |
| D6110                                                                                               | Implant /abutment supported removable denture for edentulous arch – maxillary                                                                                                               | 0 - 99 | Buy-Up Only - Enhanced Plans Only: Limited to 1 time per consecutive 60 months.                                                                                    | Y                   |
| D6111                                                                                               | Implant /abutment supported removable denture for edentulous arch – mandibular                                                                                                              | 0 - 99 | Buy-Up Only - Enhanced Plans Only: Limited to 1 time per consecutive 60 months.                                                                                    | Y                   |
| D6112                                                                                               | Implant /abutment supported removable denture for partially edentulous arch – maxillary                                                                                                     | 0 - 99 | Buy-Up Only - Enhanced Plans Only: Limited to 1 time per consecutive 60 months.                                                                                    | Y                   |
| D6113                                                                                               | Implant /abutment supported removable denture for partially edentulous arch – mandibular                                                                                                    | 0 - 99 | Buy-Up Only - Enhanced Plans Only: Limited to 1 time per consecutive 60 months.                                                                                    | Y                   |
| <b>Implant Supported Prosthetics: Implant/Abutment Supported Fixed Dentures (Hybrid Prosthesis)</b> |                                                                                                                                                                                             |        |                                                                                                                                                                    |                     |
| D6114                                                                                               | Implant /abutment supported fixed denture for edentulous arch – maxillary                                                                                                                   | 0 - 99 | Buy-Up Only - Enhanced Plans Only: Limited to 1 time per consecutive 60 months.                                                                                    | Y                   |
| D6115                                                                                               | Implant /abutment supported fixed denture for edentulous arch – mandibular                                                                                                                  | 0 - 99 | Buy-Up Only - Enhanced Plans Only: Limited to 1 time per consecutive 60 months.                                                                                    | Y                   |
| D6116                                                                                               | Implant /abutment supported fixed denture for partially edentulous arch – maxillary                                                                                                         | 0 - 99 | Buy-Up Only - Enhanced Plans Only: Limited to 1 time per consecutive 60 months.                                                                                    | Y                   |
| D6117                                                                                               | Implant /abutment supported fixed denture for partially edentulous arch – mandibular                                                                                                        | 0 - 99 | Buy-Up Only - Enhanced Plans Only: Limited to 1 time per consecutive 60 months.                                                                                    | Y                   |
| <b>Pre - Surgical Services</b>                                                                      |                                                                                                                                                                                             |        |                                                                                                                                                                    |                     |
| D6190                                                                                               | Radiographic/surgical implant index, by report                                                                                                                                              | 0 - 99 | Buy-Up Only - Enhanced Plans Only: Limited to 1 time per consecutive 60 months.                                                                                    | N                   |

| Code                                 | Description                             | Age    | Frequencies and limitations                            | Clinical review req |
|--------------------------------------|-----------------------------------------|--------|--------------------------------------------------------|---------------------|
| <b>FIXED PROSTHODONTICS</b>          |                                         |        |                                                        |                     |
| <b>Fixed Partial Denture Pontics</b> |                                         |        |                                                        |                     |
| D6205                                | Pontic – indirect resin based composite | 0 - 99 | Limited to 1 time per tooth per consecutive 60 months. | Y                   |
| D6210                                | Pontic – cast high noble metal          | 0 - 99 | Limited to 1 time per tooth per consecutive 60 months. | Y                   |

| Code                        | Description                                                                                           | Age    | Frequencies and limitations                                                                                                                                               | Clinical review req |
|-----------------------------|-------------------------------------------------------------------------------------------------------|--------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|
| <b>FIXED PROSTHODONTICS</b> |                                                                                                       |        |                                                                                                                                                                           |                     |
| <b>D6211</b>                | Pontic – cast predominantly base metal                                                                | 0 - 99 | Limited to 1 time per tooth per consecutive 60 months..                                                                                                                   | Y                   |
| <b>D6212</b>                | Pontic – cast noble metal                                                                             | 0 - 99 | Limited to 1 time per tooth per consecutive 60 months.                                                                                                                    | Y                   |
| <b>D6214</b>                | Pontic – titanium                                                                                     | 0 - 99 | Limited to 1 time per tooth per consecutive 60 months.                                                                                                                    | Y                   |
| <b>D6240</b>                | Pontic – porcelain fused to high noble metal                                                          | 0 - 99 | Limited to 1 time per tooth per consecutive 60 months.                                                                                                                    | Y                   |
| <b>D6241</b>                | Pontic – porcelain fused to predominantly base metal                                                  | 0 - 99 | Limited to 1 time per tooth per consecutive 60 months.                                                                                                                    | Y                   |
| <b>D6242</b>                | Pontic – porcelain fused to noble metal                                                               | 0 - 99 | Limited to 1 time per tooth per consecutive 60 months.                                                                                                                    | Y                   |
| <b>D6245</b>                | Pontic – porcelain/ceramic                                                                            | 0 - 99 | Limited to 1 time per tooth per consecutive 60 months.                                                                                                                    | Y                   |
| <b>D6250</b>                | Pontic – resin with high noble metal                                                                  | 0 - 99 | Limited to 1 time per tooth per consecutive 60 months.                                                                                                                    | Y                   |
| <b>D6251</b>                | Pontic – resin with predominantly base metal                                                          | 0 - 99 | Limited to 1 time per tooth per consecutive 60 months.                                                                                                                    | Y                   |
| <b>D6252</b>                | Pontic – resin with noble metal                                                                       | 0 - 99 | Limited to 1 time per tooth per consecutive 60 months.                                                                                                                    | Y                   |
| <b>D6253</b>                | Provisional pontic – further treatment of completion of diagnosis necessary prior to final impression | 0 - 99 | Limited to 1 time per tooth per consecutive 60 months.                                                                                                                    | Y                   |
| <b>D6545</b>                | Retainer – cast metal for resin bonded fixed prosthesis                                               | 0 - 99 | Limited to 1 time per tooth per consecutive 60 months.                                                                                                                    | Y                   |
| <b>D6548</b>                | Retainer – porcelain/ceramic for resin bonded fixed prosthesis                                        | 0 - 99 | Limited to 1 time per tooth per consecutive 60 months.                                                                                                                    | Y                   |
| <b>D6549</b>                | Resin retainer – for resin bonded fixed prosthesis                                                    | 0 - 99 | Limited to 1 time per tooth per consecutive 60 months.                                                                                                                    | Y                   |
| <b>D6600</b>                | Inlay – porcelain/ceramic, two surfaces                                                               | 0 - 99 | Limited to 1 time per tooth per consecutive 60 months. Not covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes. | Y                   |
| <b>D6601</b>                | Inlay – porcelain/ceramic, three or more surfaces                                                     | 0 - 99 | Limited to 1 time per tooth per consecutive 60 months. Not covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes. | Y                   |
| <b>D6602</b>                | Inlay – cast high noble metal, two surfaces                                                           | 0 - 99 | Limited to 1 time per tooth per consecutive 60 months. Not covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes. | Y                   |
| <b>D6603</b>                | Inlay – cast high noble metal, three or more surfaces                                                 | 0 - 99 | Limited to 1 time per tooth per consecutive 60 months. Not covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes. | Y                   |
| <b>D6604</b>                | inlay – cast predominantly base metal, two surfaces                                                   | 0 - 99 | Limited to 1 time per tooth per consecutive 60 months. Not covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes. | Y                   |
| <b>D6605</b>                | Inlay – cast predominantly base metal, three or more surfaces                                         | 0 - 99 | Limited to 1 time per tooth per consecutive 60 months. Not covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes. | Y                   |
| <b>D6606</b>                | Inlay – cast noble metal, two surfaces                                                                | 0 - 99 | Limited to 1 time per tooth per consecutive 60 months. Not covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes. | Y                   |
| <b>D6607</b>                | Inlay – cast noble metal, three or more surfaces                                                      | 0 - 99 | Limited to 1 time per tooth per consecutive 60 months. Not covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes. | Y                   |
| <b>D6608</b>                | Onlay – porcelain/ceramic, two surfaces                                                               | 0 - 99 | Limited to 1 time per tooth per consecutive 60 months. Not covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes. | Y                   |

| Code                                            | Description                                                   | Age    | Frequencies and limitations                                                                                                                                               | Clinical review req |
|-------------------------------------------------|---------------------------------------------------------------|--------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|
| <b>FIXED PROSTHODONTICS</b>                     |                                                               |        |                                                                                                                                                                           |                     |
| D6609                                           | Onlay – porcelain/ceramic, three or more surfaces             | 0 - 99 | Limited to 1 time per tooth per consecutive 60 months. Not covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes. | Y                   |
| D6610                                           | Onlay – cast high noble metal, two surfaces                   | 0 - 99 | Limited to 1 time per tooth per consecutive 60 months. Not covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes. | Y                   |
| D6611                                           | Onlay – cast high noble metal, three or more surfaces         | 0 - 99 | Limited to 1 time per tooth per consecutive 60 months. Not covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes. | Y                   |
| D6612                                           | Onlay – cast predominantly base metal, two surfaces           | 0 - 99 | Limited to 1 time per tooth per consecutive 60 months. Not covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes. | Y                   |
| D6613                                           | Onlay – cast predominantly base metal, three or more surfaces | 0 - 99 | Limited to 1 time per tooth per consecutive 60 months. Not covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes. | Y                   |
| D6614                                           | Onlay – cast noble metal, two surfaces                        | 0 - 99 | Limited to 1 time per tooth per consecutive 60 months. Not covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes. | Y                   |
| D6615                                           | Onlay – cast noble metal, three or more surfaces              | 0 - 99 | Limited to 1 time per tooth per consecutive 60 months. Not covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes. | Y                   |
| D6624                                           | Inlay – titanium                                              | 0 - 99 | Limited to 1 time per tooth per consecutive 60 months. Not covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes. | Y                   |
| D6634                                           | Onlay – titanium                                              | 0 - 99 | Limited to 1 time per tooth per consecutive 60 months. Not covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes. | Y                   |
| <b>Fixed Partial Denture Retainers – Crowns</b> |                                                               |        |                                                                                                                                                                           |                     |
| D6710                                           | Crown – indirect resin based composite                        | 0 - 99 | Limited to 1 time per tooth per consecutive 60 months. Not covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes. | Y                   |
| D6720                                           | Crown – resin with high noble metal                           | 0 - 99 | Limited to 1 time per tooth per consecutive 60 months. Not covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes. | Y                   |
| D6721                                           | Crown – resin with predominantly base metal                   | 0 - 99 | Limited to 1 time per tooth per consecutive 60 months. Not covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes. | Y                   |
| D6722                                           | Crown – resin with noble metal                                | 0 - 99 | Limited to 1 time per tooth per consecutive 60 months. Not covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes. | Y                   |
| D6740                                           | Crown – porcelain/ceramic                                     | 0 - 99 | Limited to 1 time per tooth per consecutive 60 months. Not covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes. | Y                   |
| D6750                                           | Crown – porcelain fused to high noble metal                   | 0 - 99 | Limited to 1 time per tooth per consecutive 60 months. Not covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes. | Y                   |
| D6751                                           | Crown – porcelain fused to predominantly base metal           | 0 - 99 | Limited to 1 time per tooth per consecutive 60 months. Not covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes. | Y                   |
| D6752                                           | Crown – porcelain fused to noble metal                        | 0 - 99 | Limited to 1 time per tooth per consecutive 60 months. Not covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes. | Y                   |

| Code                                        | Description                                                                                                   | Age    | Frequencies and limitations                                                                                                                                               | Clinical review req |
|---------------------------------------------|---------------------------------------------------------------------------------------------------------------|--------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|
| <b>FIXED PROSTHODONTICS</b>                 |                                                                                                               |        |                                                                                                                                                                           |                     |
| <b>D6780</b>                                | Crown – 3/4 cast high noble metal                                                                             | 0 - 99 | Limited to 1 time per tooth per consecutive 60 months. Not covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes. | Y                   |
| <b>D6781</b>                                | Crown – 3/4 cast predominantly base metal                                                                     | 0 - 99 | Limited to 1 time per tooth per consecutive 60 months. Not covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes. | Y                   |
| <b>D6782</b>                                | Crown – 3/4 cast noble metal                                                                                  | 0 - 99 | Limited to 1 time per tooth per consecutive 60 months. Not covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes. | Y                   |
| <b>D6783</b>                                | Crown – 3/4 porcelain/ceramic                                                                                 | 0 - 99 | Limited to 1 time per tooth per consecutive 60 months. Not covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes. | Y                   |
| <b>D6790</b>                                | Crown – full cast high noble metal                                                                            | 0 - 99 | Limited to 1 time per tooth per consecutive 60 months. Not covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes. | Y                   |
| <b>D6791</b>                                | Crown – full cast predominantly base metal                                                                    | 0 - 99 | Limited to 1 time per tooth per consecutive 60 months. Not covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes. | Y                   |
| <b>D6792</b>                                | Crown – full cast noble metal                                                                                 | 0 - 99 | Limited to 1 time per tooth per consecutive 60 months. Not covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes. | Y                   |
| <b>D6793</b>                                | Provisional retainer crown – further treatment of completion of diagnosis necessary prior to final impression | 0 - 99 | Limited to 1 time per tooth per consecutive 60 months. Not covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes. | Y                   |
| <b>D6794</b>                                | Crown – titanium                                                                                              | 0 - 99 | Limited to 1 time per tooth per consecutive 60 months. Not covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes. | Y                   |
| <b>Other Fixed Partial Denture Services</b> |                                                                                                               |        |                                                                                                                                                                           |                     |
| <b>D6930</b>                                | Recement fixed partial denture                                                                                | 0 - 99 | Limited to those performed more than 12 months after the initial insertion.                                                                                               | N                   |
| <b>D6980</b>                                | Fixed partial denture repair necessitated by restorative material failure                                     | 0 - 99 | Limited to repairs or adjustments performed more than 12 months after the initial insertion. Limited to 1 per consecutive 6 months.                                       | Y                   |



## 4.1.H Oral and Maxillofacial Surgery Services Guidelines

For the most recent and up to date clinical policy criteria and documentation requirements please follow <http://uhcdental.com>> RESOURCES> CLINICAL GUIDELINES, or you may use this [LINK](#).

| Code                                                                                               | Description                                                                                                                                                                       | Age    | Frequencies and limitations                           | Clinical review req |
|----------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------|-------------------------------------------------------|---------------------|
| <b>ORAL AND MAXILLOFACIAL SURGERY</b>                                                              |                                                                                                                                                                                   |        |                                                       |                     |
| <b>Extractions (Includes Local Anesthesia, Suturing If Needed, and Routine Postoperative Care)</b> |                                                                                                                                                                                   |        |                                                       |                     |
| D7111                                                                                              | Extraction, coronal remnants – deciduous tooth                                                                                                                                    | 0 - 99 | Limited to 1 time per tooth per lifetime.             | N                   |
| D7140                                                                                              | Extraction, erupted tooth or exposed root (elevation and/or forceps removal)                                                                                                      | 0 - 99 | Limited to 1 time per tooth per lifetime.             | N                   |
| D7210                                                                                              | Surgical removal of erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated                               | 0 - 99 | Limited to 1 time per tooth per lifetime.             | N                   |
| D7220                                                                                              | Removal of impacted tooth – soft tissue                                                                                                                                           | 0 - 99 | Limited to 1 time per tooth per lifetime.             | Y                   |
| D7230                                                                                              | Removal of impacted tooth – partially bony                                                                                                                                        | 0 - 99 | Limited to 1 time per tooth per lifetime.             | Y                   |
| D7240                                                                                              | Removal of impacted tooth – completely bony                                                                                                                                       | 0 - 99 | Limited to 1 time per tooth per lifetime.             | Y                   |
| D7241                                                                                              | Removal of impacted tooth – completely bony, with unusual surgical complications                                                                                                  | 0 - 99 | Limited to 1 time per tooth per lifetime.             | Y                   |
| D7250                                                                                              | Rurgical removal of residual tooth roots (cutting procedure)                                                                                                                      | 0 - 99 | Limited to 1 time per tooth per lifetime.             | N                   |
| <b>Other Surgical Procedures</b>                                                                   |                                                                                                                                                                                   |        |                                                       |                     |
| D7260                                                                                              | Oroantral fistula closure                                                                                                                                                         | 0 - 99 | Limited to 1 per site per lifetime.                   | N                   |
| D7261                                                                                              | Primary closure of a sinus perforation                                                                                                                                            | 0 - 99 | Limited to 1 per tooth per lifetime.                  | Y                   |
| D7270                                                                                              | Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth                                                                                              | 0 - 99 | Limited to 1 per site per lifetime.                   | N                   |
| D7272                                                                                              | Tooth transplantaion (includes reimplantation from one site to another and splinting and/or stabilization)                                                                        | 0 - 99 | Limited to 1 per site per lifetime.                   | N                   |
| D7280                                                                                              | Surgical access of an unerupted tooth                                                                                                                                             | 0 - 99 | Limited to 1 time per tooth per lifetime.             | N                   |
| D7282                                                                                              | Mobilization of erupted or malpositioned tooth to aid eruption                                                                                                                    | 0 - 99 | Limited to 1 time per tooth per lifetime.             | Y                   |
| D7283                                                                                              | Placement of device to facilitate eruption of impacted tooth                                                                                                                      | 0 - 99 | Limited to 1 time per tooth per lifetime.             | N                   |
| D7285                                                                                              | Biopsy of oral tissue – hard (bone, tooth)                                                                                                                                        | 0 - 99 | Limited to 1 biopsy per site per visit.               | N                   |
| D7286                                                                                              | Biopsy of oral tissue – soft                                                                                                                                                      | 0 - 99 | Limited to 1 biopsy per site per visit.               | N                   |
| D7287                                                                                              | Exfoliative cytological sample collection                                                                                                                                         | 0 - 99 | Limited to 1 biopsy per site per visit.               | N                   |
| D7288                                                                                              | Brush biopsy – transepithelial sample collection                                                                                                                                  | 0 - 99 | Limited to 1 biopsy per site per visit.               | N                   |
| D7291                                                                                              | Transseptal fibrotomy/supra crestal fibrotomy, by report                                                                                                                          | 0 - 99 | Limited to 1 time per tooth per lifetime.             | N                   |
| <b>Alveoloplasty – Preparation of Ridge</b>                                                        |                                                                                                                                                                                   |        |                                                       |                     |
| D7310                                                                                              | Alveoloplasty in conjunction with extractions – four or more teeth or tooth spaces, per quadrant                                                                                  | 0 - 99 | Listed in the COC with no limitation.                 | N                   |
| D7311                                                                                              | Alveoloplasty in conjunction with extractions – one to three teeth or tooth spaces, per quadrant                                                                                  | 0 - 99 | Listed in the COC with no limitation.                 | N                   |
| D7320                                                                                              | Alveoloplasty not in conjunction with extractions – four or more teeth or tooth spaces, per quadrant                                                                              | 0 - 99 | Listed in the COC with no limitation.                 | N                   |
| D7321                                                                                              | Alveoloplasty not in conjunction with extractions – one to three teeth or tooth spaces, per quadrant                                                                              | 0 - 99 | Listed in the COC with no limitation.                 | N                   |
| <b>Vestibuloplasty</b>                                                                             |                                                                                                                                                                                   |        |                                                       |                     |
| D7340                                                                                              | Vestibuloplasty – ridge extension (secondary epithelialization)                                                                                                                   | 0 - 99 | Limited to 1 time per site per consecutive 60 months. | N                   |
| D7350                                                                                              | Vestibuloplasty – ridge extension (including soft tissue grafts, muscle reattachment, revision of soft tissue attachment and management of hypertrophied and hyperplastic tissue) | 0 - 99 | Limited to 1 time per site per consecutive 60 months. | N                   |



| Code                                                                                         | Description                                                                                                           | Age     | Frequencies and limitations                                                                                                                       | Clinical review req |
|----------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------|---------|---------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|
| <b>ORAL AND MAXILLOFACIAL SURGERY</b>                                                        |                                                                                                                       |         |                                                                                                                                                   |                     |
| <b>Excision of Soft Tissue Lesions</b>                                                       |                                                                                                                       |         |                                                                                                                                                   |                     |
| D7410                                                                                        | Excision of benign lesion up to 1.25 cm                                                                               | 0 - 99  | Limited to 1 per site per visit.                                                                                                                  | N                   |
| D7411                                                                                        | Excision of benign lesion greater than 1.25 cm                                                                        | 0 - 99  | Limited to 1 per site per visit.                                                                                                                  | Y                   |
| D7412                                                                                        | Excision of benign lesion, complicated                                                                                | 0 - 99  | Limited to 1 per site per visit.                                                                                                                  | Y                   |
| <b>Excision of Bone Tissue</b>                                                               |                                                                                                                       |         |                                                                                                                                                   |                     |
| D7472                                                                                        | Removal of torus palatinus                                                                                            | 0 - 99  | Limited to 1 per site per visit.                                                                                                                  | N                   |
| D7473                                                                                        | Removal of torus mandibularis                                                                                         | 0 - 99  | Limited to 1 per site per visit.                                                                                                                  | N                   |
| <b>Surgical Incision</b>                                                                     |                                                                                                                       |         |                                                                                                                                                   |                     |
| D7510                                                                                        | Incision and drainage of abscess – intraoral soft tissue                                                              | 0 - 99  | Limited to 1 per site per visit.                                                                                                                  | N                   |
| D7511                                                                                        | Incision and drainage of abscess – intraoral soft tissue – complicated (includes drainage of multiple fascial spaces) | 0 - 99  | Limited to 1 per site per visit.                                                                                                                  | N                   |
| D7520                                                                                        | Incision and drainage of abscess – extraoral soft tissue                                                              | 0 - 99  | Limited to 1 per site per visit.                                                                                                                  | N                   |
| D7521                                                                                        | Incision and drainage of abscess – extraoral soft tissue – complicated (includes drainage of multiple fascial spaces) | 0 - 99  | Limited to 1 per site per visit.                                                                                                                  | N                   |
| D7530                                                                                        | Removal of foreign body from mucosa, skin, or subcutaneous alveolar tissue                                            | 0 - 99  | Limited to 1 per site per visit.                                                                                                                  | N                   |
| D7540                                                                                        | Removal of reaction producing foreign bodies, musculoskeletal system                                                  | 0 - 99  | Limited to 1 per site per visit.                                                                                                                  | N                   |
| D7550                                                                                        | Partial osteotomy/sequestrectomy for removal of non-vital bone                                                        | 0 - 99  | Limited to 1 per site per visit.                                                                                                                  | N                   |
| D7560                                                                                        | Maxillary sinusotomy for removal of tooth fragment or foreign body                                                    | 0 - 99  |                                                                                                                                                   | N                   |
| <b>Reduction of Dislocation and Management of Other Temporomandibular Joint Dysfunctions</b> |                                                                                                                       |         |                                                                                                                                                   |                     |
| D7880                                                                                        | Occlusal orthotic device, by report                                                                                   | 0 - 99  | TMJ plans only; not generally covered on core standard plans - Limited to 1 time every consecutive 24 months.                                     | Y                   |
| D7881                                                                                        | Occlusal orthotic device adjustment                                                                                   | 16 - 99 | Limited to repairs or adjustments performed more than 12 months after the initial insertion. Limited to 1 per consecutive 6 months.               | N                   |
| D7899                                                                                        | Unspecified TMD therapy, by report                                                                                    | 0 - 99  | TMJ plans only; not generally covered on core standard plans - Limited to 1 per visit. Cannot be billed in conjunction with other TMD procedures. | Y                   |
| <b>Other Repair Procedures</b>                                                               |                                                                                                                       |         |                                                                                                                                                   |                     |
| D7960                                                                                        | Frenulectomy – also known as frenectomy or frenotomy – separate procedure not incidental to another procedure.        | 0 - 99  | Listed in the COC with no limitation.                                                                                                             | N                   |
| D7963                                                                                        | Frenuloplasty                                                                                                         | 0 - 99  | Listed in the COC with no limitation.                                                                                                             | N                   |
| D7970                                                                                        | Excision of hyperplastic tissue – per arch                                                                            | 0 - 99  | Limited to 1 per site per consecutive 36 months.                                                                                                  | N                   |
| D7971                                                                                        | Excision of pericoronal gingiva                                                                                       | 0 - 99  | Limited to 1 per site per consecutive 36 months.                                                                                                  | N                   |
| D7972                                                                                        | Surgical reduction of fibrous tuberosity                                                                              | 0 - 99  | Limited to 1 per site per consecutive 36 months.                                                                                                  | Y                   |
| D7997                                                                                        | Appliance removal (not by dentist who placed appliance), includes removal of archbar                                  | 0 - 99  | Limited to once per appliance per lifetime.                                                                                                       | N                   |

## 4.1.1 Orthodontic Services Guidelines

For the most recent and up to date clinical policy criteria and documentation requirements please follow <http://uhcdental.com>> RESOURCES> CLINICAL GUIDELINES, or you may use this [LINK](#).

| Code                                             | Description                                                                              | Age    | Frequencies and limitations     | Clinical review req |
|--------------------------------------------------|------------------------------------------------------------------------------------------|--------|---------------------------------|---------------------|
| <b>ORTHODONTICS</b>                              |                                                                                          |        |                                 |                     |
| <b>Limited Orthodontic Treatment</b>             |                                                                                          |        |                                 |                     |
| D8010                                            | Limited orthodontic treatment of the primary dentition                                   | 0 - 99 | Plans with orthodontic benefits | N                   |
| D8020                                            | Limited orthodontic treatment of the transitional dentition                              | 0 - 99 | Plans with orthodontic benefits | N                   |
| D8030                                            | Limited orthodontic treatment of the adolescent dentition                                | 0 - 99 | Plans with orthodontic benefits | N                   |
| D8040                                            | Limited orthodontic treatment of the adult dentition                                     | 0 - 99 | Plans with orthodontic benefits | N                   |
| <b>Interceptive Orthodontic Treatment</b>        |                                                                                          |        |                                 |                     |
| D8050                                            | Interceptive orthodontic treatment of the primary dentition                              | 0 - 99 | Plans with orthodontic benefits | N                   |
| D8060                                            | Interceptive orthodontic treatment of the transitional dentition                         | 0 - 99 | Plans with orthodontic benefits | N                   |
| <b>Comprehensive Orthodontic Treatment</b>       |                                                                                          |        |                                 |                     |
| D8070                                            | Comprehensive orthodontic treatment of the transitional dentition                        | 0 - 99 | Plans with orthodontic benefits | N                   |
| D8080                                            | Comprehensive orthodontic treatment of the adolescent dentition                          | 0 - 99 | Plans with orthodontic benefits | N                   |
| D8090                                            | Comprehensive orthodontic treatment of the adult dentition                               | 0 - 99 | Plans with orthodontic benefits | N                   |
| <b>Minor Treatment to Control Harmful Habits</b> |                                                                                          |        |                                 |                     |
| D8210                                            | Removable appliance therapy                                                              | 0 - 99 | Plans with orthodontic benefits | N                   |
| D8220                                            | Fixed appliance therapy                                                                  | 0 - 99 | Plans with orthodontic benefits | N                   |
| D8660                                            | Pre-orthodontic treatment visit                                                          | 0 - 99 | Plans with orthodontic benefits | N                   |
| D8670                                            | Periodic orthodontic treatment visit (as part of contract)                               | 0 - 99 | Plans with orthodontic benefits | N                   |
| D8680                                            | Orthodontic retention (removal of appliances, construction and placement of retainer(s)) | 0 - 99 | Plans with orthodontic benefits | N                   |
| D8690                                            | Orthodontic treatment (alternative billing to a contract fee)                            | 0 - 99 | Plans with orthodontic benefits | N                   |
| D8691                                            | Repair of orthodontic appliance                                                          | 0 - 99 | Plans with orthodontic benefits | N                   |
| D8693                                            | Rebonding or recementing; and/or repair, as required, of fixed retainers                 | 0 - 99 | Plans with orthodontic benefits | N                   |
| D8694                                            | Repair of fixed retainers, includes reattachment                                         | 0 - 99 | Plans with orthodontic benefits | N                   |
| D8695                                            | Removal of fixed orthodontic appliances for reasons other than completion of treatment   | 0 - 99 | Plans with orthodontic benefits | N                   |

## 4.1.J Adjunctive Services Guidelines

For the most recent and up to date clinical policy criteria and documentation requirements please follow <http://uhcdental.com>> RESOURCES> CLINICAL GUIDELINES, or you may use this [LINK](#).

| Code                               | Description                                                                                                   | Age    | Frequencies and limitations                                                                                                                                                                                                                                                         | Clinical review req |
|------------------------------------|---------------------------------------------------------------------------------------------------------------|--------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|
| <b>ADJUNCTIVE GENERAL SERVICES</b> |                                                                                                               |        |                                                                                                                                                                                                                                                                                     |                     |
| <b>Unclassified Treatment</b>      |                                                                                                               |        |                                                                                                                                                                                                                                                                                     |                     |
| D9110                              | Palliative (emergency) treatment of dental pain – minor procedure                                             | 0 - 99 | Covered as a separate benefit only if no other services, other than exam and radiographs, were done on the same tooth during the visit.                                                                                                                                             | N                   |
| D9120                              | Fixed partial denture sectioning                                                                              | 0 - 99 | Limited to one time per bridge.                                                                                                                                                                                                                                                     | N                   |
| <b>Anesthesia</b>                  |                                                                                                               |        |                                                                                                                                                                                                                                                                                     |                     |
| D9210                              | Local anesthesia not in conjunction with operative or surgical procedures                                     | 0 - 99 |                                                                                                                                                                                                                                                                                     | N                   |
| D9219                              | Valuation for moderate sedation, deep sedation or general anesthesia                                          | 0 - 99 | Consultation (diagnostic service provided by dentists or physician other than practitioner providing treatment). Not covered if done with exams or professional visit.                                                                                                              | N                   |
| D9222                              | Deep sedation/general anesthesia – first 15 minutes                                                           | 0 - 99 | Covered when Necessary in conjunction with Covered Dental Services. If required for patients under 6 years of age or patients with behavioral problems or physical disabilities or if it is clinically Necessary. Covered for patients over age of 6 if it is clinically necessary. | Y                   |
| D9223                              | Deep sedation/general anesthesia – each subsequent 15 minutes increment                                       | 0 - 99 | Covered when Necessary in conjunction with Covered Dental Services. If required for patients under 6 years of age or patients with behavioral problems or physical disabilities or if it is clinically Necessary. Covered for patients over age of 6 if it is clinically necessary. | Y                   |
| D9230                              | Inhalation of nitrous oxide/anoxiolysis, analgesia                                                            | 0 - 99 | Covered when Necessary in conjunction with Covered Dental Services. If required for patients under 6 years of age or patients with behavioral problems or physical disabilities or if it is clinically Necessary. Covered for patients over age of 6 if it is clinically necessary. | Y                   |
| D9239                              | Intravenous moderate (conscious) sedation/Anesthesia – first 15 minutes                                       | 0 - 99 | Covered when Necessary in conjunction with Covered Dental Services. If required for patients under 6 years of age or patients with behavioral problems or physical disabilities or if it is clinically Necessary. Covered for patients over age of 6 if it is clinically necessary. | Y                   |
| D9243                              | Intravenous moderate (conscious) sedation/Analgesia – each 15 minute increment                                | 0 - 99 | Covered when Necessary in conjunction with Covered Dental Services. If required for patients under 6 years of age or patients with behavioral problems or physical disabilities or if it is clinically Necessary. Covered for patients over age of 6 if it is clinically necessary. | Y                   |
| D9248                              | Non-intravenous conscious sedation                                                                            | 0 - 99 | Covered when Necessary in conjunction with Covered Dental Services. If required for patients under 6 years of age or patients with behavioral problems or physical disabilities or if it is clinically Necessary. Covered for patients over age of 6 if it is clinically necessary. | Y                   |
| <b>Professional Consultation</b>   |                                                                                                               |        |                                                                                                                                                                                                                                                                                     |                     |
| D9310                              | Consultation – diagnostic service provided by dentist or physician other than requesting dentist or physician | 0 - 99 | Consultation (diagnostic service provided by dentists or physician other than practitioner providing treatment). Not covered if done with exams or professional visit.                                                                                                              | N                   |
| <b>Drugs</b>                       |                                                                                                               |        |                                                                                                                                                                                                                                                                                     |                     |
| D9610                              | Therapeutic parenteral drug, single administration                                                            | 0 - 99 | Therapeutic Drug Injection, by report/Other Drugs and/or Medicaments, by report - Limited to 1 per visit.                                                                                                                                                                           | Y                   |

| Code                               | Description                                                                                     | Age     | Frequencies and limitations                                                                                                           | Clinical review req |
|------------------------------------|-------------------------------------------------------------------------------------------------|---------|---------------------------------------------------------------------------------------------------------------------------------------|---------------------|
| <b>ADJUNCTIVE GENERAL SERVICES</b> |                                                                                                 |         |                                                                                                                                       |                     |
| <b>D9612</b>                       | Therapeutic parenteral drugs, two or more administrations, different medications                | 0 - 99  | Therapeutic Drug Injection, by report/Other Drugs and/or Medicaments, by report - Limited to 1 per visit.                             | Y                   |
| <b>D9630</b>                       | Other drugs and/or medicaments, by report                                                       | 0 - 99  | Therapeutic Drug Injection, by report/Other Drugs and/or Medicaments, by report - Limited to 1 per visit.                             | Y                   |
| <b>Miscellaneous Services</b>      |                                                                                                 |         |                                                                                                                                       |                     |
| <b>D9910</b>                       | Application of desensitizing medicament                                                         | 0 - 99  | Desensitizing Medicament                                                                                                              | N                   |
| <b>D9911</b>                       | Application of desensitizing resin for cervical and/or root surface, per tooth                  | 0 - 99  | Desensitizing Medicament                                                                                                              | N                   |
| <b>D9942</b>                       | Repair and/or reline of occlusal guard                                                          | 0 - 99  | Limited to relining and repair performed more than 6 months after the initial insertion. Limited to 1 time per consecutive 12 months. | N                   |
| <b>D9943</b>                       | Occlusal guard adjustment                                                                       | 16 - 99 | Limited to repairs or adjustments performed more than 12 months after the initial insertion. Limited to 1 per consecutive 6 months.   | N                   |
| <b>D9944</b>                       | Occlusal guard – hard appliance, full arch                                                      | 0 - 99  | Limited to 1 guard every consecutive 36 months and only covered if prescribed to control habitual grinding.                           | Y                   |
| <b>D9945</b>                       | Occlusal guard – soft appliance, full arch                                                      | 0 - 99  | Limited to 1 guard every consecutive 36 months and only covered if prescribed to control habitual grinding.                           | Y                   |
| <b>D9946</b>                       | Occlusal guard – hard appliance, partial arch                                                   | 0 - 99  | Limited to 1 guard every consecutive 36 months and only covered if prescribed to control habitual grinding.                           | Y                   |
| <b>D9950</b>                       | Occlusion analysis – mounted case                                                               | 0 - 99  | Limited to 1 time per consecutive 60 months.                                                                                          | N                   |
| <b>D9951</b>                       | Occlusal adjustment – limited                                                                   | 0 - 99  | In COC with no limitation.                                                                                                            | N                   |
| <b>D9952</b>                       | Occlusal adjustment – complete                                                                  | 0 - 99  | In COC with no limitation.                                                                                                            | N                   |
| <b>D9995</b>                       | Teledentistry – synchronous; real-time encounter                                                | 0 - 99  | Limited to 2 times per consecutive 12 months.                                                                                         | N                   |
| <b>D9996</b>                       | Teledentistry – asynchronous; information stored and forwarded to dentist for subsequent review | 0 - 99  | Limited to 2 times per consecutive 12 months.                                                                                         | N                   |

## 4.2 Exclusions & Limitations

### Exclusions

Except as may be specifically provided in the Schedule of Covered Dental Services or through a Rider to the Policy, the following are not covered:

- Dental Services that are not necessary.
- Hospitalization or other facility charges.
- Any Dental Procedure performed solely for cosmetic/aesthetic reasons. (Cosmetic procedures are those procedures that improve physical appearance.)
- 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.
- Any Dental Procedure not directly associated with dental disease.
- Any Dental Procedure not performed in a dental setting.
- Procedures that are considered to be Experimental, Investigational or Unproven. This includes pharmacological regimens not accepted by the American Dental Association (ADA) 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.

- Any implant procedures performed which are not listed as Covered implant procedures in the Schedule of Covered Dental Services on plans that cover implants.
- Any placement of dental implants, implant supported crowns, abutments and prostheses on plans that do not cover implants.
- Drugs/medications, obtainable with or without a prescription.
- Services for injuries or conditions covered by Workers' Compensation or employer liability laws, and services that are provided without cost to the Covered Person by any municipality, county or other political subdivision. This exclusion does not apply to any services covered by Medicaid or Medicare.
- Setting of facial bony fractures and any treatment associated with the dislocation of facial skeletal hard tissue.
- Treatment of benign neoplasms, cysts or other pathology involving benign lesions, except excisional removal. Treatment of malignant neoplasms or Congenital Anomalies of hard or soft tissue, including excision.
- Replacement of complete dentures, and fixed and removable partial dentures or crowns, and implants, implant crowns, implant prosthesis and implant supporting structures (such as connectors), if damage or breakage was directly related to provider error. This type of replacement is the responsibility of the Dentist. If replacement is Necessary because of patient non-compliance, the patient is liable for the cost of replacement.
- Services related to the temporomandibular joint (TMJ), either bilateral or unilateral. Upper and lower jaw bone surgery (including that related to the temporomandibular joint). No Coverage is provided for orthognathic surgery, jaw alignment or treatment for the temporomandibular joint.
- Charges for failure to keep a scheduled appointment without giving the dental office 24 hours notice.
- Expenses for Dental Procedures begun prior to the Covered Person becoming enrolled under the Policy.
- Fixed or removable prosthodontic restoration procedures or implant services for complete oral rehabilitation or reconstruction. Employer benefit contracts may vary. Please call **1-800-822-5353** or log on to [uhcdental.com](http://uhcdental.com) to verify benefits for a specific patient.
- Attachments to conventional removable prostheses or fixed bridgework. This includes semi-precision or precision attachments associated with partial dentures, crown or bridge abutments, full or partial overdentures, any internal attachment associated with an implant prosthesis, and any elective endodontic procedure related to a tooth or root involved in the construction of a prosthesis of this nature.
- Procedures related to the reconstruction of a patient's correct vertical dimension of occlusion (VDO).
- Replacement of crowns, bridges, and fixed or removable prosthetic appliances, and implants, implant crowns, implant prosthesis and implant supporting structures (such as connectors) inserted prior to plan Coverage unless the patient has been Covered under the Policy for 12 continuous months. If loss of a tooth requires the addition of a clasp, pontic, and/or abutment(s) within this 12-month period, the plan is responsible only for the procedures associated with the addition.
- Replacement of missing natural teeth lost prior to the onset of plan Coverage until the patient has been Covered under the Policy for 12 continuous months.
- Occlusal guards used as safety items or to affect performance primarily in sports-related activities.
- Placement of fixed partial dentures solely for the purpose of achieving periodontal stability.
- 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 spouse, brother, sister, parent or child.
- Dental Services otherwise Covered under the Policy, but rendered after the date individual Coverage under the Policy terminates, including Dental Services for dental conditions arising prior to the date individual Coverage under the Policy terminates.
- Acupuncture; acupressure and other forms of alternative treatment, whether or not used as anesthesia.
- Orthodontic coverage does not include the installation of a space maintainer, any treatment related to treatment of the temporomandibular joint, any surgical procedure to correct a malocclusion, replacement of lost or broken retainers and/or habit appliances, and any fixed or removable interceptive orthodontic appliances previously submitted for payment under the plan.

- In the event that a Non-Network Dentist routinely waives Copayments and/or the Deductible for a particular Dental Service, the Dental Service for which the Copayments and/or Deductible are waived is reduced by the amount waived by the Non-Network provider.
- Foreign Services are not Covered unless required as an Emergency.
- Dental Services received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country.
- Any Dental Services or Procedures not listed in the Schedule of Covered Dental Services.

## Limitations

- Dental services are covered at the least costly, clinically accepted treatment.
- Oral examinations are covered with a limit of two times per 12 consecutive months.
- Complete series or panoramic radiographs are limited to one time per 36 consecutive months. Exception to the 36-month limit on panoramic radiographs will be made if taken for diagnosis of third molars, cysts or neoplasms.
- Bitewing radiographs are limited to one series of films per plan year.
- Extraoral radiographs are limited to two films per plan year.
- Dental prophylaxes are limited to two times per 12 consecutive months.
- Diagnostic casts are limited to one per 24 consecutive months.
- Fluoride treatment is limited to covered persons under the age of 12 years, and limited to two times per 12 consecutive months. Treatment should be performed in conjunction with dental prophylaxis.
- Sealants are limited to covered persons under the age of 16 years, and once per first or second permanent molar every 36 consecutive months.
- Space maintainers are limited to covered persons under the age of 16 years, once per lifetime. Benefit includes all adjustments within six months of placement.
- Multiple restorations submitted for the same tooth with contiguous surfaces will be treated as a single multi-surface restoration.
- Pin retention is limited to two pins per tooth; not covered in addition to cast restorations.
- Inlays and onlays are limited to one time per 60 consecutive months. Covered only when a filling cannot restore the tooth.
- Crowns are limited to one time per 60 consecutive months. Covered only when a filling cannot restore the tooth.
- Post and cores are covered as a separate benefit only for teeth that have had root canal therapy.
- Sedative fillings are covered as a separate benefit only if no other service, other than X-rays and exam, were performed on the same tooth during the visit.
- Scaling and root planing is limited to one time per quadrant per 24 consecutive months.
- Periodontal maintenance is limited to two times per 12 consecutive months following active and adjunctive periodontal therapy within the prior 24 months, exclusive of gross debridement.
- For full dentures, there are no additional allowances for over-dentures or customized dentures.
- For partial fixed and removable dentures, there are no additional allowances for precision or semi-precision attachments.
- Relining or rebasing dentures is limited to relining performed more than six months after the initial insertion. Limited to one time every 12 consecutive months.
- Repairs and adjustments to full dentures or partial fixed or removable dentures are limited to those performed more than 12 months after the initial insertion. limited to 1 per consecutive 6 months.
- Palliative treatment is covered as a separate benefit only if no other service, other than X-rays and exam, was performed on the same tooth during that visit.
- Occlusal guards are limited to one guard every 36 consecutive months.
- Full-mouth debridement is limited to once every 36 consecutive months.
- General anesthesia is covered only when medically necessary.

## 4.3 Member Appeals and Inquiries

Members and providers acting on a member's behalf have the right to appeal how a claim was paid or how a utilization management decision was made.

Appeals regarding a denial of coverage based on dental necessity must be submitted within 60 days of the date of notification of an adverse decision unless otherwise prescribed by state regulations.

Appeals may be filed in writing or by fax and must include:

- Member name
- Claim ID
- Nature of the appeal including identification of the service
- Appropriate supporting documentation (such as X-rays or periodontal charting) and a narrative stating why the service should be covered.

Appeal reviews will be completed within state mandated time frames upon receipt of all necessary information. Providers and/or members will be notified of an appeal determination within the state law statute requirements.

### Expedited Appeals:

In time-sensitive circumstances in which the time frame for issuing determinations could seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function, an expedited appeal may be requested.

Expedited Appeals may be submitted by the member, the member's representative, or by the practitioner acting on behalf of the member in writing, telephonically, or by fax.

Determinations will be completed within 48 hours of receipt of all required documentation or within the time frame required by state law, statute, or act.

Please refer to the Resources and Services section of this manual for appeal address and fax number information. Our Provider Services line is also available for any questions.

## Section 5: Radiographs

### 5.1 Radiographs

For some procedures, it is required that copies of radiographs are submitted prior to payment. Requirements for radiographs are found at this [LINK](#). Providers should refer to the previously noted link for documentation guidelines before performing a procedure.

Guidelines for providing radiographs are as follows:

- Send a duplicate radiograph instead of the original
- Radiograph must be diagnostic for the condition or site and contain all critical anatomical landmarks
- Radiographs should be labeled with the practice name, member 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.

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: **uhcproviders.com**.



## Section 6: Claim Submission Procedures

### 6.1 Claim Submission Required Elements & Best Practices

#### Dental Claim Form

The most current Dental ADA claim form must be submitted for payment of services rendered or to obtain a Pre-Treatment Estimate.\*

#### Claim Submission Options

##### Electronic Claims

Electronic claims processing requires access to a computer and usually the use of practice management software. Electronically generated claims can be submitted through a clearinghouse or directly to our claims processing system via the Internet. Most systems have the ability to detect missing information on a claim form and notify you when errors need to be corrected. Electronic submission is private as the information being sent is encrypted. Please call **1-877-620-6194** for more information regarding electronic claims submission.

##### Paper Claims

Due to periodic revisions and varying practice management systems, dental insurance claim forms exist in various formats. Use of the most recently revised American Dental Association (ADA), 2012, format is recommended. Claims and pre-treatment estimates can be submitted directly through the portal at [www.uhcdental.com](http://www.uhcdental.com) where you can also upload x-rays, case notes and periodontal charts. The portal will indicate when required information is missing from the submission.

#### Dental Claim Form Required Information

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

##### Header Information

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

##### Subscriber Information

- Name (Last, First, and Middle Initial)
- Address, City, State, ZIP Code
- Date of Birth
- Gender
- Subscriber ID number

##### Member Information

- Name (Last, First, and Middle Initial)
- Address, City, State, ZIP Code
- Date of Birth
- Gender
- Member ID number

##### Primary Payer Information

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

##### Other Coverage

If the member 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.

\*It is recommended that pre-treatment estimates be obtained for high-dollar procedures such as crowns, bridges and dentures.

**Other Insured's Information (only if other coverage exists)**

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

- Name of subscriber / policy holder (Last, First, and Middle Initial)
- Date of Birth and Gender
- Subscriber Identification number
- Relationship to the Member

**Billing Dentist or Dental Entity**

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

- Name
- Address, City, State, ZIP Code
- License number
- TIN
- Phone number

**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
- Address, city, state, ZIP code
- Phone number

**Services Provided**

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

- Procedure date
- Area of oral cavity
- Tooth number or letter and the tooth surface
- Procedure code
- Description of procedure
- Charges for dentist's fee/charges for the procedure.
- Total sum of all charges

**Missing Teeth Information**

When submitting for periodontal or prosthodontic 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.

**Subscriber / Member Authorization**

Signature of subscriber or member authorizing payment of dental benefits is required. A claim form that indicates a signature is "on file" for a particular member will be accepted. The dentist must keep a copy of a signed claim in the member record.

## Paper Claims

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

## By Report Procedures

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

## Using Current ADA Codes

It is expected that providers use Current Dental Terminology (CDT). For the latest dental procedure codes and descriptions, you may order a current CDT book by calling the ADA or visiting the catalog Web site at [www.adacatalog.org](http://www.adacatalog.org).

## Tips on Claim Submission

The National Association of Dental Plans says dentists will be reimbursed more quickly if they include the information below on their dental claim forms.

- Attending dentist information should include dentist’s name, address and tax identification number (TIN). If any of this information has changed from the last submission, or if the payer was not informed of the change, a delay can occur while verification of correct data is made.
- Patient information should include patient’s full name, identification or member number and date of birth and relationship to the insured person (self, dependent or spouse).
- Date of service should be the day on which the service was performed.
- CDT codes of services performed – Dental claim logic systems are designed to read approved current CDT codes according to their definition. Internal codes, outdated codes or codes that are considered an integral part of another procedure can delay a claim while research is conducted.
- Tooth number or quadrant along with the surface, if appropriate, is required to identify where procedure was performed.
- Missing teeth information should be reported on claims for periodontal, prosthodontic (fixed and removable), or implant services procedures, if covered.
- Prior placement date for crowns, bridges – As many plans have frequency limitations on crowns and bridges, it is important to indicate whether this is an initial placement in the claim form box provided. If not an initial placement, the prior placement date should be indicated and an explanation included in the narrative. This is a particular problem when older versions of the ADA claim form are utilized.
- Narratives are an essential ingredient to help the treating dentist explain why a certain procedure was recommended. Payers will not try to validate the course of treatment but will assign benefits according to the plan purchased for that particular patient. If it isn’t part of their benefit design, then the dentist can charge the member accordingly.
- Coordination of benefits – If the patient is covered by more than one dental carrier, or if the procedure is also covered under the patient’s health plan, include any explanation of benefits or remittance notice from the other payer. Payers are required by state law or regulation to coordinate benefits when more than one entity is involved – this is not a payer choice. The objective is to ensure the dentist is reimbursed appropriately by the proper payer first (primary) with any other payer coordinating the benefit on the balance.
- Remarks – The Remarks section of the claim form should only be used to provide additional explanation of the procedures performed. For most payers, information included in this section will remove a claim from auto-adjudication, thus delaying the processing.

### 6.1.A Pre-Treatment Estimate (PTE)

A pre-treatment estimate is a summary estimating how planned treatment will be adjudicated according to the member’s plan design and enrollment status at the time the PTE is reviewed. These estimates may be submitted on an ADA claim form and are not a guarantee of coverage or how the claim will be ultimately adjudicated.

Pre-treatment estimates are strongly encouraged to ensure that both the practice and the member fully understand how benefits will be applied, particularly for high-dollar procedures. Your office is encouraged to use features found on the UnitedHealthcare Web site (uhcdental.com) to do your own pre-treatment estimates. In addition, many practice management systems will perform this function (consult your office's practice management system support organization to determine the capabilities of your office's systems).

If a pre-treatment is older than 90 days, a new PTE must be attained prior to delivering clinical services.

## 6.2 Claims Processing Systems

UnitedHealthcare processes claims using a proprietary claims processing platform. Claims are edited and paid according to ADA Code and Dental Procedures. There are no modifiers associated with this code set.

Claims are edited and paid according to the specific plan design for a member's employer group. Please refer to the Exclusions and Limitations section of this manual for further information or access one of the resources outlined in Section 2.

Any specific plan design questions that would assist you in determining how to administer claims for a particular member can be answered by our Provider Services line.

## 6.3 Electronic Claims Submissions

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 Funds Transfer, which is the ability to be paid electronically directly into your bank account).

UnitedHealthcare partners with electronic clearinghouses to support electronic claims submissions. While the payer ID may vary for some plans, the UnitedHealthcare number is 52133. Please refer to the Important Addresses and Phone Numbers section and Distributor Client List for additional information as needed.

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 or simply register with our preferred vendor.

## 6.4 HIPAA Compliant 837D File

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

## 6.5 HIPAA Compliant 835 File

**An 835 is an electronic remittance detailing payments and/or adjustments including cancellations, recoveries, reversals, etc., made on claims submitted electronically via an 837D transaction file or via paper.**

For practitioners participating in Electronic Payments and Statements (EPS), the 835 file can be accessed via EPS. You must be an EPS participant to access this information.

If you're not already participating with EPS and would like to take advantage of this cost-savings opportunity, simply visit uhcdental.com. The Electronic Payments and Statements section in this manual provides a detailed overview of this service and how to enroll.

For general questions, eligibility and/or claim status inquiries, please call **1-877-620-6194**. Additional tools and resources can also be found online at uhcdental.com.

## 6.6 Paper Claims Submission

To receive payment for services, practices must submit claims via paper or electronically. Network dentists are recommended to submit an American Dental Association (ADA) Dental Claim Form (2012 version or later).

Please refer to section 6.1 for more information on claims submission best practices and required information.

Our Quick Reference Guide will provide you with the appropriate claims address information to ensure your claims are routed to the correct resource for payment.

## 6.7 Coordination of Benefits (COB)

Coordination of Benefits (COB) is used when a member is covered by more than one dental insurance policy. By coordinating benefit payments, the member receives maximum benefits available under each plan. It is each provider's responsibility to assist in correct coordination of benefits by notifying all payers so that claims may be paid correctly.

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

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

## 6.8 Dental Claim Filing Limits and Adjustments

All Dental Claims should be submitted within ninety (90) days from the date of service (30 days is preferred). Payment may be considered after the date of service for up to three hundred and sixty-five (365) days. This may vary for some plans.

All adjustments or requests for reprocessing must be made within sixty (60) days from receipt of payment. An adjustment can be requested telephonically by calling our Provider Servicing team at **1-800-822-5353**.

## 6.9 Claim Adjudication and Periodic Overview

In accordance with UnitedHealthcare's standard practice, clean claims will be adjudicated and paid within five to ten days of receipt (this may vary by state and claim submission and/or payment method).

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 in general, on a daily basis, various samples of claims are selected for quality assurance reviews. QA samples include center-specific claims, adjustments, claims adjudicated

by newly hired claims processors and high-dollar claims. In addition, management selects other areas for review, including customer-specific and processor-specific audits. Management reviews the summarized results and correction is implemented, if necessary.

### Invalid or incomplete claims:

- If claims are submitted with missing information or incomplete claim forms, the claim will be returned or rejected with a request for the missing required information to be sent.
- If the claim is missing a tooth number or surface, a letter will be generated to the provider requesting this information.
- If the procedure code is invalid or expired, a letter will be sent to the provider requesting the appropriate code.
- If there are inadequate provider details to process under the submitting provider, the claim will be returned with a letter requesting appropriate provider information.
- If the member is not found or ineligible, the claim will be returned.

## 6.10 Explanation of Provider Remittance Advice

The Provider Remittance Advice is a claim detail of each member and each procedure considered for payment. Please use these as a guide to reconcile member payments. As a best practice it is recommended that Remittance Advices be kept for future reference and reconciliation.

Below is a list and description of each field:

**PROVIDER OR MBR NAME AND ID NO**

Treating dentist's name, NPI submitted with claim, Member's name and Subscriber's ID number. To conform to HIPAA regulations, the subscriber's alternate ID number is shown in place of the Social Security number.

**GROUP NO**

Group ID number assigned to the member's plan

**CLAIM NO**

Number assigned to the claim

**ADA CODE**

Procedure code submitted pertaining to the service

**DESCRIPTION**

Description of the procedure code

**DATE OF SERVICE**

Date when services were rendered

**TOOTH NO**

Tooth number or the quadrant pertaining to the procedure

**AMOUNT CLAIMED**

Amount submitted by provider

**AMOUNT ALLOWED**

Provider's contracted fee amount

**DEDUCT APPLIED**

Applicable plan deductible

**OTHER INS**

Member's primary insurance if applicable

**MEMBER RESP**

Member's copayment that pertains to the procedure

**AMOUNT PAID**

Claim paid amount

**EOB CODE**

Refers to the explanations provided within the EOB that explain how the procedure adjudicated

## 6.11 Provider Claim Appeal and Inquiry Process

Appeal rights vary by business and/or state. Refer to the appeals language on the back of the EOB for guidance with the appeals processes that are appropriate for each particular claim.

There are two types of provider appeals:

**Utilization Management (UM) Appeal:** Any appeal that is based on dental necessity and/or would require review by a dental clinician. UM appeals must include a narrative and any supporting documentation including X-rays.

**Administrative Appeal:** Appeals that are not based on dental necessity. This type of appeal would include but is not limited to appeals for timely filing of claims, member's eligibility, over/underpayment adjustment requests, etc. Administrative appeals must include a narrative.

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

## Section 7: Quality Management

### 7.1 Quality Improvement Program (QIP) Description

UnitedHealthcare has established and maintains 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 ensure that quality of care is being reviewed; that problems are being identified and that follow up is planned where indicated. The program is directed by state, federal and client requirements. The program addresses various service elements including accessibility, availability and continuity of care. It also monitors the provisions and utilization of services to ensure that professionally recognized standards of care are being met. The QIP Description is reviewed annually and updated as needed.

The QIP includes, but is not limited to, the following goals:

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

A complete copy of our QIP policy and procedure is available upon request by contacting our Provider Services line at **1-800-822-5353**.

### 7.2 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.

The Dental Director and the Credentialing Committee review the information submitted in detail based on approved credentialing criteria. UnitedHealthcare will request a resolution of any discrepancy in credentialing forms submitted. Practitioners have the right to review and correct erroneous information and to be informed of the status of their application. Credentialing criteria are reviewed by advisory committees, which include input from practicing network providers to make sure that criteria are within generally accepted guidelines. You have the right to appeal any recredentialing decision regarding your participation made by UnitedHealthcare based on information received during the recredentialing process. Appeals do not



apply to credentialing providers unless state law dictates otherwise. To initiate an appeal of a recredentialing decision, follow the instructions provided in the determination letter received from the Credentialing Department. Appeals will be accepted and reviewed for states with appeal rights.

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

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

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

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

Recredentialing requests are sent 6 months prior to the recredentialing due date. The CVO will make 3 attempts to procure a completed recredentialing application from the provider, and if they are unsuccessful, UnitedHealthcare 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)

### **Recredentialing**

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



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

We also accept the Council for Affordable Quality Healthcare (CAQH) process for credentialing/recredentialing application submissions, unless state law requires differently.

UnitedHealthcare is committed to supporting the American Dental Association (ADA) and CAQH ProView in streamlining the credentialing process, making it easier for you to complete one application for multiple insurance companies and maintain your credentials in a secure and central location at no cost to you.

If you are new to CAQH ProView, visit [ADA.org/godigital](http://ADA.org/godigital) to get started.

If you are already using CAQH ProView, we are able to accept your CAQH ID number provided that your profile data, credentialing documents and attestation show Complete and Current.

## 7.2.A Confidentiality

Our staff treats information obtained in the credentialing process as confidential. We and our delegates maintain mechanisms to properly limit review of confidential credentialing information. Our contracts require Delegated Entities to maintain the confidentiality of credentialing information.

Credentialing staff or representatives will not disclose confidential care provider credentialing information to any persons or entity except with the express written permission of the care provider or as otherwise permitted or required by law.

## 7.2.B Site Visits

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

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

## 7.3 Grievances

The member grievance process encompasses investigation, review and resolution of member issues related to the plan and/or contracted providers.

Issues are accepted via telephone, fax, email, letter, written grievance form, or through our Web portal. Grievance forms may be requested from our Customer Service Department, Web site or from a contracted dental provider office. UnitedHealthcare does not delegate grievance processing and resolution to any provider group.

All member benefit and quality of care grievances are received and reviewed in accordance with state and federal regulatory and client specific requirements both in terms of the notifications sent and the time frames allowed.

Your office is required to cooperate with UnitedHealthcare's Policies and Procedures; Member rights and Responsibilities; (including grievances) and Dental Records.

UnitedHealthcare shall have access to office records for that purpose and such information obtained from the records shall be kept confidential. Your office is required to comply with UnitedHealthcare's request for patient records and films, etc., within five business days of receiving the request.

Failure to comply will result in the grievance resolution in favor of the member. Additionally, your right to appeal the decision will be considered waived.

UnitedHealthcare recognizes the importance of thoroughly reviewing all appropriate documentation to determine if there are any potentially systemic problems.

Periodic reports on member grievance activities are made to all appropriate committees and the Board of Directors. UnitedHealthcare's Grievance policies are filed with the necessary regulatory agencies when required.

## 7.4 Preventive Health Guideline

The UnitedHealthcare approach to preventive health is a multi-focused strategy which includes several integrated areas. 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. We have a long history of working with customers on education and outreach programs focusing on wellness, oral health management and the relationship between oral disease and overall health.

We strive to ensure that all of our programs and review criteria are based on the most current clinical evidence. The UnitedHealthcare Dental Clinical Policy and Technology Committee (DCPTC) researches, develops and implements the clinical practice guidelines recommendations, based on principles of evidence-based dentistry, that are then reviewed and endorsed by the UnitedHealthcare National Medical Care Management Committee (NMCMC). Our guidelines are consistent with the most current scientific literature, along with the American Dental Association's (ADA's) current CDT- codes and specialty guidelines as suggested by organizations such as the American Academy of Periodontology, American Academy of Pediatric Dentistry, American Association of Endodontists, American College of Prosthodontists and American Association of Oral and Maxillofacial Surgeons. We also refer to additional resources such as the Journal of Evidence Based Dental Practice, the online Library of Medicine, and evidence-based clearinghouses such as the Cochrane Oral Health Group and Centre for Evidence-Based Dentistry. Other sources of input are the respected public health benchmarks, such as Healthy People 2020 and the Surgeon General's Report on Oral Health in America, along with government organizations such as the National Institutes of Health and Center for Disease Control.

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 based on the patient's health history and risk assessment/vulnerability to oral disease 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 based on age, health history, and risk assessment/vulnerability to oral disease. These preventative interventions include but are not limited to regular prophylaxis, fluoride application, placement of sealants, dietary counseling and adjunctive therapies where appropriate.
- Caries Classification and Risk Assessment Systems - methods of caries detection, classification, and risk assessment combined with prevention strategies, can help to reduce patient risk of developing advanced disease and may even arrest the disease process. Consideration should be given to these conservative nonsurgical approaches to early caries; 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.

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

## Section 8: Utilization Management Program

### 8.1 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.

### 8.2 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 over-utilization 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.

### 8.3 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.

### 8.4 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: (bullet) Provider Manual/Standards of Care

- Provider Training
- Continuing Education
- Provider News Bulletins

### 8.5 Fraud and Abuse

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

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

If adverse practice patterns are found, interventions will be implemented on a variety of levels. The first is with the individual practitioners. The emphasis is heavily weighted toward education and corrective action. In some instances, corrective action,

ranging from reimbursement of over payments to additional consideration by UnitedHealthcare's Peer Review Committee – or further action, including potential termination – may be imposed.

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

## 8.6 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 Clinical Policy and Technology Committee, Clinical Affairs 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.

(See Section 4 for treatment codes that require clinical review and documentation requirements)

# Section 9: Evidence-Based Dentistry & the Clinical Policy & Technology Committee

## 9.1 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, 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 UnitedHealthcare 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, 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 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 bimonthly 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 UnitedHealthcare Dentists with diverse dental experience and business background including but not limited to members from Utilization Management and Quality Management.

## Section 10: Practice Capacity & Appointment Scheduling Standards

UnitedHealthcare is committed to ensuring that its providers are accessible and available to their members for the full range of services specified in the UnitedHealthcare Provider Agreement and Provider Manual.

Participating providers must comply with any state-mandated appointment scheduling requirements for emergency care as well as elective or routine care appointments.

In states where there are specified access and availability standards, UnitedHealthcare will monitor the access and availability of our participating providers through a variety of methods, including member feedback/surveys, a review of appointment books, spot checks of waiting room activity, investigation of member complaints and random calls to provider offices. Any noted concerns are discussed with the participating provider(s), and corrective action may be taken.

### Walk-In Appointment Standards

Dental offices that operate by “walk-in” or “first come, first served” appointments are monitored for access and waiting times, where applicable.

### Missed Appointments

Offices should inform patients of office policies relating to missed appointments and any fees that will be incurred.

1. Appointment scheduling guidelines may vary by state. It is recommended that you confirm whether or not the state in which you're providing services has any state-specific mandates.
2. Emergency Care appointments would be needed if a patient is experiencing excessive bleeding, pain or trauma.
3. Providers are encouraged to schedule member appointments appropriately to avoid inconveniencing the members with long wait times in excess of thirty (30) minutes. Members should be notified of anticipated wait times and given the option to reschedule their appointment.

### 10.1.A Appointment Availability Requirements for Connecticut

Effective immediately all PPO Providers in Connecticut are required to follow the required appointment availability standards:

- Urgent appointment wait times within 48 hours.
- Non-urgent appointments for primary care (general dentist) within 10 business days.
- Non-urgent appointments for specialist care within 15 business days.

All Connecticut providers are required to employ an answering service or a telephone answering machine during nonbusiness hours, which provides instructions on how plan enrollees may obtain urgent or emergency care when applicable, how to contact another provider who has agreed to be on call to triage or screen by phone, or if needed deliver urgent or emergency care. We will be conducting a random survey requesting the actual measures.

### 10.1.B Appointment Availability Requirements for Maryland

Effective immediately all PPO Providers in Maryland are required to follow the required appointment availability standards:

- Urgent appointment wait times within 3 calendar days..
- Non-urgent appointments for primary care (general dentist) within 45 calendar days.
- Non-urgent appointments for specialist care within 60 calendar days.

All Maryland providers are required to employ an answering service or a telephone answering machine during nonbusiness hours, which provides instructions on how plan enrollees may obtain urgent or emergency care when applicable, how to contact another provider who has agreed to be on call to triage or screen by phone, or if needed deliver urgent or emergency care. We will be conducting a random survey requesting the actual measures



## 10.2 Emergency Coverage

All network dental providers must be available to members during normal business hours. Providers will provide members access to emergency care 24 hours a day, seven 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.

Member Services, Provider Services and Quality Management staff monitor and document all instances of provider unavailability to ensure continuity of care. UnitedHealthcare conducts periodic surveys to ensure that access and availability standards for members are in compliance with state requirements and UnitedHealthcare standards.

Network dentists are required to participate in all activities related to these surveys. Offices out of compliance will be required to submit a corrective action plan to UnitedHealthcare.

## 10.3 New Associates

As your practice expands and changes, and as new associates are added, please contact us to request an application so that they may be credentialed and listed as participating providers.

It is important to remember that an associate may not see members as a participating provider until he/she has been credentialed by our organization.

If you have any questions or need to receive a copy of our provider application packet, please contact our Provider Services line at **1-855-918-2265**.

## 10.4 Change of Address, Phone Number, Email Address, Fax or Tax Identification Number

As a Participating provider / office, when there are demographic changes within your office, it is important to notify us so we may update our records. This supports accurate claims processing as well as helps to ensure member directories are accurate.

A Participating Provider or an entity delegated to conduct credentialing activities on behalf of UnitedHealthcare is expected to review, update provider records and attest to the information available to UnitedHealthcare members, including the information listed below, on no less than a quarterly basis. You are responsible for notifying UnitedHealthcare of these changes for all of the participating providers. Requests may need to be made in writing with corresponding and/or backup documentation. For your convenience, we have included a Demographics Change Form in the Appendix section of this manual to assist in providing the required information. Examples of changes requiring notification within 30 days of the change to UnitedHealthcare:

- The status as to whether the participating provider is accepting new patients or not.
- The address(es) of the office locations where the participating provider currently practices.
- The phone number(s) of the office locations where the participating provider currently practices.
- The email address of the participating provider.
- If the participating provider is still affiliated with the listed provider groups.
- The specialty of the participating provider.
- The license(s) of the participating provider.
- The tax identification number used by the participant provider.
- The NPI(s) of the participating provider.
- The languages spoken/written by the participating provider of the staff.
- The ages/genders served by the participating provider.
- Office hours (7 days a week)



Changes should be submitted to:

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

Credentialing updates should be sent to:

UnitedHealthcare Credentialing  
 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. Changes may also be faxed to **1-855-363-9691**.

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 **1-855-918-2265** for guidance.

## 10.5 Office Conditions

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

You must submit to us an attestation from each dental office location, that the physical office meets ADA standards or describes how accommodation for ADA standards are made, and that medical record-keeping practices conform with our standards.

## 10.6 Sterilization and Asepsis Control

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

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

While standard practice is for sterilization costs to be included within office procedure charges, should your office charge this fee separately, these fees must be made known to patients in advance. This may not be a covered code on our fee schedules.

## 10.7 Recall System

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

## 10.8 Transfer of Dental Records

Your office shall copy all requested member dental files to another participating dentist as designated by UnitedHealthcare or as requested by the member. The member cannot be held liable for the cost of copying the patient dental files if the member is transferring to another provider. If your office terminates from UnitedHealthcare, dismisses the member from your practice or is terminated by UnitedHealthcare, the cost of copying files shall be borne by your office. Your office shall cooperate with

UnitedHealthcare in maintaining the confidentiality of such member dental records at all times, in accordance with state and federal law.

### 10.9 Nondiscrimination

You will accept members as new patients and provide Covered Services in the same manner as such services are provided to other patients of your practice. You will 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. You will 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.

### 10.10 Cultural Competency

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

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

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

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

## Section 11: Plan Specific Information

### 11.1 Texas Dental Health Maintenance Organization (DHMO)

National Pacific Dental, Inc. (NPD) is the legal entity of UnitedHealthcare's DHMO product located in Texas.

All providers applying to become part of the NPD TX DHMO in-network plan must initially be credentialed then recredentialed every three years. Applications are to be sent to UnitedHealthcare's credentialing office in Concord, CA. All new locations must successfully pass a Facility Site Review prior to activation.

Members must select a Primary Care Provider (PCP) and be assigned to that provider's practice before treatment is rendered. It is important that the provider verify a member's eligibility and assignment prior to providing dental services.

In-network PCPs are reimbursed at a pre-determined fixed rate. The fixed rate, known as capitation, is paid on a per member per month (PMPM) basis, and is based on member eligibility and provider selection. A monthly roster and corresponding capitation check is mailed the first week of each month to participating providers listing membership assigned to their office. Capitation is pre-paid for the month and represents NPD's payment in full.

All in-network providers also receive copayments from members at the time of service. Copayments are payments for covered procedures based on the member's contracted Schedule of Benefits.

NPD has a specialty referral process in place for treatment beyond the scope of the PCP. It is mandatory that all Specialty Referral requests be initiated by the PCP and treatment is authorized by NPD to a contracted DHMO specialist, this does not include pediatric dentist specialty referrals are no longer needed for children up to age 8 to see a pediatric dentist. Children under age 8 who need services of a specialist beyond a pediatric dentist must still obtain a specialty referral. In order to locate an in-network pediatric dentist please instruct the member to contact customer services.

Any unapproved referrals or unauthorized treatment will not be reimbursed by NPD and may become the specialist's financial responsibility. The member is not to be charged for the PCP or specialist's failure to follow the Specialty Referral process.

Plan exclusions and limitations apply. For more information on the National Pacific Dental Texas DHMO, please contact Customer Service at **1-800-232-0990**.

### 11.2 Lincoln Financial Group (LFG)

As a UnitedHealthcare provider you are considered an in-network provider for Lincoln DentalConnect members. As our membership grows, so does business for providers like you, creating more opportunities to welcome new patients to your office. Lincoln Financial Group has launched an online portal that will allow UnitedHealthcare providers to quickly and conveniently verify a patient's dental eligibility. Please go to [www.lfg.com/dentistportal](http://www.lfg.com/dentistportal) to find out whether your patients are covered under a Lincoln dental plan and confirm their benefit levels, frequencies, and date of last service.

Once registered for an online account, you and your staff no longer need to interrupt your busy days to make a phone call or wait for a fax, to make sure a patient has covered. The new Lincoln dental provider portal at [www.lfg.com/dentistportal](http://www.lfg.com/dentistportal) provides the information needed.

#### Submit claims to:

Lincoln Financial Group  
Dental Claims Processing Center  
PO Box 614008  
Orlando, FL 32861-0001  
Electronic Payer ID Number: CX061

#### Question regarding the administration or payment of claims:

Lincoln Financial Group  
Attn: Claim Service Team  
8801 Indian Hills Drive  
Omaha, NE 68114  
Email: [claims@LFG.com](mailto:claims@LFG.com)  
Phone: 1-800-423-2765 select option 3

## Sample ID Cards

**Lincoln DentalConnect****Employer:** ABC Company**Group Policy #:** 00000000 00000000 001234**Employee Name:** Smith, John**Dependent Coverage:** Yes**The Lincoln National Life Insurance Company**

Dental Claims Processing Center  
 P.O. Box 614008, Orlando, FL 32861-0001  
 Fax: 877-843-3945

Providers: please visit: [www.lfg.com/dentistportal](http://www.lfg.com/dentistportal) to verify benefits  
 or Call 800-423-2765 and select option 3  
 Payor ID number: CX061  
 To check for claim status, email: [claims@LFG.com](mailto:claims@LFG.com)

Predetermination of benefits is recommended for any non-emergency treatment costing at least \$300, but does not guarantee coverage of the treatment reviewed. Visit [www.LincolnFinancial.com](http://www.LincolnFinancial.com) to access the *Lincoln DentalConnect*<sup>®</sup> health center website for help with locating a dentist, dental health tips and information, and a dental cost estimator tool. The Lincoln National Life Insurance Company (Fort Wayne, IN) does not conduct business in New York, nor is it licensed to do so. In New York, business is conducted by Lincoln Life & Annuity Company of New York (Syracuse, NY). Both are Lincoln Financial Group<sup>®</sup> companies. Possession of this card is not a guarantee of coverage or benefits.

# Section 12: Medicare Advantage Regulatory Requirements Addendum

## Dental Benefit Providers, Inc., Provider (if applicable)

### Medicare Advantage Regulatory Requirements

This Medicare Advantage Regulatory Requirements Addendum (this “Addendum”) supplements and is made part of the provider agreement (the “Agreement”) between Dental Benefit Providers, Inc. its subsidiaries, and its affiliated companies (collectively, “DBP”) and the provider named in the Agreement (“Provider”).

#### 12.1 Applicability

This Addendum applies to the Covered Services that Provider provides to Medicare Advantage Customers. In the event of a conflict between this Addendum and other appendices or any provision of the Agreement, the provisions of this Addendum shall control except: (1) with regard to Benefit Plans outside the scope of this Addendum; or (2) as required by applicable law.

#### 12.2 Definitions

For purposes of this Addendum, the following terms shall have the meanings set forth below.

**Benefit Plan:** A certificate of coverage, summary plan description, or other document or agreement, whether delivered in paper, electronic, or other format, under which a Payer is obligated to provide coverage of Covered Services for a Customer.

**CMS Contract:** A contract between the Centers for Medicare & Medicaid Services (“CMS”) and a Medicare Advantage Organization for the provision of Medicare benefits pursuant to the Medicare Advantage Program under Title XVIII, Part C of the Social Security Act.

**Cost Sharing:** Those costs, if any, under a Benefit Plan that are the responsibility of the Customer, including deductibles, coinsurance, and copayments.

**Covered Service:** A health care service or product for which a Customer is entitled to receive coverage from a Payer, pursuant to the terms of the Customer’s Benefit Plan with that Payer.

**Customer:** A person eligible and enrolled to receive coverage from a Payer for Covered Services.

**Dual Eligible Customer:** A Medicare Advantage Customer who is: (a) eligible for Medicaid; and (b) for whom the state is responsible for paying Medicare Part A and B Cost Sharing.

**Medicare Advantage Benefit Plans:** Benefit Plans sponsored, issued or administered by a Medicare Advantage Organization as part of the Medicare Advantage program or as part of the Medicare Advantage program together with the Prescription Drug program under Title XVIII, Part C and Part D, respectively, of the Social Security Act (as those program names may change from time to time).

**Medicare Advantage Customer or MA Customer:** A Customer eligible for and enrolled in a Medicare Advantage Benefit Plan in which Provider participates pursuant to the Agreement.

**Medicare Advantage Organization or MA Organization:** For purposes of this Addendum, MA Organization is an appropriately licensed entity that has entered into: (a) a CMS Contract; and (b) a contract with DBP, either directly or indirectly, under which DBP provides certain administrative services for Benefit Plans sponsored, issued, or administered by MA Organization.

**Payer:** An entity obligated to a Customer to provide reimbursement for Covered Services under the Customer’s Benefit Plan, and authorized to access Provider’s services under the Agreement.

## 12.3 Provider Requirements

### 12.3.a Data

Provider shall submit to DBP or MA Organization, as applicable, all risk adjustment data as defined in 42 CFR 422.310(a), and other Medicare Advantage program-related information as may be requested by MA Organization, within the timeframes specified and in a form that meets Medicare Advantage program requirements. By submitting data to DBP or MA Organization, Provider represents to MA Organization, and upon MA Organization's request Provider shall certify in writing, that the data is accurate, complete, and truthful, based on Provider's best knowledge, information and belief.

### 12.3.b Policies

Provider shall cooperate and comply with MA Organization's policies and procedures.

### 12.3.c Customer Protection

Provider agrees that in no event, including but not limited to, non-payment by DBP, MA Organization or an intermediary, insolvency of, MA Organization or an intermediary, or breach by DBP of the Agreement, shall Provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against any MA Customer or person (other than MA Organization or an intermediary) acting on behalf of the MA Customer for Covered Services provided pursuant to the Agreement or for any other fees that are the legal obligation of MA Organization under the CMS Contract. This provision does not prohibit Provider from collecting from MA Customers allowable Cost Sharing. This provision also does not prohibit Provider and an MA Customer from agreeing to the provision of services solely at the expense of the MA Customer, as long as Provider has clearly informed the MA Customer, in accordance with applicable law, that the MA Customer's Benefit Plan may not cover or continue to cover a specific service or services.

In the event of MA Organization's, DBP's or an intermediary's insolvency or other cessation of operations or termination of MA Organization's contract with CMS, Provider shall continue to provide Covered Services to an MA Customer through the later of the period for which premium has been paid to MA Organization on behalf of the MA Customer, or, in the case of MA Customers who are hospitalized as of such period or date, the MA Customer's discharge.

This provision shall be construed in favor of the MA Customer, shall survive the termination of the Agreement regardless of the reason for termination, including DBP's or MA Organization's insolvency, and shall supersede any contrary agreement, oral or written, between Provider and an MA Customer or the representative of an MA Customer if the contrary agreement is inconsistent with this provision.

For the purpose of this provision, an "intermediary" is a person or entity authorized to negotiate and execute the Agreement on behalf of Provider or on behalf of a network through which Provider elects to participate.

### 12.3.d Dual Eligible Customers

Provider agrees that in no event, including but not limited to, non-payment by a State Medicaid Agency or other applicable regulatory authority, other state source, or breach by DBP of the Agreement, shall Provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against any Dual Eligible Customer, person acting on behalf of the Dual Eligible Customer, DBP or MA Organization (unless notified otherwise) for Medicare Part A and B Cost Sharing. Instead, Provider will either: (a) accept payment made by or on behalf of MA Organization as payment in full; or (b) bill the appropriate state source for such Cost Sharing amount. If Provider imposes an excess charge on a Dual Eligible Customer, Provider is subject to any lawful sanction that may be imposed under Medicare or Medicaid. This provision does not prohibit Provider and a Dual Eligible Customer from agreeing to the provision of services solely at the expense of the Dual Eligible Customer, as long as Provider has clearly informed the Dual Eligible Customer, in accordance with applicable law, that the Dual Eligible Customer's Benefit Plan may not cover or continue to cover a specific service or services.

### 12.3.e Eligibility

Provider agrees to immediately notify DBP and MA Organization in the event Provider is or becomes excluded from participation in any federal or state health care program under Section 1128 or 1128A of the Social Security Act. Provider also shall not employ or contract for the provision of health care services, utilization review, medical social work or administrative services, with or without compensation, with any individual or entity that has been excluded from participation in any federal or state health care program under Section 1128 or 1128A of the Social Security Act.

### 12.3.f Laws

Provider shall comply with all applicable federal and Medicare laws, regulations, and CMS instructions, including but not limited to: (a) federal laws and regulations designed to prevent or ameliorate fraud, waste, and abuse, including but not limited to, applicable provisions of federal criminal law, the False Claims Act (31 U.S.C. §3729 et seq.), and the anti-kickback statute (§1128B of the Social Security Act); and (b) HIPAA administrative simplification rules at 45 CFR Parts 160, 162, and 164.

### 12.3.g Federal Funds

Provider acknowledges and agrees that MA Organization receives federal payments under the CMS Contract and that payments Provider receives from or on behalf of MA Organization are, in whole or in part, from federal funds. Provider is therefore subject to certain laws that are applicable to individuals and entities receiving federal funds.

### 12.3.h CMS Contract

Provider shall perform the services set forth in the Agreement in a manner consistent with and in compliance with MA Organization's contractual obligations under the CMS Contract.

### 12.3.i Records

- **Maintenance; Privacy and Confidentiality; Customer Access.** Provider shall maintain records and information related to the services provided under the Agreement, including but not limited to MA Customer medical records and other health and enrollment information, in an accurate and timely manner. Provider shall maintain such records for at least ten (10) years or such longer period as required by law. Provider shall safeguard MA Customer privacy and confidentiality, including but not limited to the privacy and confidentiality of any information that identifies a particular MA Customer, and shall comply with all federal and state laws regarding confidentiality and disclosure of medical records or other health and enrollment information. Provider shall ensure that MA Customers have timely access to medical records and information that pertain to them, in accordance with applicable law.
- **Government Access to Records.** Provider acknowledges and agrees that the Secretary of Health and Human Services, the Comptroller General, or their designees shall have the right to audit, evaluate and inspect any pertinent books, contracts, medical records, patient care documentation and other records and information belonging to Provider that involve transactions related to the CMS Contract. This right shall extend through ten (10) years from the later of the final date of the CMS Contract period in effect at the time the records were created or the date of completion of any audit, or longer in certain instances described in the applicable Medicare Advantage regulations. For the purpose of conducting the above activities, Provider shall make available its premises, physical facilities and equipment, records relating to MA Customers, and any additional relevant information CMS may require.
- **MA Organization Access to Records.** Provider shall grant MA Organization or its designees such audit, evaluation, and inspection rights identified in subsection 3.9(b) as are necessary for MA Organization to comply with its obligations under the CMS Contract. Whenever possible, MA Organization will give Provider reasonable notice of the need for such audit, evaluation or inspection, and will conduct such audit, evaluation or inspection at a reasonable time and place. Provider shall submit medical records of MA Customers to the MA Organization as may be requested, within the timeframes specified, for the purpose of (i) CMS audits of risk adjustment data and (ii) for other purposes medical records from providers are used by MA Organization, as specified by CMS. Provision of medical records must be in the manner consistent with HIPAA privacy statute and regulations.

### 12.3.j MA Organization Accountability; Delegated Activities

Provider acknowledges and agrees that MA Organization oversees and is accountable to CMS for any functions and responsibilities described in the CMS Contract and applicable Medicare Advantage regulations, including those that DBP may sub-delegate to Provider. If DBP has sub-delegated any of MA Organization's functions and responsibilities under the CMS Contract to Provider pursuant to the Agreement, the following shall apply in addition to the other provisions of this Addendum:

- Provider shall perform those delegated activities specified in the Agreement, if any, and shall comply with any reporting responsibilities as set forth in the Agreement.
- If DBP has delegated to Provider any activities related to the credentialing of health care providers, Provider must comply with all applicable CMS requirements for credentialing, including but not limited to the requirement that the credentials of medical



professionals must either be reviewed by MA Organization or its designee, or the credentialing process must be reviewed, pre-approved and audited on an ongoing basis by MA Organization or its designee.

- If DBP has delegated to Provider the selection of health care providers to be participating providers in the MA Organization's Medicare Advantage network, MA Organization retains the right to approve, suspend or terminate the participation status of such health care providers.
- Provider acknowledges that MA Organization or its designee shall monitor Provider's performance of any delegated activities on an ongoing basis. If MA Organization or CMS determines that Provider has not performed satisfactorily, MA Organization may revoke any or all delegated activities and reporting requirements. Provider shall cooperate with MA Organization and DBP regarding the transition of any delegated activities or reporting requirements that have been revoked by MA Organization.

### 12.3.k Subcontracts

If Provider has any arrangements, in accordance with the terms of the Agreement, with affiliates, subsidiaries, or any other subcontractors, directly or through another person or entity, to perform any of the services Provider is obligated to perform under the Agreement that are the subject of this Addendum, Provider shall ensure that all such arrangements are in writing, duly executed, and include all the terms contained in this Addendum. Provider shall provide proof of such to DBP or MA Organization upon request. Provider further agrees to promptly amend its agreements with subcontractors, in the manner requested by MA Organization or DBP, to meet any additional CMS requirements that may apply to the services.

### 12.3.l Offshoring

Unless previously authorized by MA Organization in writing, all services provided pursuant to the Agreement that are subject to this Addendum must be performed within the United States, the District of Columbia, or the United States territories.

## 12.4 Other

### 12.4.a Payment

MA Organization or its designee shall promptly process and pay or deny Provider's claim no later than sixty (60) days after MA Organization or its designee receives all appropriate information as described in MA Organization's administrative procedures. If Provider is responsible for making payment to subcontracted providers for services provided to MA Customers, Provider shall pay them no later than sixty (60) days after Provider receives request for payment for those services from subcontracted providers.

### 12.4.b Regulatory Amendment

Upon the request of MA Organization, DBP may unilaterally amend this Addendum to comply with applicable laws and regulations and the requirements of applicable regulatory authorities, including but not limited to CMS. DBP or MA Organization shall provide written or electronic notice to Provider of such amendment and its effective date. Unless such laws, regulations or regulatory authority(ies) direct otherwise, the signature of Provider will not be required in order for the amendment to take effect.



## Section 13: Appendix — Provider Information

### 13.1 Definitions

#### 13.1.A Preferred Provider Organizations (PPO)

In PPO plans, practitioners treat members at an agreed-upon rate for each procedure. There is an annual maximum of benefit paid out by the plan that varies by employer group. Typically, fees are paid partially by the member and partially by the insurance company.

Distinctions among the different types of plans are as follows:

**Traditional PPO Plans** – Members can seek care and still receive benefits if they go out of network. However, members' out-of-pocket expenses are less if they seek care from a participating dentist who charges contracted rates.

**Incentive PPO Plans** – Members have a richer benefit level (percentage covered) if they seek care at a participating dental office.

**Passive PPO Plans** – Members have the same benefit level (percentage covered) whether or not they use a participating office. However, if the member seeks care from a participating dentist, his/her out-of-pocket costs are lower.

**In-Network Only (INO) Plans** – Members only receive benefits if a participating dentist provides care. The plan benefits are the same as for the PPO network, with deductibles, maximums and coinsurance payments. Members must be referred to participating specialists (excluding orthodontists) under this plan to receive benefits.

Participating practitioners in these and other plans offered receive free advertising through online and print directory publications, and gain access to hundreds of employees within the local community.

#### 13.1.B Dental Health Maintenance Organization (DHMO) Networks

DHMO plans offer a method of provider reimbursement wherein the insurance carrier or HMO pays the practitioner a fixed rate per month for assigned eligible members regardless of the utilization of dental services. In these plans, members select a designated primary care dentist that they access for all preventive, diagnostic and restorative care.

Practitioners who participate with these plans receive a single monthly payment (capitation amount) along with a roster of assigned members. This is paid whether the member accesses care or not.

Covered services are provided by the practitioner at no additional charge to the member unless otherwise stated on the plan fee schedule. In some instances, there are member and/or plan copayments to offset the cost of a procedure.

In a DHMO plan, the members must only visit dentists that are part of their DHMO network. Members must be assigned to a practice before treatment is rendered.

**For certain procedures, referrals to a specialist may be needed. Our provider Web site and Provider Services line can help in locating specialists available within the member's plan.**

#### 13.1.C Discount Plans

Discount Plans differ from traditional plans in that there are no claims to file or submit, and they are not insurance plans. The payment comes directly and solely from the member at the time of service. The member (or spouse/dependent) is entitled to a discount in accordance with the terms of your contract with UnitedHealthcare. The fee schedule is exactly the same as the UnitedHealthcare PPO fee schedule.

Members are educated to understand that the discount plans are not insurance and they are expected to pay in full upon delivery of service.

#### 13.1.D Private Label Clients

UnitedHealthcare partners with other insurance carriers and entities to assist in providing access to dental care through our network. In addition, they leverage our dental claims adjudication capabilities. In some instances, these carriers or entities retain

their own company and/or product brand and the UnitedHealthcare relationship is invisible to their members. When other insurance carriers or entities use our network in this manner, it is referred to as a Private Label Arrangement.

As a participating practitioner with the National PPO Plan, you will have access to private label members using the same contracted fee schedule that is outlined in your agreement. Private label members seeking treatment may show a membership identification card that is different from the typical UnitedHealthcare identification card. However, our name and information will appear on the back of the ID card so that you know which network the member is covered through.


Please see the Client (Distributor) Reference Guide in prior sections of this manual for examples of private label carriers we partner with.

### **13.1.E Distributor Clients**

Distributor clients are clients who have contracted with UnitedHealthcare to utilize our network of dental practitioners, in much the same way as any other PPO client contracts with us to use our dental network. The distinction is that the claims are processed by the Distributor Client. The allowed amounts paid are in accordance with the terms of your agreement with UnitedHealthcare. The fee schedule is the exact same as the UnitedHealthcare PPO fee schedule.

## Attachments

### 13.2 Demographics Change Form

| Provider Information Demographic Change Submission Form                                                                                                                                                                                                                                                                                                                                                                                                                                      |                    |                                                                                                                                                                 |               |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------|
| <b>Description of when to use form:</b> to be used by provider if the provider has made changes to ANY of their demographic information (name change, address change, TIN change, etc.). <i>Form must be signed at bottom to be processed. Failure to sign will delay your request.</i>                                                                                                                                                                                                      |                    |                                                                                                                                                                                                                                                    |               |
| <b>Providers:</b> To ensure your claims are processed correctly and on a timely basis, if you have had any changes to your demographic information, please ensure you submit your demographic changes <b>PRIOR</b> to submitting your claim(s) and within 30 days of the change taking place. <b>For</b> realtime updates and to reduce turn around times by 3-5 days, please visit Self Service section after registration and log in on <a href="http://uhcdental.com">uhcdental.com</a> . |                    |                                                                                                                                                                                                                                                    |               |
| Please check <b>ALL</b> the demographic items that <b>need</b> to be updated and complete all sections as appropriate. Please submit completed form using one of the methods to the right:<br>Request Number (if given by Customer Service): _____                                                                                                                                                                                                                                           |                    | <b>Mailing Address:</b> Dental Benefit Providers, Inc. (DBP-CA Inc)<br>ATTN: Dental Provider Services<br>PO Box 30567, Salt Lake City UT 84130<br><b>Fax:</b> 248-733-6372<br><b>Email:</b> <a href="mailto:dbpprvfx@uhc.com">dbpprvfx@uhc.com</a> |               |
| <input type="checkbox"/> Please check box if making a TIN (Tax ID Number) change. <i>Copy of updated W-9 form is required.</i>                                                                                                                                                                                                                                                                                                                                                               |                    |                                                                                                                                                                                                                                                    |               |
| <b>Current Tax ID</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | <b>New Tax ID</b>  | <b>Effective date of change</b>                                                                                                                                                                                                                    |               |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                    |                                                                                                                                                                                                                                                    |               |
| <input type="checkbox"/> Please check box if making a dentist name change. <i>Copy of updated dental license is required.</i>                                                                                                                                                                                                                                                                                                                                                                |                    |                                                                                                                                                                                                                                                    |               |
| <b>Current Name:</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                    | <b>Current Name:</b>                                                                                                                                                                                                                               |               |
| (Last)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | (First)            | (Last)                                                                                                                                                                                                                                             | (First)       |
| <b>New Name:</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                    | <b>New Name:</b>                                                                                                                                                                                                                                   |               |
| (Last)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | (First)            | (Last)                                                                                                                                                                                                                                             | (First)       |
| <input type="checkbox"/> Please check box if changing specialty. <i>Copy of specialty certification is required.</i>                                                                                                                                                                                                                                                                                                                                                                         |                    | <input type="checkbox"/> Please check box if board certified.                                                                                                                                                                                      |               |
| <input type="checkbox"/> Please check box if making office information change.                                                                                                                                                                                                                                                                                                                                                                                                               |                    |                                                                                                                                                                                                                                                    |               |
| <b>PRACTICE LOCATION</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                    | <b>REMITTANCE ADDRESS</b>                                                                                                                                                                                                                          |               |
| <b>Previous/Current Office Name:</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                    | <b>New Office Name:</b>                                                                                                                                                                                                                            |               |
| <b>Previous/Current Address:</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                    | <b>Previous/Current Address:</b>                                                                                                                                                                                                                   |               |
| (Street #)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | (Suite #)          | (Street #)                                                                                                                                                                                                                                         | (Suite #)     |
| (City)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | (State) (Zip)      | (City)                                                                                                                                                                                                                                             | (State) (Zip) |
| <b>New Address:</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                    | <b>New Address:</b>                                                                                                                                                                                                                                |               |
| (Street #)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | (Suite #)          | (Street #)                                                                                                                                                                                                                                         | (Suite #)     |
| (City)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | (State) (Zip)      | (City)                                                                                                                                                                                                                                             | (State) (Zip) |
| <b>Languages Spoken Other Than English:</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                    | <input type="checkbox"/> Please check box if remittance is same as office location.                                                                                                                                                                |               |
| <b>Phone Number:</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | <b>Fax Number:</b> | <b>Email Address:</b>                                                                                                                                                                                                                              |               |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                    |                                                                                                                                                                                                                                                    |               |
| <b>Effective date of office information change:</b>                                                                                                                                                                                                                                                                                                                                                                                                                                          |                    | <input type="checkbox"/> Please check if office is handicap accessible.                                                                                                                                                                            |               |
| <b>New Office Hours:</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | Mon                | Tue                                                                                                                                                                                                                                                | Wed           |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                    |                                                                                                                                                                                                                                                    |               |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                    |                                                                                                                                                                                                                                                    |               |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                    |                                                                                                                                                                                                                                                    |               |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                    |                                                                                                                                                                                                                                                    |               |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                    |                                                                                                                                                                                                                                                    |               |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                    |                                                                                                                                                                                                                                                    |               |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                    |                                                                                                                                                                                                                                                    |               |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                    |                                                                                                                                                                                                                                                    |               |
| <input type="checkbox"/> Please check box if changing your NPI.                                                                                                                                                                                                                                                                                                                                                                                                                              |                    |                                                                                                                                                                                                                                                    |               |
| <b>New Type 1 NPI:</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                    | <b>New Type 2 NPI:</b>                                                                                                                                                                                                                             |               |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                    |                                                                                                                                                                                                                                                    |               |
| <b>Effective date of NPI change:</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                    |                                                                                                                                                                                                                                                    |               |
| <b>PROVIDER SIGNATURE:</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                    | <b>DATE:</b>                                                                                                                                                                                                                                       |               |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                    |                                                                                                                                                                                                                                                    |               |

## Attachments

## 13.3 Member EOB Sample

20190313-003794 UHC01R 201903135030237500 31366643 03/13/19-FL-N-P--N-N



**EXPLANATION OF  
DENTAL PLAN  
REIMBURSEMENT  
THIS IS NOT A BILL**

Sheet: Page 3 of 4  
Date: 03/13/2019  
Check No: 0011111111  
Check Amt: \$51.10

JOHN DOE DDS  
1234 ANY AVE  
CITY FL 00000-0000

| PROVIDER OR MBR NAME AND ID NO; PROVIDER NETWORK STATUS; GROUP NO; CLAIM NO ADA CODE DESCRIPTION             | DATE OF SERVICE | TOOTH NO | AMOUNT CLAIMED | AMOUNT ALLOWED | DEDUCT APPLIED | OTHER INS | PATIENT RESP | AMOUNT PAID | EOB CODE |
|--------------------------------------------------------------------------------------------------------------|-----------------|----------|----------------|----------------|----------------|-----------|--------------|-------------|----------|
| JOHN DOE NPI Submitted:<br>0000000000<br>MEMBER, JANE 12345670000; Out of Network;<br>11111100; 190000000000 |                 |          |                |                |                |           |              |             |          |
| ADA CODE D2393<br>resin-based composite - three surfaces, posterior                                          | 03/11/19        | 12       | 350.00         | 77.00          | 50.00          | 0.00      | 336.50       | 13.50       | K69      |
| ADA CODE D1110<br>prophylaxis - adult                                                                        | 03/11/19        | 01 32    | 120.00         | 47.00          | 0.00           | 0.00      | 82.40        | 37.60       | PSC      |
| <b>SUB-TOTAL</b>                                                                                             |                 |          | 470.00         | 124.00         | 50.00          | 0.00      | 418.90       | 51.10       |          |

**Notes:**

PSC The charge exceeds the allowable amount for this procedure.

K69 Patient responsible for difference in cost between service rendered and the fee for the service on which the plan benefit is based.

Plan underwritten by UnitedHealthcare Insurance Company

|              | AMOUNT CLAIMED | AMOUNT ALLOWED | DEDUCT APPLIED | OTHER INS | PATIENT RESP | AMOUNT PAID |
|--------------|----------------|----------------|----------------|-----------|--------------|-------------|
| <b>TOTAL</b> | 470.00         | 124.00         | 50.00          | 0.00      | 418.90       | 51.10       |

DEN-PEOB1

## Attachments

### 13.3 Member EOB Sample—continued

Page 4 of 4

For Claim Submissions and ReSubmissions:

To ensure that that your claims are processed in a timely manner, please mail your claims to the following address:

P.O. Box 30567  
Salt Lake City, UT 84130-0567

If your claim has been denied and additional documentation was requested, please mail the additional documentation, with the original ADA claim form, to the same address as the initial claim, (listed above).

Sending correspondence to the appropriate addresses will ensure that your claim or resubmission is reviewed as quickly as possible.

For Appeals:

If you are dissatisfied with the Plan's payment of the claims listed herein, you have the right to file a complaint with the Plan. Written complaints should be mailed to:

Dental Appeals/Complaints  
P.O. Box 30569  
Salt Lake City, UT 84130

(PRC001)

Attachments

13.3 Member EOB Sample—continued

20190313-003794 UHC01R 201903135030237500 31366643 03/13/19-FL-N-P--N-N



EXPLANATION OF DENTAL PLAN REIMBURSEMENT THIS IS NOT A BILL

Sheet: Page 1 of 4
Date: 03/13/2019
Check No: 0011111111
Check Amt: \$51.10

DPS\$\$\$PKG
JOHN DOE DDS
1234 ANY AVE
CITY GA 00000-0000



DEN-PEOB1



Citibank, N.A.
One Penns Way
New Castle, DE 19720

62-20/311 0011111111

Date 03/13/19
PAY: \*\*\*\*\*\$51.10
Void If Not Cashed Within 90 Days

NOT NEGOTIABLE

Pay Fifty One Dollars and Ten Cents

TO THE ORDER OF JOHN DOE DDS
1234 ANY AVE
CITY GA 00000

Authorized Signature Required

## 13.4 Fraud, Waste and Abuse Provider Training

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

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

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

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

[https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Fraud-Waste\\_Abuse-Training\\_12\\_13\\_11.pdf](https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Fraud-Waste_Abuse-Training_12_13_11.pdf)

## 13.5 Determination of “Necessary” Services

A review of an issue for appropriateness of dental services is a prospective or retrospective review performed by licensed dentists who examine the proposed service or submitted claim to determine if the services performed will be/were necessary.

Medical necessity is completed based on the following:

- To ascertain that the procedure meets our clinical criteria, which is approved by the Clinical Policy and Technology Committee, Clinical Affairs 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.

## 13.6 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.

**NY 137 Rule**

If you are a provider in NY who is new to the area or is joining a participating group with the plan, you have a right to provisional credentialing if the process takes more than 90 days.

All written/telephonic inquiries about credentialing or recredentialing must be sent to the following addresses or phone numbers:

**Credentialing Department**

2300 Clayton Road

Suite 1000

Concord, CA 94520

**Phone: 1-855-918-2265**

**Fax: 1-855-363-9691**

**CMS Preclusion List**

The Centers for Medicare and Medicaid Services (CMS) has a Preclusion List effective for claims with dates of service on or after January 1, 2019. The Preclusion List applies to both Medicare Advantage (MA) plans as well as Part D plans.

The Preclusion is comprised of a list of prescribers and individuals or entities who:

- Are revoked from Medicare, are under an active reenrollment bar, and CMS has determined that the underlying conduct that led to the revocation is detrimental to the best interests of the Medicare program; or
- Have engaged in behavior for which CMS could have revoked the prescriber, individual or entity to the extent possible if they had been enrolled in Medicare and that the underlying conduct that would have led to the revocation is detrimental to the best interests of the Medicare program.

Providers receive notification from CMS of their placement on the Preclusion List, via letter, and will have the opportunity to appeal with CMS before the preclusion is effective. There is no opportunity to appeal with UnitedHealthcare. If you are listed on the Preclusion list you cannot participate with any UnitedHealthcare plan.

Through the Preclusion List, which CMS updates monthly, CMS advises MA and Part D plans of the date upon which providers' claims must be rejected or denied due to precluded status ("claim-rejection date"). As of the claim-rejection date, a precluded provider's claims will no longer be paid, pharmacy claims will be rejected, and the provider will be terminated from the United Healthcare network; additionally, the precluded provider must hold Medicare beneficiaries harmless from financial liability for services or items provided on or after the claim-rejection date.





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

UnitedHealthcare Dental® coverage provided by or through UnitedHealthcare Insurance Company, located in Hartford, Connecticut, or its affiliates. Administrative services provided by Dental Benefit Providers, Inc., Dental Benefit Administrative Services (CA only), United HealthCare Services, Inc. or their affiliates. Plans sold in Texas use policy form number DPOL.06.TX (11/15/2006) and associated COC form number DCOC.CER.06.

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