Dental Provider Manual

Dental Benefit Providers of California
DHMO and Direct Compensation

2024

Revised 9/11/2024

United Healthcare® | Dental Benefit Providers® of California

Contents

Section 1: Introduction — who we are

Welcome to Dental Benefit Providers of California, Inc., a UnitedHealthcare Company

Dental Benefit Providers of California, Inc. was established in 1984 in Bethesda, Maryland. As a successful dental managed care company, it was acquired by UnitedHealth Group (UHG) in 1999 and subsequently incorporated into UHG's Specialty Benefits division.

This Provider Manual (the "Manual") is designed as a comprehensive reference guide focusing on Dental Health Maintenance Organizations (DHMO) and Direct Compensation (DC) plans. Here you will find the tools and information needed to successfully administer the Dental Benefit Providers of California DHMO and DC 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 Commercial Preferred Provider Organization (PPO) plan requirements are contained in a separate Provider Manual. If you support our Commercial PPO plan and need that Manual, please log into the Provider Portal at **UHCdental.com** or contact Provider Services 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 Dental Benefit Providers of California provider services team at **1-877-732-4337.**

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

Provider Online Academy

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

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

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

Section 2: Products

Product name / client name	Plan name / copay schedule	Product ID	Agreement ID	PMPM** capitation rate	Minimum guarantee	Supple-mental	Specialty referral	Plan type
UnitedHealthcare	Laguna 110C	D0010897	DMOCARG00001	$3.53	Yes	No	Prior-Auth	Commercial
UnitedHealthcare	Laguna 110C	D0010996	DMOCARG00001	$3.53	Yes	No	Prior-Auth	Commercial
UnitedHealthcare / Lincoln Financial Group	Plan 750C	D0010689	DMOCARG00002	$5.50	Yes	No	Prior-Auth	Commercial
UnitedHealthcare / Lincoln Financial Group	Plan 750C	D0010690	DMOCARG00002	$5.50	Yes	No	Prior-Auth	Commercial
UnitedHealthcare	Malibu 130C	D0010852	DMOCARG00003	$4.12	Yes	No	Prior-Auth	Commercial
UnitedHealthcare	Malibu 130C	D0010999	DMOCARG00003	$4.12	Yes	No	Prior-Auth	Commercial
UnitedHealthcare	Newport 120C	D0010842	DMOCARG00004	$3.85	Yes	No	Prior-Auth	Commercial
UnitedHealthcare	Newport 120C	D0010859	DMOCARG00004	$3.85	Yes	No	Prior-Auth	Commercial
UnitedHealthcare / Lincoln Financial Group	Plan 450C	D0010677	DMOCARG00005	$3.75	Yes	No	Prior-Auth	Commercial
UnitedHealthcare / Lincoln Financial Group	Plan 450C	D0010678	DMOCARG00005	$3.75	Yes	No	Prior-Auth	Commercial
UnitedHealthcare	Santa Cruz 150C	D0010993	DMOCARG00006	$5.25	Yes	No	Prior-Auth	Commercial
UnitedHealthcare	Santa Cruz 150C	D0010994	DMOCARG00006	$5.25	Yes	No	Prior-Auth	Commercial
UnitedHealthcare	Pismo 140C	D0010815	DMOCARG00007	$4.45	Yes	No	Prior-Auth	Commercial
UnitedHealthcare	Pismo 140C	D0010844	DMOCARG00007	$4.45	Yes	No	Prior-Auth	Commercial
UnitedHealthcare / Lincoln Financial Group	Plan 550C	D0010681	DMOCARG00008	$4.25	Yes	No	Prior-Auth	Commercial
UnitedHealthcare / Lincoln Financial Group	Plan 550C	D0010682	DMOCARG00008	$4.25	Yes	No	Prior-Auth	Commercial
UnitedHealthcare / Lincoln Financial Group	Plan 650C	D0010685	DMOCARG00009	$4.60	Yes	No	Prior-Auth	Commercial
UnitedHealthcare / Lincoln Financial Group	Plan 650C	D0010686	DMOCARG00009	$4.60	Yes	No	Prior-Auth	Commercial
UnitedHealthcare	Laguna 110	D0010881	DMOCARG00010	$3.75	Yes	No	Prior-Auth	Commercial
UnitedHealthcare	Laguna 110	D0010995	DMOCARG00010	$3.75	Yes	No	Prior-Auth	Commercial
UnitedHealthcare / Lincoln Financial Group	Plan 450	D0010675	DMOCARG00011	$3.97	Yes	No	Prior-Auth	Commercial

Product name / client name	Plan name / copay schedule	Product ID	Agreement ID	PMPM** capitation rate	Minimum guarantee	Supple-mental	Specialty referral	Plan type
UnitedHealthcare / Lincoln Financial Group	Plan 450	D0010676	DMOCARG00011	$3.97	Yes	No	Prior-Auth	Commercial
UnitedHealthcare	Newport 120	D0010997	DMOCARG00012	$4.07	Yes	No	Prior-Auth	Commercial
UnitedHealthcare	Newport 120	D0010998	DMOCARG00012	$4.07	Yes	No	Prior-Auth	Commercial
UnitedHealthcare / Lincoln Financial Group	Plan 550	D0010679	DMOCARG00013	$4.47	Yes	No	Prior-Auth	Commercial
UnitedHealthcare / Lincoln Financial Group	Plan 550	D0010680	DMOCARG00013	$4.47	Yes	No	Prior-Auth	Commercial
UnitedHealthcare	Pismo 140	D0010898	DMOCARG00014	$4.67	Yes	No	Prior-Auth	Commercial
UnitedHealthcare	Pismo 140	D0011000	DMOCARG00014	$4.67	Yes	No	Prior-Auth	Commercial
UnitedHealthcare / Lincoln Financial Group	Plan 650	D0010683	DMOCARG00015	$4.82	Yes	No	Prior-Auth	Commercial
UnitedHealthcare / Lincoln Financial Group	Plan 650	D0010684	DMOCARG00015	$4.82	Yes	No	Prior-Auth	Commercial
UnitedHealthcare	Santa Cruz 150	D0010971	DMOCARG00016	$5.47	Yes	No	Prior-Auth	Commercial
UnitedHealthcare	Santa Cruz 150	D0010981	DMOCARG00016	$5.47	Yes	No	Prior-Auth	Commercial
UnitedHealthcare	Santa Cruz 150	D0025003	DMOCARG00016	$5.47	Yes	No	Prior-Auth	Commercial
UnitedHealthcare / Lincoln Financial Group	Plan 750	D0010687	DMOCARG00017	$5.72	Yes	No	Prior-Auth	Commercial
UnitedHealthcare / Lincoln Financial Group	Plan 750	D0010688	DMOCARG00017	$5.72	Yes	No	Prior-Auth	Commercial
UnitedHealthcare	Malibu 130	D0011001	DMOCARG00018	$4.34	Yes	No	Prior-Auth	Commercial
UnitedHealthcare	Malibu 130	D0011002	DMOCARG00018	$4.34	Yes	No	Prior-Auth	Commercial
UnitedHealthcare	UHC AON Exchange CA DHMO Plan 130	D0012794	DMOCARG00018	$4.34	Yes	No	Prior-Auth	Commercial
UnitedHealthcare	UHC AON Exchange CA DHMO Plan 130	D0018631	DMOCARG00018	$4.34	Yes	No	Prior-Auth	Commercial
UnitedHealthcare	UHC AON Exchange CA DHMO Plan 130	D0023628	DMOCARG00018	$4.34	Yes	No	Prior-Auth	Commercial
Blue Shield of CA	BSCA FEHBP DHMO Voluntary	D0002313	SCFG00000015	$5.39	No	No	Direct	Commercial
Blue Shield of CA	BSCA Printers Association DHMO Plan 252	D0001267	SCFG00000017	$4.63	No	No	Direct	Commercial
Blue Shield of CA	BSCA Employees DHMO Deluxe	D0001293	SCFG00000019	$6.48	No	No	Direct	Commercial

Product name / client name	Plan name / copay schedule	Product ID	Agreement ID	PMPM** capitation rate	Minimum guarantee	Supple-mental	Specialty referral	Plan type
Blue Shield of CA	BSCA Employees DHMO Deluxe	D0001307	SCFG00000019	$6.48	No	No	Direct	Commercial
Blue Shield of CA	BSCA Custom Plan IFP DHMO	D0001302	SCFG00000030	$5.78	Yes	No	Direct	Commercial
Blue Shield of CA	BSCA Custom Plan IFP DHMO	D0001310	SCFG00000030	$5.78	Yes	No	Direct	Commercial
Pacific Union Dental	Blue Shield High-Option (Dental Plus)	D1000139	SCFG00000160	$6.00	No	No	Prior-Auth	Medicare
Health Net of CA	HN Value DHMO 50	D0005611	SCFG00000189	$4.60	Yes	No	Prior-Auth	Commercial
Health Net of CA	HN Value DHMO 50	D0005612	SCFG00000189	$4.60	Yes	No	Prior-Auth	Commercial
Health Net of CA	HN Value DHMO 85	D0005633	SCFG00000190	$4.00	Yes	No	Prior-Auth	Commercial
Health Net of CA	HN Value DHMO 85	D0005634	SCFG00000190	$4.00	Yes	No	Prior-Auth	Commercial
Health Net of CA	HN Value DHMO 115	D0005625	SCFG00000191	$3.74	Yes	No	Prior-Auth	Commercial
Health Net of CA	HN Value DHMO 115	D0005626	SCFG00000191	$3.74	Yes	No	Prior-Auth	Commercial
Health Net of CA	HN Value DHMO 115	D0005627	SCFG00000191	$3.74	Yes	No	Prior-Auth	Commercial
Health Net of CA	HN Value DHMO 115	D0005628	SCFG00000191	$3.74	Yes	No	Prior-Auth	Commercial
Health Net of CA	HN Value DHMO 150	D0005629	SCFG00000192	$3.22	Yes	No	Prior-Auth	Commercial
Health Net of CA	HN Value DHMO 150	D0005630	SCFG00000192	$3.22	Yes	No	Prior-Auth	Commercial
Health Net of CA	HN Value DHMO 150	D0005631	SCFG00000192	$3.22	Yes	No	Prior-Auth	Commercial
Health Net of CA	HN Value DHMO 150	D0005632	SCFG00000192	$3.22	Yes	No	Prior-Auth	Commercial
Health Net of CA	HN Value DHMO 175	D0005621	SCFG00000193	$3.01	Yes	No	Prior-Auth	Commercial
Health Net of CA	HN Value DHMO 175	D0005622	SCFG00000193	$3.01	Yes	No	Prior-Auth	Commercial
Health Net of CA	HN Value DHMO 175	D0005623	SCFG00000193	$3.01	Yes	No	Prior-Auth	Commercial
Health Net of CA	HN Value DHMO 175	D0005624	SCFG00000193	$3.01	Yes	No	Prior-Auth	Commercial
Health Net of CA	HN Value DHMO 225	D0005617	SCFG00000194	$2.79	Yes	No	Prior-Auth	Commercial
Health Net of CA	HN Value DHMO 225	D0005618	SCFG00000194	$2.79	Yes	No	Prior-Auth	Commercial
Health Net of CA	HN Value DHMO 225	D0005619	SCFG00000194	$2.79	Yes	No	Prior-Auth	Commercial
Health Net of CA	HN Value DHMO 225	D0005620	SCFG00000194	$2.79	Yes	No	Prior-Auth	Commercial
Health Net of CA	HN Value DHMO 275	D0005613	SCFG00000195	$2.64	Yes	No	Prior-Auth	Commercial
Health Net of CA	HN Value DHMO 275	D0005614	SCFG00000195	$2.64	Yes	No	Prior-Auth	Commercial
Health Net of CA	HN Value DHMO 275	D0005615	SCFG00000195	$2.64	Yes	No	Prior-Auth	Commercial
Health Net of CA	HN Value DHMO 275	D0005616	SCFG00000195	$2.64	Yes	No	Prior-Auth	Commercial
Health Net of CA	HN Plus DHMO 85	D0005597	SCFG00000196	$3.58	Yes	No	Direct	Commercial
Health Net of CA	HN Plus DHMO 85	D0005604	SCFG00000196	$3.58	Yes	No	Direct	Commercial
Health Net of CA	HN Plus DHMO 100	D0005602	SCFG00000197	$3.52	Yes	No	Direct	Commercial
Health Net of CA	HN Plus DHMO 100	D0005605	SCFG00000197	$3.52	Yes	No	Direct	Commercial
Health Net of CA	HN Plus DHMO 150	D0005599	SCFG00000198	$3.46	Yes	No	Direct	Commercial
Health Net of CA	HN Plus DHMO 150	D0005603	SCFG00000198	$3.46	Yes	No	Direct	Commercial
Health Net of CA	HN Plus DHMO 150	D0005606	SCFG00000198	$3.46	Yes	No	Direct	Commercial
Health Net of CA	HN Plus DHMO 150	D0005607	SCFG00000198	$3.46	Yes	No	Direct	Commercial

Product name / client name	Plan name / copay schedule	Product ID	Agreement ID	PMPM** capitation rate	Minimum guarantee	Supple-mental	Specialty referral	Plan type
Health Net of CA	HN Plus DHMO 150	D0015602	SCFG00000198	$3.46	Yes	No	Direct	Commercial
Health Net of CA	HN Plus DHMO 150	D0015937	SCFG00000198	$3.46	Yes	No	Direct	Commercial
Health Net of CA	HN Plus DHMO 150	D0015946	SCFG00000198	$3.46	Yes	No	Direct	Commercial
Health Net of CA	HN Plus DHMO 185	D0005601	SCFG00000199	$3.35	Yes	No	Direct	Commercial
Health Net of CA	HN Plus DHMO 185	D0005608	SCFG00000199	$3.35	Yes	No	Direct	Commercial
Health Net of CA	HN Plus DHMO 225	D0005598	SCFG00000200	$3.30	Yes	No	Direct	Commercial
Health Net of CA	HN Plus DHMO 225	D0005600	SCFG00000200	$3.30	Yes	No	Direct	Commercial
Health Net of CA	HN Plus DHMO 225	D0005609	SCFG00000200	$3.30	Yes	No	Direct	Commercial
Health Net of CA	HN Plus DHMO 225	D0005610	SCFG00000200	$3.30	Yes	No	Direct	Commercial
Health Net of CA	HN Plus DHMO 225	D0011399	SCFG00000200	$3.30	Yes	No	Direct	Commercial
Health Net of CA	HN Plus DHMO 225	D0015604	SCFG00000200	$3.30	Yes	No	Direct	Commercial
Health Net of CA	HN Plus DHMO 225	D0015939	SCFG00000200	$3.30	Yes	No	Direct	Commercial
Health Net of CA	HN Plus DHMO 225	D0015945	SCFG00000200	$3.30	Yes	No	Direct	Commercial
Health Net of CA	HN Group Plan 90-SD	D0005636	SCFG00000203	$2.99	Yes	No	Direct	Commercial
Health Net of CA	HN Gemini DHMO 50-S	D0005635	SCFG00000205	$4.22	Yes	No	Prior-Auth	Commercial
Centene	HN IFP DHMO Adult Buy Up	D0013661	SCFG00000206	$1.51	Yes	No	Prior-Auth	Commercial
Health Net of CA	Buy Up Group	D0005644	SCFG00000207	$2.00	No	No	Direct	Medicare
Centene	HN DHMO Medicare Supp Buy Up	D0005662	SCFG00000208	$3.50	No	No	Direct	Medicare
Centene	HN SNP RMC DHMO Supp	D0005663	SCFG00000208	$3.50	No	No	Direct	Medicare
Health Net of CA	Boeing DHMO Buy Up Group	D0011500	SCFG00000219	$2.00	No	No	Direct	Medicare
Health Net of CA	HN Value DHMO 115 (UC Post)	D0012811	SCFG00000221	$3.74	Yes	No	Prior-Auth	Commercial
Blue Shield of CA	BSC SG DHMO Basic	D0013872	SCFG00000268	$4.26	Yes	No	Direct	Commercial
Blue Shield of CA	BSC SG DHMO Plus	D0013873	SCFG00000269	$6.12	Yes	No	Direct	Commercial
Blue Shield of CA	BSC SG DHMO Deluxe	D0013874	SCFG00000270	$6.48	Yes	No	Direct	Commercial
Blue Shield of CA	BSC SG DHMO Voluntary	D0013875	SCFG00000271	$5.39	Yes	No	Direct	Commercial
Blue Shield of CA	EHB DHMO Pediatric	All E Product IDs	SCFG00000272 SCFG00000273 SCFG00000282 SCFG06990ST1	$0.00 (Adult) $3.28 (Child 0-19)	Yes	No	Prior-Auth	EHB
Blue Shield of CA	BSC IFP Enhanced DHMO	D0014799	SCFG00000274	$5.08	Yes	No	Direct	Commercial

Product name / client name	Plan name / copay schedule	Product ID	Agreement ID	PMPM** capitation rate	Minimum guarantee	Supple-mental	Specialty referral	Plan type
Blue Shield of CA	65 Plus Optional Supplemental	D0013613	SCFG00000275	$6.00	No	No	Direct	Medicare
Blue Shield of CA	65 Plus Optional Supplemental	D0033014	SCFG00000275	$6.00	No	No	Direct	Medicare
Blue Shield of CA	BSC DHMO Core Basic	D0031446	SCFG00000278	$4.26	Yes	No	Direct	Commercial
Blue Shield of CA	BSC DHMO Core Basic	D0031768	SCFG00000278	$4.26	Yes	No	Direct	Commercial
Blue Shield of CA	BSC DHMO Core Plus	D0031449	SCFG00000279	$6.12	Yes	No	Direct	Commercial
Blue Shield of CA	BSC DHMO Core Plus	D0031782	SCFG00000279	$6.12	Yes	No	Direct	Commercial
Blue Shield of CA	BSC DHMO Core Deluxe	D0031448	SCFG00000280	$6.48	Yes	No	Direct	Commercial
Blue Shield of CA	BSC DHMO Core Deluxe	D0031771	SCFG00000280	$6.48	Yes	No	Direct	Commercial
Centene Health Net of CA	EHB DHMO	All other E Product IDs	SCFG00000284	$0 (Adult) $2.45 (Child 0-19)	Yes	No	Prior-Auth	EHB
Centene	Jade and Amber SNP CHF Core	D0011953	SCFG00000285	$3.50	Yes	No	Direct	Medicare
Centene	Jade and Amber SNP CHF Core	D0016391	SCFG00000285	$3.50	Yes	No	Direct	Medicare
Centene	Jade and Amber SNP CHF Core	D0016392	SCFG00000285	$3.50	Yes	No	Direct	Medicare
Centene	Medicare DHMO Plan	D0019968	SCFG00000285	$3.50	Yes	No	Direct	Medicare
Centene	Medicare DHMO Plan	D0019969	SCFG00000285	$3.50	Yes	No	Direct	Medicare
Centene Health Net of CA	EHB Tribal DHMO	E0005356	SCFG00000286	$0 (Adult) $2.45 (Child 0-19)	Yes	No	Prior-Auth	EHB
Blue Shield of CA	BSC Core DHMO Standard	D0022851	SCFG00000289	$5.39	Yes	No	Direct	Commercial
Blue Shield of CA	BSC Core DHMO Standard	D0022852	SCFG00000289	$5.39	Yes	No	Direct	Commercial
Blue Shield of CA	BSC Core DHMO Standard	D0031452	SCFG00000289	$5.39	Yes	No	Direct	Commercial
Blue Shield of CA	BSC Core DHMO Standard	D0031770	SCFG00000289	$5.39	Yes	No	Direct	Commercial
Blue Shield of CA	Family Dental Plan - Adult	D0025758	SCFG00000291	$5.73	Yes	No	Prior-Auth	Individual
Blue Shield of CA	Family Dental Plan - Child	D0025758	SCFG00000292	$5.73	Yes	No	Prior-Auth	Individual

Product name / client name	Plan name / copay schedule	Product ID	Agreement ID	PMPM** capitation rate	Minimum guarantee	Supple-mental	Specialty referral	Plan type
UnitedHealthcare	UHC 2019 CA EHB DHMO	All E Product IDs	SCFG00000698	$3.10 (Child 0-19)	Yes	No	Prior-Auth	EHB
Blue Shield of CA	BSC DHMO Core Elite 75	D0031400	SCFG000743T3	$5.39	Yes	No	Direct	Commercial
Blue Shield of CA	BSC DHMO Core Elite 75	D0031767	SCFG000743T3	$5.39	Yes	No	Direct	Commercial
Blue Shield of CA	BSC DHMO Core Elite 100	D0031401	SCFG000744T3	$5.39	Yes	No	Direct	Commercial
Blue Shield of CA	BSC DHMO Core Elite 100	D0031766	SCFG000744T3	$5.39	Yes	No	Direct	Commercial
AARP Medicare Complete Secure Horizons (Ovations)	SH100 Retiree	D0012023	SFSGD0000002	$0.00	No	Yes*	Not Covered	Medicare
UnitedHealthcare (PacifiCare)	UHC DENTAL 144	D0012018	SFSGD0000003	$3.83	No	Yes	Prior-Auth	Commercial
UnitedHealthcare (PacifiCare)	UHC DENTAL 142	D0012017	SFSGD0000007	$3.42	No	Yes	Prior-Auth	Commercial
UnitedHealthcare (PacifiCare)	UHC DENTAL 100	D0012009	SFSGD0000008	$0.00	No	No	Prior-Auth (No Spec Benefit except Ortho)	Commercial
UnitedHealthcare (PacifiCare)	UHC DENTAL 132	D0012013	SFSGD0000013	$3.65	No	Yes	Prior-Auth	Commercial
UnitedHealthcare (PacifiCare)	UHC DENTAL 140	D0012015	SFSGD0000014	$2.41	No	Yes	Prior-Auth	Commercial
UnitedHealthcare (PacifiCare)	UHC 590H	D0012027	SFSGD0000015	$6.00	No	No	Prior-Auth	Commercial
UnitedHealthcare (PacifiCare)	UHC DENTAL 142 FEDS	D0012016	SFSGD0000016	$3.65	No	Yes	Prior-Auth	Commercial
UnitedHealthcare (PacifiCare)	UHC DENTAL 146	D0012020	SFSGD0000018	$4.80	No	Yes	Prior-Auth	Commercial
UnitedHealthcare (PacifiCare)	UHC DENTAL 160	D0012002	SFSGD0000019	$3.09	No	No	Prior-Auth (No Spec Benefit except Ortho)	Commercial
UnitedHealthcare (PacifiCare)	UHC DENTAL 161	D0012003	SFSGD0000020	$4.94	No	No	Prior-Auth	Commercial

**Minimum guarantee applies to ADA code D0999 only ($2.00 Encounter Reimbursement)
**Per Member/Per Month (PMPM) Capitation Rates

Product name / client name	Plan name / copayment schedule	Product ID	Compensation	Specialty referral process	Plan type
UnitedHealthcare	CA 210	D0014420	Relative Value Unit	Pre-Auth	Direct Compensation
UnitedHealthcare	CA 210	D0014421	Relative Value Unit	Pre-Auth	Direct Compensation
UnitedHealthcare	CA 220	D0014422	Relative Value Unit	Pre-Auth	Direct Compensation
UnitedHealthcare	CA 220	D0014423	Relative Value Unit	Pre-Auth	Direct Compensation
UnitedHealthcare	CA 230	D0014424	Relative Value Unit	Pre-Auth	Direct Compensation
UnitedHealthcare	CA 230	D0014425	Relative Value Unit	Pre-Auth	Direct Compensation
UnitedHealthcare	CA 240	D0014454	Relative Value Unit	Pre-Auth	Direct Compensation
UnitedHealthcare	CA 240	D0014455	Relative Value Unit	Pre-Auth	Direct Compensation
UnitedHealthcare	CA 250	D0014456	Relative Value Unit	Pre-Auth	Direct Compensation
UnitedHealthcare	CA 250	D0014457	Relative Value Unit	Pre-Auth	Direct Compensation
UnitedHealthcare	D1076 General Employees Trust Fund	D0018084	Relative Value Unit	Pre-Auth	Direct Compensation
UnitedHealthcare	D1077 General Employees Trust Fund	D0018085	Relative Value Unit	Pre-Auth	Direct Compensation
UnitedHealthcare	D1048 Plan 240	D0018118	Relative Value Unit	Pre-Auth	Direct Compensation
UnitedHealthcare	D1085 Fresno City Employees Health & Welfare Trust	D0018294	Relative Value Unit	Pre-Auth	Direct Compensation
UnitedHealthcare	D1090 Southwest Carpenters Health	D0019934	Relative Value Unit	Pre-Auth	Direct Compensation
Pacific Union Dental	IMPERIAL	D1000154	Relative Value Unit	Pre-Auth	Direct Compensation
Pacific Union Dental	IMPERIAL	D1000165	Relative Value Unit	Pre-Auth	Direct Compensation
Pacific Union Dental	RFK OPTION 1 (MANAGED CARE)	D1000176	Relative Value Unit	Pre-Auth	Direct Compensation
Pacific Union Dental	VENTURA	D1000182	Relative Value Unit	Pre-Auth	Direct Compensation
Pacific Union Dental	RFK OPTION 2 (MANAGED CARE)	D1000224	Relative Value Unit	Pre-Auth	Direct Compensation
Pacific Union Dental	RFK OPTION 3 (MANAGED CARE)	D1000225	Relative Value Unit	Pre-Auth	Direct Compensation
Pacific Union Dental	RFK OPTION 4 (MANAGED CARE)	D1000226	Relative Value Unit	Pre-Auth	Direct Compensation
Pacific Union Dental	AVALON 200	D1000290	Relative Value Unit	Pre-Auth	Direct Compensation
Pacific Union Dental	FOSTER FARMS	D1000385	Relative Value Unit	Pre-Auth	Direct Compensation
Pacific Union Dental	NAPA REGENCY	D1000387	Relative Value Unit	Pre-Auth	Direct Compensation

Product name / client name	Plan name / copayment schedule	Product ID	Compensation	Specialty referral process	Plan type
Blue Shield of CA	65 Plus Choice Embedded Discount	D0013817	Member Copay Only	No Specialty Care Benefit	Medicare
Pacific Union Dental	Patient's Choice	D1000391	Member Copay Only	Pre-Auth	Commercial
Pacific Union Dental	Individual Advantage	D1000392	Member Copay Only	Pre-Auth (No Ortho)	Commercial
Pacific Union Dental	Patient's Choice	D1000394	Member Copay Only	Pre-Auth (No Ortho)	Commercial

Section 3: Capitation overview

3.1 Capitation

Capitation is an alternative to the traditional PPO/Indemnity insurance system. Under a capitation arrangement, a comprehensive set of dental benefits is provided to the members who have selected a General Dentist as their Primary Care Provider (PCP). The General Dentist is compensated monthly at a predetermined fixed rate. The fixed rate, known as a capitation fee or PMPM (per member per month) is paid for a specific period, usually monthly. In return, the General Dentist's obligation to provide any and all needed dental treatment for these members.

How it works:

1. A capitation roster is mailed in the first couple business days each month. The roster details the capitation being paid for each covered member.
2. The member's eligibility is typically effective the first day of the month.
3. It is important that your facility verify member eligibility prior to treatment.
4. If a member does not show on the roster, we offer several ways to verify eligibility.
   - DBP website at **UHCdental.com**
   - Customer Service
   - Integrated Voice Response (IVR)

Please refer to the IVR and Customer Service telephone numbers found in the Quick Reference Guide under **Section 5.1.**

1. Copayments are due and should be collected from the member at the time services are rendered. Refer to the member's specific dental plan/copayment schedule.
2. Submit general dentistry utilization by submitting an ADA claim form for all plans.
3. If you need to refer the member to a specialist, please follow the "Specialty Referral Criteria" found in Section 6 of this manual.
4. There are two capitation rosters mailed out each month. One will include UnitedHealthcare, Blue Shield of CA, Health Net of CA and PacifiCare DHMO members and the other will include Pacific Union Dental DHMO members only.
5. Some dental practices provide a mailing and a primary (location) address. If the office mailing address is different from primary (location) address, the capitation checks will be mailed to the mailing address and the capitation roster will be mailed to the primary (location) address.
6. From time to time, the client group may be late in reporting eligibility to DBP-CA. As such, DBP-CA will apply a member termination or addition to your capitation payment up to two months from your current month's capitation.

Example:

Member's effective date is 7/1/23.

Member's eligibility received on 8/15/23.

September capitation payment will reflect September capitation plus July and August retro capitation.

3.2 Capitation roster

Your office will receive monthly eligibility lists for DHMO plans on or about the 5th of each month. Please refer to the chart below for information on how to verify member eligibility prior to treatment.

Status	Description	Instructions
"A" – Active	Patient Eligible	Locate AGREEMENT ID on eligibility list and refer to fee schedule for copayments (Ex: SCFG00000019)
"N" – Not Eligible	Patient Not Eligible	Contact DBP-CA with patient information to verify status
"T" – Transferred	Patient Eligible in Another DBP-CA Office	Contact DBP-CA with patient information to verify or change office assignment

Note: In the event that a member presents himself/herself for treatment and does not appear on your current eligibility list, your office should immediately call DBP-CA to obtain eligibility verification, determine the appropriate patient and plan copayments, plan exclusion and limitation and, if deemed eligible for care, treat the member accordingly.

Please refer to the IVR telephone numbers found in the Quick Reference Guide under **Section 5.1.**

Section 4: Direct compensation overview

Direct Compensation (DC) is a unique managed care product that is designed to compensate the dentist on a per procedure basis.

Reimbursement in the Direct Compensation program is funded by a percentage of the Group premiums collected. Specialist claims and Quality Assurance expenses are deducted from this amount and the balance of the premium dollars are placed into a pool and distributed monthly to all treating dentists based on the reported Relative Value Unit (RVU) utilization activity reported each month. See Appendix A: Attachment A.4.a for example.

4.1 IPA (Individual Practice Association)

All membership enrolled in the Direct Compensation product is separated into a number of groupings called IPAs, which can be organized by geography or by employer group.

The IPA is a partnership between DBP-CA and the IPA dentists that manages the patient population and the associated revenue and expenses. Each IPA is managed independently and the participating dentist's compensation is determined by the overall performance of the IPA. Dentists generally participate in multiple IPAs. The dentist's total reimbursement from the Direct Compensation program is the sum of the payments from each of the participating IPAs. Reimbursement is issued separately for each IPA. See Appendix A: Attachment A.4.b for example.

DBP-CA funds the IPA from the insurance premiums and performs the necessary administrative, operational and quality assurance functions. The IPA network dentist manages the patient's care by:

- Providing patient education with a strong preventive orientation
- Controlling the extent of specialist referrals
- Maintaining good patient satisfaction

4.2 Patient Detail Report

The Patient Detail Report is a detail of each patient and each procedure considered for payment during the statement period. See Appendix A: Attachment A.4.c for example. The Plan highly recommends that you keep these reports for future reference and reconciliation.

Production is listed by patient name.

MEMBER ID AND SUFFIX	To conform to HIPAA regulations, the subscriber's alternate ID number is shown in place of the Social Security number. The suffix number is the identifier that indicates each individual member assigned to a subscriber.
THE GROUP#	Prints out the entire group number.
SERVICE DATE	Indicates the Date of Service reported.
QTY	Will always be indicated as 1.
TOOTH NO.	Reports the Tooth Number or the Quadrant pertaining to the service.
PAID AMOUNT	Indicates that a dollar amount other than the RVU value is being paid.
VALUE	Shows the RVU value for the procedure reported.

COPAY	Shows the copayment that pertains to this procedure for this group. Sometimes adjustments may have been made to reflect copayment to align with lower RVU. Please remember to charge the member/patient the applicable copayment as defined on the benefit schedule.
PROC DT	Indicates the date the service was processed for payment.
EOB CODE	Refers to any EOB reason codes that pertain to the reported procedure or coverage.
THE EOB CODE LEGEND	Is printed at the bottom of the page for easy reference.

4.3 Coordination of Benefits for California Direct Compensation

California DC plans do not follow the standard Coordination of Benefits for CA outlined in this manual. The CA DC product always considers the patient to be prime and does not coordinate benefits. The provider is paid only once for each service and should not expect dual payment if both patient and spouse are covered by this product.

The exception is:

- If both Member and Spouse are insured with either Foster Farms or the RFK Farmworkers, then the provider may bill and be paid by the plan the amount of any copayments due from the patient. The plan will pay Direct Compensation for the patient, and pay the copayment under the spouse. If the patient is a child, then the prime (DC) payment will be made using the Birthday Rule, and would be paid under the parent whose birthday falls earliest in the year.
- Provider may only bill for applicable copayments, and may not double bill for RVUs.

4.4 General guidelines for all direct compensation plans

As dentistry is both an art and a science, there are often several clinically acceptable treatment options associated with the repair and restoration of the hard and soft tissues of the oral cavity. To ensure that the Plan delivers acceptable dental benefits in a consistent manner, the following guidelines have been developed. Please be aware that these guidelines are subject to change based upon emerging technologies, outcomes based research and evolving clinical practices.

Optional treatment

To ensure that the Plan is able to provide both comprehensive and cost effective dental benefits, the least expensive generally accepted dental service or plan of treatment shall be considered the “covered benefit”. All other alternative treatments shall be considered “optional treatment (s).” If the Member selects a treatment plan that includes one or more optional treatments, the Member is responsible for any difference in cost(s) between the participating dentist’s Usual, Customary and Reasonable fees (“UCR”) associated with the optional treatment, and the UCR fees associated with the covered benefit, plus any applicable copayment associated with the covered benefit.

In addition to those items identified in the limitations and exclusions, optional treatments shall specifically include any restoration or device placed where the principle benefit is cosmetic enhancement; or the procedure is performed prophylactically to prevent the potential loss of tooth structure.

Treatment planning

The Plan desires to bring and maintain each Member to an optimal level or oral health. To achieve this objective, the Plan recognizes the importance of the dentist-patient relationship in diagnosis, treatment

planning and delivery of necessary services. To assist in this effort, the Plan has established the following treatment priorities:

First priority is to be given to those procedures, which, if not performed in a timely manner, will have an immediate, adverse impact upon a Member's overall oral health. (Examples include treatment of avulsed teeth, gross caries, acute periodontal disease or endodontic infection, and related diagnostic entities.)

Second priority is to be given to the removal and restoration of active pathology. (Examples include the treatment of periodontal disease – gingivitis and periodontitis – and the removal and restoration of dental caries.)

Third priority is given to replacement of missing teeth not causing gross impairment of function. (Examples include bridges, partial dentures and related appliances.)

Exceptions to these planning guidelines may occasionally occur based upon individual circumstances consistent with good dental practices.

Restorative dentistry

General policies

The replacement of any prosthetic device (removable partial denture, full denture, crown or fixed bridge) is only considered to be a covered benefit if the original device is no longer functional and cannot be adequately repaired or relined, if the replacement occurs 5 or more years after the date that the device was originally placed, regardless of payor, and all abutment teeth are periodontally sound and do not require any surgical procedure. Optional treatment includes the use or incorporation of noble metal in the construction of any prosthesis; any device used to secure or temporarily retain a fixed or removable appliance.

Fillings

The Plan provides amalgam (silver) and resin restorations (composites) as covered benefits when the procedure is required to restore tooth structure lost as a result of dental caries or normal masticatory function. Amalgam and resin fillings are the covered restoration when there is enough retentive quality left to retain the filling, i.e. buccal and/or lingual walls are intact. If an adequate restoration can be achieved with either an amalgam or a resin material, all other services (cast restorations, inlays and onlays) are considered optional forms of treatment. Resin restorations (composites) placed on anterior teeth or the facial surfaces of bicuspids are considered covered benefits. Resins are considered optional treatment if they are placed on the occlusal or interproximal surfaces of bicuspids or molars (unless the contracted provider considers this the necessary and appropriate treatment of choice).

Crowns

Crowns (or other cast restorations) are covered benefits only if all of the following criteria are met:

- There is radiographic evidence of enough restorable tooth structure to retain a crown without surgical procedure,
- The remaining alveolar bone and periodontal tissues are adequate to support the crown, and
- The need for the restoration is related to caries or a result of normal masticatory function.
- The expected longevity of the restored tooth is at least 5 years.

Optional treatments for crowns

A crown shall be considered optional treatment if:

- The crown is required as a result of a Member-influenced habit or behavior such as abrasion, erosion, atypical attrition, or bruxism, or if the primary diagnostic justification for a fixed, cast restoration is based upon visible enamel checks, fracture or crazing lines; the presence of existing large restorations without other symptoms or pathology that do not clinically justify the placement of a cast restoration; prevention of a possible cusp or tooth fracture; prevention of possible recurrent caries which are not identifiable by radiograph or clinical exam, or if
- The sole reason for placing a crown is to provide abutment for a posterior bridge or partial denture.
- Optional treatment also includes the use of porcelain or porcelain fused to metal crowns on molars;
- Procedures performed where the primary benefit is cosmetic enhancement, including, but not limited to, remaking crowns where the metal margin is visible due to gingival recession or other reasons, when there is no recurrent decay present;
- Cast restorations solely placed to accommodate removable partial dentures; and
- Cast metal, porcelain or porcelain fused to metal crowns if the beneficiary is 16 or under.

Partial dentures

A removable partial denture (with cast metal framework) is considered the covered benefit rather than a fixed bridge for the replacement of missing teeth if:

- The probability exists that the beneficiary will experience a clear clinical benefit and significantly improve function,
- The prosthesis replaces missing teeth in two quadrants of the same arch,
- Any of the proposed abutments are third molars,
- Three or more adjacent teeth are missing, or
- There is insufficient and/or compromised (periodontally involved) abutment teeth and/or soft tissue necessary to support the placement of a fixed prosthesis.

Optional treatments for partial dentures

Optional treatment includes:

- Crown restoration on abutment teeth, when the crown is needed solely to provide retention for the removable partial denture;
- Specialized acrylic bases such as “Valplast” or others designed for special needs or for a more cosmetic result; and
- Replacement of long-standing missing teeth in an otherwise stable dentition.

Related services for partial dentures

- An acrylic partial denture (with clasps) may be considered a covered benefit for Members presenting with clinically compromised abutment teeth and/or active periodontal disease. In this situation the Member is responsible for paying the applicable copayment associated with a cast metal partial denture.
- Interim Partial Dentures (stayplates) constructed in conjunction with fixed or removable appliances are considered Covered Benefits if employed as a replacement for a tooth extracted under coverage during the healing period or as a space maintainer for beneficiaries under the age of 16, or if it is intended to be used for a minimum of 3 months or longer.

Complete dentures

Complete dentures should be fabricated only after proper case evaluation of the Member and their tissues occur. Age, denture history, adequate ridge, habits, length of time of edentulism, and provider skill and comfort with denture techniques should all be considered prior to consenting to fabricate complete dentures. The provider determines the treatment plan and determines that dentures are a viable treatment with a good chance for success and longevity of at least 5 years. A Member’s desire or request for treatment is only honored insofar as it agrees with generally accepted professional practices.

Optional treatments for complete dentures

Optional treatment includes:

- The use of non-standard techniques including, but not limited to, overdentures with or without attachments, copings, and implants or
- The use of non-standard materials including, but not limited to, characterized resin bases, specialized base materials, or the use of porcelain or special application teeth.
- The fabrication of a complete denture, when, in the opinion of the treating dentist, that an adequate result cannot be obtained or predicted. This includes cases such as inadequate ridge for retention, repeat denture fabrication over recent years, long-standing full or partial edentulism, and/or tongue-thrust or other habits which could contribute to denture failure.

Fixed bridge

Fixed Bridge is considered a covered benefit if the bridge is employed to replace a missing permanent anterior tooth or to replace a single missing permanent molar, in an otherwise intact arch, and is not excluded for other reasons stated herein.

Optional treatments for a fixed bridge

Optional treatment includes:

- Posterior bridges supported by crowns placed on otherwise sound abutment teeth where the sole reason for placing a crown is to support a pontic;

- A fixed bridge placed in the same arch as a partial denture;
- Fixed bridges placed to replace bilaterally missing teeth (e.g. two or more bridges in the same arch);
- A fixed bridge when any of the proposed abutments are third molars; and
- Gnathological recordings, diagnostic study models, and/or equilibrating the dentition;
- Replacement of long-standing missing teeth in an otherwise stable dentition;
- Fixed bridges for patients under age 16 (an allowance will be made for a space maintainer);
- A fixed bridge placed in conjunction with full-mouth reconstruction
- Full mouth reconstruction is defined as any procedure or combination of procedures which results in:
- The placement of five more units of fixed bridgework being placed in a single arch OR more than ten units are being placed in aggregate;
- An increase or decrease in the beneficiary's vertical dimension.

In full-mouth reconstruction cases, an allowance will be made for complete or partial dentures. The Member will be responsible for all additional charges, plus the copayment for the complete or partial dentures allowed.

Oral surgery

Extraction is a covered benefit only when accompanied by associated pathology. The extraction of asymptomatic teeth is not a covered benefit.

Optional treatments for oral surgery

Optional treatment includes:

- The extraction of asymptomatic teeth for preventive purposes;
- Hard and soft tissue grafts in association with extractions.

Periodontics

Prophylaxis ("cleaning"), periodontal pocket charting, periodontal scaling and root planing ("SRP"), oral hygiene instruction ("OHI") are covered benefits considered to be within the scope of the general dentist.

Optional treatments for periodontics

Optional treatment includes:

- Soft tissue management programs (except as identified above),
- Hard and soft tissue grafts including pedicle flaps, and
- All types of temporary or permanent implants
- Guided tissue regeneration
- Crown lengthening procedures
- Prescription and non-prescription medications including mouth rinses, chips, gels, infusions, irrigation and irrigation devices, etc.

Endodontics

Routine endodontic treatment of anterior, bicuspid and uncomplicated first molar teeth are considered within the scope of general dentist. Surgical and retreatment procedures are considered appropriate for referral to an endodontic specialist practice.

Endodontic treatment is a covered benefit if:

- The tooth has a fair or better clinical prognosis and

- The tooth has a reasonable clinical significance and
- There is adequate supporting bone.
- Is restorable with routine restorative procedures, and does not need surgical intervention.

Optional treatments for Endodontics

Endodontic treatment of third molars is considered optional treatment unless the tooth will function as a distal abutment for a qualifying prosthetic device.

Related services (post and cores)

- Post and core procedures are to be performed by the general dentist, unless unusual circumstances can be documented and pre-authorized.
- Buildups are considered part of the post and core procedure.

Section 5: Resources and services

5.1. CA DHMO Quick Reference Guide

Product/client name	Pacific Union Dental Direct Compensation	AARP Medicare Complete (Secure Horizons) DHMO	United-Healthcare Dental (Pacifi-Care Dental)	United-Healthcare Dental	Lincoln Financial Group
Client name on capitation roster	**(Non-Capitated)**	**Ovations**	**United Healthcare UHC Dental Individual Membership**	**United Healthcare**	**Lincoln Financial Group**
Website Offers many time-saving features including eligibility verification, claims status and network specialist locations	**UHCdental.com**				
Using our website to locate dentists including specialists After Login, Select "Dentist Referral" on the left bar. Select the applicable Plan Name listed on the right.	CA Direct Compensation Pacific Union	CA DHMO AARP Medicare Complete	CA DHMO Legacy Pacificare	CA DHMO Plan	
Specialty Referral Process: • **Pre-Authorization:** General Dentist must obtain preauthorization for all specialty services. Services without prior authorization will not be covered. • **Direct Referral:** General Dentist may directly refer a patient to any participating specialist. • **Self Referral:** Member may self-refer to any participating specialist.	Pre-Authorization				
Member ID cards The following brand names are found on the member ID cards for your reference.					
Integrated Voice Response (IVR) System • Enables you to access information 24 hours a day by responding to the system's voice prompts • Obtain immediate eligibility information • Assign a member to your office • Obtain claims status and copies of EOBs • Fax eligibility confirmation directly to the caller	**1-877-732-4337**				**1-888-877-7828**

Product/client name	Pacific Union Dental Direct Compensation	AARP Medicare Complete (Secure Horizons) DHMO	United-Healthcare Dental (Pacifi-Care Dental)	United-Healthcare Dental	Lincoln Financial Group
Dedicated toll free customer service Knowledgeable trained specialists who can handle specific dentist issues such as eligibility, claims and dental plan information	**1-877-732-4337**				**1-888-877-7828**
Provider relations Questions regarding fee schedules, monthly rosters and contracts	**1-877-732-4337**				**1-888-877-7828**
Emergency specialty referral phone number	**1-877-732-4337**				**1-888-877-7828**
Address Encounter Data, Minimum Guarantee/ Supplemental Claims	PO Box 30567, Salt Lake City, UT 84130				
Specialty referral and pre-treatment estimates	PO Box 30552, Salt Lake City, UT 84130				
Written inquiries and appeals	PO Box 30569, Salt Lake City, UT 84130				
Electronic claims submission - Payor ID #	52133				
California Language Assistance Program: If language assistance is required, contact DBP-CA at the number provided on the back of the member's ID Card. You will then be connected with the Language Line, via a customer service representative, where certified interpreters are available to provide telephonic interpretation services.					
Request for specialty referral form and provider manual	**1-877-732-4337**				**1-888-877-7828**

Product/client name	Blue Shield of California			Pacific Union Dental DHMO (Offered to Blue Shield of CA members)	Health Net of California
Client name on capitation roster	**EHB Pediatric DHMO (On Exchange**	**Commercial and EHB Pediatric DHMO (Off Exchange)**	**65 Plus Optional Supplemental**	**Blue Shield High-Option (Dental Plus)**	**Commercial, Medicare and EHB DHMO (Off Exchange**
Client name on capitation roster	Blue Shield of California			Pacific Dental Benefits	Health Net, Inc - California
Website Offers many time-saving features including eligibility verification, claims status and network specialist locations	**UHCdental.com**				
Using our website to locate dentists including specialists After Login, Select "Dentist Referral" on the left bar. Select the applicable Plan Name listed on the right.	Blue Shield Dental HMO		Blue Shield Dental Plus (High Option Plan)		Health Net DHMO CA only

Product/client name	Blue Shield of California			Pacific Union Dental DHMO (Offered to Blue Shield of CA members)	Health Net of California
Specialty Referral Process: • **Pre-Authorization:** General Dentist must obtain preauthorization for all specialty services. Services without prior authorization will not be covered. • **Direct Referral:** General Dentist may directly refer a patient to any participating specialist. • **Self Referral:** Member may self-refer to any participating specialist.	Direct Referral				Pre-Authorization, Direct or Self Referral (Refer to HN of CA copay schedule)
Member ID cards The following brand names are found on the member id cards for your reference.	blue of california * EHB Pediatric DHMO (On Exchange) will also have Covered California logo				Health Net
Integrated Voice Response (IVR) System • Enables you to access information 24 hours a day by responding to the system's voice prompts • Obtain immediate eligibility information • Assign a member to your office • Obtain claims status and copies of EOBs • Fax eligibility confirmation directly to the caller	**1-800-286-7401**	**1-800-585-8111**	**1-888-679-8928**	**1-888-271-4929**	**1-866-249-2382**
Dedicated toll free customer service Knowledgeable trained specialists who can handle specific dentist issues such as eligibility, claims and dental plan information	**1-800-286-7401**	**1-800-585-8111**	**1-888-679-8928**	**1-888-271-4929**	**1-866-249-2382**
Provider relations Questions regarding fee schedules, monthly rosters and contracts	**1-800-286-7401**	**1-800-585-8111**	**1-888-679-8928**	**1-888-271-4929**	**1-866-249-2382**
Emergency specialty referral phone number	**1-800-286-7401**	**1-800-585-8111**	**1-888-679-8928**	**1-888-271-4929**	**1-866-249-2382**
Address Encounter Data, Minimum Guarantee/Supplemental Claims	Blue Shield of CA PO Box 400 Chico, CA 95927-0400	Blue Shield of CA PO Box 272590 Chico, CA 95927		PO Box 30567 Salt Lake City, UT 84130	
Specialty referral and pre-treatment estimates	PO Box 30552, Salt Lake City, UT 84130				

Product/client name	Blue Shield of California	Pacific Union Dental DHMO (Offered to Blue Shield of CA members)	Health Net of California
Written inquiries and appeals	PO Box 30569, Salt Lake City, UT 84130		
Electronic claims submission - Payor ID #	52133		
California Language Assistance Program: If language assistance is required, contact DBP-CA at the number provided on the back of the member's ID Card. You will then be connected with the Language Line, via a customer service representative, where certified interpreters are available to provide telephonic interpretation services.			
Request for specialty referral form and provider manual	**1-800-286-7401**	**1-800-585-8111**	**1-888-679-8928**	**1-888-271-4929**	**1-866-249-2382**

5.2 Integrated Voice Response (IVR) System

We have a toll-free Integrated Voice Response (IVR) system that enables you to access information 24 hours a day, 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. Refer to Section 5.1 CA DHMO Quick Reference Guide for telephone numbers.

5.3 Website UHCdental.com

The Dental Benefit Providers of California website, **UHCdental.com**, offers helpful tools to assist with verifying eligibility, pre-authorization, claim status, remittance, procedure level pricing, fee schedules, benefit information, provider search and much more 24 hours a day, seven days a week.

We also have a self-service feature that allows your office to validate, change and attest to your office information online. We recommend that you validate your demographic information every 90 days. To access this feature, click on Provider Self Service after you register and log in to **UHCdental.com**.

Through this site, you may also enroll in Electronic Payments and Statements (EPS), a free direct deposit service. To obtain the necessary forms and/or complete enrollment for these services, register and log in to **UHCdental.com**, go to Quick Links and click Electronic Payments and Statements. Also refer to Section 5.4 Electronic Payments and Statements for more information.

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

5.4 Electronic payments and statements

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

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

ePayment Center allows you to:

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

To register:

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

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

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

The Zelis Payments advantage:

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

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

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

Section 6: Plan eligibility

Prior to rendering services, you must verify the member's eligibility. Eligibility may be verified one of three ways:

1. At our website (**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.

6.1 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 IVR System.

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: Refer to Section 5.1 CA DHMO Quick Reference Guide

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.

6.2.A Specialty referral processes (Non-emergency)

The general dentist is responsible for performing services specifically listed on the Schedule of Benefits. However, during the course of patient treatment, the general dentist may determine that the services of a specialist are necessary to address the patient's dental needs. Specialty care referral requests are coordinated through the general dentist.

Not all referrals for specialty care are processed in the same manner; therefore it is essential that you check the member's specific Schedule of Benefits to ensure you are following appropriate guidelines for their specialty referral.

Following the completion of specialty services, the referring general dentist is responsible for maintaining the continuity of care, including the coordination and follow up of care for the patient. In almost every situation it is advisable that the contracting general dentist and the contracting specialist consult in order to clarify treatment objectives. The dental plan encourages a close working relationship with communication between referring dentists and specialists to improve treatment outcomes.

Referral requests initiated by contracting specialists providing services to an enrollee, e.g. a periodontist recommending endodontic procedures, must be coordinated and requested through the contracting general dentist.

Direct referral

Some of Dental Benefit Providers of California, Inc. (DBP-CA) managed dental care plans are designed with a direct referral feature. DBP-CA established the direct referral process to facilitate delivery of dental care, to reduce paperwork for the dental office, and to improve customer satisfaction. The Copayment Schedule will verify referral process for each plan found under Section 2: Products. As a general dentist, you may locate a contracting Specialist by visiting **UHCdental.com** or by contacting our customer service department. You may directly refer your DBP-CA patients for routine or emergency specialty care to any of the specialists listed in the Directory on our website, or names you received from customer service, without requesting pre-authorization.

When a routine or emergent specialty care referral is indicated for enrollees whose plan allows for direct referral, the contracting general dentist will:

1. Verify the enrollee's eligibility and coverage of benefits for the proposed dental care services.
2. Select a contracting specialty care dentist from **UHCdental.com** or call the Provider Service number found in Quick Reference Guide under Section 5.1.
3. Complete the Specialty Referral form. All sections of the form must be completed. Refer to Appendix: Attachment A.2 and A.3 for Specialty Referral Forms.
4. Give the Specialty Referral form and all clinical documentation to the patient for transmittal to the specialty care dentist. If time permits, the referring dentist may mail all documentation to the specialty care dentist.
5. The contracting general dentist is responsible to follow up with the patient to assure completion of referred specialty care.

The specialty care dentist should:

6. Verify the enrollee's eligibility and coverage of benefits for the proposed dental care services by calling the Provider Service number found in Quick Reference Guide under Section 5.1.
7. Determine if proposed treatment listed is an appropriate referral. Please refer to Section 6.2.C: Specialty referral criteria.
8. It is advisable that the contracting specialty care dentist and the contracting general dentist consult to clarify treatment objectives. DBP-CA encourages a close working relationship and communication between referring dentists and specialty care dentists to improve treatment outcomes.
9. Provide treatment and submit a dental claim form for payment within ninety (90) days from the date of service, along with the Specialty Referral Form and appropriate clinical documentation, i.e., radiographs, periodontal charting, etc.

10. DBP-CA recommends that your office provide a report to the referring dentist upon completion of treatment.

If there is no specialist in your area, call the Provider Service number found in the Client Quick Reference Guide under Section 5.1 for assistance in locating a specialist and to acquire pre-authorization of this type of referral. If allowed, the non-participating specialist will generally have authorization only for the initial consultation and necessary radiographs. For definitive treatment, additional pre-authorization must be obtained through the same process. If your office refers to nonparticipating specialist, without prior approval from DBP-CA, your office may be financially liable for the difference in fees between participating and nonparticipating specialists.

Complete the specialty referral form in duplicate, retain a copy for your records and give the member a copy to accompany them to the specialty appointment.

Although, pre-authorization of specialty treatment services by a participating specialist is not required, they may submit voluntarily for pre-authorization, particularly for expensive services (exceeding $200).

Direct referrals are subject to retrospective review by DBP-CA Dental Director or Dental Consultant to confirm that the referral guidelines and criteria were met. In cases where the referral was deemed inappropriate, DBP-CA will notify the referring dentist of such determination within thirty (30) days of the completed review. In such cases, the member will be financially responsible only for the applicable copayment and the treating specialist shall receive payment of benefits for covered services. The referring dentist may be subject to a back charge to cover the costs DBP-CA incurred for the inappropriate referral. The referring dentist may appeal the determination in writing via letter, e-mail, or facsimile. DBP-CA will process the appeal request in accordance with any regulatory requirements and existing policies and procedures.

Self referral

Some plans permit the member to self-refer to a contracted specialist. If the member has a plan that allows self-referral, the general dentist should direct the member to review the details of his or her Schedule of Benefits and to call our Dedicated Toll Free Customer Service numbers found in Quick Reference Guide under Section 5.1.

Where self referral is a plan option, the member may go directly to a contracted specialist without prior authorization from the plan. As above, although voluntary, the specialist may submit a request for pre-authorization of specialty services, particularly for expensive services (exceeding $200).

Self-referrals are also are subject to retrospective review by the DBP-CA Dental Director or Dental Consultant to confirm that the referral guidelines and criteria were met. In cases where the referral was deemed inappropriate, DBP-CA will notify the referring dentist of such determination within thirty (30) days of the completed review.

Pre-authorization

For DBP-CA plans that require pre-authorization of benefits prior to referring the patient to a specialty practice, the contracting general dentist will complete the following steps to obtain the preauthorization of benefits for non-emergent services:

1. Verify patient eligibility and plan coverage for dental services. A specialist referral will not be authorized for procedures that are not covered on the enrollee's specific plan.
2. Complete the DBP-CA Specialty Referral Form. Refer to Appendix: Attachment A.2 and A.3 for Specialty Referral Forms.

3. Attach supporting documentation (diagnostic radiographs, pocket charting, if indicated, and any other documentation that supports clinical indication/rationale for the referral). Please label all radiographs with patient name, date taken and your facility's name and address.
4. Have the patient or guardian sign the Specialty Referral Form.
5. Sign the form.
6. Send the form with all documentation attached to the DBP-CA plan address as indicated on the Specialty Referral Form.

Upon receipt of the pre-determination of benefits, the enrollee will contact the specialty office to schedule an appointment for completion of treatment.

Should a situation arise where additional information is required to determine the coverage of benefits, the following should occur:

1. A Pre-Determination of Benefits Form will be generated and mailed to the enrollee indicating that additional information has been requested from the referring dentist.
2. A Pre-Determination of Benefits Form will be sent to the referring general dentist with the original referral request, records and documentation indicating what additional information is required to determine coverage of benefits.

When coverage of benefits is denied, a copy of denial of benefits is generated to the member and referring general dentist. A reconsideration of denied benefits will be re-evaluated by resubmitting the original Specialty Referral Form with all appropriate documentation and any additional information pertinent to the appeal.

6.2.B Emergency specialty referral

A dental emergency is considered to be a patient with:

- Acute pain,
- Fever,
- Swelling,
- Infection and/or,
- Any condition, which a reasonable person under the circumstances believes, if left untreated may result in disability, death, or the delay of treatment would be medically inadvisable.

For such situations, treatment should be limited to services necessary for:

- Relief of pain,
- Control of bleeding,
- Treatment of swelling,
- Treatment of infection, and/or
- Stabilization of trauma and related emergency conditions.

There may be many circumstances when it will be necessary to refer a member to a specialist to receive emergency treatment. The Plan, though, normally expects the general dentist to provide proper stabilization of any situations or conditions to allow the Plan to conduct its review of requests for specialty care. In many cases, it may be appropriate for the general dentist to treat the emergency. Treatment provided by a specialist may be reviewed retrospectively to determine if the treatment could have been provided by the general dentist. As stated in the Provider Agreement, the provider is obligated to provide 24-hour emergency service. There are several ways to ensure the patient this 24-hour accessibility

to emergency care in your office, by provider's office or home recording, pager, cellular phone, or answering service.

In emergency situations requiring pre-authorization of benefits, the contracting general dentist will complete the following actions to obtain a pre-authorization referral number for all emergency appointments (including a consultation with radiographs and/or any treatment rendered), prior to scheduling:

1. Verify member eligibility.
2. Examine the member.
3. Take appropriate radiographs.
4. Render an accurate diagnosis.
5. Develop an emergency treatment plan that is appropriate for the diagnosis and consistent with the overall treatment plan for the member.
6. Perform any appropriate palliative treatment to alleviate pain and or improve/stabilize the condition of the member.
7. For emergency referral authorization while the member is still present in the office, please refer to the Emergency Specialty Referral Phone Number found in the Quick Reference Guide under Section 5.1.
8. Give the appropriate records to the member including x-rays to hand carry to the specialist appointment.
9. For plans where direct referral applies, complete the referral form and refer the member to the specialty office with a copy of the referral form and any necessary clinical documents including x-rays.
10. Give the appropriate records to the member to hand carry to the specialist appointment.

For pre-authorization of benefits, DBP-CA will:

1. Verify member eligibility.
2. Verify member benefits.
3. Assist the referring dentist in identifying a contracted specialist in proximity to the member's home or place of business.
4. Provide the referring dentist with an authorization number, eligibility and member copayment.
5. Mail a Pre-Determination of Benefits Form to the selected specialist the following day. The specialty care dentist may contact our provider hotline directly for pre-authorization of benefits for services other than those listed on the referral form. Please refer to the Provider Services telephone numbers found in the Quick Reference Guide under Section 5.1.

Authorization of benefits for emergency referral is valid for 48 hours

All documentation for emergency referrals is subject to retrospective review. The referring dentist may be financially responsible when the referral for emergency dental services does not fall within plan guidelines

If you have any questions concerning our emergency care guidelines and requirements, please refer to the Provider Relations telephone numbers found in the Quick Reference Guide under Section 5.1.

6.2.C Specialty referral criteria

Please refer to the following criteria to determine the appropriateness of specialty referral for your patient. In order for benefits to apply, the member must be eligible at the time services are rendered.

Endodontic

When appropriate and listed as covered services on the eligible member's plan, the general dentist may refer a member to a contracted specialist who may render treatment when one or more of the following conditions or treatments are indicated. In order for benefits to apply, the member must be eligible at the time services are rendered.

- Teeth with extreme curvature of the roots;
- Teeth with incomplete apex formation;
- Teeth with completely calcified canals (totally obliterated); teeth with partially calcified canals (after a documented unsuccessful attempt to fully negotiate the canals and treat the tooth has been made);
- Retreatments of teeth that have had previous root canal therapy and are exhibiting one or more of the following conditions:
  - Unresolved periradicular pathology with radiographic evidence of a deficiency in the quality of the root canal filling;
  - Teeth with questionable quality root canal therapy treatment planned for restorative or prosthetic procedures; or
  - Persistent symptoms associated with a previously treated tooth when there is reason to question the adequacy of previous endodontic therapy.
- Apicoectomies/retrofills of teeth that meet with one or more of the following conditions:
  - A marked apical or lateral overextension of root canal filling material;
  - A periradicular lesion that is enlarging as noted on follow-up radiographs;
  - A persistent periradicular lesion that has not decreased in size one to two years after the completion of root canal therapy;
  - A persistent sinus tract;
  - An unfilled apical portion of the root canal system or previously treated canal is not accessible because of unusual anatomy or obstruction; or
  - Root amputations.
- Apexification/recalcification procedures.

Non-covered endodontic services may include but, are not limited to (per individual plan):

- Teeth with a poor, guarded or hopeless periodontal or endodontic prognosis;
- Teeth that cannot be adequately restored;
- Teeth that are non-functional and for which no future function is treatment planned (i.e., unopposed third molars); or
- Endodontic consultations for treatments that are not covered benefits.

Oral surgery

When appropriate and listed as covered services on the eligible member's plan, the general dentist may refer a member to a contracted specialist who may render treatment when one or more of the following conditions or treatments are indicated. In order for benefits to apply, the member must be eligible at the time services are rendered.

- Soft tissue/bony impacted third molars and other teeth that have caused or become associated with one or more of the following pathologic conditions:
  - Follicular cysts or tumors;

  - Persistent infection; or
  - Periodontitis caused by or exacerbated by third molars.
- Biopsy of cysts, neoplasms, soft and hard tissue lesions;
- Extractions for a member whose general health necessitates treatment by a specialist (with letter from a physician);
- Soft tissue surgeries including frenulectomy, frenectomy or surgical exposures; and
- Alveoloplasty, exostosis/torus removal.

Non-covered oral surgery services may include but are not limited to (per individual plan):

- The prophylactic removal (elective removal) of third molars, impacted teeth and residual roots impacted in bone;
- Third-molar extractions for orthodontic purposes only (based on the patient's benefit plan);
- Orthognathic surgery;
- Treatment of fractures
- Placement/removal of implants or any other services related to implants.
- Ridge augmentations;
- Treatment of malignancies, cysts, or neoplasms;
- Treatment of TMJ disorders;
- General anesthesia or IV sedation unless otherwise listed as a covered benefit; and
- Oral surgery consultations for procedures that are not covered benefits.

Pediatric dentistry

When appropriate and listed as covered services on the eligible member's plan, the general dentist may refer a member to a contracted specialist who may render treatment when one or more of the following conditions or treatments are indicated. In order for benefits to apply, the member must be eligible at the time services are rendered.

General dentists are expected to provide routine dental care for children. A referral to a pediatric dentist is appropriate when, in the opinion of the general dentist, such referral is warranted. The previous treatment attempt should be documented on the referral form and include the specific date and circumstances. Coverage of benefits to a contracting specialist may be indicated when one or more of the following medically compromised conditions, such as, but not limited to, exists:

- Down syndrome;
- Deafness;
- Autism;
- Multiple sclerosis;
- Mentally/physically disadvantaged;
- Severe medical problems as documented in writing by a licensed treating physician;
- Baby Bottle syndrome (rampant early childhood caries);
- Root canal therapy on permanent teeth with incomplete root formation; or
- Other conditions/syndromes where formation of the teeth is incomplete or inadequate and restoration or removal of most of the teeth will be necessary.

Periodontics

When appropriate and listed as covered services on the eligible member's plan, the general dentist may refer a member to a contracted specialist who may render treatment when one or more of the following conditions or treatments are indicated. In order for benefits to apply, the member must be eligible at the time services are rendered.

- Gingivectomy;
- Soft tissue flap surgery;
- Crown lengthening;
- Mucogingival surgery;
- Osseous surgery;
- Soft tissue grafts;
- Distal wedge procedure; and
- Root amputation/hemisection.
- Consultations for aid in diagnosis: The general dentist may recommend referral to the periodontist when a member presents a periodontal condition in which the general dentist requires assistance to determine the restorability of teeth and/or periodontal diagnosis/treatment plan prior to initial periodontal treatment (i.e., scaling and root planing, etc.). It is important that this be clearly documented on the referral form.

Non-covered periodontal services may include but are not limited to (per individual plan):

- Consultations for non-covered services;
- Splinting;
- Occlusal guards;
- Implant services; and
- Periodontal surgery for teeth with a guarded, poor, or hopeless endodontic, restorative or periodontal prognosis.

Orthodontics

Not all members have orthodontic coverage. Patients with orthodontic coverage must be referred to a contracted orthodontic office.

Restorative and prosthetics

The general dentist is required to perform all appropriate operative, crown, bridge and removable-prosthetic treatment. The general dentist should be proficient in procedures that are considered covered and non-covered benefits. Non-covered procedures should be available to the patient on a fee-for-service basis. Services provided by a prosthodontist are not covered.

Miscellaneous

The general dentist is responsible for providing routine diagnostic procedures and treatment planning, TMJ dysfunction identification, diagnostic therapy, and the coordination of multi-disciplinary treatment as needed. The general dentist is also responsible for providing routine and after hours emergency care.

Section 7: Optional, Upgraded or Alternative Treatment Guideline

IMPORTANT NOTE: The Exclusions & Limitations under each DHMO Plan will vary. Optional treatment does not apply to all plans. Please refer to the member's specific fee schedules.

7.1 Overview

The Plan recognizes that there may be treatment situations when there may be more than one approach to a dental treatment, and both are listed as covered benefits.

Usually, the least expensive, necessary, adequate and appropriate procedure would be considered to be the covered benefit.

"Professionally recognized standards of care" means that the treatment and/or treatment plan could reasonably be expected to be performed by similar dentists in the same area under the similar treatment circumstances.

Some procedures are expressly excluded from coverage as stated in each plan's Exclusions and Limitations. Excluded procedures may be charged at a dentist's Usual, Customary and Reasonable (UCR) fee, as though the service was rendered to a private, fee-for-service patient. The Plan recommends a signed financial disclosure and consent in these cases. A signed and completed Advance Beneficiary Notice (ABN) is required for Medicare members for charges associated with any non covered or optional services.

When a dentist wishes to present care that is considered to be optional, upgraded, or "alternate," the dentist must perform the following:

1. Inform the member of all treatment options available. Present all options in a fair manner, with all necessary information that a person would need to reasonably make the decision. The member cannot be coerced into making the decision for the upgraded or optional service. The decision cannot be based on unfair or inaccurate portrayal of the procedures in question.
2. Explain to the member that, of the multiple covered treatments, the least expensive treatment would be considered the covered treatment; and if the member chooses the more expensive treatment, the member will be financially responsible for the difference.
3. Provide the patient with the amount he/she will ultimately be responsible for. You may do so by following the basic formula listed below.
4. Obtain a signed acknowledgment from the patient for the charges proposed clearly indicating which procedure is optional and not considered a covered benefit.
5. Document in the member's chart any conversations regarding the proposed treatment, the choices, the member's decision, and a signed copy of the financial responsibility acknowledgment. Verbal agreements are less binding and may be subject to interpretation. Written documentation provides the best defense for the dentist.

Upgrade or optional care fee calculation:

Member can be charged:
UCR of upgraded procedure
– UCR of covered benefit procedure
+ Copayment for covered benefit procedure (if any)
= Patient portion

7.2 What should the dental office report on their encounter forms or claim forms?

The Dental Office should report the actual procedure performed on the Member. However, they should write prominently on the face of the claim form or the encounter form, "UPGRADE – BENEFIT IS xxxxxxxxxxx." (i.e. "partial denture," or "base metal crown," or "amalgam") AND WRITE A PROCEDURE CODE NUMBER FOR THE ACTUAL BENEFIT. This way when Provider Compensation sees this on the form the office will be credited for the proper RVU reimbursement, on plans where there is reimbursement, and the system will track the teeth numbers and the accurate record of exactly what treatment was rendered on the member.

Examples of unacceptable applications of this policy:

1. If a provider does not perform silver amalgam restorations, they cannot charge an upgraded fee for a posterior composite, but must charge the member his/her copay for the amalgam restoration.
2. If a provider does not routinely perform base metal crowns, the office cannot charge an upgrade for noble metal (semi-precious) when the semi-precious crown is the crown routinely performed in that office. The office must charge the member his/her copay for the base metal crown.
3. If a provider makes a treatment recommendation based on a diagnosis, then it becomes the prescribed treatment.

Common examples of proper application of this policy:

1. UPGRADE A FILLING TO A CROWN: "You have decay in this tooth. The tooth will hold a filling adequately, and that would be your benefit on your plan in this case. We could do a crown which could provide a more lasting result, and/or a more cosmetic result. We can apply the benefit of a filling toward the charge for the crown, and you would only be responsible for the difference in charges, if you so choose."
2. UPGRADE BASE METAL CROWN TO A DIFFERENT METAL: "Your tooth needs a crown due to the fracture of a section of the tooth. There are several materials that could be used in making this crown. In this case a base metal (non-precious) crown will function adequately for you. We can provide semi-precious or gold as the metal used if you so choose. You would only be responsible for the difference in cost for the different metal."
3. UPGRADE A PARTIAL DENTURE TO A FIXED BRIDGE: "Several teeth are missing in several areas of your upper arch. A removable partial denture will function adequately to replace them and stabilize your bite. If you'd like a fixed (nonremovable) bridge as an alternative procedure, we can apply your benefit for the partial denture toward the bridge and make arrangements for you to pay the difference."
4. UPGRADE SILVER AMALGAM FILLINGS TO POSTERIOR COMPOSITE (TOOTH-COLORED) FILLINGS: "You have several areas of decay which need fillings. There are several materials that can be considered for your fillings. Silver amalgam is a perfectly adequate material and has certain advantages. Your plan covers silver amalgam fillings. If you'd like to have a more cosmetic material, tooth-colored fillings can be placed as an alternative treatment. We will apply your benefit for silver amalgam fillings toward the

tooth-colored "resin composite" fillings, and you would be responsible only for the difference. Which material would you like?"

Sample upgrade calculations:

When a Removable Partial Denture is the covered benefit, and a provider offers the option of fixed bridge, the following calculation would be indicated:

Example of an Upgrade from a Partial Denture (covered) to a Fixed Bridge (optional):

NOTE: Each provider to insert the UCR from his office in the following calculation.

Doctor's UCR for a fixed bridge:	$1,950
Less UCR for a partial denture:	-1,200
Difference charged to member	$750
Plus copayment for partial denture	+340
Total member payment	**$1,090**

Section 8: Claim/encounter submission procedures

All DHMO utilization encounter submissions and minimum guarantee claim submissions should be submitted within thirty (30) days of the date of service. All Direct Compensation claims should be submitted by the 5th day of the month. All claims must list the name of the treating dentist. To ensure that the claim is paid correctly, please make certain that the Tax ID Number (TIN) matches the number that DBP-CA has on file for your office.

Please submit a current ADA claim form to the appropriate address, along with any additional information required, as shown in the table.

- Accuracy in reporting procedure code, procedure description, area of oral cavity, etc, will expedite processing.
- Use the ID number of the Subscriber rather than the spouse or dependent's ID number.
- USE ONLY VALID CDT CODES (Please refer to the most current CDT book). Failure to use a valid code may result in an unreported service.
- Refer to Section 5.1 CA DHMO Quick Reference Guide for claims submission mailing addresses.

8.1 Required documentation for DHMO claims payment:

Procedure	Description	Supplemental information required for payment
Single Unit Fixed Restorations	Crown(s), Core Buildup(s), and/or Post and Core(s)	Labeled and dated pre-operative X-ray(s) Prior placement date(s) if replacing existing crown(s)
Multiple Unit Fixed Restorations	Multiple Crown(s), Fixed Partial Denture Crown(s) and Pontic(s), Core Buildup(s), and/or Post and Core(s)	Mounted, labeled and dated full-arch pre-operative X-rays Prior placement date(s) if replacing existing crown(s) or fixed prosthodontic(s)
Removable Restorations	Full and Partial Dentures	Mounted, labeled and dated full-arch pre-operative X-rays Prior placement date(s) if replacing existing prosthesis
Endodontics	Root Canal Therapy (RCT) and Retreatment of RCT for Permanent Teeth and Endodontic Surgery	Labeled and dated pre- and post-operative X-rays Date of original RCT if performing retreatment
Oral Surgery	Surgical and Impacted Extractions, Alveoplasty, and Pathology	Labeled and dated pre-operative X-rays and narrative where appropriate Pathology reports where appropriate
Pedodontics	All Pedodontic Services	Labeled and dated pre-operative X-rays, when possible Narrative of any existing medical condition/physical limitation and/or inability of patient cooperation
Periodontics	Root Planing and Scaling, Gingivectomy, Crown lengthening, and Periodontal surgery	Mounted, labeled and dated pre-operative X-rays Perio case type Dated periodontal charting Date(s) of prior root planing and scaling by quadrant(s) and re-evaluation date(s)
Anesthesia	General Anesthesia and/or I.V. Sedation	Type and duration of agent and narrative of necessity where appropriate

8.2 Encounter data submissions

Accurate and timely submission of encounter data is critical to analyzing dentist compensation, negotiating group contract renewals, and determining appropriate premium rates, capitation rates and fee schedules.

Encounter reporting is vital. The data collected validates the volume and frequency of dental care delivered. We use the data to justify premium and provider compensation levels as well as to perform quality reviews.

For capitation plans, services that do not require a payment from the plan should be reported on a current ADA claim form. This data should be submitted to DBP-CA on a monthly basis.

In order to submit encounter information, your office will need to utilize a current ADA claim form for all encounter data. The ADA claim needs to be completed like any other claim which would include items such as:

- Subscriber Name
- Subscriber ID
- Subscriber Date of Birth
- Group Name or Number
- Patient's Full Name
- Relationship to Subscriber
- Patient's Date of Birth
- Date of Service
- ADA Code Performed
- Tooth # / Quadrant
- Surface
- Treating Dentist Name
- Dentist Tax I.D. for Billing
- Physical Address
- Billing Address

Encounter data can be submitted via electronic claims as you would do with your fee-for-service claims. Your encounter information submitted via claim form is to be mailed to one of the appropriate Plan addresses in the CA DHMO Quick Reference Guide in Section 5.1.

8.3 Claim submission best practices

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

- Treating 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, are 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.

Notes: The notes 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. A common note added to claims is "Please pay promptly." Adding this note actually has the opposite effect—delaying the claim.

8.4 Coordination of Benefits for California

Occasionally, DBP-CA members have benefit coverage under another dental plan. In this situation, the determination of how much each plan pays or provides in benefits is coordinated between the plans. Coordination of Benefits is regulated for group carriers licensed by the state, so it is largely standardized. The exceptions are for employer-sponsored and collectively bargained (labor union) plans.

This sequential system was developed to determine which benefit plan is primary (the plan which determines its benefit obligation first) and which plan is secondary (the one which determines its benefits obligation second). The coordination of benefits basics are as follows:

- If a member has two HMO dental plans, the Provider will charge the lesser of the two plans' copayments applicable to the services rendered.
- If the other coverage is an indemnity or PPO program, the Plan Provider may use his or her usual and customary fees for submitting insurance claims for covered services, but he or she may not collect more, from both the insurance payments and the member payments combined, than the Provider's usual and customary fee for covered services. Any excess must be returned to the insurance company.
- The member must never be charged more than the listed DBP-CA copayment for any covered service. In the case of dual coverage, the other carrier's payment must always first pay the member's copayment so the member will receive benefit of having both plans.

Coordination of Benefits and the Dental Benefit Providers Dental Plan

Coordination of Benefits can be quite confusing for all parties involved therefore it is important to consider Coordination of Benefits provisions as well as the dental benefits providers' contractual obligations whenever there is double coverage;

- Under the terms of the DBP-CA contracts, the network dentists may never hold a patient financially responsible for more then the patient's benefit schedule amount for the applicable procedure.
- If DBP-CA benefits extend to a spouse and/or other dependents, than those family members are considered DBP-CA members thus, as a DBP-CA member they cannot be held financially responsible for more than the applicable patient scheduled amount.
- A network dentist may not bill any plan or person for services rendered to a DBP-CA member when service is fully covered by DBP-CA monthly capitation. The network dentist contract with DBP-CA prohibits such billing.
- There may be instances when network dentists may bill another plan for services rendered. If the payment is received from the other plan and the sum of the payment plus any patient charge already collected from the DBP-CA member is more than the patient charge, the network dentist must refund to the member the amount of such difference, up to the full patient charge.

8.5 Paper claims submission

To receive payment for services, practices must submit claims via paper or electronically. Network dentists are recommended to submit an American Dental Association (ADA) Dental Claim Form (2019 version or later).

Please refer to section 8.3 for more information on claims submission best practices and required information.

Our Quick Reference Guide in Section 5.1 will provide you with the appropriate claims address information to ensure your claims are routed to the correct resource for payment.

8.6 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).

Dental Benefit Providers of California partners with electronic clearinghouses to support electronic claims submissions. While the payer ID may vary for some plans, the Dental Benefit Providers of California number is 52133. Please refer to our Quick Reference Guide in Section 5.1 or the Client Reference Guide in Appendix A.1 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. The Dental Benefit Providers of California website (**UHCdental.com**) also offers the feature to directly submit your claims online through the provider portal.

Section 9: Member appeals

9.1 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 Quick Reference Guide in Section 5.1 for appeal address and fax number information. Our Provider Services line is also available for any questions.

Section 10: Quality management

Dental Benefit Providers of California 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 conducted where indicated. The Plan is directed by all state, federal, and client requirements. The Plan addresses various service elements including accessibility, availability, and continuity of care. It also monitors the provisions and utilization of services to ensure they met professionally recognized standards of care. The Plan is reviewed and updated annually.

10.1 Quality Improvement Program (QIP) description

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

- To measure, monitor, trend, and analyze the quality of patient care delivery against performance goals and/or recognized benchmarks.
- To foster continuous quality improvement in the delivery of patient care by identifying aberrant practice patterns and opportunities for improvement.
- When indicated, implement improvement plans and document actions taken to increase performance.
- To evaluate the effectiveness of implemented changes to the QI Program.
- To reduce or minimize opportunity for adverse impact to Members.
- To improve efficiency, value, and productivity in the delivery of oral health services.
- To promote effective communications, awareness, and cooperation between Members, participating Providers and the Plan.
- To ensure quality of care, dentists are vetted through a credentialing and recredentialing process.
- To comply with all pertinent legal, professional and regulatory standards.
- To foster the provision of appropriate dental care according to professionally recognized standards.
- 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.
- To communicate results of performance measurement to the committees and Board of Directors

10.2 Credentialing

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

DBP-CA will review all current information relative to your license, sanctions, malpractice insurance coverage, etc. DBP-CA will request a written explanation regarding any adverse incident and its resolution, and corrective action 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 some plans and/or markets. This typically applies to DHMO plans based on the West coast as well as some Medicaid plans. Your Professional Networks Representative will you inform you of any facility visits needed during the recruiting process. Where required, the office

must pass the facility review prior to activation. DBP-CA will request a resolution of any discrepancy in credentialing forms submitted.

The Dental Director and the Credentialing Committee review the information submitted in detail based on approved credentialing criteria. Credentialing criteria are reviewed by advisory committees, which include input from practicing network providers to ensure that criteria are within generally accepted guidelines. You have the right to appeal any decision regarding your participation made by DBP-CA based on information received during the credentialing or recredentialing process. To initiate an appeal of a credentialing or recredentialing decision, please follow the instructions provided in the determination letter received from the Credentialing department.

DBP-CA may contract with an affiliated 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 ensure 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 DBP-CA. Any failure to comply with the recredentialing process constitutes termination for cause under the 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, DBP-CA 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 six months prior to the recredentialing due date. The CVO will make three attempts to procure a completed recredentialing application from the provider, and if they are unsuccessful, DBP-CA will also make an additional three attempts. If there is still no response, a termination letter will be sent to the provider in accordance with the provider agreement.

A list of the documents required for Initial Credentialing and Recredentialing is as follows:

Initial credentialing

- Completed application
- Signed and dated Attestation
- Current copy of state license
- Current copy of Drug Enforcement Agency (DEA) certificate
- Current copy of Controlled Dangerous Substance (CDS) certificate, if applicable
- Malpractice face sheet which shows the provider name on the certificate, expiration dates and limits – limits $1/3m
- Explanation of any adverse information, if applicable
- Five years of work history in month/date format with no gaps of six months or more; if there are gaps, an explanation should be submitted
- Education (which is incorporated in the application)

Recredentialing

- Completed Recredentialing application

- Signed and dated Attestation
- Current copy of state license
- Current copy of Drug Enforcement Agency (DEA) certificate
- Current copy of Controlled Dangerous Substance (CDS) certificate, if applicable
- Malpractice face sheet which shows the provider name on the certificate, expiration dates and limits – limits $1/3m
- Explanation of any adverse information, if applicable

Any questions regarding your initial or recredentialing status can be directed to our Provider Services line. Please refer to the Provider Services telephone numbers found in the Client Reference Guide under Appendix A.1.

10.2.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.

10.2.B Site visits

With appropriate notice, provider locations may receive a facility and chart review as part of our quality management oversight processes. All surveyed offices are expected to perform quality dental work, maintain appropriate dental records and a clean and safe facility.

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

10.3 Grievances

Dental Benefit Providers of California (DBP-CA) is required by the Department of Managed Health Care (DMHC) to review grievances submitted by our members. Participating providers are required to assist members in filing a complaint or grievance and maintain grievance forms in their office for member use. See Appendix A: Attachment A.14 for example.

Grievance definitions and examples

A grievance is any verbal or written complaint or dispute involving a decision or determination made by DBP-CA:

- Regarding health care services a member is entitled to receive
- The quality of the services rendered by a provider
- Amounts that the member must pay for a covered service
- Administrative matters in a dental office or at the Plan
- Any other customer service issue involving a participating provider or DBP-CA itself

Requirements of your office

- Your office is required to cooperate with DBP-CA's Policies and Procedures; Members Rights and Responsibilities; (including complaints and grievances) and Dental Records
- DBP-CA 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 DBP-CA's requests for patient records films, etc., within five (5) business days of receiving the request
- Failure to comply may result in the grievance resolution in favor of the member and/or a fine in the amount of $150.00. Additionally, your right to appeal will be considered waived.
- Failure to comply with the Plan's findings may result in a capitation deduction.
- Your office may not charge DBP-CA or the patient for any cost associated with documentation or duplication of materials involved in a grievance investigation

The provider and/or the member have the right to appeal any determination made by DBP-CA based on the result of a grievance investigation. Appeals should be submitted in writing and mailed within 30 days after you receive the determination to:

Dental Benefit Providers of California, Inc.

P.O. Box 30569

Salt Lake City, Utah 84130-0569

Fax: (714) 364-6266

Attention: Appeals & Grievance Department

10.4 Preventive health guideline

Dental Benefit Providers Inc. of CA's (DBP-CA) approach to preventive health is a multi-focused strategy which includes several integrated areas. The following guidelines are for informational purposes for the dental provider, and will be referred to in a general way, in judging clinical appropriateness and competence.

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

Preventive health focuses primarily on the prevention, assessment for risk, and early treatment of caries and periodontal diseases, but also encompasses areas including prevention of malocclusion, oral cancer prevention and detection, injury prevention, avoidance of harmful habits, and the impact of oral disease on overall health.

Caries management – begins with a complete evaluation including an assessment or risk.

- X-ray periodicity – X-ray examination should be tailored to the individual patient and should follow current professionally accepted dental guidelines necessary for appropriate diagnosis and monitoring.
- Recall periodicity – frequency of recall examination should also be tailored to the individual patient based on clinical assessment and risk assessment.

- Preventive interventions – interventions to prevent caries should be tailored to the needs of the individual patient and based on age, results of a clinical assessment, and risk, including application of prophylaxis, fluoride application and placement of sealants.
- Consideration should be given to conservative nonsurgical approaches to early caries where the lesion is non-cavitating, slowing progressing or restricted to the enamel or just the dentin.

Periodontal management – screening, and as appropriate, complete evaluation for periodontal diseases should be performed on all adults, 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.
- 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 pre-term/low-birthweight infants, cardiovascular disease, and diabetes

Oral cancer screening – should be performed for all adults and children in late adolescence or younger if there is a personal or family history, or if the patient uses tobacco products. 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 for the appropriate patient.

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

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

Multiple channels of communication will be used to share information for providers and members via manuals, websites, newsletters, training sessions, individual contact, health fairs, in-service programs, and educational materials.

It is the mission of DBP-CA to educate providers and members in maintaining oral health, specifically in the areas of prevention, caries, periodontal disease, and oral cancer screening.

10.5 Organizational structure and responsibility

The Board of Directors has overall responsibility for the environment of care and services provided to Members. The Board delegates responsibility for oversight of the effectiveness of operational components of the QIP to the Quality Improvement Committee. Reports are received and acted upon by the Board at its regularly scheduled meetings. The minutes from the Quality Improvement Committee are forwarded to the Board of Directors for review quarterly.

Job descriptions

The Plan's Dental Director is a licensed California dentist responsible for the oversight and evaluation of the clinical quality of health care services provided to Members and supervises and provides clinical direction to the QIP.

The Director of Quality Management oversees quality improvement activities and provides direction to the QIP. The Director of Quality Management has the responsibility for implementation, direction, and evaluation of related program objectives, which are to:

1. Objectively and systematically monitor and evaluate aspects of Member care including the measures identified in the Mechanisms for Overseeing Program Effectiveness;
2. Provide a system for the identification of opportunities for improvement and implement strategies to achieve improvement in care and services to Members;
3. Promote the coordination, documentation, and communication of plan wide quality management and quality improvement activities;
4. Monitor the effectiveness of network quality management/peer review activities, including the selection and performance of dentists who review issues, the outcomes and effectiveness of those reviews, and their remedial actions;
5. Promote inter-departmental collaboration in network-wide quality improvement activities;
6. Promote compliance by network Providers with defined credentialing requirements, standards of care, access, availability of services, dental record documentation, and guidelines for the use of preventive health services and clinical guidelines;
7. Provide a mechanism for the credentialing and recredentialing of network and oversight of delegated credentialing that complies with nationally recognized credentialing standards; and
8. Implement and oversee preventive dental health systems to improve the oral and overall health status of Members.

It is the policy of the Plan to have sufficient support staff to ensure that all aspects of the QIP are properly implemented and evaluated, including tracking, monitoring, reporting, and the performance of regulatory compliance activities.

Confidentiality

Federal and state laws govern responsibility and liability for quality improvement activities. All quality assessment, peer review, and clinical review activities, including claims review, are confidential and privileged. Information obtained will be disclosed only to the extent necessary to carry out objectives of the QIP and applicable contractual or regulatory guidelines, including the Health Insurance Portability and Accountability Act of 1996. All proceedings of formal QIP activities shall be recorded and all documentation of the QIP shall be maintained in a confidential manner. Reviewers do not receive incentives to perform reviews. The Plan does not maintain original dental charts at its administrative offices. Plan auditors and Committee Members sign confidentiality statements ensuring the confidential treatment of all Member information.

10.6 Committee structure

The Board of Directors structures the Quality Improvement Committee (QIC) to coordinate and oversee all metrics of the organization, including clinical measures such as: quality management, quality improvement, utilization management, credentialing, Members' rights, dental records, and preventive health services in addition to operational metrics.

Quality Improvement Committee (QIC)

The QIC oversees the effectiveness of The Plan quality improvement activities. The committee acts to plan and coordinate network-wide improvements in environment of care and service. Responsibilities of this committee are to:

- Determine what Quality Improvement projects or activities to undertake;
- Design, oversee, and evaluate the Quality Improvement activities including dental health management programs;.
- Endorse performance benchmarks and goals;
- Receive reports from Quality Improvement project teams;
- Approve action plans and follow-up to ensure actions are effective;
- Review results of network-wide quality measurements, including annual Satisfaction Survey Reports and identify opportunities for improvement;
- Conduct annual review of quality improvement effectiveness;
- Oversee all survey data and action plans that result from those surveys;.
- The committee reviews all aspects of clinical quality and provides representative operational and network input on clinical; .
- Provide input on network standards such as access, dental record documentation, preventive service, credentialing and recredentialing processes, Member complaints and utilization;
- Review all clinical aspects of QIP including credentialing and recredentialing, Provider sanctions and terminations, complaints and grievances, quality-of-care matters, peer review activities, site visits, dental record audits, utilization, and access;
- Review and make recommendations on clinical policies and clinical studies;
- Review and approve activities performed by the National Clinical Policy & Technology and Credentialing committees; and
- Effectively communicate quality management reports and metrics, best practices and opportunities for improvement to participating Providers.

National clinical policy and technology committee

The Plan is a subsidiary of Dental Benefit Providers, Inc.

(DBP), and thus participates in DBP's National Clinical Policy and Technology Committee (CPT). The National Clinical Policy and Technology Committee researches, adopts, and disseminates clinical guidelines based on the principles of Evidence Based Dentistry. The Committee also:

- Provides a comprehensive evaluation of current as well as emerging technologies and products used in the practice of dentistry;
- Provides a systemic mechanism for continuing Clinical policy evaluation and Dentist input. This information is disseminated to network dentist and other external and internal stakeholders; and
- Provides recommendations for the incorporation of guidelines and/or new technologies in areas such as plan benefit design and adjudication criteria, utilization review criteria, marketing and underwriting collaterals, and new product development.

Credentialing committee

The Dental Director, or designated California licensed dentist shall chair the Committee. The Credentialing Committee includes participating network dentists as voting Members. Responsibilities of this committee are to:

- Identify trends related to credentialing and recredentialing; and
- Review and make determinations on credentialing and recredentialing applications with or without adverse issues.

Peer review committee

The Peer Review Committee reviews and makes determinations for all clinical quality issues related to individual dentists including, but not limited to:

- Individual quality of care complaints from Members or any other source;
- Appeals for the Credentialing Committee;
- Report any action to the QIC on peer review recommendations;
- Site visit and Chart audit results as appropriate; and
- Review and make recommendations for cases of fraud and abuse.

10.7 processes and procedures

Access and availability

Participating Providers are required by contract to comply with the Plan's access standards to ensure that care is available and is properly coordinated. Standards are published as mandated by state and/or client requirement. The Plan ensures that all requirements are met relating to the access and availability of our Providers, and has filed the current access and availability standards with the state regulatory agencies as required. The Plan monitors the following appointment availability:

- Initial visits;
- Routine visits;
- Hygiene visits;
- Emergency care; and
- In office wait time.

The Plan uses several means to measure and monitor access to care within the network such as, but not limited to:

- Access surveys;
- Grievance data;
- Geo-Access reports;
- Member satisfaction surveys;
- On-site audits; and
- Provider after hours accessibility.

The Plan uses Geo-Access reports to ensure that the locations of its contracted Providers are within reasonable proximity to the Members.

As part of the QIP, Access and Availability reports are provided to the various advisory committees on a regular basis. This allows for the identification of improvement opportunities.

The Plan will monitor after-hours availability, provide emergency out-of-area coverage, and offer payment to non-participating Providers when compliance with access or availability standards is not possible.

The Plan evaluates the access and availability of Providers, and monitors continuity and coordination of care as part of the QIP and Quality Improvement Annual Work Plan activities, which may include, but are not limited to, Member surveys, Provider surveys, and Member and Provider complaints.

DBP-CA addresses any identified deficiencies through corrective action as part of the Quality Improvement activities.

Member satisfaction survey

The Plan has policies and procedures to track and trend Member satisfaction using various data fields, such as, but not limited to: Employer groups and specific dental plans. The Plan shall report the results, findings, and corrective actions, if any, to the appropriate committees. Survey questions are designed to assess Member satisfaction with access to care, quality of care, staff and Provider attitudes, satisfaction with the dental office, communication, and overall satisfaction with the Plan.

Member complaint/grievance resolution process

The Plan has a grievance system and mechanism in place to allow for its Members and/or their representatives to file grievances against both the Providers and the Plan.

The Member appeal and grievance process encompasses investigation, review and resolution of Member issues related to the Plan and/or contracted and non-contracted Providers. Issues are accepted via telephone, fax, email, letter, written grievance form, or through the Plan's web portal. Grievance forms may be requested from our Customer Service Department, the Plan's website or from a contracted dental Provider office. The Plan does not delegate grievance processing and resolution to any Provider group. All Member benefit complaints and quality of care grievances are received and processed by the Plan.

The Plan ensures that all state and Federal regulatory, and client specific requirements are met relating to the specific time frame and notices required. The Plan also recognizes the importance of thoroughly reviewing all appropriate documentation to determine if there are any potentially systemic problems.

Periodic reports on Member complaint and grievance activities are made to all appropriate committees and the Board of Directors.

The Plan's Complaint, Grievance and Appeals policies are filed with the necessary regulatory agencies when required.

Provider disputes, grievances and appeals

Participating Providers or formerly contracted Providers, who believe they have been adversely impacted by the policies, procedures, decisions, or actions of the Plan may have a right to file a dispute with the Plan as provided by state regulation. Any such dispute or Provider grievance shall be submitted in writing to the Plan, as provided in the Plan's Provider Dispute Resolution Policy. In the process, Provider disputes will be logged and routed to the appropriate department for resolution. The Plan accepts Provider disputes relating to, but not limited to, the following:

- Capitation or other reimbursement reductions (or withholds);
- Claim modifications/denials for all types of coverage plans;
- Contract issues;
- Plan policies and procedures; and
- Quality of care issues.

The Plan will acknowledge receipt of the dispute within 15 days and resolve the dispute within forty-five (45) days of receipt of all information necessary to make a resolution. Following notification of the Plan resolution, if unsatisfactory, the Provider may appeal this decision as stated in the Provider Contract. In some cases, parties may seek further action through independent arbitration services.

The Provider Dispute Resolution policy completely outlines the process in which the Provider's dispute or grievance is handled, including the timeframes and sample letters. Provider Dispute policies are filed with the state regulatory agency when required.

Guidelines for quality of care and quality of services

The Plan has developed and maintains criteria and guidelines for care and service to ensure that Plan Members receive all necessary, adequate and appropriate preventive, and restorative dental services which are consistent with generally accepted professionally recognized standards. The Plan continues to research and develop evidence based clinical guidelines.

Quality of care oversight and monitoring

The Plan has various methods for monitoring quality of care to ensure Members receive the necessary, adequate and appropriate preventive and restorative dental services which are consistent with generally accepted professionally recognized standards and within expected guidelines. These methods include, but are not limited to, On-Site Audits, Potential Quality Issue investigation, analysis of Grievances and Appeals, review of Credentialing issues, Utilization statistics, and Member Satisfaction surveys.

Potential Quality Issues (PQI)

The Plan tracks Quality of Care, Quality of Service and/ or Access issues to identify systemic issues that may relate to specific Providers or the Plan itself. Information that is tracked comes from various sources, such as, but not limited to: Member grievances, on-site Provider reviews, outside sources, and access surveys. Information is collated from these various sources to identify any systemic quality issues. PQIs are reported to the various advisory committees to foster change and improvement in plan design and operations, and to improve quality of care and/or service wherever possible. The PQI program is aimed at continuously reviewing Providers for quality of care and quality of service issues, and to coordinate corrective actions to improve care and service where appropriate.

Identification of clinical and/or high risk issues

To identify and prioritize quality issues, Membership data is reviewed periodically to identify and prioritize quality issues using basic demographics, such as age and geographic location (including suburban, urban and rural) and comparing this data to available local and or national benchmark data. Among the items reviewed periodically are audits of Members' most frequent dental treatment procedures. The data is reviewed to establish benchmarks for future health care study and quality improvement. The quality improvement focus includes, but is not limited to, populations in urban or suburban environments and rural communities. These are compared to local or national data when available.

Credentialing

The Plan maintains a comprehensive credentialing process to verify the professional credentials of all its contracted dentist Providers. The Plan contracts with a NCQA Certified Credentialing Verification Organization (CVO) to assist in the required data collection to complete the credentialing process. The Plan may also perform "in-house" credentialing following all NCQA guidelines.

Before an applicant dentist is accepted as a participating Provider, the dentist's credentials are evaluated. Initial facility site visits are completed for all DHMO offices. The office must pass the facility review prior to activation. The Plan will request a written explanation from the applicant of any adverse incident and its resolution, as well as corrective action taken to prevent future occurrences. The Plan will request a resolution of any discrepancies in credentialing forms submitted by the applicant.

The Dental Director and the Credentialing Committee review the information in detail based on approved credentialing criteria. Credentialing criteria is reviewed by committees which include input from practicing network Providers to ensure that criteria is within generally accepted guidelines.

Peer review committee

The Plan maintains a comprehensive recredentialing process. The Plan contracts with a CVO to assist in the required data collection to complete the recredentialing process of all contracted Providers. Dentists are recredentialed on a 3 year cycle.

In order for a thorough review to be completed at the time of recredentialing, in addition to the items verified in the initial credentialing process, the Plan may review Provider performance measures such as, but not limited to:

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

The Plan will request a written explanation of any adverse incident, its resolution and corrective action taken to prevent future occurrences.

Provider on-site reviews

The QIP includes mechanisms for regular evaluation of the structural aspects of care at participating dental offices, as well as mechanisms for regular evaluation regarding the clinical process of care rendered by participating dentists at dental plan offices, including regular audits of clinical records.

The Plan uses valid and reliable data collection and analysis methodologies to evaluate the clinical process of care at dental plan offices, and evaluates participating dentists against current professionally recognized standards of practice as promulgated by the California Association of Dental Plans (CADP) and national dental professional associations. The clinical evaluations are conducted by qualified licensed dentists and overseen by the Dental Director where such oversight includes regular training, calibration, and validation of results.

The Plan's evaluations are of sufficient scope to address all aspects of clinical care rendered at participating dental offices, taking into account Member/patient mix and covered services. The Plan evaluates each participating dentist on a sufficiently frequent basis to assure that dental quality problems that arise at participating offices are identified and corrected in a timely manner. The evaluation processes provide for progressive corrective action and follow-up with participating Providers, where required, and the results of are reported to the committees and the governing body and Board of Directors. Such reports may include peer review, and be considered in the recredentialing process.

On-Site Reviews are conducted to determine if a new DHMO dental office is qualified to participate with the Plan's program, to determine whether existing dental offices have met the contractual performance standards, and to respond to specific complaints from dental plan Members or if the Provider has been identified as having a potential quality issue.

Facility reviews may be conducted by a licensed dentist, by Plan personnel, or other appropriate and trained persons. Chart reviews are conducted by licensed dentists. The interval between reviews is determined by the score of the previous review and/or quality indicators used throughout the QI Program. More frequent audits may be needed based on Provider profile indices or triggers, such as, but not limited to, grievance history, utilization history, or other quality improvement data.

A post-audit summary letter detailing deficiencies to be corrected is mailed to the contracted Provider and any corrective actions plans are monitored for closure. Non-compliance with any requests for corrective actions may result in additional action or sanction up to and including termination.

Corrective actions may include:

- Telephonic counseling;
- Written corrective action plan to be submitted to the Plan by the Provider;
- Recall patient(s) for re-evaluation;
- Submission of patient records;
- Obtain missing items noted on the facility review and submit evidence of purchase; and
- Obtain new chart forms.

A focused office review may be required because of a grievance, utilization review, or other trigger. A Provider or Provider group exhibiting these issues will be referred to the Peer Review Committee for oversight and corrective action as deemed necessary.

The Plan currently performs On-Site Facility reviews of all new DHMO applicant dentists/dental offices as part of the credentialing process.

The Plan currently performs On-Site Facility and Chart reviews of, at minimum, a cross-section of 10% of all existing Provider offices each year. The Plan selects Providers/Provider offices for such On-Site review based on triggering activities such as but not limited to high-volume, enrollment threshold, previous audit score, outstanding credentialing issues, identified utilization Issues, complaints/grievances and/or inquiry reports, and Provider transfer reports.

The Plan will participate in the California Association of Dental Plan's (CADP) Shared Audit Program and utilize the CADP audit tool. The audit tool meets regulatory requirements and participating in the Shared Audit Program is less intrusive on the Provider and, combined with the Plan's quality indicators, will allow for identification of possible quality issues.

The Plan shall utilize the Shared Audit Program for routine reviews, as appropriate, but shall ensure that all offices selected for focus reviews will be performed by the Plan. Audits that are performed by the Plan, that do not pass satisfactorily will be put on corrective action and re-audited within 1 year. The Provider will be required to show improvement to a satisfactory score or additional corrective actions will be required up to and including termination.

Dental records

The Plan maintains policies regarding Dental Records requirements, such as required and recommended information to be contained in proper dental records. The Plan may perform dental record audits if concerns exist about quality or when the Plan has concerns about dental record keeping. In addition, chart review may be involved in anti-fraud investigation.

The Plan requires contracted Providers to make the contents of the dental records available upon request as part of Quality Improvement activities or Utilization Management.

The Plan requires Providers to cooperate with Member requests for copies of their dental records. Providers may charge a nominal fee for this service in accordance with state laws.

Providers must comply with all state laws requiring the storage of dental records for the requisite time periods.

Provider satisfaction survey

The Plan periodically conducts Provider Satisfaction Surveys to assess the Provider perception of Plan performance and to identify opportunities for improvement. Areas surveyed include, but are not limited to, the following: Provider Relations (internal and field representatives), Customer Service, specialty referrals, quality management activities, and Provider involvement in grievances and appeals.

Survey results are presented to the appropriate committees for the identification of opportunities for improvement .

Provider sanctions and disciplinary actions

The Plan maintains policies and procedures for corrective action of Providers when deficiencies are noted or when non-compliance with Plan-required activities is identified. The Plan may employ a variety of disciplinary actions up to and including Provider Probation and Provider Termination. In some cases, the Plan must comply with fair hearing requirements in accordance with federal or state regulations. If a Provider is terminated for medical disciplinary reasons, the Plan must inform the state dental licensing board as required by Section 805 of the Business and Professions Code.

Preventive care guidelines and dental health education

The Plan preventive dental health services activities are designed to measure indicators of preventive health and to share feedback to clients, individual Providers, and internally at The Plan. The goal is increase the utilization of preventive health services, in an effort to promote healthy behaviors and wellness of the Member. Additional efforts are offered to educate Members on the importance of preventive health and the services available in their plan, through communication and outreach, coordinated with the health plan. Primary responsibility is coordinated between Quality Management and the Dental Director, with input from Client Operations, Network Development and Marketing. Employer and Member input is obtained through direct contact, survey results and in specific promotional activities with employer groups. Results of individual studies are reported to the QIC with recommendations for improvement.

HIPAA compliance

The Plan adheres to all required HIPAA requirements in the processing of Member's protected health information (PHI). The Plan maintains HIPAA Policies and Procedures and performs the required training for all employees. The Plan also encourages all contracted Providers to handle Member health care information with the same sensitivity. Chart audits are reviewed for confidentiality issues. Providers are subject to their own Federal HIPAA requirements. The Plan requires signed business agreements ensuring that HIPAA requirements are met for all required activities.

Emergency care/emergency dental services

Within the scope of dental care benefits under the Member's benefit plan, emergency dental services are services required in the event of unforeseen medical conditions such as pain, hemorrhage, infection, or trauma, where immediate attention is necessary. In general, emergency services include relief of pain, swelling, infection, and/or bleeding by procedures to stabilize the emergency condition, and may include issuing prescription medications. Definitive procedures may need to be deferred to a more appropriate time.

Emergency services do not require pre-authorization when performed by the Member's general dentist. Emergency treatment from other than the Member's general dentist (i.e. contracted specialist, non-contracted general dentist or specialist) also requires no preauthorization, but should be limited to the services necessary for the relief of pain, or to stabilize any emergency situation.

Member and provider notification of substantive changes

The Plan provides timely and full disclosure of all substantive changes to Member contracts, Certificates of Coverage, Evidence of Coverage or to Provider Contracts and Provider materials such as Provider Reference Manuals, by providing written notification as prescribed by law or in the contract.

Government programs

Government programs may have unique quality management requirements as required by the government proposal, statute or regulation. The Plan is in full compliance with all quality management requirements of any government programs under contract.

Fraud and abuse program

A key component of the Plan's management of benefit costs is the identification and investigation of potential fraudulent, abusive, unusual services, or aberrant patterns of care. Should it be seen that a Provider's utilization falls outside of the expected norms; if a Provider submits an improper claim or makes an improper referral; if the Member's activity is inconsistent with claims or enrollment documents submitted; or if a third party vendor submits invoices that are inconsistent with its contract terms, this will initiate a process for further review and analysis. The goal of the analysis and investigation is to determine if the activities in question are supported, the result of honest error, or indicative of fraudulent or abusive behavior.

The Fraud and Abuse Program is reviewed periodically as required by specific contract, state, and/or federal requirements. The Fraud and Abuse Program is concerned with all sources of potential fraud including Provider, Member and operational. For those cases that are verified as being "fraudulent", they are summarized at the appropriate committees, and referred to the appropriate authorities for further action. Annual reports of Fraud and Abuse activity are filed with the state regulatory agency when required.

Delegation arrangements

When delegating QIP activities, the Plan shall ensure there is a process in place for appropriate regular and periodic oversight of the delegated activity. The Plan shall ensure that there is a written and executed agreement delegating specific activities to the delegated entity. Results of the oversight activities are periodically reported to the appropriate committees and the Board of Directors.

Annual quality improvement activities and work plan

The Plan is committed to quality improvement activities to identify systemic quality of care and quality of service issues, and to create initiatives to improve identified quality parameters and hence to improve care and service.

The QIP includes mechanisms to evaluate and report upon trends and patterns with complaints, appeals, and other data sources used to measure quality performance. Such reports are reviewed and acted upon by the QIC. The QIP uses established quality of care indicators relevant to its Membership and based on current and sound clinical knowledge and practice, such as national evidence-based guidelines or national consensus guidelines to evaluate the quality of care provided.

The Plan uses valid and reliable data collection and analysis methodologies to identify, track, and trend quality of care and quality of service issues. The Plan establishes performance goals for the quality of care and quality of service indicators to assess performance, identify and set priority areas for improvement, and determine desired level of improvement, as applicable. The Plan tracks and trends performance on quality of care indicators, on a Provider-specific basis, as appropriate.

A written evaluation of the QIP is prepared annually and submitted to the QIC and the Board of Directors for review and approval. This evaluation focuses on strengths and weaknesses, trends and patterns, barriers to improvement, and demonstrated accomplishments in improving dental care and services to Members. Input is obtained from the QIC, staff, data sources, satisfaction indicators, and the Plan management.

A Quality Improvement Work Plan is prepared for the upcoming year for submission to the Board of Directors for approval. The Work Plan incorporates aspects of the QM annual evaluation, and revisions, if applicable, indicator requirements and employer requests for monitoring and reporting. The Quality Improvement Work Plan is prepared and based primarily on the annual QM evaluation but may also include client and regulatory requirements or other quality improvement initiatives.

If the Plan does not achieve its quality of care or quality of service performance goals, the Plan performs quantitative and qualitative data analysis to identify barriers to the improvement of both clinical and non-clinical aspects of its health service delivery system. The Plan designs and implements interventions to address the identified barriers in order to improve performance. Also, the Plan re-measures its performance to determine if it has improved its performance and met its goals.

Utilization management

The Plan maintains a comprehensive Utilization Management (UM) Program with supporting policies and procedures. Utilization data may be analyzed to ensure that Members receive quality oral health services. UM activities identify aberrant utilization patterns, and provides source data for outcomes studies, allowing analysis of client performance which can suggest targeted QI interventions aimed at improving Member oral health outcomes.

UM is an additional source of quality indicators, which can be used to evaluate quality in the following four areas: clinical results or treatment choices, over and under utilization compared to network base lines, accuracy of coding procedures, and cost of care. Utilization and dental management information is incorporated in the processes for evaluating new technologies and determining dental appropriateness for use and coverage, and detailing access standards and plan/benefit design. The Annual Work Plan may contain initiatives aimed at improving identified utilization parameters.

Member's rights and responsibilities

Members may have rights according to their plan or state requirements including, but not limited to: access, second opinions, linguistic and cultural sensitivity, external clinical review (Independent Review) and the complaint/grievance process.

Members have the responsibility to treat contracting dentists, office staff, and Plan employees with respect and courtesy; to keep scheduled appointments or contact dental offices in advance to cancel appointments; to make applicable co-payments at the time of treatment; and to notify their employer of any changes in family status, address, or other life-change event.

Further rights and responsibilities may be enumerated in each benefit plan's collateral materials.

Mechanisms for overseeing program effectiveness

The Quality Improvement Committee (QIC) oversees the effectiveness of the Plan quality management, quality improvement and preventive health education activities. Quarterly status reports are provided by the committee and made available to the Plan's Management, Clients (as required) and quarterly to the Board of Directors for review and evaluation of effectiveness.

The Dental Director and the Manager of Quality Management are responsible for monitoring follow-through when clinical and service opportunities for improvement are identified. Documentation regarding the implementation of recommendations for system changes, corrective actions, educational endeavors, and overall effectiveness is maintained.

Annual evaluation of the Quality Management Program is completed to ascertain that the goals are met and improvement initiatives are effective. Such review focuses on evaluation of defined goals and objectives, review of completed QI activities, program scope and organization. Highlights include trending of key clinical and service indicators, documentation of quantitative improvements in care and service attributable to QI initiatives, evaluation of QI resources, and recommendations for the coming year in the workplan. Any barriers to the QI process are analyzed and identified to create actions to overcome any and all barriers to the improvement process. It is the desire of the Quality Management staff for the QIP and any and all QI activities to be successful and effective.

Formulation of the annual Quality Improvement Program incorporates findings from the program evaluation (i.e., needed improvements, changes in process or structure, follow-up studies) in addition to activities mandated state and federal programs, and client contractual agreements. The Quality Improvement Program Evaluation and Annual Quality Improvement Work Plan are reviewed and approved by the QIC and the Plan's Board of Directors.

Section 11: Practice capacity and appointment scheduling standards

11.1 Practice capacity and appointment scheduling

DBP-CA requires your office to appoint eligible members, for both new and interval appointments, within 40 business days of the member's request for appointment. Thirty minutes or less wait time in the office for a scheduled appointment is also required by DBP-CA. This will allow eligible members reasonable access to care and will allow your office to complete treatment plans in a timely manner.

If your office or DBP-CA determines your practice has reached capacity and can no longer schedule appointments for members in a manner that allows reason able access and promotes the completion of treatment plans within an appropriate and efficient time frame, your office will be temporarily placed in an "unpublished status" (i.e., will be closed to new members), within 60 days of this determination. Your office is required to provide covered services to all members who have chosen or will choose your office during the 60-day notice period. When both your office and DBP-CA agree that the practice can again become "published" on our dentist directory, DBP-CA will do so immediately.

11.2 Emergency coverage

Your office is required to provide 24-hour emergency coverage to eligible members assigned to your office. Emergency patients must be seen within 72 hours of their initial request for treatment. All contracted providers must employ an answering service or a telephone answering machine during non-business hours, which provide instructions regarding how enrollees may obtain urgent or emergency care including, 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.

11.3 New associates

Your office is required to inform DBP-CA in writing within 30 days if the practice employs, or in some other manner associates with, other dentists who will treat eligible DBP-CA members. Such notification shall occur prior to any treatment being rendered by such dentist. A DBP-CA Credentialing Application must be submitted for each new dentist to initiate the credentialing process. In addition, your office is required to notify DBP-CA in writing in the event that any dentist terminates his or her employment and will no longer be treating DBP-CA members.

11.4 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 Dental Benefit Providers of California is expected to review, update provider records and attest to the information available to Dental Benefit Providers of California members, including the information listed below, on no less than a quarterly basis. You are responsible for notifying Dental Benefit Providers of California 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 Dental Benefit Providers of California:

- 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. Tax identification number updates require a new provider agreement(s) to be completed.
- The NPI(s) of the participating provider.
- The languages spoken/written by the participating provider of the staff.
- The ages served by the participating provider.
- Office hours (7 days a week)

Changes should be submitted to:

Dental Benefit Providers of California - RMO
ATTN: 224-Prov Misc Mail WPN
PO BOX 30567
SALT LAKE CITY, UT 84130

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

Credentialing updates should be sent to:

Email: dbpcredsupport@uhc.com

Dental Benefit Providers of California Credentialing
2300 Clayton Road, Suite 1000
Concord, CA 94520

Requests must be made in writing with corresponding and/or backup documentation. A team member will reach out to provide the necessary Provider Agreement(s) if necessary. For example, a tax identification number (TIN) change would require submission of a copy of the new W-9 and a new Provider Agreement(s), versus an office closing notice where we would need the notice submitted in writing on office letterhead. Changes may also be submitted through the provider self-service portal at **UHCdental.com**.

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 TIN(s) and/or name(s) for all associates to whom that the changes apply.

Dental Benefit Providers of California 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, contact Provider Services at 1-877-732-4337 for guidance.

11.5 Office conditions

Dental plan office equipment should be in good working condition. The office should be kept neat and clean. Dental plan providers' offices and treatment accessibility should comply with the Americans with Disabilities Act. A portable oxygen unit or ambu bag should be readily available for emergency use.

11.6 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.

11.7 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. The recall system should be individualized to the patient's need and should not be a fixed interval for all patients.

11.8 Transfer of dental records

Your office shall copy all requested member dental files to another participating dentist as designated by DBP-CA. The member is responsible for the cost of copying the patient dental files if the member is transferring to another provider. Please refer to the member's fee schedule to determine if there is a plan copayment. If your office terminates from DBP-CA, dismisses the member from your practice, or is terminated by DBP-CA, the cost of copying files shall be borne by your office. Your office shall cooperate with DBP-CA in maintaining the confidentiality of such member dental records at all times, in accordance with state and federal law.

11.9 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.

11.10 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.

Dental Benefit Providers of California recognizes that the diversity of American society has long been reflected in our member population. Dental Benefit Providers of California 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.

Dental Benefit Providers of California 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://hrsa.gov/culturalcompetence/index.html

11.11 Provider dispute resolution process

What is a provider dispute?

- A written notice to DBP-CA challenging, appealing or requesting reconsideration of a claim (or a bundled group of substantially similar multiple claims that are individually numbered) that have been denied, adjusted or contested.
- Or seeking resolution of a billing determination or other contract dispute (or bundled group of substantially similar multiple billing or other contractual disputes that are individually numbered).
- Or disputing a request for reimbursement of an overpayment of a claim.

What information is required from the provider?

Each provider dispute must contain the following information: treating dentist name, full address, tax identification number, and contact information. If it involves a claim(s) dispute, (e.g., overpayment, denial or adjustment of a claim), please provide the following information:

- The claim number, subscriber I.D., date(s) of service and a clear explanation of the issue and the provider's position on such issue.
- If the provider dispute is not about a claim, please provide the following information:
- A clear explanation of the issue and the provider's position on such issue.

If the provider dispute involves an enrollee or group of enrollees, please provide the following information:

- The name and subscriber I.D. number(s) of the enrollee or enrollees, including the date(s) of service and a clear explanation of the issue and the provider(s) position on such issue.

Where to send your written dispute?

Mail or fax to:

Dental Benefit Providers of California, Inc.
Grievance and Appeals
P.O. Box 25187
Santa Ana, CA 92799

(714) 513-6542 - Fax

What is the time frame for submitting a dispute?

Provider disputes must be received by DBP-CA no later than 365 days from DBP-CA's action that led to the dispute, or in the case of inaction, no later than 365 days after DBP-CA's time for contesting or denying a claim has expired.

If the provider dispute relates to a "demonstrable and unfair payment pattern" as defined in Section 1300.71(a) (8) of Title 28 of the California Code of Regulations, such provider dispute must be received by DBP-CA no later than 365 days from DBP-CA's most recent action that led to the dispute, or in the case of inaction, no later than 365 days after DBP-CA's most recent time for contesting or denying a claim has expired.

If all required information is not included in the provider dispute, DBP-CA may return such dispute to the provider with an indication of the missing information. The provider may submit an amended provider dispute to DBP-CA within thirty (30) working days of the date of receipt of a returned provider dispute setting forth the missing information.

Acknowledgment of provider disputes

- Provider disputes will be acknowledged by DBP-CA within fifteen (15) working days of the date of receipt by DBP-CA.

Contacting DBP-CA regarding provider disputes

- If you have a question regarding the status of a dispute or about filing a provider dispute, please call 1-800-445-9090.

Instructions for filing substantially similar provider disputes

If the provider has substantially similar multiple claim, billing or contractual disputes, the provider may file these disputes in batches as a single dispute, provided that such disputes are submitted in the following format:

- Sort provider disputes by similar issue
- Provide cover sheet for each batch
- Number each cover sheet
- Provide a cover letter for the entire submission describing each provider dispute with references to the numbered cover sheets

Time period for resolution and written determination

DBP-CA will issue a written determination stating the pertinent facts and explaining the reasons for its determination within forty-five (45) working days after the date of receipt of the provider dispute or the amended provider dispute.

Past due payments

If the provider dispute or amended provider dispute involves a claim and is determined in whole or in part in favor of the provider, DBP-CA will pay any outstanding monies determined to be due, and all interest and penalties required by law or regulation, within five (5) working days of the issuance of the written determination.

Section 12: California Language Assistance Program

12.1 California Language Assistance Program summary

The legislation outlines specific requirements of the plans and the contracted network when working with Limited English Proficient (LEP) members. Detailed information about these requirements can be found on the California Department of Managed Health Care (dmhc.ca.gov) website.

12.1.A. The DBP of CA Language Assistance Program includes:

- Surveying members to determine language preferences
- Making the information collected about members' language preferences available to network clinicians and facilities upon request via customer service representatives
- Informing members and providers of the availability of free language services. Providing information to members on the availability of bilingual clinicians in the online Provider Directory
- Free interpreter services in the caller's language of choice via the Language Line to any member who requires language assistance by calling the customer service number on the back of the members' ID card
- Written Dental Benefit Providers of California member documents interpreted via the Language Line, for all relevant documents according to the regulations
- Written translation of member documents will be provided if spoken interpretation is refused

12.1.B. What is required of clinicians and facilities?

- Offer free interpretation services through Dental Benefit Providers of California to members with LEP, even when the member is accompanied by a family member or friend who can interpret.
- Document the acceptance or denial of interpreter services in the member's treatment record.
- Make the DMHC's grievance process and Independent Medical Review(IMR) application and instructions available to member upon request. Providers may access the DMHC grievance instructions and IMR application on the Department's website at dmhc.ca.gov. The IMR application and instructions are available in more than 10 languages.
- Go to **UHCdental.com** to obtain the pre-translated versions of the grievance form in each threshold language as well as the English version, accompanied by the notice of availability of language assistance. The website will be updated prior to January 1, 2009. You may also contact us to obtain a paper copy for the member by calling the number on the back of the member's ID card.
- If language assistance is required, contact Dental Benefit Providers of California at the number provided on the back of the member's ID Card. You will then be connected with the Language Line, via a customer service representative, where certified interpreters are available to provide telephonic interpretation services.
- Dental Benefit Providers of California will be monitoring provider compliance with the language assistance programing 2009, as required by the regulations, through site visits and chart reviews.

12.2 Frequently asked questions

Department of Managed Health Care's (DMHC) Language Assistance Program

1. What are the DMHC Language Assistance Program regulations (previously referred to asSB853)?

Effective January 1, 2009, in accordance with Section 1367.04 of the California Knox-Keene Act, the Department of Managed Health Care regulations—Section 1300.67.04, Title 28, California Code of Regulations—require that health plans establish a Language Assistance Program ("LAP") for enrollees who are Limited English Proficient ("LEP"). (Similarly, the California Department of Insurance promulgated its own LAP regulations, in accordance with Sections 10133.8 and 10133.9, California Insurance Code—see Section 2538, Title 10, California Code of Regulations.) Note this regulation only applies to Knox-Keene licensed plans, such as Healthy Families & Healthy Kids, and not Medi-Cal or Medicare.

A Limited English Proficient (LEP) enrollee is "an enrollee who has an inability or a limited ability to speak, read, write or understand the English language on a level that permits that individual to interact effectively with health care providers or health plan employees."

Each health plan's Language Assistance Program (LAP) must include the following:

- Written policies and procedures
- Assessment to identify enrollees' spoken and written language needs
- Demographic profile of the health plan's enrollee population, including enrollee race and ethnicity
- Identification of the health plan's threshold languages (language(s) other than English spoken by a specific proportion, defined by the law, of the health plan's enrollees)
- Translating vital documents at no charge to the enrollee (translation refers to the transfer of the written word to one language to another)
- Providing interpreter services at no charge to the enrollee at all points of contact, administrative and clinical (interpreting refers to the transfer of spoken word from one language to another)
- Informing enrollees of the availability of language assistance services
- Proficiency and quality standards for translation and interpretation services
- Training of health plan staff on the LAP and cultural diversity of the health plan's enrollee population
- Compliance reporting and quality monitoring

2. What is the individual provider's role and responsibility regarding the health plan's Language Assistance Program?

A provider's responsibility for language assistance will depend upon their contractual arrangement with each health plan. But at a minimum, providers will need to cooperate and comply with the health plan's LAP services by facilitating an LEP enrollee's access of a health plan's LAP services—particularly a health plan's oral interpreter's services—in the clinical setting. You will also be required to document offers of language assistance, acceptance or refusal of interpreter services, and the individual providing interpretation (health plan interpreter, relative, child, etc.) in the patient's medical record.

3. What is a Language Assistance Program (LAP) Notice? With what documents is a notice included?

Health plans will use a Language Assistance Program Notice to inform their enrollees of the availability of language assistance services (e.g., oral interpretation and written translation services).

Additionally, enrollee-specific vital documents produced in English will include a notice that offers assistance to interpret the document in any language or to translate the document into the health plan's threshold language(s).

4. **How do I get an oral interpreter service for my Dental Benefit Providers of California patient ?**

   If language assistance is required, contact Dental Benefit Providers of California at the number provided on the back of the enrollee's ID Card. You will then be connected with the Language Line via a customer service representative, where certified interpreters are available to provide telephonic interpretation services.

5. **Can I use my own bilingual staff to interpret?**

   You may access the health plan's qualified interpreter services (see access information in #6). From a health plan's perspective, it is strongly recommend that providers help LEP members make informed decisions about when to use highly skilled, qualified health plan interpreters, a service which is available at no cost to LEP members or providers.

   The health plan's interpreters are trained in medical and insurance terminology, in addition to being proficient in—and culturally sensitive to—diverse ethnic and linguistic nuances. LEP members may prefer to rely upon the objectivity, accuracy and confidentiality of professional interpreter services. However, if the LEP member refuses to access the health plan's interpreter services, the provider must document that refusal in the member's medical record.

   The law obligates health plans to provide and monitor the delivery of the health plan's qualified interpreter services to LEP patients at all points of contact (administrative and clinical) in order to ensure meaningful access to health care.

6. **Do these regulations prohibit family members from serving as interpreters for enrollees?**

   No. Family members are not banned from serving as interpreters for enrollees under this legislation; however, health plans must ensure that its LEP members are notified of the availability of the health plan's free, quality language assistance (interpretation and translation) services. Should an LEP member refuse to access a health plan's language assistance services, then the provider must document that refusal in the patient's medical record.

12.3 Tips for documenting interpretive services

For Limited English Proficient (LEP) Patients: Notating the provision or the refusal of interpretive services

California law requires that health plans and insurers offer free interpreter services to both LEP members and health care providers and also ensures that the interpreters are professionally trained and are versed in medical terminology and health care benefits.

Documenting refusal of interpretive services in the medical record not only protects you and your practice, it also ensures consistency when your medical records are monitored through site reviews/ audits by contracted health plans to ensure adequacy of the plan's Language Assistance Program.

- It is preferable to use professionally trained interpreters and to document the use of the interpreter in the patient's medical record.
- If the patient was offered an interpreter and refused the service, it is important to note that refusal in the medical record for that visit.
- Although using a family member or friend to interpret should be discouraged, if the patient insists on using a family member or friend, it is extremely important to document this in the medical record, especially if the chosen interpreter is a minor.
- Smart Practice Tip: Consider offering a telephonic interpreter in addition to the family member/friend to ensure accuracy of interpretation.

- For all LEP patients, it is a best practice to document the patient's preferred language in paper and/or electronic medical records (EMR) in the manner that best fits your practice flow.*
- For a paper record, one way to do this is to post color stickers on the patient's chart to flag when an interpreter is needed. (For example: Orange = Spanish, Yellow = Vietnamese, Green = Russian)*
- For EMRs, contact your IT department to determine the best method of advising all health care team members of a preferred spoken language.

*Source: Industry Collaboration Effort (ICE) Tips for Communicating Across Language Barriers; iceforhealth.org

12.4 Tips for working with Limited English Proficient (LEP) members

California law requires that health plans and insurers offer free interpreter services to both LEP members and health care providers and also ensures that the interpreters are professionally trained and are versed in medical terminology and health care benefits.

Who is an LEP member?

Individuals who do not speak English as their primary language and who have a limited ability to read, speak, write or understand English may be considered limited English proficient (LEP).

How to identify an LEP member over the phone?

- Member is quiet or does not respond to questions
- Member simply says yes or no, or gives inappropriate or inconsistent answers to your questions
- Member may have trouble communicating in English or you may have a very difficult time understanding what he or she is trying to communicate
- Member self-identifies as LEP by requesting language assistance

Tips for working with LEP members and how to offer interpreter services

1. Member speaks no English and you are unable to discern the language
   - Connect with contracted telephonic interpretation vendor to identify language needed.
2. Member speaks some English:
   - Speak slowly and clearly. Do not speak loudly or shout. Use simple words and short sentences.
   - How to offer interpreter services:
     "I think I am having trouble explaining this to you, and I really want to make sure you understand. Would you mind if we connected with an interpreter to help us? Which language do you speak?"
     OR
     "May I put you on hold? I am going to connect us with an interpreter." (If you are having a difficult time communicating with the member)

Best practice to capture language preference

For LEP members it is a best practice to capture the members' preferred language and record it in the plan's member data system.

"In order for me (or Health Plan) to be able to communicate most effectively with you, may I ask what your preferred spoken and written language is?"

Appendix: Attachments

A.1 DBP-CA Client Reference Guide for Managed Care plans

Dental Benefit Providers of California (DBP-CA) client reference guide for Managed Care plans

For member eligibility, claims, prior authorization, payment or other service-related inquiries that you are unable to find answers using the Provider Portal, please reach out to Provider Services Provider Service for the correct plan in which the member is enrolled.

Client/Product name	Managed Care plans available	Encounter/Claim address Electronic Payor ID:52133	Provider service
AARP Medicare Complete SecureHorizons (Ovations)	Medicare DHMO	UnitedHealthcare Dental P.O. Box 30567	(877) 732-4337
Blue Shield of California	Commercial DHMO and EHB Pediatric DHMO (Off Exchange)	Blue Shield of California P.O. Box 30567 Salt Lake City, UT 84130-0567	(800) 585-8111
Blue Shield of California	EHB Pediatric DHMO (On Exchange) Family Dental DHMO (On Exchange) *Member ID card has Covered	Blue Shield of California P.O. Box 30567 Salt Lake City, UT 84130-0567	(800) 286-7401
Blue Shield of California	65 Plus Optional Supplemental Medicare DHMO Blue Shield 65 - Embedded DHMO Plan Embedded Discount Dental to the Blue Shield 65 Plus Choice *Member Pay Only	Blue Shield of California P.O. Box 30567 Salt Lake City, UT 84130-0567	(888) 679-8928
Health Net of California	Commercial, Medicare, IFP and EHB DHMO (On and Off Exchange)	Health Net of California P. O. Box 30567 Salt Lake City, UT 84130-0567	(866) 249-2382
Lincoln Financial Group (LFG) **Lincoln DentalConnect**	Commercial DHMO *Included in the UHC and LFG DHMO Fee Schedule	Lincoln Financial Group P.O. Box 30567 Salt Lake City, UT 84130-0567	(888) 877-7828
Pacific Union Dental	Blue Shield High-Option (Dental Plus) Medicare DHMO	Pacific Union Dental P.O. Box 30567 Salt Lake City, UT 84130-0567	(888) 271-4929
Pacific Union Dental	Individual Advantage and Patient's Choice *Member Pay Only	Pacific Union Dental P.O. Box 30567 Salt Lake City, UT 84130-056	(877) 732-4337
Pacific Union Dental	Direct Compensation (DC) *RVU Fee-For- Service Schedule	Pacific Union Dental P.O. Box 30567 Salt Lake City, UT 84130-0567	(877) 732-4337
UnitedHealthcare Dental (PacifiCare Dental)	Commercial and Individual DHMO	UnitedHealthcare Dental P.O. Box 30567	(877) 732-4337

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A.2 Specialty Referral Form (Blue Shield of California) — page 1 of 2

Specialty Referral Request Form

blue of california
Blue Shield of California
An Independent Member of the Blue Shield Association

☐ Pre-Authorization ☐ Direct ☐ Self ☐ Emergency

Referring Provider Name	Phone number	Employee Name	ID #
Street Address		Street Address	
City, State and ZIP Code		City, State and ZIP code	Home Phone
Employee Name	Group Number	Patient's Name	Birth Date Relationship

SPECIALIST (check one)	ATTESTATION (Must be completed for the specialty type, or request will be returned)	OTHER REASONS/NARRATIVE
ENDODONTICS X-rays needed	Yes No All teeth to be treated by endodontist are restorable? Yes No Teeth to be treated have a good periodontal prognosis? Yes No Hemisection or root amputation planned? Yes No Crown lengthening will be needed? Yes No Treatment needed is beyond the scope of a general dentist? **If "Yes" check why below:** Canal(s) cannot be located; Severely curved canal(s)/root; Surgical procedure; Canal(s) calcified/blocked; Retreatment ☐ **Other** – *provide narrative in area at right*	
ORAL SURGERY X-rays needed for most requests	Yes No Referral is due to medical condition or physical limitation? Yes No All teeth requested currently symptomatic? Yes No Service(s) for orthodontic purpose(s)? Yes No Removal of supernumerary tooth/teeth? Yes No Treatment needed is beyond the scope of a general dentist? **If "Yes" check why below:** Treatment of tumor and/or neoplasm; Treatment of fractured jaw; Treatment TMJ/myofascial pain; Patient wants general anesthesia when local would normally suffice; Consultation needed to aid in treatment planning or to evaluate a lesion; Surgery too complex for general dentist; Treatment of nondentigerous cyst; Treatment of disclocation or subluxation; Specialized test or equipment needed ☐ **Other** – *provide narrative in area at right including tooth numbers and pathology*	
ORTHODONTICS	☐ Yes ☐ No Patient's oral hygiene/home care adequate? ☐ Yes ☐ No All diagnosed preventive and restorative treatment completed? Orthodontic treatment is needed because of: Treatment TMJ/myofascial pain; Relapse after orthodontics; Myofunctional therapy; Micrognathia, macroglossia or other congenital/developmental condition?; Retreatment; Jaw positioning; Malocclusion or crowding; Orthodontic treatment is in progress	
PEDIATRIC DENTISTRY X-rays needed for most requests	☐ Yes ☐ No If patient is over 3 years, treatment was attempted? ☐ Yes ☐ No Treatment needed is beyond the scope of a general dentist? **If "Yes" check why below:** Complexity of case, **not** related to medical condition or limitations; Inability to cooperate, **not** related to medical condition or limitations; Medical condition/physical limitations ☐ **Other** – *provide narrative in area at right*	
PERIODONTICS X-rays & Perio Chart needed for most requests	☐ Yes ☐ No Patient's oral hygiene/home care is adequate? ☐ Yes ☐ No Prophylaxis and scaling/root planing completed? ☐ Yes ☐ No Pocket charting done before & after scaling/root planing? ☐ Yes ☐ No Bone graft/bone replacement? ☐ Yes ☐ No Crown lengthening? ☐ Yes ☐ No Treatment needed is beyond the scope of a general dentist? **If "Yes" check why below:** Dates of SRPs UR_____ Re-Eval Date_____ LR_____ Case Type IV_____ UL_____ Perio Prognosis#_____ LL_____ Osseous mucogingival surgery is needed to reduce pockets; Gingival grafting is needed to treat recession in absence of pockets; Patient has not responded to treatment by general practice provider; To aid in treatment planning ☐ **Other** – *provide narrative in area at right*	

SERVICES REQUESTED FOR REFERRAL

Procedure Code	Tooth/Quad/Arch	Description of Procedure

NOTE: For additional services, a standard claim form may be appended to this form.

As the referring dentist, I affirm that all information above is true and accurate.

Referring Dentist's Signature:_____ **Signature Date:**_____

Mail completed form to:

Specialty Referral Request, P.O. Box 30552, Salt Lake City, UT 84130

Specialist Information:

Specialist Name	Street Address	City, State and ZIP Code
		Phone Number

A.2 Specialty Referral Form (Blue Shield of California) — page 2 of 2

Specialty Referral Process

To prevent any delay in processing, Specialty Referral Request Forms must be completed in full per requirements of the specific referral type request (pre-authorization/direct/self/emergency). Include all of the following information necessary to review the referral:

- Specific ADA Procedure Codes
- Tooth numbers or Quadrants
- X-rays, Photographs
- Narrative
- Periodontal Probing

In cases of direct referral, the General Dentist must complete the referral form and provide the original copy and all clinical documentation to the patient for transmittal to the participating specialty care dentist.

For those referrals requiring or requesting pre-authorization, all pertinent supporting attachments must be included and forwarded to:

Specialty Referral Requests
P.O. Box 30552
Salt Lake City, UT 84130-0552

For pre-auth specialty referrals, the Referral will be reviewed and if found to meet the Referral Criteria, approval and notification will be sent to the General Dentist, the authorized Specialty Care Provider and Member/Patient. The referring dentist may be financially liable for treatment not pre-authorized. Emergency treatment should be limited to the services necessary to treat pain, swelling, infection and/or stabilization of the emergency conditions. Definitive care should be deferred until a proper pre-authorization can be performed with X-rays, narrative and other necessary documentation.

In cases where EMERGENCY SERVICES are referred to a specialist, a Specialty Referral Form should be completed and accompany the patient to the specialist, whenever possible. Otherwise the General Dentist or Member may contact Member Services for an authorization number to give to the specialist for approval of the consultation and/or specialty treatment necessary for the stabilization of emergency conditions.

Commonly Referred Specialty Procedure Codes

Oral Surgery

- 9310 Consultation
- 7140 Extraction, erupted tooth or exposed root
- 7210 Surgical removal of erupted tooth
- 7220 Removal of impacted tooth - soft tissue
- 7230 Removal of impacted tooth - partially bony
- 7240 Removal of impacted tooth - completely bony
- 7250 Surgical removal of residual tooth roots (cutting procedure)
- 7285 – 7288 Biopsy (various types, subject to coverage)
- 7310 – 7321 Alveoloplasty (various types)
- 7510 Incision and drainage of abscess

Periodontics

- 9310 Consultation
- 4210 - 4211 Gingivectomy
- 4260 Osseous surgery 4+ contiguous teeth or bounded teeth spaces per quadrant
- 4361 Osseous surgery 1-3 teeth or bounded teeth spaces per quadrant
- 4910 Periodontal Maintenance
- 4263-4267 Bone grafting
- 4270-4276 Soft tissue grafting

Pediatric Dentistry

- 9310 Consultation
- 2140 - 2161 Amalgam restorations
- 2330 - 2335 Composite restorations
- 2930 - 2932 Pre-fabricated crowns (various)
- 3220 Therapeutic pulpotomy
- 3230 - 3240 Pulpal therapy on Primary Teeth
- 7111 Extraction, coronal remnants, deciduous tooth

Endodontics

- 9310 Consultation
- 3310 Anterior root canal (excluding final restoration)
- 3320 Bicuspid root canal (excluding final restoration)
- 3330 Molar root canal (excluding final restoration)
- 3346 Re-treatment of previous root canal therapy-anterior
- 3347 Re-treatment of previous root canal therapy-bicuspid
- 3348 Re-treatment of previous root canal therapy-molar
- 3351-3353 Apexification
- 3410-3430 Apicioectomy/Retrograde filling

Orthodontics

- 9310 Consultation

PROVIDER HOTLINE
1.888.271.4929

10/12 OA100-8364

A.3 Specialty Referral Form (DBP-CA) — page 1 of 2

Specialty Referral Request Form

☐ Pre-Authorization ☐ Direct ☐ Self ☐ Emergency

Dental Benefit Providers® of California

Referring Provider Name	Phone Number	Employee Name	ID #
Street Address		Street Address	
City, State, and ZIP Code		City, State, and ZIP Code	Home Phone
Employer Name	Group Number	Patient's Name / Birth Date	Relationship

Specialist *(check one)*	**Attestation** *(Must be completed for the specialty type, or request will be returned)*	**Other Reasons/Narrative**
☐ **Endodontics**	☐ Yes ☐ No All teeth to be treated by endodontist are restorable? Emergency Palliative Date_____ ☐ Yes ☐ No Teeth to be treated have a good periodontal prognosis? Tooth/Teeth #s _____ ☐ Yes ☐ No Hemisection or root amputation planned? ☐ Yes ☐ No Crown lengthening will be needed? ☐ Yes ☐ No Treatment needed is beyond the scope of a general dentist? **If "Yes" check why below** ☐ Canal(s) cannot be located ☐ Severely curved canal(s)/root ☐ Surgical Procedure ☐ Canal(s) calcified/blocked ☐ Retreatment ☐ Other – *provide narrative in area at right*	
X-rays needed		
☐ **Oral Surgery**	☐ Yes ☐ No Referral is due to medical condition or physical limitation? ☐ Yes ☐ No All teeth requested currently symptomatic? ☐ Yes ☐ No Service(s) for orthodontic purpose(s)? ☐ Yes ☐ No Removal of supernumerary tooth/teeth? ☐ Yes ☐ No Treatment needed is beyond the scope of a general dentist? **If "Yes" check why below** ☐ Treatment of tumor and/or neoplasm ☐ Treatment of nondentigerous cyst ☐ Treatment fractured jaw ☐ Treatment of dislocation or subluxation ☐ Treatment TMJ/myofascial pain ☐ Specialized test or equipment needed ☐ Patient wants general anesthesia when local would normally suffice ☐ Consultation needed to aid in treatment planning or to evaluate a lesion ☐ Surgery too complex for general dentist ☐ Other – *provide narrative in area at right including tooth numbers and pathology*	
X-rays needed for most requests		
☐ **Orthodontics**	☐ Yes ☐ No Patient's oral hygiene/home care is adequate? ☐ Yes ☐ No All diagnosed preventive and restorative treatment completed? Orthodontic treatment is needed because of: ☐ Treatment TMJ/myofascial pain ☐ Retreatment ☐ Malocclusion or crowding ☐ Relapse after orthodontics ☐ Jaw positioning ☐ Micrognathia, macroglossia or other congenital/developmental condition? ☐ Myofunctional therapy ☐ Orthodontic treatment is in progress	
☐ **Pediatric Dentistry**	☐ Yes ☐ No If patient is over 3 years, treatment was attempted? ☐ Yes ☐ No Treatment needed is beyond the scope of a general dentist? **If "Yes" check why below** ☐ Complexity of case, **not** related to medical condition or limitations ☐ Inability to cooperate, **not** related to medical condition or limitations ☐ Medical condition/physical limitations ☐ Other – *provide narrative in area at right*	
X-rays needed for most requests		
☐ **Periodontics**	☐ Yes ☐ No Patient's oral hygiene/home care is adequate? ☐ Yes ☐ No Prophylaxis and scaling/root planing completed? ☐ Yes ☐ No Pocket charting done before & after scaling/root planing? ☐ Yes ☐ No Bone graft/bone replacement? ☐ Yes ☐ No Crown lengthening? ☐ Yes ☐ No Treatment needed is beyond the scope of a general dentist? **If "Yes" check why below** ☐ Osseous mucogingival surgery is needed to reduce pockets ☐ Gingival grafting is needed to treat recession in absence of pockets ☐ Patient has not responded to treatment by general practice provider ☐ To aid in treatment planning ☐ Dates of SRPs UR _____ LR _____ UL _____ LL _____ ☐ Re-Eval Date _____ ☐ Case Type IV ☐ Perio Prognosis # _____ ☐ Other – *provide narrative in area at right*	
X-rays & Perio Chart needed for most requests		

Services Requested for Referral

Procedure Code	Tooth/Quad/Arch	Description of Procedure

NOTE: For additional services, a standard claim form may be appended to this form.

As the referring dentist, I affirm that all information above is true and accurate.

Referring Dentist's Signature: _____ Signature Date: _____

Mail Completed Form to:

Specialty Referral Request, P.O. Box 30552, Salt Lake City, UT 84130

Specialist Information:

Specialist Name	Phone
Street Address	City, State, and ZIP Code

7/23 OA 100-7673

A.3 Specialty Referral Form (DBP-CA) — page 2 of 2

Specialty Referral Process

To prevent any delay in processing, Specialty Referral Request Forms must be completed in full per requirements of the specific referral type request (pre-authorization/direct/self/emergency). Include all of the following information necessary to review the referral:

- Specific ADA Procedure Codes
- Tooth numbers or Quadrants
- X-Rays, Photographs
- Narrative
- Periodontal Probing

In cases of direct referral, the General Dentist must complete the referral form and provide the original copy and all clinical documentation to the patient for transmittal to the participating specialty care dentist.

For those referrals requiring or requesting pre-authorization, all pertinent supporting attachments must be included and forwarded to:

Specialty Referral Requests
P.O. Box 30552
Salt Lake City, UT 84130-0552

For pre-auth specialty referrals, the Referral will be reviewed and if found to meet the Referral Criteria, approval and notification will be sent to the General Dentist, the authorized Specialty Care Provider and Member/Patient. The referring dentist may be financially liable for treatment not pre-authorized. Emergency treatment should be limited to the services necessary to treat pain, swelling, infection and/or stabilization of the emergency conditions. Definitive care should be deferred until a proper pre-authorization can be performed with x-rays, narrative and other necessary documentation.

In cases where **Emergency Services** are referred to a specialist, a Specialty Referral Form should be completed and accompany the patient to the specialist, whenever possible. Otherwise the General Dentist or Member may contact Member Services for an authorization number to give to the specialist for approval of the consultation and/or specialty treatment necessary for the stabilization of emergency conditions.

Commonly Referred Specialty Procedure Codes

Oral Surgery
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- 7140 Extraction, erupted tooth or exposed root
- 7210 Surgical removal of erupted tooth
- 7220 Removal of impacted tooth - soft tissue
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- 7240 Removal of impacted tooth - completely bony
- 7250 Surgical removal of residual tooth roots (cutting procedure)
- 7285 – 7288 Biopsy (various types, subject to coverage)
- 7310 – 7321 Alveoloplasty (various types)
- 7510 Incision and drainage of abscess

Periodontics
- 9310 Consultation
- 4210 – 4211 Gingivectomy
- 4260 Osseous surgery 4+ contiguous teeth or bounded teeth spaces per quadrant
- 4361 Osseous surgery 1-3 teeth or bounded teeth spaces per quadrant
- 4910 Periodontal Maintenance
- 4263 – 4267 Bone grafting
- 4270 – 4276 Soft tissue grafting

Pediatric Dentistry
- 9310 Consultation
- 2140 – 2161 Amalgam restorations
- 2330 – 2335 Composite restorations
- 2930 – 2932 Prefabricated crowns (various)
- 3220 Therapeutic pulpotomy
- 3230 – 3240 Pulpal therapy on Primary Teeth
- 7111 Extraction, coronal remnants, deciduous tooth

Endodontics
- 9310 Consultation
- 3310 Anterior root canal (excluding final restoration)
- 3320 Bicuspid root canal (excluding final restoration)
- 3330 Molar root canal (excluding final restoration)
- 3346 Re-treatment of previous root canal therapy-anterior
- 3347 Re-treatment of previous root canal therapy-bicuspid
- 3348 Re-treatment of previous root canal therapy-molar
- 3351– 3353 Apexification
- 3410 – 3430 Apicioectomy/Retrograde filling

Orthodontics
- 9310 Consultation

Provider Hotline:

1-877-732-4337	UnitedHealthcare Dental Pacific Union Dental Direct Compensation UnitedHealthcare Dental (PacifiCare Dental)
1-888-877-7828	Lincoln Financial Group
1-866-249-2382	Health Net of CA
1-888-271-4929	Blue Shield of California

A.4.a Direct Compensation IPA Summary

PACIFIC UNION DENTAL
A Dental Benefit Providers of California, Inc. Product

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

DATE: 09/17/2022

IPA SUMMARY

Net Premium for IPA 1	:	$1,338,380.02		
% Premium to Healthcare:		75.00%		
Health Care Premium:		$1,003,785.02	Net Production Units:	1489
Less Specialty Care:		($253,786.94)	% Compensation to Prod:	90.60%
Less Ortho Care:		($19,557.03)	Total Compensation:	$1,349.03
Less Quality Assurance:		($7,756.68)	Copays Collected in Office:	$142.00
Plus Total Copayments:		$94,447.00	Total Direct Compensation:	$1,207.03
Total Compensation:		$817,131.37	Net Direct Compensation:	$5,754.09
Total RVU Production Units:		901,911		
% RVU Comp to Prod:		90.60%		

A.4.b Direct Compensation Provider Statement

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

PROVIDER STATEMENT

Check Date:	09/17/2022
Payee Number:	000000123456
Check Amount:	$4,546.89

Dr John Smith DDS
2300 Clayton Rd Ste 1000
Concord CA 94520

Quantity Total:	175
RVU Total:	6,678
Copay Total:	$177.00

IPA Number	Total Paid	IPA Number	Total Paid
1	$1,207.03	5	$4,546.89

PACIFIC UNION DENTAL™
A Dental Benefit Providers of California, Inc. Product

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

Patient Detail Report - By Provider

IPA Number: 1
Provider Name: Smith, John
Provider Number: 000000012345

Member ID and Suffix Group Number	Claim ID	Member Name	Service Date	QTY	ADA Code	Description	Tooth No	Surface	Paid Amount	Value	Copay	Proc Date	EOB Code
999999999, 00 222222	081111111111	Doe, John	04/28/2022	1	D2150	amalgam - two surfaces	5	DO	0.00	54	6.00	06/18/2022	
			05/05/2022	1	D2140	amalgam - one surface	6	D	0.00	36	5.00	06/18/2022	
888888888, 01 333333	081111111112	Jones, Jane	05/07/2022	1	D1110	prophylaxis - adult			0.00	45	0.00	06/18/2022	
777777777, 00 444444	081111111113	Brown, Alice	05/12/2022	1	D0120	periodic oral evaluation			0.00	10	0.00	06/18/2022	
			05/12/2022	1	D0220	intraoral - periapical - first			0.00	09	0.00	06/18/2022	
			05/12/2022	1	D0230	intraoral - periapical -			0.00	05	0.00	06/18/2022	
			05/12/2022	each 1	D0274	bitewings - four films			0.00	24	0.00	06/18/2022	
666666666, 02 111111	081111111114	Green, Robert	05/16/2022	1	D1110	prophylaxis - adult			0.00	00	0.00	06/18/2022	DP2
555555555, 00 222222	081111111115	Black, Sandra	05/27/2022	1	D2791	crown - full cast predominant	31		450.00	00	0.00	06/18/2022	
Provider Totals:				9					450.00	183	11.00		
Totals for Payee and IPA				9					450.00	183	11.00		

Remark code Legend:
DP2 Service denied. Does not meet the frequency requirements of the plan.
Adjustments may have been made to reflect co-payment to align with lower RVU. Please charge member applicable co-payment as defined on benefit schedule.

A.5 Demographics Change Form

Provider Information Demographic Change Submission Form

United Healthcare | Dental Benefit Providers

Description of when to use form: To be used by provider if the provider has made changes to ANY of their demographic information (name change, address change, TIN change, etc.). *Form must be signed at bottom to be processed. Please list all providers associated with this change. Failure to sign, list all associated providers requesting the update, or attach required documentation will delay your request.*

Providers: 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 **PRIOR** to submitting your claim(s) and within 30 days of the change taking place.
For real-time updates and to reduce turn around times by 3-5 days, please visit the Self Service section after registration and log-in on uhcdental.com

Please check **ALL** the demographic items that **need** to be updated and complete all sections as appropriate. Please submit completed form using one of the methods to the right:
Request Number (if given by Customer Service):_____

Mailing Address: Dental Benefit Providers, Inc. (DBP-CA Inc)
ATTN: Dental Provider Services
PO Box 30567, Salt Lake City UT 84130
Fax: 248-733-6372
Email: dbpprvfx@uhc.com

☐ Please check box if making a TIN (Tax ID Number) change. (***Copy of updated W-9 form is required)*** ***May be subject to new contracting.***

Current Tax ID:	**New Tax ID:**	**Effective date of change :**	**Reprocess Claims? :** ☐ ***Yes***

☐ Please check box if making a dentist name change. (***Copy of updated dental license is required)***

Current Name: (Last) (First)

New Name: (Last) (First)

☐ Please check box if changing specialty. (***Copy of specialty certification is required)*** ☐ Please check box if board certified.

Effective date of office information change: ☐ Please check if office is handicap accessible.

PRACTICE LOCATION	**REMITTANCE ADDRESS**
Previous/Current Office Name:	**New Office Name:**
Previous/Current Address:	**Previous/Current Address:**
(Street #) (Suite #)	(Street #) (Suite #)
(City) (State) (Zip)	(City) (State) (Zip)
New Address:	**New Address:**
(Street #) (Suite #)	(Street #) (Suite #)
(City) (State) (Zip)	(City) (State) (Zip)
Languages Spoken Other Than English:	☐ Please check box if remittance is same as office location.
Phone Number: **Fax Number:**	**Email Address:**

New Office Hours:	Mon	Tue	Wed	Thu	Fri	Sat	Sun

☐ ***Please check box if Associate Provider(s) need to be termed*** **Term Reason** ☐ **Provider Left Practice** ☐ **Other**

Providers associated with the requested change: _____

PROVIDER SIGNATURE: **DATE:**

WPN: Prov W9 Rev May 2023

A.6 Site Audit Structural Review and Chart Form — page 1 of 2

Office/Provider Name:		Prac #:	United Healthcare | Dental Benefit Providers of California
Address:		Plan:	
City:	State:	Auditor:	
Zip Code:		Date:	

***1=Acceptable**
***0=Unacceptable**
***/ =Non Applicable**

NOTES:

STRUCTURAL REVIEW

**** = Must have items for all offices. Automatic FAIL without these items.**

Languages:

☐ Other(non English) ☐ Armenian ☐ Korean ☐ Farsi/Persian ☐ Tagalog/Filipino
☐ French ☐ Hindi ☐ Cantonese ☐ Spanish ☐ Vietnamese
☐ Arabic ☐ Bengali ☐ Russian ☐ German ☐ Chinese

I. ACCESSIBILITY	*Earned	*Possible	Comments
A. 24-hour emergency contact system.			
B. Reasonable appointment scheduling for plan members.			
C. Language Assistance Program and Documents (California Only)			
II. FACILITY AND EQUIPMENT			
A. Clean, safe, neat and well maintained.			
B. Compliance with mercury hygiene, safety regulations.			
C. Nitrous oxide recovery system.			
D. Lead apron (with thyroid collar) for patient.			
III. EMERGENCY PROCEDURES AND EQUIPMENT			
A. Written emergency protocols.			
B. Medical emergency kit on-site.			
C. Portable emergency oxygen available.			
IV. STERILIZATION AND INFECTION CONTROL			
A. Sterilization and infection control protocols followed.			
B. Protocol posted for sterilization procedures.			
C. Weekly biological (spore) monitoring of sterilizer.			
D. All instruments and hand-pieces properly cleaned, sterilized, and stored.			
E. Log kept monitoring changing of sterilization solutions.			
F. Staff wears appropriate personal protective equipment.			
G. Proper and adequate use of barrier techniques.			
H. Hand-pieces & waterlines flushed appropriately.			
I. Infection control and cross-contamination prevention procedures followed in the office and laboratory.			
TOTAL			**Ratio out of 50** (Earned points / Possible points x 0.5 x 100 = Ratio)

Signature of Provider/Office Manager/Designee	Date	Reviewer's Signature	Date

Rev 04/2013

A.6 Site Audit Structural Review and Chart Form — page 2 of 2

United Healthcare | Dental Benefit Providers of California

Chart Forms

(Please attach blank chart forms. Chart forms are not required for change of address.)

*1=Acceptable *0=Unacceptable */ =Non Applicable	NOTES:

I. Medical/Dental History	*Earned	*Possible	Comments
A. Comprehensive form: Phen fen, latex allergy, joint replacement, pacemaker, heart problems: Yes/No Answers			
B. Space for MD's name, address and phone number			
C. Spaces for signature of patient and date			
D. Spaces for signature of dentist			
E. Specific location in chart identified to prominently display allergies and other medical alerts			
F. Area to update medical history			
II. DIAGNOSTIC INFORMATION			
A. Area for charting existing restorations			
B. Area for charting periodontal screening and diagnosis			
C. Area for charting soft tissue/oral cancer examination			
D. Area for charting status of occlusion/malocclusion			
E. Forms available for a complete periodontal examination with pocket			
F. Area for recording TMJ condition			
III. PROGRESS NOTES AND CONSENT FORM			
A. Section for progress notes			
B. Adequate space available to fully describe dental procedures			
C. Spaces for date and signature of dentist			
D. Includes consent form(s) with spaces for date, signature of patient/guardian.			
IV. DIAGNOSIS, TREATMENT PLAN, FINANCIAL AGREEMENT			
A. Patient record includes a section for a treatment plan with fees			
B. Area for treatment plan includes space for signature/initials of patient to indicate presentation and acceptance of the direct patient costs			
C. Area included for alternative treatment plans			
D. Area to document existing dental pathology			
V. RECALL SYSTEM			
A. Forms (Recall Cards/Computer Generated) facilitate a functional recall system			
TOTAL			**Ratio out of 50** (Earned points / Possible points x 0.5 x 100 = Ratio)

Total Audit Points Earned (Ratio)	
Total Chart Points Earned (Ratio)	
Score (Chart+	

Signature of Provider/Office Manager/Designee	Date	Reviewer's Signature	Date

Rev 04/2013

A.7 Site Visit Procedural Audit Documentation — page 1 of 6

United Healthcare | Dental Benefit Providers of California

Procedural Audit

Office/Provider Name:	Office ID	1)
Address:	Plan:	2)
	Auditor:	3)
	Date:	4)
		5)
PROCESS OF CARE	**Chart IDs:**	6)
A=Acceptable		7)
U=Unacceptable		8)
/ = Non Applicable		9)
		10)

I. DOCUMENTATION **A. Medical History**	**Rating**									
*1. Comprehensive information collection	1)	2)	3)	4)	5)	6)	7)	8)	9)	10)
2. Medical follow-up	1)	2)	3)	4)	5)	6)	7)	8)	9)	10)
3. Appropriate medical alert	1)	2)	3)	4)	5)	6)	7)	8)	9)	10)
4. Doctor signature and date	1)	2)	3)	4)	5)	6)	7)	8)	9)	10)
5. Periodic update	1)	2)	3)	4)	5)	6)	7)	8)	9)	10)

Notes:

B. Dental History/Chief Complaint										
1. Dental History/Chief Complaint	1)	2)	3)	4)	5)	6)	7)	8)	9)	10)

Notes:

C. Documentation of Baseline Intra/Extra Oral Examination										
1. Status of teeth/existing conditions	1)	2)	3)	4)	5)	6)	7)	8)	9)	10)
*2. TMJ/occlusion evaluation	1)	2)	3)	4)	5)	6)	7)	8)	9)	10)
3. Prosthetics	1)	2)	3)	4)	5)	6)	7)	8)	9)	10)
4. Status of periodontal condition	1)	2)	3)	4)	5)	6)	7)	8)	9)	10)
*5. Soft tissue/oral cancer exam	1)	2)	3)	4)	5)	6)	7)	8)	9)	10)

Notes:

A.7 Site Visit Procedural Audit Documentation — page 2 of 6

United Healthcare | Dental Benefit Providers of California

D. Progress Notes										
1. Legible and in ink	1)	2)	3)	4)	5)	6)	7)	8)	9)	10)
2. Signed and dated by provider	1)	2)	3)	4)	5)	6)	7)	8)	9)	10)
3. Anesthetics notes	1)	2)	3)	4)	5)	6)	7)	8)	9)	10)
4. Prescriptions noted	1)	2)	3)	4)	5)	6)	7)	8)	9)	10)
Notes:										

II. QUALITY OF CARE A. Radiographs										
*1. Quantity/frequency	1)	2)	3)	4)	5)	6)	7)	8)	9)	10)
2. Technical quality	1)	2)	3)	4)	5)	6)	7)	8)	9)	10)
3. Mounted, labeled and dated	1)	2)	3)	4)	5)	6)	7)	8)	9)	10)
Notes:										

B. Treatment Plan										
1. Present and in ink	1)	2)	3)	4)	5)	6)	7)	8)	9)	10)
2. Sequenced	1)	2)	3)	4)	5)	6)	7)	8)	9)	10)
*3. Informed Consent	1)	2)	3)	4)	5)	6)	7)	8)	9)	10)
Notes:										

III. TREATMENT OUTCOMES OF CARE A. Preventative Services										
*1. Diagnosis	1)	2)	3)	4)	5)	6)	7)	8)	9)	10)
2. Oral hygiene instructions	1)	2)	3)	4)	5)	6)	7)	8)	9)	10)
3. Recall	1)	2)	3)	4)	5)	6)	7)	8)	9)	10)
Notes:										

A.7 Site Visit Procedural Audit Documentation — page 3 of 6

United Healthcare | Dental Benefit Providers of California

B. Operative Services										
*1. Diagnosis	1)	2)	3)	4)	5)	6)	7)	8)	9)	10)
2. Restorative outcome and follow-up	1)	2)	3)	4)	5)	6)	7)	8)	9)	10)
3. Specialist Referral	1)	2)	3)	4)	5)	6)	7)	8)	9)	10)
Notes:										

C. Crown and Bridge Services										
*1. Diagnosis	1)	2)	3)	4)	5)	6)	7)	8)	9)	10)
*2. Restorative outcome and follow-up	1)	2)	3)	4)	5)	6)	7)	8)	9)	10)
3. Specialist Referral	1)	2)	3)	4)	5)	6)	7)	8)	9)	10)
Notes:										

D. Endodontic Services										
*1. Diagnosis	1)	2)	3)	4)	5)	6)	7)	8)	9)	10)
*2. Rubber dam use	1)	2)	3)	4)	5)	6)	7)	8)	9)	10)
3. Endodontic outcome and follow-up	1)	2)	3)	4)	5)	6)	7)	8)	9)	10)
4. Specialist Referral	1)	2)	3)	4)	5)	6)	7)	8)	9)	10)
Notes:										

E. Periodontic Services										
*1. Diagnosis	1)	2)	3)	4)	5)	6)	7)	8)	9)	10)
2. Treatment per visit	1)	2)	3)	4)	5)	6)	7)	8)	9)	10)
3. Periodontal follow-up/outcome	1)	2)	3)	4)	5)	6)	7)	8)	9)	10)
4. Specialist Referral	1)	2)	3)	4)	5)	6)	7)	8)	9)	10)
Notes:										

A.7 Site Visit Procedural Audit Documentation — page 4 of 6

United Healthcare | Dental Benefit Providers of California

F. Prosthetic Services										
*1. Diagnosis	1)	2)	3)	4)	5)	6)	7)	8)	9)	10)
2. Prosthetic outcome and follow-up	1)	2)	3)	4)	5)	6)	7)	8)	9)	10)
3. Specialist Referral	1)	2)	3)	4)	5)	6)	7)	8)	9)	10)
Notes:										

G. Surgical Services										
*1. Diagnosis	1)	2)	3)	4)	5)	6)	7)	8)	9)	10)
2. Surgical outcome and follow-up	1)	2)	3)	4)	5)	6)	7)	8)	9)	10)
3. Specialist Referral	1)	2)	3)	4)	5)	6)	7)	8)	9)	10)
Notes:										

H. Overall Patient Care										
*Overall care meets professionally recognized standards	1)	2)	3)	4)	5)	6)	7)	8)	9)	10)
Notes:										

General Notes

A.7 Site Visit Procedural Audit Documentation — page 5 of 6

United Healthcare | Dental Benefit Providers of California

Patient Comments:

Patient 1:
Patient 2:
Patient 3:
Patient 4:
Patient 5:
Patient 6:
Patient 7:
Patient 8:
Patient 9:
Patient 10:

Signature of Provider	Date	Chart Reviewer's Signature	Date

A.7 Site Visit Procedural Audit Documentation — page 6 of 6

United Healthcare | Dental Benefit Providers of California

Structural Review		
Office/Provider Name:	Office ID	NOTES
Address:	Plan:	
	Auditor:	
	Date:	

A=Acceptable
U=Unacceptable
/ = Non Applicable

STRUCTURAL REVIEW

Languages: ☐ Arabic ☐ Armenian ☐ Korean ☐ Farsi/Persian ☐ Chinese
☐ French ☐ Hindi ☐ German ☐ Spanish ☐ Cantonese
☐ Other (non English) ☐ Bengali ☐ Russian ☐ Tagalog/Filipino ☐ Mandarin

I. ACCESSIBILITY	Rating	Comments/Recommendations
A. 24-hour emergency contact system.		
B. Reasonable appointment scheduling for plan members.		
C. Language assistance program and documents.		
II. FACILITY AND EQUIPMENT		
A. Clean, safe, neat and well maintained.		
B. Compliance with mercury hygiene, safety regulations.		
C. Nitrous oxide recovery system.		
D. Lead apron (with thyroid collar) for patient.		
III. EMERGENCY PROCEDURES AND EQUIPMENT		
A. Written emergency protocols.		
*B. Medical emergency kit on-site.		
*C. Portable emergency oxygen available.		
IV. STERILIZATION AND INFECTION CONTROL		
*A. Sterilization and infection control protocols followed.		
B. Protocol posted for sterilization procedures.		
*C. Weekly biological (spore) monitoring of sterilizer.		
*D. All instruments and hand-pieces properly cleaned, sterilized, and stored.		
E. Log kept monitoring changing of sterilization solutions.		
F. Staff wears appropriate personal protective equipment.		
G. Proper and adequate use of barrier techniques.		
H. Hand-pieces & waterlines flushed appropriately.		
I. Infection control and cross contamination prevention procedures followed in the office and laboratory.		

Signature of Provider	Date	Chart Reviewer's Signature	Date

A.8 Site Visit CADP Orthodontic Procedural Audit Documentation — page 1 of 6

United Healthcare | Dental Benefit Providers of California

CADP Orthodontic Procedural Audit

Office/Provider Name:	Office ID:	1)
Address:	Plan:	2)
	Auditor:	3)
	Date:	4)
		5)
PROCESS OF CARE	**Chart IDs:**	6)
A=Acceptable		7)
U=Unacceptable		8)
/ = Non Applicable		9)
		10)

1. INFORMED CONSENT FORM	**Rating**									
a. Appropriate content?	1)	2)	3)	4)	5)	6)	7)	8)	9)	10)
b. Signed/dated by DDS?	1)	2)	3)	4)	5)	6)	7)	8)	9)	10)
c. Signed/dated by patient (or guardian)?	1)	2)	3)	4)	5)	6)	7)	8)	9)	10)
Notes:										

2. MEDICAL-DENTAL HISTORY										
a. Collected, comprehensive, Y/N format?	1)	2)	3)	4)	5)	6)	7)	8)	9)	10)
b. Initialed/dated by DDS?	1)	2)	3)	4)	5)	6)	7)	8)	9)	10)
c. Signed/dated by patient (or guardian)?	1)	2)	3)	4)	5)	6)	7)	8)	9)	10)
d. Updated periodically?	1)	2)	3)	4)	5)	6)	7)	8)	9)	10)
e. Appropriate medical alerts posted?	1)	2)	3)	4)	5)	6)	7)	8)	9)	10)
f. Follow-up on positive responses?	1)	2)	3)	4)	5)	6)	7)	8)	9)	10)
Notes:										

3. INTRA/EXTRA ORAL EXAMINATION										
a. *Periodontal screening	1)	2)	3)	4)	5)	6)	7)	8)	9)	10)
b. *Soft tissue status/oral cancer screening	1)	2)	3)	4)	5)	6)	7)	8)	9)	10)
c. TMJ status	1)	2)	3)	4)	5)	6)	7)	8)	9)	10)
d. *Baseline conditions (midline, overbite, overjet, crowding, crossbites)	1)	2)	3)	4)	5)	6)	7)	8)	9)	10)
e. Habits	1)	2)	3)	4)	5)	6)	7)	8)	9)	10)
Notes:										

A.8 Site Visit CADP Orthodontic Procedural Audit Documentation — page 2 of 6

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4. LEGIBILITY										
a. All records, names, dates, procedures legible	1)	2)	3)	4)	5)	6)	7)	8)	9)	10)
Notes:										
5. RADIOGRAPHS										
a. Technical quality	1)	2)	3)	4)	5)	6)	7)	8)	9)	10)
b. Appropriate baseline	1)	2)	3)	4)	5)	6)	7)	8)	9)	10)
c. Cephalometric film	1)	2)	3)	4)	5)	6)	7)	8)	9)	10)
d. *Cephalometric tracing	1)	2)	3)	4)	5)	6)	7)	8)	9)	10)
e. *FMX/panoramic radiograph	1)	2)	3)	4)	5)	6)	7)	8)	9)	10)
f. Tomograph survey (if appropriate)	1)	2)	3)	4)	5)	6)	7)	8)	9)	10)
g. Organized (current, mounted, dated, name)	1)	2)	3)	4)	5)	6)	7)	8)	9)	10)
h. Mid treatment x-ray	1)	2)	3)	4)	5)	6)	7)	8)	9)	10)
Notes:										
6. DIAGNOSIS										
a. Angle classification	1)	2)	3)	4)	5)	6)	7)	8)	9)	10)
b. *Caries, restorative problems (or clearance)	1)	2)	3)	4)	5)	6)	7)	8)	9)	10)
c. *Periodontal diagnosis	1)	2)	3)	4)	5)	6)	7)	8)	9)	10)
d. Impactions, missing teeth, other pathology	1)	2)	3)	4)	5)	6)	7)	8)	9)	10)
e. Periapical pathology, root problems	1)	2)	3)	4)	5)	6)	7)	8)	9)	10)
f. *Endodontics	1)	2)	3)	4)	5)	6)	7)	8)	9)	10)
g. *Appropriate for patient's condition	1)	2)	3)	4)	5)	6)	7)	8)	9)	10)
Notes:										

A.8 Site Visit CADP Orthodontic Procedural Audit Documentation — page 3 of 6

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7. ORTHO WORK-UP										
a. Study models trimmed to bile	1)	2)	3)	4)	5)	6)	7)	8)	9)	10)
b. Charting/measurements	1)	2)	3)	4)	5)	6)	7)	8)	9)	10)
c. Photos (to AAO guidelines)	1)	2)	3)	4)	5)	6)	7)	8)	9)	10)
Notes:										
8. TREATMENT PLAN										
a. Treatment plan goals listed	1)	2)	3)	4)	5)	6)	7)	8)	9)	10)
b. Patient's chief compliant	1)	2)	3)	4)	5)	6)	7)	8)	9)	10)
c. *Treatment plan appropriate, detailed, sequenced	1)	2)	3)	4)	5)	6)	7)	8)	9)	10)
d. Extractions or non-extraction specified	1)	2)	3)	4)	5)	6)	7)	8)	9)	10)
e. Treatment plan options or compromises listed	1)	2)	3)	4)	5)	6)	7)	8)	9)	10)
f. Estimated treatment time	1)	2)	3)	4)	5)	6)	7)	8)	9)	10)
Notes:										
9. PREVENTIVE										
a. Regular prophylaxis recommended or performed	1)	2)	3)	4)	5)	6)	7)	8)	9)	10)
b. Initial oral hygiene instruction documented	1)	2)	3)	4)	5)	6)	7)	8)	9)	10)
c. Hygiene monitored	1)	2)	3)	4)	5)	6)	7)	8)	9)	10)
Notes:										
10. PROGRESS NOTES										
a. General (in ink, clear, complete, next visit noted)	1)	2)	3)	4)	5)	6)	7)	8)	9)	10)
b. Prescription drugs (Rx, disp, sig, etc.)	1)	2)	3)	4)	5)	6)	7)	8)	9)	10)
c. Signed/Initialed & dated by licensed provider	1)	2)	3)	4)	5)	6)	7)	8)	9)	10)
d. Noncompliance noted	1)	2)	3)	4)	5)	6)	7)	8)	9)	10)
Notes:										

A.8 Site Visit CADP Orthodontic Procedural Audit Documentation — page 4 of 6

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11. TREATMENT										
a. Appointment interval document and appropriate	1)	2)	3)	4)	5)	6)	7)	8)	9)	10)
b. Efficient and timely treatment	1)	2)	3)	4)	5)	6)	7)	8)	9)	10)
c. Documentation of treatment declined	1)	2)	3)	4)	5)	6)	7)	8)	9)	10)
d. *Overall care meets professionally recognized standards	1)	2)	3)	4)	5)	6)	7)	8)	9)	10)
e. Final records include x-rays, photos	1)	2)	3)	4)	5)	6)	7)	8)	9)	10)
f. Retainers monitored properly	1)	2)	3)	4)	5)	6)	7)	8)	9)	10)
Notes:										
12. CONTINUITY OF CARE										
a. Documentation of broken appointment follow-up	1)	2)	3)	4)	5)	6)	7)	8)	9)	10)
b. Documentation of noncompliance follow-up	1)	2)	3)	4)	5)	6)	7)	8)	9)	10)
c. Referral to GP or specialist when indicated	1)	2)	3)	4)	5)	6)	7)	8)	9)	10)
d. Referral confirmation and follow-up	1)	2)	3)	4)	5)	6)	7)	8)	9)	10)
e. Transfer case protocol followed	1)	2)	3)	4)	5)	6)	7)	8)	9)	10)
Notes:										

General Notes

A.8 Site Visit CADP Orthodontic Procedural Audit Documentation — page 5 of 6

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Patient Comments:

Patient 1:
Patient 2:
Patient 3:
Patient 4:
Patient 5:
Patient 6:
Patient 7:
Patient 8:
Patient 9:
Patient 10:

Signature of Provider	Date	Chart Reviewer's Signature	Date

A.8 Site Visit CADP Orthodontic Procedural Audit Documentation — page 6 of 6

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CADP Orthodontic Structural Review		
Office/Provider Name:	Office ID:	NOTES
Address:	Plan:	
	Auditor:	
	Date:	

A=Acceptable
U=Unacceptable
/ = Non Applicable

STRUCTURAL REVIEW

Languages: ☐ Arabic ☐ Armenian ☐ Korean ☐ Farsi/Persian ☐ Chinese
☐ French ☐ Hindi ☐ German ☐ Spanish ☐ Cantonese
☐ Other (non English) ☐ Bengali ☐ Russian ☐ Tagalog/Filipino ☐ Mandarin

I. ACCESSIBILITY	Rating	Comments
A. 24-hour emergency contact system.		
B. Reasonable appointment scheduling for plan members.		
C. Language assistance program and documents.		
II. FACILITY AND EQUIPMENT		
A. Clean, safe, neat and well maintained.		
B. Lead apron (with thyroid collar) for patient.		
III. EMERGENCY PROCEDURES AND EQUIPMENT		
A. Written emergency protocols.		
*B. Medical emergency kit on-site.		
*C. Portable emergency oxygen available.		
IV. STERILIZATION AND INFECTION CONTROL		
*A. Sterilization and infection control protocols followed.		
B. Protocol posted for sterilization procedures.		
*C. Weekly biological (spore) monitoring of sterilizer.		
*D. All instruments and hand-pieces properly cleaned, sterilized, and stored.		
E. Log kept monitoring changing of sterilization solutions.		
F. Staff wears appropriate personal protective equipment.		
G. Proper and adequate use of barrier techniques.		
H. Hand-pieces & waterlines flushed appropriately.		
I. Infection control and cross-contamination prevention procedures followed in the office and laboratory.		

Signature of Provider	Date	Chart Reviewer's Signature	Date

A.9 Orthodontic Criteria & Guidelines — page 1 of 7

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SECTION I: **ORTHODONTIC CRITERIA & GUIDELINES**

A. Introduction

The following criteria and guidelines for monitoring orthodontic care are presented for the use of the Plan and their orthodontic care providers in order to facilitate a high level of treatment quality for their orthodontic patients. Included in this document are guidelines to assist in compliance with the requirements of Federal and State regulatory authorities.

The material presented is ***not intended to establish or dictate standards of care*** for the orthodontic profession. It is understood that standards of care are variables that are determined by the orthodontists practicing in a specific community or geographic area, as well as, orthodontic societies, educational institutions, teaching foundations and regulatory bodies.

The Plan acknowledges that the responsibility for proper treatment of orthodontic patients is determined and carried out by trained orthodontic specialists in response to the needs and the best interests of their patients.

B. The Review Process

1. Purpose: To provide a specific process for reviewing and monitoring the quality and delivery of orthodontic treatment. This process will be concerned with the patient's dental health, function, stability and aesthetics, and will be a means for identifying potential deficiencies in the delivery of orthodontic services.

2. Policy: A major component of this Quality Improvement Program is the review of orthodontic provider's charts, facilities and grievances to ensure compliance with professionally recognized community standards of care and to help establish and maintain high levels of treatment outcomes and patient satisfaction.

3. Criteria: The audit cycle shall be as follows:

A periodic cycle of auditing is used for all The Plan offices where orthodontic treatment is provided. The audit score, the nature of the deficiencies, and the consultant's comments can determine the audit follow-up process. The overall audit score shall be determined as follows:

a. Orthodontic providers must attain a score of at least 80% on both the Orthodontic Facility and Chart Review checklist. If a provider does not attain a score of at least 80%, the orthodontic consultant, in conjunction with other appropriate Plan representatives, shall take corrective action with the reviewed orthodontist. Critical area(s) of concern will require immediate attention and correction verification.

b. The Plan will communicate with the provider following the facility and chart audit with an audit response letter with details of the audit findings (and require a return signed agreement of compliance). The Quality Improvement Manager will contact the provider on a case by case basis. A written response from the provider will be requested when needed.

The orthodontic consultant will be available to review all member complaints and grievances relating to quality of care issues and will report all findings and recommendations to the Dental Director, the Quality Assurance Committee, and / or the Peer Review Committee as necessary.

Facility scores below passing are counseled and monitored by the Plan.

c. A standard "Orthodontic Facility and Chart Review" checklist (audit tool) shall be used for each provider audit.

d. Orthodontic providers must attain an overall score of at least 80%. If a provider does not attain a score of at least 80%, the orthodontic consultant, in conjunction with other appropriate Plan representatives, shall take the appropriate corrective actions (listed above) with the reviewed orthodontist. Critical area(s) of concern will require immediate attention and correction verification.

C. Credentials and Calibration of Auditors

If more than one orthodontic auditor is used by the Plan, the auditors will be calibrated. All auditors will be licensed dentists in California with orthodontic credentials based on the same guidelines as the orthodontic providers.

A.9 Orthodontic Criteria & Guidelines — page 2 of 7

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Orthodontic auditors must have current CADP certification.

The objectives of calibration of orthodontic auditors are:

1. to provide and keep current the "Quality of Care Guidelines and Criteria";
2. to assess auditing tools and auditing protocol;
3. to verify auditor consistency in the review of treatment records;
4. to review objectives and protocols for identifying problems; and
5. to review the process and effectiveness of corrective actions.

If more than one orthodontic auditor is used by the Plan, the Plan will hold periodic calibration meetings. Calibration meetings will be held at least annually with all auditors in attendance and participate in evaluating orthodontic charts. Semi-annual chart calibrations may be conducted by telephone or mail. Variations in response will be discussed and clarified. Modifications of the process will be taken, as necessary, to assure consistency of orthodontic reviews.

D. General Criteria (modified and updated from the American Dental Association)

Orthodontics includes space maintenance, tooth guidance, interceptive procedures and full orthodontic treatment to influence growth as well as the positions of individual teeth by applying various forms and degrees of force. Removable and/or fixed appliances may be used to accomplish these goals. Candidates for orthodontic treatment should be in good oral health.

Of particular importance is the timing of treatment, which may be initiated in the deciduous dentition, the mixed dentition or the adult dentition. Orthodontics may be completed in one or more phases of treatment.

The principles and practices of prevention should be employed in the diagnosis and treatment of orthodontic problems, including counseling the patient regarding diet, plaque control and topical fluoride application prior to placement of orthodontic appliances and at appropriate intervals thereafter.

A satisfactory result in orthodontics is dependent upon the combination of professional skill and patient cooperation during all phases of treatment. Considerations include the age of the patient, the severity of the presenting malocclusion, the desired treatment objectives, and the individual ***growth*** (modified) patterns occurring during treatment.

Baseline conditions shall be recorded by means of full mouth radiographs (including at least one lateral cephalogram and tracing and their analysis); study casts oriented in centric relation; intra and extra oral photographs; a complete oral examination; and a complete dental, medical, and family history. Oral myofunctional evaluations are performed as necessary. All diagnostic records shall meet professionally recognized community standards of care.

The appliances and treatments used shall be appropriate for the treatment of the orthodontic problems.

Appliances should fit well. Bands and brackets are adapted and cemented/bonded so that cement margins or bonding material "flash" (modified) are barely visible.

The final outcome of orthodontic treatment should be an optimal end-result for each patient to achieve esthetic improvement and stability of the resultant correction. Key elements include, but are not limited to, the dentition, supporting bone relationships, interdigitation, contact points, overbite and overjet. Active orthodontic treatment should be followed with retention appliances and supervision to help assure stability of correction. It is recommended that final records (x-rays, panorex, photographs and final study models) be utilized to confirm final result goals within a **specified** period of time.

Axial inclination of the anterior and posterior teeth is such that optimal aesthetic and functional results are achieved based on existing patient conditions and, skeletal growth and cooperation.

Interproximal spaces (contacts) are closed.

There is no significant gingival recession, evidence of loss of supporting bone, root resorption, caries or decalcification of the teeth as documented by full mouth radiographs and an oral exam. Factors exhibiting no problem must be noted as "WNL".

Complex orthodontic cases such as that requiring orthognathic surgery may require a multi-disciplinary approach for provision of orthodontic treatment and may necessitate coordination of orthodontist, oral surgeon, physician and periodontist for delivery of care.

A.9 Orthodontic Criteria & Guidelines — page 3 of 7

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For orthodontic treatment of patients that elect to pursue orthodontic treatment alone after disclosure of the benefits of surgical/orthodontic combined treatment, the orthodontist should document that parent/patient was advised of surgery and that parent/patient desired to pursue orthodontic treatment alone. Communication of risks, limitations, complications, consequences and delay of treatment or non-treatment should be documented.

Initial records (modified) should be adequate in amount and quality to properly diagnose the case. Lack of these necessary records will be marked unsatisfactory unless explained. All inter-dental and intra-dental relationship problems, both anterior and posterior, shall be described.

Treatment planning and outcome documentation (modified) shall be specific, sequenced, and detailed as outlined in the "Chart Review Criteria".

Nothing in these criteria/guidelines should be construed as a description of plan benefits. Coverage for particular aspects of orthodontic treatment is between the Plan and member/purchaser, and is, as described, in the member's Coverage Booklet.

SECTION II: **ORTHODONTIC CHART REVIEW PROCESS**

A. Criteria

1. **Chart Selection** The auditor will randomly select a minimum of five (5) of the Pan's patient's charts. Four cases in treatment and one finished cases, or as close to that number and ratio as possible. The charts will be selected from a requested group of fourteen patient's charts. Representative groups of patients in treatment for 1-6 months, 6-18 months and 18-24 months will be chosen when possible. Charts will be identified by patient name and patient chart number if available.

2. **Elements of Record Review: (must be in writing)**

   a. Health History: Comprehensive health history forms shall meet professionally recognized community standards and be used for every patient. The health history form shall include, but not necessarily be limited to, at least the following information:

      1) Dental history / problems (dentist name and phone number)
      2) Patient's treatment goals, **chief complaint** or concerns. (Can also be recorded in Treatment Plan section)
      3) Systemic disease such as:
         Cardiac diseases
         History of rheumatic fever, prosthetic valves, pacemaker
         History of prosthetic joints
         Diabetes
         Hepatitis
         Viral diseases
         Venereal diseases
         HIV status / AIDS
         Bleeding disorders, hemophilia
         History of substance abuse
         Pregnancy state
         Nervous disorder, epilepsy, seizures
      4) Allergies and sensitivity to drugs, dental anesthetics or latex products
      5) Name and telephone number of physician
      6) Present medical treatment/medications (including anti-rejection drug therapy)
      7) Past or present use of appetite suppressant drugs such as Fen-phen (Fen-fluramine and Dexten fluramine)
      8) Family health history
      9) Oral habit history

   b. Health History Evaluation Process:

      1) Each patient shall complete all questions on the history form.
      2) Questions should be in **Yes / No format**.
      3) The **patient or responsible adult** shall **sign and date** the health history form at the **initial** examination.
      4) The **doctor** shall **initial and date** the health history form at the **initial** examination and **all subsequent** updates.

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5) There shall be written evidence of **follow-up** by the doctor for patients with significant medical findings. Follow-up includes verification of the need for antibiotic pre-medication by the physician.
6) **Medical alerts and allergy indicators** shall be prominently displayed on the treatment record for every patient with significant medical problems. Confidentiality must always be maintained. HIPAA regulations must be observed and personal medical information shall not be displayed in a manner that is available for other patients to see. No specific medical information shall be written on the outside of the chart. Ideally, a coded sticker on the outside of the chart will guide the provider and staff to the treatment record alert. The alert must be recorded in an area additional to the health history form.
7) The medical history shall be updated and documented in the chart record or on the prior medical history form by both the patient and the doctor at appropriate intervals. A 12 month or less update interval is recommended.
8) When a patient requires antibiotic pre-medication, the use of antibiotic will be noted in the progress notes.
9) Special need of the patient, i.e. language, physical access, will be documented.

B. Diagnosis and Treatment Plan

1. Intra-oral Examination: The orthodontic chart shall record the following:

a. Oral Soft tissue examination findings including cancer screening. Clearance from the general dentist is acceptable.
b. Documentation of missing teeth and presence and condition of dental prosthesis.
c. Documentation of the presence of pathology, decay and enamel defects. Clearance from the general dentist is acceptable. Notation of "No problem to begin orthodontics", or similar, is needed if no pathology or decay is noted.
d. Periodontal evaluation and screening including recommendations. If visual and radiographic evidence indicated a periodontal problem, the patient should have a full mouth probing or be referred. Periodontal clearance then will be necessary before starting orthodontic treatment. Periodontal assessment or documentation of periodontal referral and status report is necessary on all adults

2. Orthodontic Diagnosis: Diagnosis should be appropriate, adequate and written legibly describing the patient's condition including the following diagnostic aids and observations:

a. Results of intra-oral examination
b. TMJ screening
c. Orthodontic Angle classifications, including sub-divisions (Left or Right), bite relationships (overbite, overjet, mid-line and anterior/posterior cross-bites or open-bites, and functional shifts).
d. Crowding or spacing should be listed in millimeters
e. Habits that may harm or effect the teeth or supporting structures
f. Asymmetries
g. Space analysis
h. Missing or deformed teeth (or roots of teeth)
i. Impactions or eruption irregularities (i.e., ectopic eruption)
j. Cephalometric and x-ray measurements and findings, including profile relationships. Lateral head film of sufficient quality to discern skeletal and soft tissue landmarks and a head film tracing with angular and linear measurements.
k. Radiographs. The following criteria shall apply. The doctor must examine the patient before ordering radiographs at the initial examination.
    1) The quality and quantity of radiographs taken, based on the needs of the patient, shall be sufficient for proper diagnosis and treatment planning. The apices and crowns of all erupted and non-erupted teeth must be visible.
    2) Radiographs and tracings shall be **mounted, identified and dated**.
    3) Radiographs that are non-diagnostic but are necessary to complete the diagnosis should be re-taken. Original radiographs should be maintained in the patient chart, and only radiograph copies shall be mailed out of the office.
    4) **Refusal of radiographs** by the patient should be documented and signed by the patient.
    5) **Frequency of radiographs** for both adults and children shall be in accordance with ADA recommendations and the patient's needs.
    6) **Tomograms** if indicated.

Study Models. Trimmed to wax bite centric relation or mounted to correct bite relationship. Models will show all erupted teeth and be absent of any broken plaster or teeth. Digitized three dimensional electronically recorded models are acceptable. Plaster models are preferred. All models shall have names and dates.

Intra and extra oral photos of proper quality and orientation (use AAO Guidelines for orientation and number)

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Five properly oriented intra-oral and three extra-oral, quality images, are the minimum. All photos shall be named and dated.

3. **Treatment Plans: Written** treatment plan, signed by the treating doctor and patient, shall contain sufficient details to document treatment procedures and shall be consistent with the diagnosis appropriately **dated, sequenced** and include coordination with other providers as indicated. **Alternate treatment plans, if indicated, shall be documented**. Additionally, treatment plan shall describe techniques to achieve treatment goals, bite relationships, dental relationships, soft tissue profile, and skeletal relationships. Content:

   a. Patient's expectations (chief complaint, patient goals, patient's expectations)
   b. Goals of treatment (orthodontist goals)
   c. Appliance and auxiliaries anticipated to be used
   d. Extractions listed and rationale for extraction or non-extraction plan documented
   e. Treatment sequencing
   f. Treatment options and anticipated compromises
   g. Specialist referrals
   h. Estimated treatment time
   i. Limitations to ideal results
   j. Retention Plan included in treatment plan

C. Consent Form and Finances

1. **Informed Consent:** Should be comprehensive, in writing and signed/dated by patient or guardian and initialed by the treating doctor.

   A comprehensive informed consent provides sufficient information to the patient/guardian, verbally and in writing, on benefits and risks of treatment or non-treatment for specific conditions. This form must be sufficient to allow the patient to make an informed decision. The patient's understanding is required for all treatment and treatment recommendations. Approved informed consent forms (i.e. from the AAO) are recommended. Any treatment that is not on a standard consent form shall have an additional specific, written, dated and signed statement of informed consent.

2. **Patient's financial responsibility** is clearly specified and signed/dated by the patient.

D. Progress Notes

Treatment Chart or Treatment Record shall include a written diagnosis, treatment plan, treatment goals, extractions, appliances and auxiliaries, and retention plan (see individual sections).

1. Progress notes or individual appointment entries in chart: Entries must be legible, in ink or typed, signed or initialed and dated by the treating doctor, and must thoroughly describe the following:

   a. Procedures or treatment performed
   b. Poor patient cooperation
   c. Patient progress
   d. Auxiliaries to be worn (elastics, headgear, etc.) including instructions.
   e. Broken or lost appliances
   f. Initial oral hygiene instructions and monitoring
   g. Medications prescribed and instructions given
   h. Any special or post treatment instructions
   i. Next appointment date and procedure(s)
   j. Materials used

   Computerized entries must be unalterable.

2. Orthodontic Records and Chart Notations (general guidelines)

   a. Signature of orthodontist (or initials with unique and documented ID number) must be on each progress note.
   b. All orthodontic records (see Patient Records) properly documented with names and dates.
   c. Records should be stored a minimum of seven (7) years and readily retrievable. Lifetime storage is recommended.
   d. For minor patients, written letters or documentation of verbal counseling will be sent to parent or guardian reporting non-compliance with treatment requirements.
   e. Periodic written referrals to primary care dentist or specialist, including a request for return verification of

A.9 Orthodontic Criteria & Guidelines — page 6 of 7

United Healthcare | Dental Benefit Providers of California

compliance. Documentation of general dentist notification of non-compliance with oral hygiene (i.e., extractions, restorations).

f. Removal of appliances for patient non-compliance will be documented by a release signed by patient and/or guardian.
g. Documentation of any adverse telephone calls or any adverse patient comments at the time of treatment.
h. Record entries and treatment progress notes shall be legible and comprehensive.
i. The strength, dosage, quantity and instructions for their use ("sig.") will describe drugs given or prescribed.
j. Cooperation items will be recorded:
    1) Keeping appointment
    2) Observing eating restrictions
    3) Appliance breakage
    4) Wearing of auxiliaries (elastics, headgear, appliances)
    5) Oral hygiene
    6) Periodic dental check-ups
k. Refusal of recommended treatment
l. Dental lab prescriptions are to be documented

E. Emergency Care

Any emergency care for the patient is to be appropriate, timely, and documented in the patient's record. Appropriate x-rays, medications and conversations should be noted.

F. Continuity of Care

Progress Records (progress monitoring aids) and procedures

1. Progress (mid-treatment) x-ray(s): Yearly, during active treatment, or as needed to check root and bone structure especially on adults and high root resorption risk patients (possibly every three to six months), or patients with pathology or unusual circumstances. X-rays should demonstrate progress toward treatment goals. Mid-treatment x-rays are mandatory on patients over 18 years old and as indicated for patients under 18 years of age. Progress x-rays should be taken on any incoming transfer patients.
2. Progress evaluation and notations: Documentation of progress reporting in writing or verbal to patient/parent is recommended.
3. X-rays to document or diagnose accidents or trauma.
4. TMJ re-evaluation, if indicated.
5. Extraction or non-extraction treatment must be specified.
6. Periodontal and TMJ re-evaluation, if indicated.
7. Regular cleanings performed by the general dentist.
8. Incoming transfer cases: Transfer records must include beginning treatment records and original orthodontist's treatment plan. Transfer cases will be sent for new beginning records and be re-diagnosed and treatment planned if initial records are inadequate. Current status x-rays are strongly recommended.
9. Treatment record shall show evidence that the initial treatment was completed, or have documentation indicating why the Planned treatment was not completed or changed.
10. Treatment shall be timely and efficient or, if delayed, documentation of reason.
11. Treatment intervals shall be documented meeting professionally recognized community standards of care.
12. Recall and next visit appointments shall be documented in the treatment record.
13. Follow-up of broken or missed appointments shall be documented in the treatment records.
14. Specialty referral shall be documented in the treatment record and followed to completion, when indicated.
15. Retention phase follow-up must be at appropriate intervals and be documented.

G. Final Records and Overall Outcome of Care

Final Records should demonstrate that there was a resolution of the original orthodontic problem(s), and that the patient's goals and the orthodontist's treatment goals were reasonably accomplished. (See 6. a,b,c below)

1. X-rays, as appropriate (minimum acceptable is a Panorex). Quality and number must meet the standards of the American Association of Orthodontists.
2. Photos Intra-oral and extra-oral photos are mandatory
3. Models with bite registration
4. Lateral head film and tracing (recommended)
5. Refusal of final records must have a signature and date.
6. Overall treatment: Post treatment records (see final records) shall be taken and must demonstrate:
    a. Improvement in the orthodontic health status of the member
    b. Improvement in the dental relationships, both functional and esthetic

A.9 Orthodontic Criteria & Guidelines — page 7 of 7

United Healthcare | Dental Benefit Providers of California

c. Treatment goals achieved (patient's and orthodontist's goals)
d. Patient's satisfaction with outcome should be documented.

H. Auxiliaries

Chart notations will verify that auxiliaries only work within the scope of their license.

I. Auditors Special Instructions

1. An exit interview shall be conducted with the doctor or his representative. A brief description of subjects discussed will be signed and a copy submitted with the audit.
2. Use comment section to note any special circumstances that impact the quality of care.
3. Unacceptable treatment outcomes will be reported under "Comments" even though the patient signs statement of satisfaction.
4. Any N/A responses that are not self-evident will be clarified in the final "Comments" section.

A.10 Provider EOB Sample — page 1 of 3

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

UnitedHealthcare

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

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: 0000000000 MEMBER, JANE 12345670000; Out of Network; 11111100; 190000000000									
ADA CODE D2393 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 prophylaxis - adult	03/11/19	01 32	120.00	47.00	0.00	0.00	82.40	37.60	PSC
SUB-TOTAL			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
TOTAL	470.00	124.00	50.00	0.00	418.90	51.10

DEN-PEOB1

A.10 Provider EOB Sample — page 2 of 3

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)

A.10 Provider EOB Sample — page 3 of 3

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

UnitedHealthcare

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

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

UnitedHealthcare

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

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

A.11 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://cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Fraud-Waste_Abuse-Training_12_13_11.pdf

A.12 Dental Grievance Form — page 1 of 2

Dental Grievance Form

United Healthcare | Dental Benefit Providers of California

Please complete and return this form to the mailing address shown below at your earliest convenience. Receipt from you will be acknowledged within 5 calendar days, and you will be notified of the resolution within 30 calendar days. Thank you for your cooperation.

MEMBER INFORMATION

Member Name | Identification #

Patient Name (if applicable)

Member Address | Apt # | City | State | Zip Code

Day Phone # | Evening Phone # | Email Address

PROVIDER INFORMATION

Provider Name

Provider Address

Provider Address | City | State | Zip Code

Date of First Visit | Date Problem Occurred

DESCRIBE YOUR GRIEVANCE (PROBLEM)

Please attach additional sheet if necessary

If you talked with the Provider office and/or plan personnel about this matter, please list their name(s)

I hereby certify that this information is true and correct to the best of my knowledge

Member Signature | Date

Mailing Address: Attn: Grievances and Appeals Department,
PO Box 30569

Salt Lake City, UT 84130-0569
1-800-445-9090

1 of 2

A.12 Dental Grievance Form — page 2 of 2

United Healthcare | Dental Benefit Providers of California

EXPEDITED REVIEW

The Plan makes every effort to process your appeal as quickly as possible. In some cases, you have a right to an expedited 72-hour appeal if your health or ability to function could be seriously harmed by waiting for a standard appeal, which may take up to 30 days. You may file an oral or written request for a 72-hour appeal. Call, write or fax the Plan. Ask for an "expedited review," a "72-hour review," or say, "I believe my health could be seriously harmed by waiting for a standard review."

Call:

1-800-445-9090 (5 a.m. – 8 p.m. Pacific)

Or Write:

Grievances and Appeals Department,
PO Box 30569
Salt Lake City, UT 84130-0569

Or Fax:

(714) 364-6266

"TDD" is available by calling 1-800-735-2989.

FOR ALL CALIFORNIA MEMBERS

If a complaint has been sent for immediate expedited review, the Plan will immediately inform you in writing of your right to notify the Department of Managed Health Care of the grievance. The Plan will provide you and the Department of Managed Health Care with a written statement of the disposition of pending status of the expedited review no later than three days from receipt of the complaint.

The following language is required by the Department of Managed Health Care:

"The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan at 1-800-228-3384 or 1-800-735-2989 (TDD) and use your health plan's grievance process before contacting the department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The department also has a toll-free telephone number (1-888-HMO-2219) and a TDD line (1- 877-688-9891) for the hearing and speech impaired. The department's Internet Web site http://www.hmohelp.ca.gov has complaint forms, IMR application forms and instructions online."

10012012

Page 2 of 2

A.13 CADP – Process of care

Procedural Audit

United Healthcare | Dental Benefit Providers of California

Office/Provider Name:		
Address	Office ID:	1
	Plan:	2
	Auditor:	3
	Date:	4
Process of care	**Chart IDs**	5
1 = Acceptable 0 = Unacceptable / = Non Applicable		6
		7
		8
		9
		10

I. Documentation

A. Medical history	**Rating**				
1. Comprehensive information collection	1	2	3	4	5
	6	7	8	9	10
2. Medical follow-up	1	2	3	4	5
	6	7	8	9	10
3. Appropriate medical alert	1	2	3	4	5
	6	7	8	9	10
4. Doctor signature and date	1	2	3	4	5
	6	7	8	9	10
5. Periodic update	1	2	3	4	5
	6	7	8	9	10
Notes					

B. Dental history/chief complaint					
1. Dental history/chief complaint	1	2	3	4	5
	6	7	8	9	10
Notes					

C. Documentation of baseline intra/extra oral examination					
1. Status of teeth/existing conditions	1	2	3	4	5
	6	7	8	9	10

2. TMJ/occlusion evaluation	1	2	3	4	5
	6	7	8	9	10
3. Prosthetics	1	2	3	4	5
	6	7	8	9	10
4. Status of periodontal condition	1	2	3	4	5
	6	7	8	9	10
*5. Soft tissue/oral cancer exam	1	2	3	4	5
	6	7	8	9	10
Notes					

D. Crown and bridge services					
*1. Diagnosis	1	2	3	4	5
	6	7	8	9	10
*2. Restorative outcome and follow-up	1	2	3	4	5
	6	7	8	9	10
3. Specialist referral	1	2	3	4	5
	6	7	8	9	10
Notes					

E. Endodontic services					
*1. Diagnosis	1	2	3	4	5
	6	7	8	9	10
2. Rubber dam use	1	2	3	4	5
	6	7	8	9	10
*3. Endodontic outcome and follow-up	1	2	3	4	5
	6	7	8	9	10
4. Specialist referral	1	2	3	4	5
	6	7	8	9	10
Notes					

F. Periodontic services					
*1. Diagnosis	1	2	3	4	5
	6	7	8	9	10
2. Treatment per visit	1	2	3	4	5
	6	7	8	9	10
*3. Periodontal follow-up/outcome	1	2	3	4	5
	6	7	8	9	10
4. Specialist referral	1	2	3	4	5
	6	7	8	9	10

Notes					
G. Prosthetic services					
*1. Diagnosis	1	2	3	4	5
	6	7	8	9	10
2. Prosthetic outcome and follow-up	1	2	3	4	5
	6	7	8	9	10
3. Specialist referral	1	2	3	4	5
	6	7	8	9	10
Notes					
H. Surgical services					
*1. Diagnosis	1	2	3	4	5
	6	7	8	9	10
2. Prosthetic outcome and follow-up	1	2	3	4	5
	6	7	8	9	10
3. Specialist referral	1	2	3	4	5
	6	7	8	9	10
Notes					
I. Overall patient care					
*Overall care meets professionally recognized standards	1	2	3	4	5
	6	7	8	9	10
Notes					

Additional notes

Signature of Provider	**Date**	**Chart Reviewer's Signature**	**Date**

A.14 CADP – Structural Audit

Structural Review

United Healthcare | Dental Benefit Providers of California

Office/Provider Name:		
Address	Office ID:	**Notes**
	Plan:	
	Auditor:	
	Date:	

1 = Acceptable 0 = Unacceptable / = Non Applicable

Languages:
☐ Arabic ☐ Other (non English) ☐ Bengali ☐ Russian ☐ German
☐ French ☐ Armenian ☐ Korean ☐ Farsi/Persian ☐ Tagalog/ Filipino
☐ Hindi ☐ Cantonese ☐ Spanish

I. Accessibility	Rating	Comments
A. 24-hour emergency contact system.		
B. Reasonable appointment scheduling for plan members.		
C. Language assistance program and documents.		
II. Facility and equipment		
A. Clean, safe, neat and well maintained.		
B. Compliance with mercury hygiene, safety regulations.		
C. Nitrous oxide recovery system.		
D. Lead apron (with thyroid collar) for patient.		
III. Emergency procedures and equipment		
A. Written emergency protocols.		
*B. Medical emergency kit on site.		
*C. Portable emergency oxygen available.		
IV. Sterilization and infection control		
*A. Sterilization and infection control protocols followed.		
B. Protocol posted for sterilization procedures.		
*C. Weekly biological (spore) monitoring of sterilizer.		
*D. All instruments and hand-pieces properly cleaned, sterilized, and stored.		
E. Log kept monitoring changing of sterilization solutions.		
F. Staff wears appropriate personal protective equipment.		
G. Proper and adequate use of barrier techniques.		
H. Hand-pieces & waterlines flushed appropriately.		
I. Infection control and cross contamination prevention procedures followed in the office and laboratory.		

Signature of Provider	Date	Chart Reviewer's Signature	Date

A.15 CADP Process of Care Evaluation Criteria

Review criteria	Reviewer evaluation measures
I. Documentation	
A. Medical history	
1. Comprehensive information collection	General medical history with information pertaining to general health and appearance, systemic disease, allergies and reactions to anesthetics. Should include a list of any current medications and/or treatment. Proactive format is recommended. Name & telephone number of physician and person to contact in an emergency. Patient must sign and date all baseline medical histories. Must Questions: 1) Bisphosphonate Use and 2) Latex Sensitivity
2. Medical follow-up	Patient comments, DDS/DMD notes, or consultation with a physician should be documented in the chart.
3. Appropriate medical alert	Should be uniform and conspicuously located on the portion of the chart used during treatment and should reflect current medical history.
4. Doctor signature and date	Dentist must sign and date all baseline medical histories after review with patient.
5. Periodic update	Documentation of medical history updates at appropriate intervals. Must be signed by the patient and the provider. Acceptable on medical history form or in the progress notes. Should reflect changes or no changes. Recommend update be done at least annually.
B. Dental history/chief complaint	
	Documentation of chief complaint and pertinent information relative to patient's dental history.
C. Documentation of baseline intra/extra oral examination	
1. Status of teeth/existing conditions	Grid or narrative of existing restorations and conditions.
2. TMJ/occlusal evaluation	Evidence of TMJ exam or evaluation of occlusion (classification) should be determined.
3. Prosthetics	Evaluation of existing appliance(s)(age, condition etc.), teeth replaced, clasps, etc.
4. Status of periodontal condition	a. Condition of gingival tissue, calculus, plaque, bleeding on probing, etc. b. Evidence of baseline probing should be documented (if indicated). c. Case type of perio conditions (Type I-IV) or (Normal, Gingivitis, or Slight, Moderate or Severe Periodontitis). Should be verified with radiographs/ pocket documentation.
5. Soft tissue/oral cancer exam	a. Evidence that soft tissue /oral cancer exam was performed initially and periodically (at least annually). b. Notation of any anatomical abnormalities
D. Progress notes	
1. Legible and in ink	Provider should be reminded that progress notes are a legal document, all should be in ink, legible and should be in sufficient detail. Corrections should be made by lining-out. Documentation of any follow-up instructions to the patient or recommendations for future care. Documentation of patient leaving the practice and reasons, if known. Documentation if any records forwarded, etc.
2. Signed and dated by provider	All entries must be signed or initialed and dated by the treating provider. (Per CA. Dental Practice Act, Section 1683)
3. Anesthetics	Notation in progress notes as to the type and amount of anesthetic used; or notation "no anesthesia used" for applicable situations. (Including info on vaso-constrictors used, if any)

Review criteria	Reviewer evaluation measures
4. Prescriptions	Medications prescribed for the patient are documented and Sig., Rx, and Disp. in the progress notes or copies of all prescriptions are kept in the chart. Notation of an Rx given on phone. Recommended that dental lab prescriptions be documented in the progress notes or a copy kept in the chart.
II. Quality of care	
A. Radiographs	
1. Quantity/frequency	a. Adequate number of radiographs to make an appropriate diagnosis and treatment plan, per current FDA guidelines. Evidence of baseline probing should be documented (if indicated). b. Recall x-rays should be based on current FDA guidelines. Depends on complexity of previous & proposed care, caries susceptibility, amount and type of treatment and time since last radiographic exposure. c. Whenever possible, radiographs should not be taken if recent acceptable films are available from another source (previous Dentist). d. Any refusal of radiographs should be documented.
2. Technical quality	a. No overlapping contacts, or cone cuts that affect diagnostic value; periapical films should show apices. b. Good contrast, not over or underdeveloped; no chemical stains.
3. Mounted, labeled and dated	Recent radiographs must be mounted, labeled and dated for reviewing and comparison with past radiographs.
B. Treatment plan	
1. Present and in ink	a. Comprehensive documentation of patient needs and treatment recommendations, all documentation in ink. b. Consistent with diagnosis and clinical exam findings. c. Alternative treatment plans and options should be documented with clear concise indication of what the patient has elected to have performed. d. Consultations and referrals should be noted when necessary.
2. Sequenced	Case should be sequenced in order of need and consistent with diagnostic and examination findings, and in compliance with recognized accepted professional standards. (Dental Practice Act, Section 1685) A possible sequence follows: a. Relief of pain, discomfort and infection. b. Prophylaxis and instructions in preventive care. c. Treatment of extensive caries and pulpal inflammation. Endodontic therapy. d. Periodontal treatment. e. Replacement of missing teeth, or restorative treatment. f. Placement of patient on recall schedule with documentation of progress notes.
3. Informed consent	a. Documentation that treatment plan has been reviewed with the patient and that the patient understands the risks, benefits and alternatives to care. Patient should also understand the financial component of the treatment proposed. Indicate dates solution changed, and dates of expiration of fresh solution. b. An appropriate form signed by the patient is recommended. Documentation that all patient's questions were answered. Evidence of a 'meeting of the minds'. c. Documentation of any refusal of recommended care, including referrals.
III. Treatment outcomes of care	
A. Preventive services	

Review criteria	Reviewer evaluation measures
1. Diagnosis	Documentation that prophylaxis was performed in a timely manner. Documentation of fluoride treatments planned or rendered, as appropriate to age of patient and caries incidence.
2. Oral hygiene instructions	Documentation of Home Care/Oral Hygiene instructions given to patient.
3. Recall	Documentation of timely, case appropriate recall of patient.
B. Operative service	
1. Diagnosis	Recall and past radiographs used to evaluate proper diagnosis of caries and the need for treatment. Treatment performed in a timely manner.
2. Restorative outcome and follow-up	a. Margins, contours, and contacts appear radiographically acceptable. b. Prognosis good for appropriate longevity. Minimal subsequent unplanned treatment. Unplanned treatment-redo of recent restorations due to fracture, extraction, RCT, etc.
3. Specialist referral	Referral to a specialist in appropriate circumstances and in a timely manner.
C. Crown and bridge services	
1. Diagnosis	Recall and past radiographs used to evaluate the need for treatment. Treatment performed in a timely manner.
2. Restorative outcome and follow-up	a. Margins, contours, and contacts appear radiographically acceptable. b. Prognosis good for appropriate longevity. Minimal subsequent unplanned treatment. Unplanned treatment-redo of recent restorations due to fracture, extraction, RCT, etc.
3. Specialist referral	Referral to a specialist in appropriate circumstances and in a timely manner.
D. Endodontic services	
1. Diagnosis	Signs and symptoms documented (if need not evident on radiographs).
2. Rubber dam use	Evidence of rubber dam use on working images and/or documentation of use in progress notes.
3. Endodontic outcome and follow-up	a. Radiographic evaluation of treatment to determine that canal(s) is/are properly filled and well condensed. b. Prognosis good for appropriate longevity. Minimal subsequent unplanned treatment, no evidence of extraction of recently completed endo. c. Documentation of final restoration. d. Recall follow-up recommend with PA image.
4. Specialist referral	Referral to a specialist in appropriate circumstances and in a timely manner.
E. Periodontal services	
1. Diagnosis	Evidence that clinical examination including pocket charting and radiographs is available to determine proper type of treatment needed.
2. Treatment per visit	Rationale for more than 2 quadrants of scaling/root planing per visit should be documented.
3. Periodontal follow-up/outcome	Recall follow-up recommended with radiographs or probing.
4. Specialist referral	Referral to a specialist in appropriate circumstances and in a timely manner.
F. Prosthetic services	
1. Diagnosis	Evaluation of form, fit, and function of existing prosthesis. Evaluation of need where no previous prosthesis exists.
2. Prosthetic outcome and follow-up	a. Treatment was done in a timely manner, including necessary adjustments. b. Prognosis good for appropriate longevity.
3. Specialist referral	Referral to a specialist in appropriate circumstances and in a timely manner.
G. Surgical services	
1. Diagnosis	Radiographic and/or soft tissue/clinical exam supports treatment rendered.

Review criteria	Reviewer evaluation measures
2. Surgical outcome and follow-up	a. Comprehensive documentation of treatment done, materials used, and any noteworthy occurrences during the procedure. b. Documentation of post-operative instructions to patient. c. Documentation of any needed post-operative care, including suture removal.
3. Specialist Referral	Referral to a specialist in appropriate circumstances and in a timely manner.
IV. Overall patient care Overall care is clinically acceptable (to the extent that it is possible to determine by x-rays and available	

A.16 CADP-Structural Review Evaluation Measures

Review criteria	Reviewer evaluation measures
I. Accessibility	
A. 24 hour emergency contact system?	Active after hours mechanism (Answering machine, answering service, cell phone, or pager) available for 24 hour/7 day a week contact or instructions. 1. Patients informed of emergency system for 24/7 access 2. Inability to provide 24 hour access for dental emergencies is a departure from accepted standards of care.
B. Reasonable appointment scheduling for plan members?	The patients wait time to schedule an appointment should be reasonable and appropriate according to filed access standards (Individual to each Plan). Please specify actual access in the comments area. (Minimal Access Regulations noted below) 1. Urgent Appointments - Within 72 Hours 2. Non-urgent Appointments - Within 36 Business Days 3. Preventive Dental Care Appointments - Within 40 Business Days
C. Language assistance program and documents?	Patients requiring Language Assistance can receive it. Confirm languages spoken in office- indicate in check box or via manual entry those languages spoken. Provider knows how to contact plan to obtain language assistance for patients needing translation and/or interpretation services. Provider knows to document a patient's refusal of assistance in the patient's treatment record.
II. Facility and equipment	
A. Clean, safe neat and well maintained	Verification made that facility and equipment are clean, safe and in good repair
	1. There are no visible stains or significant scarring of furniture or floors.
	2. There is no debris on floors or other areas, especially patient care, reception, infection control areas and laboratories.
	3. Decor should be in good taste, easily cleaned and well maintained.
	4. For protection of everyone, employees and patients, lighting should be sufficient to allow safe ingress/egress and to maintain good vision without fatigue.
	5. Dental equipment should be appropriate and in good working condition:
	5a. No equipment with obviously broken parts, visible damage, temporary repairs or grossly torn upholstery.
	5b. Current certification results for equipment requiring local, state or federal certification on file at the facility. (Radiographic equip/ medical waste).
B. Compliance with mercury hygiene, safety regulations?	Compliance with mercury hygiene, safety regulations. 1. Amalgamators covered. 2. Bulk mercury and scrap amalgam stored in sealed, unbreakable containers. 3. Mercury spill kit.
C. Nitrous oxide recovery system?	Verification that nitrous oxide equipment is clean, safe and in good repair.
D. Lead apron (with thyroid collar for patient)	1. No visible cracking or destruction to hoses or nose piece. 2. Recovery System with connection to exhaust or suction system. Usually requires a minimum of four hoses for this to be accomplished. 3. Fail Safe mechanism present for correct delivery of gasses. There should be a lead apron present with a thyroid collar. The collar does not have to be attached to the apron, but must be used on all patients when exposing radiographs. Separate thyroid collar is acceptable.
III. Emergency procedures and equipment	

Review criteria	Reviewer evaluation measures
A. Written emergency protocols? For fire and/or natural disasters:	1. A plan indicating escape routes and staff member's responsibilities, including calling for help.
	2. Exits clearly marked with exit signs.
	3. Emergency numbers posted, (911, Fire, Ambulance and local 7-digit numbers in both front office and back office or lab.) Written protocol for calling for help. Note: If office protocol entails only calling 911, then this section does not apply and evaluation should be marked "N/A".
B. Medical emergency kit on-site?	Medical emergency kit should be easily accessible and labeled with an inventory of contents. All required drugs (per JADA 3/2002 article) are current. Staff should be aware of location of kit. Recommend staff in-service training for general use of contents.
C. Portable oxygen supply available?	Portable oxygen supply tank/ambu- bag for medical emergencies should be available. 1. Recommend tanks be maintained full and a positive pressure bag or ambu bag be available. 2. Recommend staff in-service training for use of emergency oxygen source. 3. Staff should be aware of and have access to location.
IV. Sterilization and infection control	
A. Sterilization and infection control protocols followed?	Verify sterilization and infection control procedures are in place. Verify staff trained in sterilization and infection control procedures and protocols. Sterilization and infection control procedures shall conform to the Dental Board of California. (DPA Section 1680dd, January 1993)
B Sterilization and infection control protocols followed?	Protocols conspicuously posted. Dental Board of California. (DPA Section 1005b23, January 2001)
C. Weekly biological (spore) monitoring of sterilizer?	Sterilization procedures shall be monitored weekly and recorded, by appropriate methods, as required by the Dental Board of California. (DPA Section 1005b14, January 2001) Log must be maintained for minimum of 12 months.
D. All instruments and hand-pieces properly cleaned, sterilized, and stored?	1. Contaminated instruments are properly cleaned. a. Utility gloves used. b. Ultrasonic cleaning recommended. Solutions changed per manufacture's specifications. 2. Acceptable procedures for sterilization are: a. Storage of instruments shall be in dated sterile bags or packs that are sealed. There should be no evidence of moisture or torn bags. Instruments must remain in sealed, dated sterile bags or packs until ready for use. Once opened, all instruments must be rebagged, dated and resterilized, regardless of whether they were used or not. b. Hand-pieces must be properly sterilized between patients and bagged and dated until use. c. Instruments, which cannot be cold-sterilized, or autoclaved, must be disposable and must be disposed of immediately after use. d. High level disinfectant should be utilized only on instruments that cannot be subjected to other methods of sterilization.
E. Log kept monitoring changing of sterilization solution?	Maintain a written log indicating: 1. Acceptable EPA registered brand name of the cold sterilant (high-level disinfectant) tuberculocidal hospital disinfectant, utilized according to the manufacturer's recommendations for sterilization. 2. Indicate dates solution changed, and dates of expiration of fresh solution. 3. Indicate name of staff member making the change. (Dental Practice Act)
F. Staff wears appropriate personal protective equipment?	1. Personnel shall always use protective gloves, masks, eyewear, coats or gowns during patient care. 2. Splattered garments should be replaced as necessary. Masks must be changed between patients. 3. Gloves must be changed between patients and before leaving the operatory.

Review criteria	Reviewer evaluation measures
G. Proper and adequate use of barrier techniques?	1. Verification made that hard surfaces in all operatories are disinfected between patients and at the end of each day. A Cal OSHA/EPA approved solution should be used. 2. Verification made that surfaces not capable of being disinfected by routine methods should be covered with impervious materials.
H. Hand-pieces and waterlines flushed appropriately?	Operatory unit water lines shall be flushed between each patient for 20 seconds and in the morning before use for at least 2 minutes,(DPA 1005b21). Must have anti-retraction valves.
I. Infection control and cross contamination prevention procedures followed in the office and laboratory?	1. The pumice pan should be changed after each use and rag wheels should be sterilized after each use or discarded. 2. Impressions, dentures and other appliances going to and coming from the laboratory should be properly rinsed and disinfected. (DPA 1005b 24)

A.17 CADP Orthodontic Quality Assurance Guidelines

A.17.a Orthodontic Criteria & Guidelines

Introduction

The following criteria and guidelines for monitoring orthodontic care are presented for the use of the Plan and their orthodontic care providers in order to facilitate a high level of treatment quality for their orthodontic patients. Included in this document are guidelines to assist in compliance with the requirements of Federal and State regulatory authorities.

The material presented is not intended to establish or dictate standards of care for the orthodontic profession. It is understood that standards of care are variables that are determined by the orthodontists practicing in a specific community or geographic area, as well as orthodontic societies, educational institutions, teaching foundations and regulatory bodies.

The Plan acknowledges that the responsibility for proper treatment of orthodontic patients is determined and carried out by trained orthodontic specialists in response to the needs and the best interests of their patients.

The review process

1. **Purpose:** To provide a specific process for reviewing and monitoring the quality and delivery of orthodontic treatment. This process will be concerned with the patient's dental health, function, stability and aesthetics, and will be a means for identifying potential deficiencies in the delivery of orthodontic services.
2. **Policy:** A major component of this Quality Improvement Program is the review of orthodontic provider's charts, facilities and grievances to ensure compliance with professionally recognized community standards of care and to help establish and maintain high levels of treatment outcomes and patient satisfaction.
3. **Criteria:** The audit cycle shall be as follows:

A periodic cycle of auditing is used for all the Plan offices where orthodontic treatment is provided. The audit score, the nature of the deficiencies, and the consultant's comments can determine the audit follow-up process. The overall audit score shall be determined as follows:

a. Orthodontic providers must attain a score of at least 80% on both the Orthodontic Facility and Chart Review checklist. If a provider does not attain a score of at least 80%, the orthodontic consultant, in conjunction with other appropriate Plan representatives, shall take corrective action with the reviewed orthodontist. Critical area(s) of concern will require immediate attention and correction verification.

b. The Plan will communicate with the provider following the facility and chart audit with an audit response letter with details of the audit findings (and require a return signed agreement of compliance). The Quality Improvement Manager will contact the provider on a case-by-case basis. A written response from the provider will be requested when needed. The orthodontic consultant will be available to review all member complaints and grievances relating to quality of care issues and will report all findings and recommendations to the Dental Director, the Quality Assurance Committee, and/or the Peer Review Committee as necessary. Facility scores below passing are counseled and monitored by the Plan.

c. A standard "Orthodontic Facility and Chart Review" checklist (audit tool) shall be used for each provider audit.

d. Orthodontic providers must attain an overall score of at least 80%. If a provider does not attain a score of at least 80%, the orthodontic consultant, in conjunction with other appropriate Plan representatives, shall take the appropriate corrective actions (listed above) with the reviewed orthodontist. Critical area(s) of concern will require immediate attention and correction verification.

Credentials and calibration of auditors

If more than one orthodontic auditor is used by the Plan, the auditors will be calibrated. All auditors will be licensed dentists in California with orthodontic credentials based on the same guidelines as the orthodontic providers. Orthodontic auditors must have current CADP certification.

The objectives of calibration of orthodontic auditors are:

1. To provide and keep current the "Quality of Care Guidelines and Criteria";
2. To assess auditing tools and auditing protocol;
3. To verify auditor consistency in the review of treatment records;
4. To review objectives and protocols for identifying problems; and
5. To review the process and effectiveness of corrective actions.

If more than one orthodontic auditor is used by the Plan, the Plan will hold periodic calibration meetings. Calibration meetings will be held at least annually with all auditors in attendance and participate in evaluating orthodontic charts. Semi-annual chart calibrations may be conducted by telephone or mail. Variations in response will be discussed and clarified. Modifications of the process will be taken, as necessary, to assure consistency of orthodontic reviews.

General criteria (modified and updated from the American Dental Association)

Orthodontics includes space maintenance, tooth guidance, interceptive procedures and full orthodontic treatment to influence growth as well as the positions of individual teeth by applying various forms and degrees of force. Removable and/or fixed appliances may be used to accomplish these goals. Candidates for orthodontic treatment should be in good oral health.

Of particular importance is the timing of treatment, which may be initiated in the deciduous dentition, the mixed dentition or the adult dentition. Orthodontics may be completed in one or more phases of treatment.

The principles and practices of prevention should be employed in the diagnosis and treatment of orthodontic problems, including counseling the patient regarding diet, plaque control and topical fluoride application prior to placement of orthodontic appliances and at appropriate intervals thereafter.

A satisfactory result in orthodontics is dependent upon the combination of professional skill and patient cooperation during all phases of treatment. Considerations include the age of the patient, the severity

of the presenting malocclusion, the desired treatment objectives, and the individual growth (modified) patterns occurring during treatment.

Baseline conditions shall be recorded by means of full-mouth radiographs (including at least one lateral cephalogram and tracing and their analysis); study casts oriented in centric relation; intra and extra oral photographs; a complete oral examination; and a complete dental, medical, and family history. Oral myofunctional evaluations are performed as necessary. All diagnostic records shall meet professionally recognized community standards of care.

The appliances and treatments used shall be appropriate for the treatment of the orthodontic problems.

Appliances should fit well. Bands and brackets are adapted and cemented/bonded so that cement margins or bonding material "flash" (modified) are barely visible.

The final outcome of orthodontic treatment should be an optimal end-result for each patient to achieve aesthetic improvement and stability of the resultant correction. Key elements include, but are not limited to, the dentition, supporting bone relationships, interdigitation, contact points, overbite and overjet.

Active orthodontic treatment should be followed with retention appliances and supervision to help assure stability of correction. It is recommended that final records (X-rays, panorex, photographs and final study models) be utilized to confirm final result goals within a specified period of time.

Axial inclination of the anterior and posterior teeth is such that optimal aesthetic and functional results are achieved based on existing patient conditions and skeletal growth and cooperation.

Interproximal spaces (contacts) are closed.

There is no significant gingival recession, evidence of loss of supporting bone, root resorption, caries or decalcification of the teeth as documented by full-mouth radiographs and an oral exam. Factors exhibiting no problem must be noted as "WNL."

Complex orthodontic cases such as that requiring orthognathic surgery may require a multidisciplinary approach for provision of orthodontic treatment and may necessitate coordination of orthodontist, oral surgeon, physician and periodontist for delivery of care.

For orthodontic treatment of patients that elect to pursue orthodontic treatment alone after disclosure of the benefits of surgical/orthodontic combined treatment, the orthodontist should document that parent/patient was advised of surgery and that parent/patient desired to pursue orthodontic treatment alone. Communication of risks, limitations, complications, consequences and delay of treatment or non-treatment should be documented.

Initial records (modified) should be adequate in amount and quality to properly diagnose the case. Lack of these necessary records will be marked unsatisfactory unless explained. All inter-dental and intra-dental relationship problems, both anterior and posterior, shall be described.

Treatment planning and outcome documentation (modified) shall be specific, sequenced, and detailed as outlined in the "Chart Review Criteria."

Nothing in these criteria/guidelines should be construed as a description of plan benefits. Coverage for particular aspects of orthodontic treatment is between the Plan and member/purchaser and is, as described, in the member's Coverage Booklet.

A.17.b Orthodontic Chart Review Process

Criteria

1. **Chart selection:** The auditor will randomly select a minimum of five (5) of the Plan's patient's charts. Four cases in treatment and one finished case, or as close to that number and ratio as possible.

The charts will be selected from a requested group of 14 patient's charts. Representative groups of patients in treatment for 1-6 months, 6-18 months and 18-24 months will be chosen when possible. Charts will be identified by patient name and patient chart number if available.

2. **Elements of record review:** (must be in writing)

a. Health History: Comprehensive health history forms shall meet professionally recognized community standards and be used for every patient. The health history form shall include, but not necessarily be limited to, at least the following information:

1. Dental history/problems (dentist name and phone number)
2. Patient's treatment goals, chief complaint or concerns (can also be recorded in Treatment Plan section)
3. Systemic disease such as:
   - Cardiac diseases
   - History of rheumatic fever, prosthetic valves, pacemaker
   - History of prosthetic joints
   - Diabetes
   - Hepatitis
   - Viral diseases
   - Venereal diseases
   - HIV status/AIDS
   - Bleeding disorders, hemophilia
   - History of substance abuse
   - Pregnancy state
   - Nervous disorder, epilepsy, seizures
4. Allergies and sensitivity to drugs, dental anesthetics or latex products
5. Name and telephone number of physician
6. Present medical treatment/medications (including anti-rejection drug therapy)
7. Past or present use of appetite suppressant drugs such as Fen-phen (Fen-fluramine and Dexten fluramine)
8. Family health history
9. Oral habit history

b. Health History Evaluation Process:

1. Each patient shall complete all questions on the history form.
2. Questions should be in Yes/No format.
3. The patient or responsible adult shall sign and date the health history form at the initial examination.
4. The doctor shall initial and date the health history form at the initial examination and all subsequent updates.
5. There shall be written evidence of follow-up by the doctor for patients with significant medical findings. Follow-up includes verification of the need for antibiotic pre-medication by the physician.

6. Medical alerts and allergy indicators shall be prominently displayed on the treatment record for every patient with significant medical problems. Confidentiality must always be maintained. HIPAA regulations must be observed and personal medical information shall not be displayed in a manner that is available for other patients to see. No specific medical information shall be written on the outside of the chart. Ideally, a coded sticker on the outside of the chart will guide the provider and staff to the treatment record alert. The alert must be recorded in an area additional to the health history form.
7. The medical history shall be updated and documented in the chart record or on the prior medical history form by both the patient and the doctor at appropriate intervals. A 12-month or less update interval is recommended.
8. When a patient requires antibiotic pre-medication, the use of antibiotic will be noted in the progress notes.
9. Special need of the patient, e.g., language or physical access, will be documented.

Diagnosis and treatment plan

1. **Intraoral examination:** The orthodontic chart shall record the following:
   a. Oral soft tissue examination findings including cancer screening. Clearance from the general dentist is acceptable.
   b. Documentation of missing teeth and presence and condition of dental prosthesis.
   c. Documentation of the presence of pathology, decay and enamel defects. Clearance from the general dentist is acceptable. Notation of "No problem to begin orthodontics," or similar, is needed if no pathology or decay is noted.
   d. Periodontal evaluation and screening including recommendations. If visual and radiographic evidence indicated a periodontal problem, the patient should have a full-mouth probing or be referred. Periodontal clearance will then be necessary before starting orthodontic treatment. Periodontal assessment or documentation of periodontal referral and status report is necessary on all adults.
2. **Orthodontic diagnosis:** Diagnosis should be appropriate, adequate and written legibly describing the patient's condition including the following diagnostic aids and observations:
   a. Results of intraoral examination
   b. TMJ screening
   c. Orthodontic angle classifications, including subdivisions (left or right), bite relationships (overbite, overjet, mid-line and anterior/ posterior cross-bites or open-bites, and functional shifts).
   d. Crowding or spacing should be listed in millimeters
   e. Habits that may harm or affect the teeth or supporting structures
   f. Asymmetries
   g. Space analysis
   h. Missing or deformed teeth (or roots of teeth)
   i. Impactions or eruption irregularities (i.e., ectopic eruption)
   j. Cephalometric and X-ray measurements and findings, including profile relationships. Lateral head film of sufficient quality to discern skeletal and soft tissue landmarks and a head film tracing with angular and linear measurements.

k. Radiographs. The following criteria shall apply. The doctor must examine the patient before ordering radiographs at the initial examination.

1. The quality and quantity of radiographs taken, based on the needs of the patient, shall be sufficient for proper diagnosis and treatment planning. The apices and crowns of all erupted and non-erupted teeth must be visible.
2. Radiographs and tracings shall be mounted, identified and dated.
3. Radiographs that are non-diagnostic but are necessary to complete the diagnosis should be retaken. Original radiographs should be maintained in the patient chart, and only radiograph copies shall be mailed out of the office.
4. Refusal of radiographs by the patient should be documented and signed by the patient.
5. Frequency of radiographs for both adults and children shall be in accordance with ADA recommendations and the patient's needs.
6. Tomograms if indicated.

Study Models. Trimmed to wax bite centric relation or mounted to correct bite relationship. Models will show all erupted teeth and be absent of any broken plaster or teeth. Digitized three-dimensional electronically recorded models are acceptable. Plaster models are preferred. All models shall have names and dates. Intra- and extraoral photos of proper quality and orientation (use AAO Guidelines for orientation and number). Five properly oriented intraoral and three extraoral quality images are the minimum. All photos shall be named and dated.

3. **Treatment plans:** Written treatment plan, signed by the treating doctor and patient, shall contain sufficient details to document treatment procedures and shall be consistent with the diagnosis appropriately dated, sequenced and include coordination with other providers as indicated. Alternate treatment plans, if indicated, shall be documented. Additionally, treatment plan shall describe techniques to achieve treatment goals, bite relationships, dental relationships, soft tissue profile, and skeletal relationships. Content:

a. Patient's expectations (chief complaint, patient goals, patient's expectations)

b. Goals of treatment (orthodontist goals)

c. Appliance and auxiliaries anticipated to be used

d. Extractions listed and rationale for extraction or non-extraction plan documented

e. Treatment sequencing

f. Treatment options and anticipated compromises

g. Specialist referrals

h. Estimated treatment time

i. Limitations to ideal results

j. Retention plan included in treatment plan

Consent form and finances

1. **Informed consent:** Should be comprehensive, in writing and signed/dated by patient or guardian and initialed by the treating doctor. A comprehensive informed consent provides sufficient information to the patient/guardian, verbally and in writing, on benefits and risks of treatment or non-treatment for specific conditions. This form must be sufficient to allow the patient to make an informed decision. The patient's understanding is required for all treatment and treatment recommendations.

Approved informed consent forms (i.e., from the AAO) are recommended. Any treatment that is not on a standard consent form shall have an additional specific, written, dated and signed statement of informed consent.

2. **Patient's financial responsibility** is clearly specified and signed/dated by the patient.

Progress notes

Treatment Chart or Treatment Record shall include a written diagnosis, treatment plan, treatment goals, extractions, appliances and auxiliaries, and retention plan (see individual sections).

1. Progress notes or individual appointment entries in chart: Entries must be legible, in ink or typed, signed or initialed and dated by the treating doctor, and must thoroughly describe the following:
   a. Procedures or treatment performed
   b. Poor patient cooperation
   c. Patient progress
   d. Auxiliaries to be worn (elastics, headgear, etc.) including instructions.
   e. Broken or lost appliances
   f. Initial oral hygiene instructions and monitoring
   g. Medications prescribed and instructions given
   h. Any special or post-treatment instructions
   i. Next appointment date and procedure(s)
   j. Materials used

Computerized entries must be unalterable.

2. Orthodontic Records and Chart Notations (general guidelines)
   a. Signature of orthodontist (or initials with unique and documented ID number) must be on each progress note.
   b. All orthodontic records (see Patient Records) properly documented with names and dates.
   c. Records should be stored a minimum of seven (7) years and readily retrievable. Lifetime storage is recommended.
   d. For minor patients, written letters or documentation of verbal counseling will be sent to parent or guardian reporting noncompliance with treatment requirements.
   e. Periodic written referrals to primary care dentist or specialist, including a request for return verification of compliance. Documentation of general dentist notification of noncompliance with oral hygiene (e.g., extractions, restorations).
   f. Removal of appliances for patient noncompliance will be documented by a release signed by patient and/or guardian.
   g. Documentation of any adverse telephone calls or any adverse patient comments at the time of treatment.
   h. Record entries and treatment progress notes shall be legible and comprehensive.
   i. The strength, dosage, quantity and instructions for their use ("sig.") will describe drugs given or prescribed.
   j. Cooperation items will be recorded:

1. Keeping appointment
2. Observing eating restrictions
3. Appliance breakage
4. Wearing of auxiliaries (elastics, headgear, appliances)
5. Oral hygiene
6. Periodic dental checkups

k. Refusal of recommended treatment

l. Dental lab prescriptions are to be documented

Emergency care

Any emergency care for the patient is to be appropriate, timely and documented in the patient's record. Appropriate X-rays, medications and conversations should be noted.

Continuity of care

Progress Records (progress monitoring aids) and procedures:

1. Progress (mid-treatment) X-ray(s): Yearly, during active treatment, or as needed to check root and bone structure especially on adults and high root resorption risk patients (possibly every three to six months), or patients with pathology or unusual circumstances. X-rays should demonstrate progress toward treatment goals. Mid-treatment X-rays are mandatory on patients older than 18 years old and as indicated for patients younger than 18 years of age. Progress X-rays should be taken on any incoming transfer patients.
2. Progress evaluation and notations: Documentation of progress reporting in writing or verbal to patient/parent is recommended.
3. X-rays to document or diagnose accidents or trauma.
4. TMJ re-evaluation, if indicated.
5. Extraction or non-extraction treatment must be specified.
6. Periodontal and TMJ re-evaluation, if indicated.
7. Regular cleanings performed by the general dentist.
8. Incoming transfer cases: Transfer records must include beginning treatment records and original orthodontist's treatment plan. Transfer cases will be sent for new beginning records and be re-diagnosed and treatment planned if initial records are inadequate. Current status X-rays are strongly recommended.
9. Treatment record shall show evidence that the initial treatment was completed, or have documentation indicating why the planned treatment was not completed or changed.
10. Treatment shall be timely and efficient or, if delayed, include documentation of reason.
11. Treatment intervals shall be documented, meeting professionally recognized community standards of care.
12. Recall and next visit appointments shall be documented in the treatment record.
13. Follow-up of broken or missed appointments shall be documented in the treatment records.
14. Specialty referral shall be documented in the treatment record and followed to completion, when indicated.
15. Retention phase follow-up must be at appropriate intervals and be documented.

Final records and overall outcome of care

Final records should demonstrate that there was a resolution of the original orthodontic problem(s), and that the patient's goals and the orthodontist's treatment goals were reasonably accomplished. (See 6. a, b and c below.)

1. X-rays, as appropriate (minimum acceptable is a panorex). Quality and number must meet the standards of the American Association of Orthodontists.
2. Photos: intraoral and extraoral photos are mandatory
3. Models with bite registration
4. Lateral head film and tracing (recommended)
5. Refusal of final records must have a signature and date.
6. Overall treatment: Post-treatment records (see final records) shall be taken and must demonstrate:

   a. Improvement in the orthodontic health status of the member

   b. Improvement in the dental relationships, both functional and aesthetic

   c. Treatment goals achieved (patient's and orthodontist's goals)

   d. Patient's satisfaction with outcome should be documented.

Auxiliaries

Chart notations will verify that auxiliaries only work within the scope of their license.

Auditors' Special Instructions

1. An exit interview shall be conducted with the doctor or his or her representative. A brief description of subjects discussed will be signed and a copy submitted with the audit.
2. Use comment section to note any special circumstances that impact the quality of care.
3. Unacceptable treatment outcomes will be reported under "Comments" even though the patient signs statement of satisfaction.
4. Any N/A responses that are not self-evident will be clarified in the final "Comments" section.

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