Dental Provider Manual

Dental Benefit Providers of California
Commercial PPO

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United Healthcare | Dental Benefit Providers® of California

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Section 1: Introduction — who we are

Welcome to Dental Benefit Providers of California, Inc., a United Healthcare 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 is designed as a comprehensive reference guide focusing on Preferred Provider Organizations (PPO). Here you will find the tools and information needed to successfully administer Dental Benefit Providers of California PPO 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.

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 **1-800-822-5353**.

UHC On Air

UHC On Air is a source for 24/7 on demand video broadcasts created specifically for UnitedHealthcare Dental providers. UHC On Air provides instant access to content for providers, such as:

- Educational video resources,
- Interactive provider training materials,
- Onboarding content for new dentists,
- Up-to-date operational and clinical policy information,
- Market-specific programs, and
- Provider advocate profiles.

To access UHC On Air, log into **uhcdental.com** with your Optum ID, or you may use this link, **https://cx.uhc.com/content/uhc-provider/dentalprovidereducation/en.html**.

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

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

Section 2: Resources and services

2.1. Quick Reference Guides – Addresses and Phone Numbers

Dental Benefit Providers of California is committed to providing your office with accurate and timely information about our programs, products and policies.

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

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

You want to:	Provider Services Line —Dedicated Service Representatives Phone: 1-800-822-5353 Hours: 5 am–8 pm PST	Online: UHCdental.com	Interactive Voice Response (IVR) System Phone: 1-800-822-5353 Hours: 24 / 7
Inquire about a claim	✓	✓	✓
Ask a benefit / plan question (including prior authorization requirements)	✓	✓	✓
Inquire about eligibility	✓	✓	✓
Request an Explanation of Benefits	✓	✓	
Request a Fee Schedule	✓	✓	
Request a copy of your contract	✓		
Ask a question about your contract	✓		
Inquire about the In-Network Practitioner Listing	✓	✓	✓
Nominate a provider for participation	✓	✓	
Changes to Practice Information (e.g., associate updates, address changes, adding or deleting addresses, Tax Identification Number change, specialty designation, demographic updates)	✓	✓	
Request participation status change	✓		
Request documents	✓	✓	
Request benefit information	✓	✓	

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

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

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

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

2.2.B 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 2.3 Electronic Payments and Statements for more information.

In addition to payments, we offer free and direct electronic claim submission at **UHCdental.com** > Claim Information > Online Claim and Pre-treatment Estimate Form.

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).

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

2.3. 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:

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

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

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

The Zelis Payments advantage:

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

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

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

Section 3: Plan 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.

3.1 Member identification card

Members are issued an identification (ID) card to all recipients enrolled in benefits. When members of a family enroll, separate cards may be issued to each family member. The ID cards are customized with the toll-free customer service number. ID cards also include the member's group ID number.

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

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

3.2 Eligibility verification

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

The Interactive Voice Response (IVR) system

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

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

Important note: A member's ID card is not proof of eligibility. Verification of eligibility is not a guarantee of payment. Payment can only be made after the claim has been received and reviewed in light of eligibility, dental necessity and other limitations and/or exclusions.

It's easy to get started.

All you need is the following:

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

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

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

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

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

3.3 Specialty care referral guidelines

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

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

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

Section 4: Member appeals

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

Section 5: Radiographs

5.1 Radiographs

For some procedures, it is required that copies of radiographs are submitted prior to payment. Providers should refer to this section for radiographs guidelines before performing a procedure.

Guidelines for providing radiographs are as follows:

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

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

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

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

Section 6: Claim submission procedures

6.1 Claim submission required elements & best practices

Dental claim form

The most current Dental ADA claim form must be submitted for payment of services rendered or to obtain a Pre-Treatment Estimate.[2]

Claim submission options

Electronic claims

Electronic claims processing requires access to a computer and usually the use of practice management software. Electronically generated claims can be submitted through a clearinghouse or at no cost directly to our website at **UHCdental.com** > Claim Information > Online Claim and Pre-treatment Estimate Form. Most systems have the ability to detect missing information on a claim form and notify you when errors need to be corrected. Electronic submission is private as the information being sent is encrypted. Please call **1-877-620-6194** for more information regarding electronic claims submission.

Paper claims

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

Dental claim form required information

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

Header information

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

Subscriber information

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

Member information

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

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

Primary payer information

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

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

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

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

Billing dentist or dental entity

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

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

Treating dentist and treatment location

List the following information regarding the dentist that provided treatment:

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

Services provided

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

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

Missing teeth information

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

Remarks section

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

Subscriber / member authorization

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

Paper claims

All dental claims must be legible. Computer-generated forms are recommended. Additional documentation and radiographs should be attached when applicable. Such attachments are required for pre-treatment estimates and for the submission of claims for complex clinical procedures.

By Report procedures

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

Using current ADA codes

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

Tips on claim submission

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

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

6.1.A Pre-Treatment Estimate (PTE)

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

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

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

6.2 Claims processing systems

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

Claims are edited and paid according to the specific plan design for a member's employer group. Please refer to the resources outlined in Section 2.

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

6.3 Electronic claims submissions

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

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 the Important Addresses and Phone Numbers section and Distributor Client List for additional information as needed.

If you wish to submit claims electronically, please contact your clearinghouse to initiate this process. If you do not currently work with a clearinghouse, you may either sign up with one to initiate this process or simply register with our preferred vendor. The Dental Benefit Providers of California website (**UHCdental.com**) also offers the feature to directly submit your claims online through the provider portal.

6.4 HIPAA compliant 837D file

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

6.5 HIPAA compliant 835 file

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

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

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

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

6.6 Paper claims submission

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

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

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

6.7 Coordination of Benefits (COB)

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

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

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

6.8 Dental claim filing limits and adjustments

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

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

6.9 Claim adjudication and periodic overview

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

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

Invalid or incomplete claims:

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

6.10 Explanation of Provider Remittance Advice

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

Below is a list and description of each field:

PROVIDER OR MBR NAME AND ID NO
Treating dentist's name, NPI submitted with claim, Member's name and Subscriber's ID number. To conform to HIPAA regulations, the subscriber's alternate ID number is shown in place of the Social Security number.

GROUP NO
Group ID number assigned to the member's plan

CLAIM NO
Number assigned to the claim

ADA CODE
Procedure code submitted pertaining to the service

DESCRIPTION
Description of the procedure code

DATE OF SERVICE
Date when services were rendered

TOOTH NO
Tooth number or the quadrant pertaining to the procedure

AMOUNT CLAIMED
Amount submitted by provider

AMOUNT ALLOWED
Provider's contracted fee amount

DEDUCT APPLIED
Applicable plan deductible

OTHER INS
Member's primary insurance if applicable

MEMBER RESP
Member's copayment that pertains to the procedure

AMOUNT PAID
Claim paid amount

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

6.11 Provider claim appeal and inquiry process

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

There are two types of provider appeals:

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

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

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

Section 7: Quality management

7.1 Quality Improvement Program (QIP) description

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.

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.

7.2 Credentialing

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

Dental Benefit Providers of California will request a written explanation regarding any adverse incident and its resolution, and will request corrective action be taken to prevent future occurrences.

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

The Dental Director and the Credentialing Committee review the information submitted in detail based on approved credentialing criteria. Dental Benefit Providers of California will request a resolution of any discrepancy in credentialing forms submitted. Practitioners have the right to review and correct erroneous information and to be informed of the status of their application. Credentialing criteria are reviewed by advisory committees, which include input from practicing network providers to make sure that criteria are within generally accepted guidelines.

Dental Benefit Providers of California contracts with an external Credentialing Verification Organization (CVO) to assist with collecting the data required for the credentialing and recredentialing process. Please respond to calls or inquiries from

this organization or our offices to make sure that the credentialing and/or recredentialing process is completed as quickly as possible.

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

Recredentialing requests are sent 9 months prior to the recredentialing due date. The CVO will make 3 attempts to procure a completed recredentialing application from the provider, and if they are unsuccessful, Dental Benefit Providers of California will also make an additional 3 attempts, at which time if there is no response, a termination letter will be sent to the provider as per their provider agreement.

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

Initial credentialing

- Completed application
- Signed and dated Attestation
- Current copy of their state license
- Current copy of their Drug Enforcement Agency (DEA) certificate
- Current copy of their Controlled Dangerous Substance (CDS) certificate, if applicable
- Current copy of their Sedation and/or General Anesthesia certificates, if applicable
- Copy of their Sedation and/or General Anesthesia training certificate/diploma, if applicable
- Signed and dated Sedation and/or General Anesthesia Attestation, if applicable
- Malpractice face sheet which shows their name on the certificate, expiration dates and limits — limits $1/3m
- Explanation of any adverse information, if applicable
- Five years' work in month/date format with no gaps of 6 months or more; if there are, an explanation of the gap should be submitted
- Education (which is incorporated in the application)
- Current Medicaid ID (as required by state)

Recredentialing

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

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

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

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

If you are new to CAQH ProView, visit ADA.org/godigital to get started. If you are already using CAQH ProView, we are able to accept your CAQH ID number provided that your profile data, credentialing documents and attestation show Complete and Current.

7.2.A Confidentiality

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

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

7.2.B Site visits

With appropriate notice, provider locations may receive 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 Clinical Affairs Committee, leading to a corrective action plan or possible termination. If terminated, the dentist can reapply for network participation once a second review has been completed and a passing score has been achieved.

7.3 Grievances

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

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

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

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

Dental Benefit Providers of California 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 Dental Benefit Providers of California's request for patient records and films, etc., within five business days of receiving the request.

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

Dental Benefit Providers of California recognizes the importance of thoroughly reviewing all appropriate documentation to determine if there are any potentially systemic problems.

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

7.4 Preventive health guideline

The Dental Benefit Providers of California approach to preventive health is a multi-focused strategy which includes several integrated areas. Preventive health focuses primarily on the prevention, assessment for risk, and early treatment of caries

and periodontal diseases, but also encompasses areas including prevention of malocclusion, oral cancer prevention and detection, injury prevention, avoidance of harmful habits and the impact of oral disease on overall health. We have a long history of working with customers on education and outreach programs focusing on wellness, oral health management and the relationship between oral disease and overall health.

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

Preventive health recommendations for children are intended to be consistent with American Academy of Pediatric Dentistry periodicity recommendations.

Caries management—Begins with a complete evaluation including an assessment for risk.

- X-ray periodicity—X-ray examination should be tailored to the individual patient based on the patient's health history and risk assessment/vulnerability to oral disease and should follow current professionally accepted dental guidelines necessary for appropriate diagnosis and monitoring.
- Recall periodicity—Frequency of recall examination should also be tailored to the individual patient based on clinical assessment and risk assessment.
- Preventive interventions—Interventions to prevent caries should consider AAPD periodicity guidelines while remaining tailored to the needs of the individual patient based on age, health history, and risk assessment/vulnerability to oral disease. These preventative interventions include but are not limited to regular prophylaxis, fluoride application, placement of sealants, dietary counseling and adjunctive therapies where appropriate.
- Caries Classification and Risk Assessment Systems—methods of caries detection, classification, and risk assessment combined with prevention strategies, can help to reduce patient risk of developing advanced disease and may even arrest the disease process. Consideration should be given to these conservative nonsurgical approaches to early caries; or alternatively, where appropriate, to minimally invasive approaches, conserving tooth structure whenever possible.

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

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

Oral cancer screening – Should be performed for all adults and children in late adolescence or younger if there is a personal or family history, if the patient uses tobacco products, or if there are additional factors in the patient history, which in the judgment of the practitioner elevate their risk.

- Screening should be done at the initial evaluation and again at each recall.
- Screening should include, at a minimum, a manual/visual exam, but may include newer screening procedures, such as light contrast or brush biopsy, for the appropriate patient.

Additional areas for prevention evaluation and intervention – Include malocclusion, prevention of sports injuries and harmful habits (including, but not limited to, digit- and pacifier-sucking, tongue thrusting, mouth breathing, intraoral and perioral piercing, and the use of tobacco products). Other preventive concerns may include preservation of primary teeth, space maintenance and eruption of permanent dentition.

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

Section 8: Utilization management program

8.1 Utilization management

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

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

8.2 Community practice patterns

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

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

8.3 Evaluation of utilization management data

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

8.4 Utilization management analysis results

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

Feedback and recommended follow-up may also be communicated to the provider network as a whole. This is done by using a variety of currently available communication tools including: (bullet) Provider Manual/Standards of Care

- Provider Training
- Continuing Education
- Provider News Bulletins

8.5 Fraud and abuse

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

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

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

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

8.6 Utilization review

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

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

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

Utilization review is completed based on the following:

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

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

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

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

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

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

- Systematic review and meta-analysis
- Randomized controlled trials (RCT)
- Retrospective studies
- Case series
- Case studies
- Anecdotal/expert opinion (including professional society statements, white papers and practice guidelines)

Evidence is found in a variety of sources including:

- Electronic database searches such as Medline®, PubMed®, and the Cochrane Library.
- Hand search of the scientific literature
- Recognized dental school textbooks

Evidence based dentistry can be used clinically to guide treatment decisions, and aid health plans in the development of benefits. At Dental Benefit Providers of California, we use evidence as the foundation of our efforts, including:

- Practice guidelines, parameters and algorithms based on evidence and consensus.
- Comparing dentist quality and utilization data
- Conducting audits and site visits
- Development of dental policies and coverage guidelines

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

Section 10: Practice capacity and appointment scheduling standards

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

Participating providers must comply with any state-mandated appointment scheduling requirements for Emergency Care as well as Elective or Routine Care Appointments.

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

Missed appointments

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

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

10.1.A Appointment availability requirements for California

Dental Benefits Provider of California has established the following access standards:

Specialty Type: General Dentists, Specialists, and Orthodontists

Participating Dentist shall provide appointments to all Members within a reasonable time following Member's request. In non-emergency cases, a reasonable amount of time shall be not more than fourteen (14) business days for initial appointment, follow-up appointments, and hygiene appointments for dental prophylaxis.

Participating Dentist shall provide emergency care within twenty-four (24) hours of request, seven days a week. Additionally, Participating Dentist shall provide urgent care within seventy-two (72) hours of request. Wait time in office shall be thirty (30) minutes or less for scheduled appointment.

10.2 Emergency coverage

California After-hour Emergency Requirement

Each year, the Plan is required to inform you of the after-hour emergency requirement mandating that all California providers provide after-hour emergency services to plan enrollees. All contracted California providers must employ an answering service or a telephone answering machine during non-business hours, which provides instructions on how plan enrollees may obtain urgent or emergency care when applicable, how to contact another provider who has agreed to be on call to triage or screen by phone, or if needed deliver urgent or emergency care.

10.3 New associates

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

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

If you have any questions, please contact our Provider Services line at **1-800-822-5353**. If you need to receive a copy of our provider application packet, please visit **UHCdental.com** > Join Our Network page and request a provider packet.

10.4 Change of address, phone number, email address, fax or Tax Identification Number

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

A Participating Provider or an entity delegated to conduct credentialing activities on behalf of 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.
- The NPI(s) of the participating provider.
- The languages spoken/written by the participating provider of the staff.
- The ages/genders served by the participating provider.
- Office hours (7 days a week)

Changes should be submitted to:

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:

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. For example, a tax identification number (TIN) change would require submission of a copy of the new W-9, 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 name(s), TIN(s) and/or Practitioner ID(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, don't hesitate to contact Provider Services at **1-800-822-5353** for guidance.

10.5 Office conditions

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

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

10.6 Sterilization and asepsis control

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

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

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

10.7 Recall system

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

10.8 Transfer of dental records

Your office shall copy all requested member dental files to another participating dentist as designated by Dental Benefit Providers of California or as requested by the member. The member cannot be held liable for the cost of copying the patient dental files if the member is transferring to another provider. If your office terminates from Dental Benefit Providers of California, dismisses the member from your practice or is terminated by Dental Benefit Providers of California, the cost of copying files shall be borne by your office. Your office shall cooperate with Dental Benefit Providers of California in maintaining the confidentiality of such member dental records at all times, in accordance with state and federal law.

10.9 Nondiscrimination

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

10.10 Cultural competency

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

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

Section 11: California Language Assistance Program

11.1 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.

11.1.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

11.1.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.

11.2 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.

11.3 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

11.4 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: Provider information

A.1 Definitions

A.1.a Preferred Provider Organizations (PPO)

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

Distinctions among the different types of plans are as follows:

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

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

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

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

A.1.b Private label clients

Dental Benefit Providers of California partners with other insurance carriers and entities to assist in providing access to dental care through our network. In addition, they leverage our dental claims adjudication capabilities. In some instances, these carriers or entities retain their own company and/or product brand and the Dental Benefit Providers of California relationship is invisible to their members. When other insurance carriers or entities use our network in this manner, it is referred to as a Private Label Arrangement.

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

Attachments

A.2 Demographic 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 Providers need to be termed*** **Term Reason:** ☐ **Provider Left Practice** ☐ **Other**

Providers associated with the requested change: ____________________

____

____

PROVIDER SIGNATURE: **DATE:**

WPN: Prov W9 Rev April 2021

A.3 Structural review evaluation measures

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. Certain medical alerts may be placed outside chart. Example of conditions that may apply: Latex sensitivity; allergies to penicillin, local anesthetic, or dental materials. Electronic offices, the EHR (Electronic Health Record) should have alerts that prominently display on each page of the record.
4. Doctor signature and date	Dentist must sign and date all baseline medical histories after review with patient. Some computer programs do not permit any alteration (such as the DDS Signature) on the medical history after the patient has signed it. In this case it is acceptable for the chart narrative to reflect the review. Electronic records may not show DDS review on the actual medical history, but ask office to show where the DDS review is reflected in the EHR.
5. Periodic update	Documentation of medical history updates at appropriate intervals. Evidence of periodic evaluation/update should be documented on a case specific basis. Must be signed by the patient and the provider. Acceptable for update to be on medical history form or in the progress notes. Should reflect changes or no changes. Recommend update be done at least annually. Best practices are if there are changes to the medical history (significant- such as medical condition/medication change etc.) a new medical history should be completed and executed by both patient and DDS. EHR should be able to capture updates. Ask office to demonstrate where in the EHR the updates exist.
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. If orthodontics involved should also include documentation of habits (thumb sucking, tongue thrust etc.)
2. TMJ/Occlusal evaluation	Evidence of TMJ exam or evaluation of occlusion (classification) should be determined. If orthodontics involved both items required and should include midline, overbite, overjet, crowding and crossbites . This may include charting/measurements as appropriate. Evidence of periodic evaluation should be documented on a case specific basis.
3. Prosthetics	Evaluation of existing appliance(s)(age, condition etc.), teeth replaced, clasps, etc. This section should include implants as well as removable appliances.
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)
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.

Review criteria	Reviewer evaluation measures
II. Quality of care	
A. Radiographs	
1. Quantity/Frequency	a. Adequate number of radiographs or images to make an appropriate diagnosis and treatment plan, per current FDA/ADA guidelines. b. Recall radiographs or images should be based on current FDA/ADA guidelines. Number and type depends on complexity of previous & proposed care, caries susceptibility, amount and type of treatment and time since last radiographic exposure. c. Whenever possible, radiographs or images should not be taken if recent acceptable images are available from another source (previous Dentist). d. Any refusal of radiographs should be documented. e. If orthodontics involved: should evaluate presence of full mouth radiograph or panoramic image. In addition the presence of cephalometric film (and tracing if appropriate). Based on TMJ examination tomographic survey should be exposed and analyzed with results incorporated in to treatment plan. Mid treatment images recommended for all orthodontic cases. Study models should be trimmed to the correct bite.
2. Technical Quality	a. No overlapping contacts, or cone cuts that affect diagnostic value; periapical images should show apices b. Good contrast, not over or underdeveloped; no chemical stains. c. Photographic images clear and correctly developed and printed to AAO guidelines (for orthodontics)
3. Mounted, labeled and dated	Recent radiographs or images must be mounted, labeled and dated for reviewing and comparison with past images. Past images do not need to be mounted, but should be kept in order with name and date (envelopes are acceptable)
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. Covered benefit and alternative or optional treatment should be clearly indicated. d. Consultations and referrals should be noted when necessary and appropriate. e. If orthodontics involved, treatment plan goals are listed, extraction vs. non-extraction is specified, any potential compromises are identified and an estimate of the treatment time is included.
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 (if appropriate for the patients condition). c. Treatment of extensive caries and pulpal inflammation. Endodontic therapy. d. Periodontal treatment e. Restorative treatment f. Replacement of missing teeth g. 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. 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 specialty referrals. d. If orthodontics involved: should have appropriate content and extraction vs. non-extraction is identified. Patient compliance expectations should likewise be disclosed in this process.
III. Treatment outcomes of care	
A. Preventive services	
1. Diagnosis	Documentation that a prophylaxis was performed in a timely manner (this may not apply to all patients, based on presenting conditions). Documentation of fluoride treatments planned or rendered, as appropriate to age of patient and caries incidence. If orthodontics involved-prophy could be recommended or performed.
2. Oral Hygiene Instructions	Documentation of Home Care/Oral Hygiene instructions given to patient (either during periodontal treatment or preventive treatment appointments). If orthodontics involved initial OHi should be documented initially and monitored throughout the treatment period.
3. Recall	Documentation of timely, case appropriate recall of patient (best practices would include the interval documented in the treatment record).
B. Operative service	
1. Diagnosis	Recall and past radiographs or images used to evaluate proper diagnosis of caries and the need for treatment. Treatment performed in a timely manner. If orthodontics involved, documentation of caries clearance is expected. Active caries should be identified and restored.
2. Restorative Outcome and Follow-Up	a. Margins, contours, and contacts appear radiographically acceptable. b. Prognosis good for appropriate longevity. Minimal subsequent unplanned treatment. Examples of unplanned treatment-redo of recent restorations due to fracture, extraction, RCT, etc. Evidence patient was offered covered benefit.
3. Specialist Referral	Referral to a specialist in appropriate circumstances and in a timely manner.

Review criteria	Reviewer evaluation measures
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. Examples of unplanned treatment-redo of recent restorations due to fracture, extraction, RCT, etc. Evidence patient was offered covered benefit.
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 or images).
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. (Final film or image) b. Prognosis good for appropriate longevity. Minimal subsequent unplanned treatment, no evidence of extraction of recently completed endo. c. Documentation of final restoration (final film or image). 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 or images) is available to determine proper type of treatment needed. If orthodontics involved- diagnosis or periodontal clearance from general dentist requested.
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. Implants would be evaluated in this section. It is possible to evaluate the surgical aspect of the implant process in surgical services section, however the prosthetic aspect of the implant process should be evaluated here. Best practice would be to identify in the comment section that it is implants being evaluated.
2. Prosthetic Outcome and Follow-Up	a. Treatment was done in a timely manner, including necessary adjustments. b. Prognosis good for appropriate longevity. Evidence patient was offered covered benefit
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. Surgical phase of Implant prosthesis can be evaluated in this section.
2. Surgical Outcome and Follow-Up	a. Comprehensive documentation of treatment done, materials used, and any noteworthy occurrences during the procedure. Notations on General Anesthesia/Sedation should be documented. b. Documentation of appropriate post-operative instructions given to patient. c. Documentation of any needed post-operative care, including suture removal. Evidence patient was offered covered benefit. No evidence of improper coding of type of extraction.
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 radiographs or images and other available information.) Consideration should be given to significant concerns with diagnosis, treatment outcomes, and/or treatment plan presentation. Evidence patient was offered their covered benefit plays a role in outcomes as well. This is perhaps the hardest item to determine on a chart review, but these items, coupled with outcomes in all the above chart review categories, should provide adequate guidance to permit a determination to be made. If orthodontics involved: Appointment interval appropriate, treatment performed in timely fashion, non-compliance with treatment noted, if completed case are final records available including radiographic images and photos. Are retainers monitored properly?

A.4 Process of care evaluation criteria (General and Orthodontics)

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 24hour/7 day a week contact or instructions for contacting emergency contact 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 by dentist(s) 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. Décor 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. (This applies to amalgam free practices as well)
C. Nitrous Oxide Recovery System?	Verification that nitrous oxide equipment is clean, safe and in good repair. 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. (There is a current model made by Med-Dent Corp which as 2 hoses and is considered a scavenger system) 3. Fail Safe mechanism present for correct delivery of gasses.
D. Lead Apron (with thyroid collar for patient)	There should be a lead apron present with a thyroid collar. It is acceptable for a lead equivalent material to be used. This is required for use for all exposures to ionizing radiation. 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	
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. Should include backup responsibilities for 2. Exits clearly marked with exit signs. (May vary based on local ordinances) 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” Medical emergency kit should be easily accessible and labeled with an inventory of contents. All required drugs per current CADP guidelines/course are present. All Drugs present (both required and non-required) are current. Staff should be aware of location of kit. Recommend staff in-service training for general use of contents.
B. Medical emergency kit on-site?	Medical emergency kit should be easily accessible and labeled with an inventory of contents. All required drugs per current CADP guidelines/course are present. All Drugs present (both required and non-required) 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 or 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.

Review Criteria	Reviewer Evaluation Measures
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 1680ad). All protocols are followed in the practice.
B. Protocols posted for sterilization procedures?	Protocols conspicuously posted. Dental Board of California. (CCR Section 1005b23)
C. Weekly biological (spore) monitoring of sterilizer?	All sterilizers present in the office, including back-up sterilizer shall be monitored weekly and recorded, by appropriate methods, as required by the Dental Board of California (CCR Section 1005b17, January 2001). Log must be maintained for minimum of 12 months. Recommend for sake of prevention of accusations, it be kept as permanent record.
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 manufacturer'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, stains or torn bags. Instruments must remain in sealed, dated sterile bags (CCR 1005b 12 & 13) or packs until ready for use. Once bag is opened, all instruments must be re-bagged , dated and re-sterilized, 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 indicting: 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. The time may also vary based on load use. 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 contact. 2. Splattered or soiled garments should be replaced as necessary. Masks must be changed minimally between patients or when visibly soiled while treating the same patient. 3. Gloves must be changed between patients and before leaving the operatory.
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 that are changed between patients.
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,(CCR 1005b21) Must have anti-retraction valves. Best practices are to leave waterlines free from fluids (dry) overnight.
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 if they are single use wheels. 2. Impressions, dentures and other appliances going to and coming from the laboratory should be properly rinsed and disinfected. (CCR 1005b 24)

A.5 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)
		7)
		8)
		9)
		10)

A=Acceptable
U=Unacceptable
/ = Non Applicable

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.5 Site Visit Procedural Audit Documentation—page 2 of 6

United Healthcare | Dental Benefit Providers® of California

2 of 6

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.5 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.5 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.5 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.5 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
- ☐ French
- ☐ Other (non English)
- ☐ Armenian
- ☐ Hindi
- ☐ Bengali
- ☐ Korean
- ☐ German
- ☐ Russian
- ☐ Farsi/Persian
- ☐ Spanish
- ☐ Tagalog/Filipino
- ☐ Chinese
- ☐ Cantonese
- ☐ 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.6 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 U=Unacceptable / = Non Applicable		7)
		8)
		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.6 Site Visit CADP Orthodontic Procedural Audit Documentation—page 2 of 6

United Healthcare | Dental Benefit Providers® of California

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

United Healthcare | Dental Benefit Providers® of California

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

United Healthcare | Dental Benefit Providers® of California

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

United Healthcare | Dental Benefit Providers® of California

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.7 Orthodontic Criteria & Guidelines—page 1 of 7

Dental Benefit Providers of California

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.7 Orthodontic Criteria & Guidelines—page 2 of 7

Dental Benefit Providers of California

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.

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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 <u>indicators</u>** 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. <u>Diagnosis and Treatment Plan</u>

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. <u>Consent Form and Finances</u>

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

   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. <u>Progress Notes</u>

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

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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

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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.8 Provider EOB Sample—page 1 of 3

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

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.8 Provider EOB Sample—page 2 of 3

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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.8 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.9 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.10 Determination of "necessary" services

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

Medical necessity is completed based on the following:

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

A.11 CMS Preclusion List

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

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

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

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

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

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

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

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