Missouri Medicare Dental Provider Manual for UnitedHealthcare Dual Complete

UnitedHealthcare®

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Table of Contents

Section 1: Introduction

Introduction - Who We Are

Welcome to UnitedHealthcare®

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

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

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

This Provider Manual (the "Manual") is designed as a comprehensive reference guide for the dental plans in your area, primarily UnitedHealthcare Medicaid and Medicare plans. Here you will find the tools and information needed to successfully administer UnitedHealthcare plans. As changes and new information arise, we will send these updates to you.

Our Commercial program plan requirements are contained in a separate Provider Manual. If you support one of our Commercial plans and need that Manual, please contact Provider Services at**1-800-822-5353** (Please note: all other concerns should be directed to **1-844-275-8750**).

If you have any questions or concerns about the information contained within this Manual, please contact the UnitedHealthcare Provider Services team at **1-844-275-8750**.

Unless otherwise specified herein, this Manual is effective on January 1, 2018 for dental providers currently participating in the UnitedHealthcare network, and effective immediately for newly contracted dental providers.

Please note: "Member" is used in this Manual to refer to a person eligible and enrolled to receive coverage for covered services in connection with your agreement with us. "Manual" refers to this 2018 Provider Manual. "You" or "your" refers to any provider subject to this Manual. "Us", "we" or "our" refers to UnitedHealthcare on behalf of itself and its other affiliates for those products and services subject to this Manual.

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

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

Sincerely,

UnitedHealthcare, Professional Networks

SECTION 2: Resources and Services – How We Help You

2.1 Quick Reference Guides – addresses and phone numbers

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

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

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

	RESOURCE:		
YOU WANT TO:	Provider Services Line – Dedicated Service Representatives Phone: 1-844-275-8750 Hours: 9 a.m.-6 p.m. (ET) Monday – Friday, (EST)	Online www.uhcproviders.com	Interactive Voice Response (IVR) System Phone: 1-844-275-8750 Hours: 24 hours a day, 7 days a week
Ask a Benefit/Plan Question (including prior authorization requirements)	✓	✓	
Ask a question about your contract	✓		
Changes to practice information (e.g., associate updates, address changes, adding or deleting addresses, Tax Identification Number change, specialty designation)	✓	✓	
Inquire about a claim	✓	✓	✓
Inquire about eligibility	✓	✓	✓
Inquire about the In-Network Practitioner Listing	✓	✓	✓
Nominate a provider for participation	✓	✓	
Request a copy of your contract	✓		
Request a Fee Schedule	✓	✓	
Request an EOB	✓	✓	
Request an office visit (e.g., staff training)	✓		
Request benefit information	✓	✓	
Request documents	✓	✓	
Request participation status change	✓		

	RESOURCE:				
NEED:	**Address:**	**Phone Number:**	**Payor I.D.**	**Submission Guidelines**	**Form(s) Required:**
Claim Submission (initial)	**Claims:** UnitedHealthcare PO Box 2176 Milwaukee, WI 53201	1-844-275-8750	GP133	Within 365 days	ADA* Claim Form, 2012 version or later
Prior Authorization Requests	**PTE/Preauthorizations:** UnitedHealthcare PO Box 2053 Milwaukee, WI 53201	1-844-275-8750	GP133		ADA Claim Form – check the box titled: Request for Predetermination/ Preauthorization section of the ADA Dental Claim Form
Provider Claim Disputes, Reprocessing & Adjustment Requests	**Provider Disputes:** UnitedHealthcare P.O. Box 361 Milwaukee, WI 53201	1-844-275-8750	N/A	Within 90 days from receipt of payment	ADA Claim Form Reason for requesting adjustment or resubmission
Corrected Claims	**Corrected Claims:** UnitedHealthcare P.O. Box 541 Milwaukee, WI 53201	1-844-275-8750	N/A	Within 90 days from receipt of payment	ADA* Claim Form, 2012 version or later
UnitedHealthcare Member Complaints & Appeals	**UnitedHealthcare** Attn: Appeals and Grievances PO Box 31364 Salt Lake City, UT 84131	1-844-368-6886	N/A	N/A	N/A
UnitedHealthcare Provider UM Appeals	**UnitedHealthcare** Attn: Appeals and Grievances PO Box 31364 Salt Lake City, UT 84131	1-844-368-6886	N/A	Appeals must be submitted within 60 days of the date of authorization decision.	N/A

2.2.a Integrated Voice Response (IVR) System –1-844-275-8750

We have a toll-free Integrated Voice Response (IVR) system that enables you to access information 24 hours a day, 7 days a week, by responding to the system's voice prompts.

Through this system, network dental offices can obtain immediate **eligibility information**, validate **practitioner participation status**, and perform member **claim history** search (by surfaced code and tooth number).

2.2.b Website

The UnitedHealthcare website at **www.uhcproviders.com** offers many time-saving features including **eligibility verification, benefits, claims submission and status, prior-authorization submission and status, demographic updates, print remittance information, claim receipt acknowledgement** and **network specialist locations**.

To use the website, please go to **www.uhcproviders.com** and register as a participating user.
For assistance, please call **1-844-275-8750**.

SECTION 3: Patient Eligibility Verification Procedures

3.1 Member Eligibility

UnitedHealthcare Community Plan's Special Needs Plan is named UnitedHealthcare Dual Complete. Member eligibility or dental benefits may be verified online or via phone.

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

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

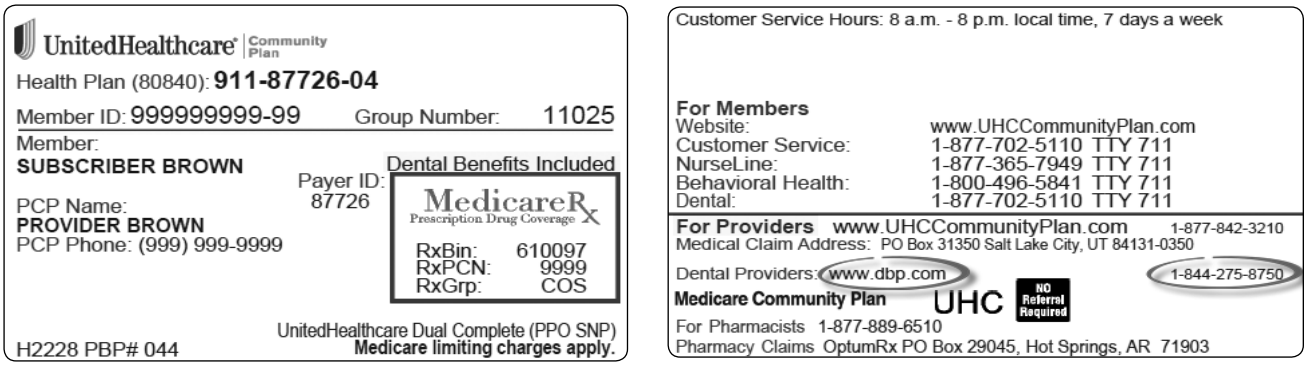
3.2 Member Identification Card

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

A member ID card is not a guarantee of payment. It is the responsibility of the provider to verify eligibility at the time of service.

To verify a member's dental coverage, go to **www.uhcproviders.com** or contact the dental Provider Services line at **1-844-275-8750**.

A sample ID card is provided below. The member's actual ID card may look slightly different.



3.3 Eligibility Verification

Eligibility can be verified on our website at **www.uhcproviders.com** 24 hours a day, 7 days a week. In addition to current eligibility verification, our website offers other functionality for your convenience, such as claim status. Once you have registered on our provider website, you can verify your patients' eligibility online with just a few clicks.

To register on the site, you will need the following information:

☐ Payee ID number from a remittance advice

The username and password that are established during the registration process will be used to access the website. One username and password are granted for each payee ID number. Please call **1-844-275-8750** during normal business hours for assistance with website issues.

UnitedHealthcare also offers an Interactive Voice Response (IVR) system; simply call **1-844-275-8750**. Through our IVR system, you may access real-time information, 24 hours a day, 7 days a week. The UnitedHealthcare IVR system enables you to do the following:

☐ Verify Eligibility

☐ Obtain Claim Status

3.4 Specialist Referral Process

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

To obtain a list of participating dental network specialists, go to our website at **uhcproviders.com** or contact Provider Services at **1-844-275-8750**.

SECTION 4: Member Benefits / Exclusions & Limitations

4.1 Covered Services for UnitedHealthcare Dual Complete

Provider Quick Covered Services Reference Guide for the UnitedHealthcare Community Plan Medicare Special Needs plan, UnitedHealthcare Dual Complete:

The following dental services are covered under the plan and are subject to a Calendar Year Maximum of $1500:

Code		Frequency/Limitation	Auth. Required
D0120	Periodic Oral Evaluation	Once every 6 months	
D0140	Limited Oral Evaluation - Problem focused	Once every 6 months	
D0150	Comprehensive Oral Evaluation - New or Established Patient	Once every 6 months	
D0210	Intraoral - Complete Series of Radiographic Images	Once every 6 months	
D0220	Intraoral - Periapical First Radiographic Image	Once every 6 months	
D0230	Intraoral - Periapical Each Additional Image	Once every 6 months	
D0240	Intraoral - Occlusal Radiographic Image	Once every 6 months	
D0270	Bitewing - Single Radiographic Image	Once every 6 months	
D0272	Bitewings - Two Radiographic Images	Once every 6 months	
D0273	Bitewings - Three Radiographic Images	Once every 6 months	
D0274	Bitewings - Four Radiographic Images	Once every 6 months	
D0330	Panoramic Radiographic Image	Once every three years	
D1110	Prophylaxis - Adult	Once every 6 months	
D2140	Amalgam - One Surface, Primary Or Permanent		
D2150	Amalgam - Two Surfaces, Primary Or Permanent		
D2160	Amalgam - Three Surfaces, Primary Or Permanent		
D2161	Amalgam - Four Or More Surfaces, Primary Or Permanent		
D2330	Resin-Based Composite - One Surface, Anterior		
D2331	Resin-Based Composite - Two Surfaces, Anterior		
D2332	Resin-Based Composite - Three Surfaces, Anterior		
D2335	Resin-Based Composite - Four Or More Surfaces Or Involving Incisal Angle		
D2390	Resin-Based Composite Crown, Anterior		
D2391	Resin-Based Composite - One Surface, Posterior		
D2392	Resin-Based Composite - Two Surfaces, Posterior		
D2393	Resin-Based Composite - Three Surfaces, Posterior		
D2394	Resin-Based Composite - Four Or More Surfaces, Posterior		
D2710	Crown - Resin-Based Composite (Indirect)	Once per 36 months	Yes
D2740	Crown - Porcelain/Ceramic Substrate	Once per 36 months	Yes
D2750	Crown - Porcelain Fused To High Noble Metal	Once per 36 months	Yes
D2751	Crown - Porcelain Fused To Predominantly Base Metal	Once per 36 months	Yes
D2752	Crown - Porcelain Fused To Noble Metal	Once per 36 months	Yes
D2791	Crown - Full Cast Predominantly Base Metal	Once per 36 months	Yes
D2792	Crown - Full Cast Noble Metal	Once per 36 months	Yes
D2920	Recement Crown		
D2930	Prefabricated Stainless Steel Crown - Primary Tooth		
D2931	Prefabricated Stainless Steel Crown - Permanent Tooth		
D2940	Protective Restoration		
D2950	Core Buildup, Including Any Pins When Required		Yes
D2954	Prefabricated Post And Core In Addition To Crown		Yes
D4341	Periodontal Scaling And Root Planing - Four Or More Teeth Per Quadrant	Once per 24 months	Yes
D4342	Periodontal Scaling And Root Planing - One To Three Teeth Per Quadrant	Once per 24 months	Yes
D4355	Full Mouth Debridement	Once per 24 months	
D4910	Periodontal Maintenance		
D7111	Extraction, Coronal Remnants - Deciduous Tooth		
D7140	Extraction, Erupted Tooth Or Exposed Root		
D7210	Surgical Removal Of Erupted Tooth		
D7250	Surgical Removal Of Residual Tooth (Cutting Procedure)		Yes
D7310	Alveoloplasty In Conjunction With Extractions - Four Or More Teeth		
D7311	Alveoloplasty In Conjunction With Extractions - One To Three Teeth		
D9110	Palliative (Emergency) Treatment Of Dental Pain - Minor Procedure		

*This chart does not constitute a guarantee of payment. Coverage is determined based on the subscriber's eligibility and the Plan benefits at the time of service. Benefits are subject to change.

4.2 *Exclusions & Limitations

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

Any service not listed as a covered service in the benefit grid (Section 4.1) is excluded.

Please call Provider Services at **844-275-8750** if you have any questions regarding frequency limitations.

Additional Exclusions

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

4.3 Member Appeals & Inquiries

Providers may file an appeal on behalf of a member if that provider is named as the member's representative. For more information about this process please call the applicable member services number listed under Pre-Service (Utilization Management) Appeals below.

Claim Appeals

Members have the right to file an appeal within 60 calendar days of an organization decision. Appeals must be submitted in writing to this address:

☐ **UnitedHealthcare Dual Complete:**
Grievance and Appeals Department
PO Box 31364
Salt Lake City, UT 84131

Pre-Service (Utilization Management) Appeals

There are two types of appeals, Standard (30 calendar days) and Expedited (72 hour review). Standard appeals must be submitted in writing to the addresses listed above.

Written appeals must include the member's name, address, member number, the reason for appealing and any additional supporting information for the appeal.

Members may initiate an expedited appeal in writing or by calling the member service number listed below:

☐ **UnitedHealthcare Dual Complete: 1-844-368-6886**,

Additional Resources for Members

☐ **Medicare Rights Center**
Toll-Free Number: **1-888-HMO-9050**

☐ **1-800-MEDICARE (1-800-633-4227)**
TTY: **1-877-486-2048**

☐ **Elder Care Locator**
Toll-Free Number: **1-800-677-1116**

4.4 Provider Disputes

An In Network Provider Contractual Dispute is a dispute regarding the rate or amount paid on a claim. Members are not financially responsible or impacted by the outcome of such a dispute. If there is any member liability outside of their normal cost share, please refer to section 4.3 Member Appeals.

A Reprocessing or Adjustment Request is a request to reprocess a claim. Examples include submitting a corrected bill, resubmitting a claim with requested information, data entry errors made on the claim or errors in participation status.

Reprocessing Requests and Contractual Disputes may be initiated verbally or in writing to the number and address below:

☐ **1-844-275-8750**
Dual Complete Adjustment Unit
P.O. Box 361
Milwaukee, WI 53201

When a claim is reprocessed as a result of a Reprocessing or Adjustment Request or Contractual Dispute, providers will receive a new remittance advice within 30 calendar days of receipt of the Reprocessing/ Adjustment Request or Contractual Dispute. If the Reprocessing or Adjustment Request or Contractual Dispute does not result in the reprocessing of a claim, providers will receive written notification of the outcome within 30 calendar days of receipt of the Reprocessing or Adjustment Request or Contractual Dispute.

SECTION 5: Authorization for Treatment

5.1 Dental Treatment Requiring Authorization

To make sure that desirable quality of care standards are achieved and to maintain the overall clinical effectiveness of the program, there are times when prior authorization is required prior to the delivery of clinical services.

These services may include specific restorative, endodontic, periodontic, prosthodontic and oral surgery procedures. For a complete listing of procedures requiring authorization, refer to the benefit grid within this Manual.

Prior authorization means the practitioner must submit those procedures for approval with clinical documentation supporting necessity before initiating treatment. For questions concerning prior authorization, dental claim procedures, or to request clinical criteria, please call the Provider Services Line at **1-844–275-8750**.

Prior authorization requests may be forwarded:

1. By mail: P.O. Box 2053
   Milwaukee, WI 53201
2. Electronically: Payor ID GP133
3. Online: **uhcproviders.com**

5.1.a Prior Authorization Submission Criteria

Code	Description	Required Documents
D2710	Crown - Resin-Based Composite (Indirect)	Pre-op x-rays
D2740	Crown - Porcelain/Ceramic Substrate	Pre-op x-rays
D2750	Crown - Porcelain Fused To High Noble Metal	Pre-op x-rays
D2751	Crown - Porcelain Fused To Predominantly Base Metal	Pre-op x-rays
D2752	Crown - Porcelain Fused To Noble Metal	Pre-op x-rays
D2791	Crown - Full Cast Predominantly Base Metal	Pre-op x-rays
D2792	Crown - Full Cast Noble Metal	Pre-op x-rays
D2950	Core Buildup, Including Any Pins When Required	Pre-op x-rays
D2954	Prefabricated Post And Core In Addition To Crown	Pre-op x-rays
D4341	Periodontal Scaling And Root Planing - Four Or More Teeth Per Quadrant	Periodontal charting and pre-op x-rays
D4342	Periodontal Scaling And Root Planing - One To Three Teeth Per Quadrant	Periodontal charting and pre-op x-rays
D7250	Surgical Removal of Residual Tooth Roots (Cutting Procedure)	Pre-op x-rays (excluding bitewings) and narrative of medical necessity

5.1.b Authorization Approval Criteria

When submitting documentation for prior authorization / retrospective review of these procedures, please note the requirements listed below.

The UnitedHealthcare criteria utilized for medical necessity determination were developed from information collected from American Dental Association's Code Manuals, clinical articles and guidelines, as well as dental schools, practicing dentists, insurance companies, other dental related organizations, and local state or health plan requirements.

The criteria UnitedHealhcare reviewers will look for in order to approve the request is listed below. Should the procedure need to be initiated under an emergency condition to relieve pain and suffering, you are to provide treatment to alleviate the patient's condition. However, to receive reimbursement for the treatment, UnitedHealthcare will require the same criteria / documentation be provided (with the claim for payment) and the same criteria be met to receive payment for the treatment.

Crowns D2710, D2740, D2750, D2751, D2752, D2791, D2792

- Minimum 50% bone support
- No periodontal furcation
- No subcrestal caries
- Clinically acceptable RCT, if present
- Planned RCT, if necessary
- Anterior - 50% incisal edge / 4+ surfaces involved
- Bicuspid – 1 cusp / 3+ surfaces involved
- Molar – 2 cusps / 4+ surfaces involved

Core buildup D2950

- Minimum 50% bone support
- No periodontal furcation
- No subcrestal caries
- Clinically acceptable RCT, if present
- Cuspid – 1 cusp / 2+ surfaces involved
- Bicuspid – 1 cusp / 3+ surfaces involved
- Molar – 2 cusps / 4+ surfaces involved

Prefabricated post and cores D2954

- Minimum 50% bone support
- No periodontal furcation
- No subcrestal caries
- Clinically acceptable RCT, if present
- Planned RCT, if necessary

Scaling and root planning D4341, D4342

- D4341
  1. Four or more teeth in the quadrant
  2. 5 mm or more pocketing on 2 or more teeth indicated on the perio charting
  3. Presence of root surface calculus and/or noticeable loss of bone support on x-rays
- D4342
  1. One to three teeth in the quadrant
  2. 5 mm or more pocketing on 1 or more teeth indicated on the perio charting
  3. Presence of root surface calculus and/or noticeable loss of bone support on x-rays

Removal of Residual Tooth D7250

- Tooth root is completely covered by tissue on x-ray and/or documentation indicates cutting of soft tissue and bone, removal of tooth structures and closure
- Documentation describes pain, swelling, etc. around tooth (must be symptomatic) and documentation noted in patient record

5.1.c Authorization Decisions - Turnaround Times & Filing Limits

Providers will receive a faxed notification of the decision within 14 calendar days of receipt of a prior authorization request.

If approved, services must be performed within 180 calendar days from the date that the approval notification is received by the provider.

5.1.d Authorization Appeal & Inquiry Process

Please call **1-844-275-8750** for questions regarding the prior authorization process or to obtain the status of a prior authorization request.

For information regarding filing an appeal of a prior authorization decision, please refer to the Member Appeals section of this Manual (section 4.3).

5.1.e Payment for Non-covered Services:

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

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

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

Please note that it is recommended that benefits and eligibility be confirmed by the provider before treatment is rendered. Members are held harmless and cannot be billed for services that are covered under the plan, in excess of cost sharing as required under the Member's benefit plan.

5.1.f After Hours Emergency

When a provider treats a patient outside of the normal business hours of 8 a.m. to 6 p.m., Monday through Friday, providers should:

1. Confirm patient eligibility on the date of service through our website, or our Interactive Voice Response system.
2. Consult the benefit guide included in this Manual to determine if services are covered under the plan and if prior authorization is required for the service.
3. Provide covered services that do not require prior authorization.
4. If prior authorization is required for a needed service, the provider should relieve the patient's immediate pain with covered services that do not require prior authorization (e.g., palliative treatment or sedative filling). The provider will submit a written request for prior authorization, and may call the provider call center on the next business day to request information for submitting an expedited prior authorization request.

Please note: Prior authorization requirements are not waived for emergency appointments. Prior authorization requests and supporting documents must be received in writing via paper, electronic or website submission, and the request must be approved **prior** to rendering service. Claims will be denied for services that require prior authorization, when prior authorization has not been obtained.

SECTION 6: Radiology Requirements

To learn what Prior Authorization requests would require radiographs, refer to Section 5.1.a of the Manual (Prior Authorization Submission Criteria).

Guidelines for providing radiographs are as follows:

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

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

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

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

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

SECTION 7: Claim Submission Procedures

7.1 Claim submission best practices and required elements

Dental claim form

The most current Dental ADA claim form (2012 or later) must be submitted for payment of services rendered.

Claim submission options

Electronic claims

Electronic claims processing requires access to a computer and usually the use of practice management software. Electronically generated claims can be submitted through a clearinghouse or directly to our claims processing system via the Internet. Most systems have the ability to detect missing information on a claim form and notify you when errors need to be corrected.

Electronic submission is private as the information being sent is encrypted. Please call **1-844-275-8750** for more information regarding electronic claims submission.

Please note that our **Payor ID is GP133**

Paper Claims

Due to periodic revisions and varying practice management systems, dental insurance claim forms exist in various formats. Use of the 2012 or later American Dental Association (ADA) form is required.

Dental claim form required information

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

Header Information

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

Subscriber information

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

Patient Information

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

Primary payer information

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

Other coverage

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

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

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

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

Billing dentist or dental entity

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

- ☐ Name
- ☐ Address (street, city, state, ZIP code)
- ☐ License number
- ☐ Social security number (SSN) or Tax identification number (TIN)
- ☐ Phone number
- ☐ National provider identifier (NPI)

Treating dentist and treatment location

List the following information regarding the dentist that provided treatment

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

Record of services provided

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

- ☐ Procedure date
- ☐ Area of oral cavity
- ☐ Tooth number or letter and the tooth surface
- ☐ Procedure code
- ☐ Description of procedure
- ☐ Billed charges – report the dentist's full fee for the procedure
- ☐ Total sum of all fees

Missing teeth information

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

Remarks section

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

Timely submission

All **Medicare** claims should be submitted within 365 days.

Paper claims

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

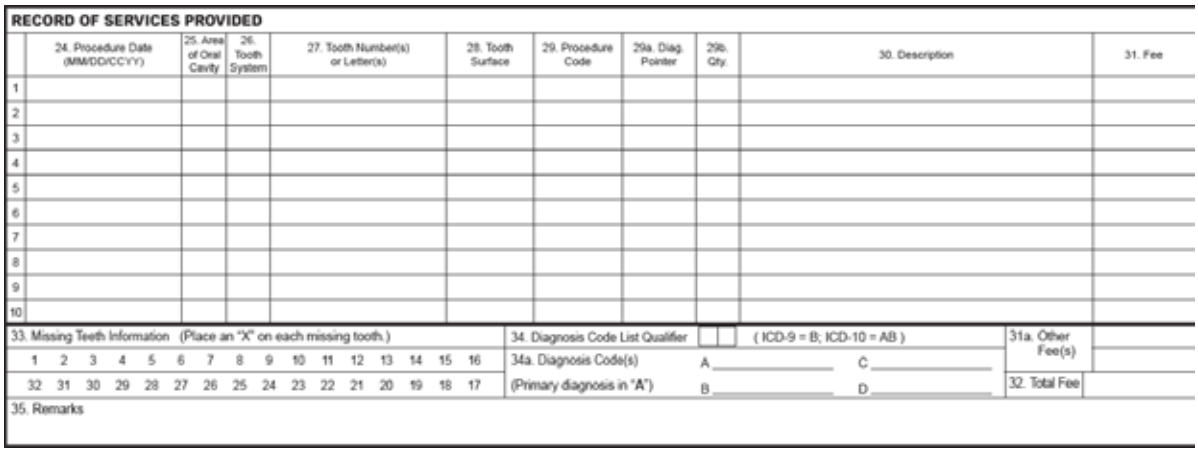
By report procedures

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

Using current ADA codes

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

ICD-10 Instructions



RECORD OF SERVICES PROVIDED

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

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

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16

32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17

34. Diagnosis Code List Qualifier (ICD-9 = B; ICD-10 = AB)

34a. Diagnosis Code(s) (Primary diagnosis in "A") A B C D

31a. Other Fee(s)

32. Total Fee

35. Remarks

Instructions:

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

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

34 **Diagnosis Code List Qualifier:** Enter the appropriate code to identify the diagnosis code source:

B = ICD-9-CM **AB** = ICD-10-CM (as of October 1, 2013)

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

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

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

Insurance fraud

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

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

7.2 Electronic claims submissions

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

UnitedHealthcare partners with electronic clearing houses to support electronic claims submissions. While the payor ID may vary for some plans, the UnitedHealthcare number for **Dual Complete members is GP133**. Please refer to the Important Addresses and Phone Numbers section for additional information as needed. If you wish to submit claims electronically, please contact your clearinghouse to initiate this process.

7.3 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.

7.4 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 or version or later). If an incorrect claim form is used, the claim cannot be processed and will be returned.

Please refer to section 7.1 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.

7.5 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. Coordination of Benefits rules are mandated by the Department of Insurance and it is each provider's responsibility to correctly coordinate benefits.

The practitioner office is required to identify when a patient has coverage through multiple carriers and to inform DBP Dental on the claim form.

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.

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.

Medicaid payers, such as DBP when acting on behalf of a Medicaid program, are considered secondary payers. When COB is present in this situation, providers should bill the appropriate primary carrier first, and then submit to DBP Dental for any additional payment along with primary payer's Explanation of Benefits (EOB).

7.6 Dental Claim Filing Limits & Adjustments

All Dental Claims must be submitted within one year of the date of service.

All adjustments or requests for reprocessing must be made within sixty (60) calendar days from receipt of payment. An adjustment can be requested in writing or telephonically. Please refer to the Quick Reference guide for address and phone number information.

7.7 Claim Adjudication & Periodic Overview

Claim Processing Standards:

☐ 97% of Clean Claims will be adjudicated within 30 days of receipt of the claim.

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

Invalid or incomplete claims:

If claims are submitted with missing information, incomplete or outdated claim forms, the claim will be rejected or returned to the provider and a request for the missing information will be sent to the provider.

If the claim is missing a tooth number or surface, a letter will be generated to the provider requesting this information.

7.8 Explanation of dental plan reimbursement

The Practitioner Remittance Advice is a claim detail of each patient 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 advice is kept for future reference and reconciliation.

Below is a list and description of each field:

PROVIDER NAME AND ID NUMBER - Treating dentist's name, practitioner ID number

PROVIDER LOCATION AND ID - Treating location as identified on submitted claim and location ID number

AMOUNT BILLED - Amount submitted by provider

AMOUNT PAYABLE - Amount payable after benefits have been applied

PATIENT PAY - Any amounts owed by the patient after benefits have been applied

OTHER INSURANCE - Amount payable by another carrier

PRIOR MONTH ADJUSTMENT - Adjustment amount(s) applied to prior overpayments

NET AMOUNT (Summary Page) - Total amount paid

PATIENT NAME

SUBSCRIBER / MEMBER NO - Identifying number on the subscriber's ID card

PATIENT DOB

PLAN - Health plan through which the member receives benefits (i.e., DBP Community Plan)

PRODUCT - Benefit plan that the member is under (i.e., Medicaid or Family Care)

ENCOUNTER NUMBER - Claim reference number

BENEFIT LEVEL - In our out-of-network coverage

LINE ITEM NUMBER - Reference number for item number within a claim

DOS

CDTCODE

TOOTH NO.

SURFACE(S)

PLACE OF SERVICE - Treating location (office, hospital, other)

QTY OR NO. OF UNITS

PAYMENT PERCENTAGE - Reflects benefit coverage level in terms of percentage to be paid by plan **PAYABLE**

AMOUNT - Contracted amount

CO-PAY AMOUNT - Member responsibility

COINSURANCE AMOUNT - Member responsibility of total payment amount DEDUCTIBLE AMOUNT Member responsibility before benefits begin PATIENT PAY Amount to be paid by the member

DEDUCTIBLE AMOUNT - Member responsibility before benefits begin

PATIENT PAY - Amount to be paid by the member

OTHER INSURANCE AMOUNT - Amount paid by other carriers

NET AMOUNT (Services Detail) - Final amount to be paid

EXCEPTION CODES - Codes that explain how the claim was adjudicated

7.9 Explanation of Benefits Sample (Page 1)

UnitedHealthcare Dental

Payee ID: Payee Name: Martin Pittman Remittance Date: 12/20/2010

UnitedHealthcare Dental **Please address questions to:**

UnitedHealthcare Dental
1001 Brinton Road
Pittsburgh, PA 15221

Contact: United Healthcare Dental - Provider Services
Phone:
Fax:

Current Period: 12/20/2010
Payee ID:
Phone:
Fax:
Tax ID:

Remittance Summary

Fee For Service:	**$2,300.00**
Budget Allocation:	**$0.00**
Capitation:	**$0.00**
Case Fees:	**$0.00**
Additional Compensation:	**$0.00**
Prior Period Recovery and other Payee Adjustments:	**$0.00**
Total:	**$2,300.00**

Administrative Appeals by Practitioners: Requests for reconsideration of administrative denials of claims submitted by practitioners must be received with required documentation within 60 days of the notice of denial. Late appeals will not be considered. Practitioners should send requests for reconsideration of administrative denials to the following address:

UnitedHealthcare
Attn: Appeals and Grievances
P.O. Box 31364
Salt Lake City, UT 84131

IMPORTANT NOTICE: Effective with claims and pre-authorizations received July 5, 2010 and later, in order to maintain HIPAA compliance, only ADA 2012 Dental Claim forms will be accepted when submitting claims and pre-authorizations. All other forms, including ADA forms from years prior to 2012, will not be accepted and will result in a rejection of the claim or pre-authorization request. Additionally, please send clearly marked 'Corrected Claims' on ADA 2012 forms, to the Appeals mailbox. Please contact the customer service toll free number if you have questions. If you are in need of the new Dental Claim forms, please visit the ADA website at www.ada.org for ordering information.

Ref #: 679 / 3 Page 1

7.9.a Explanation of Benefits Sample (Page 2)

UnitedHealthcare Dental

Payee Name: Remittance Date: 12/20/2010

Fee For Service Summary

Provider / ID	Location / ID	Amount Billed	Amount Payable	Patient Pay	Other Insurance	Prior Mo. Adj	Net Amount
Martin Pittman / 1586	Martin Pittman / 1090	$2,300.00	$2,300.00	$0.00	$0.00	$0.00	$2,300.00
	Totals:	$2,300.00	$2,300.00	$0.00	$0.00	$0.00	$2,300.00

Ref #: 679 / 4 Page 2

7.9.b Explanation of Benefits Sample (Page 3)

UnitedHealthcare Dental -

Payee Name: Remittance Date: 12/20/2010

Services Detail

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

Patient Name:
Subscriber/Member:
DOB:
Office Reference No:

Provider Name:
Provider NPI:
Plan:
Product:

Encounter #: 20101202000737
Referral #:
Referral Date:
Benefit Level: In Network

			BILLED		ALLOWED	PAYABLE	COPAY	COINS	DEDUCT	OVER MAX	PATIENT	OTHER	NET	PAY
ITM	DOS	CODE	QTY AMOUNT	QTY	AMOUNT	AMOUNT	AMOUNT	AMOUNT	AMOUNT	AMOUNT	PAY	INSUR	AMOUNT	CODE
1	11/29/10	D7210 1	1 $230.00	1	$230.00	$230.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$230.00	FFS
2	11/29/10	D7210 2	1 $230.00	1	$230.00	$230.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$230.00	FFS
3	11/29/10	D7210 19	1 $230.00	1	$230.00	$230.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$230.00	FFS
4	11/29/10	D7210 20	1 $230.00	1	$230.00	$230.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$230.00	FFS
5	11/29/10	D7210 21	1 $230.00	1	$230.00	$230.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$230.00	FFS
6	11/29/10	D7210 22	1 $230.00	1	$230.00	$230.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$230.00	FFS
7	11/29/10	D7210 26	1 $230.00	1	$230.00	$230.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$230.00	FFS
8	11/29/10	D7210 27	1 $230.00	1	$230.00	$230.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$230.00	FFS
9	11/29/10	D7210 28	1 $230.00	1	$230.00	$230.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$230.00	FFS
10	11/29/10	D7210 29	1 $230.00	1	$230.00	$230.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$230.00	FFS
			$2,300.00		$2,300.00	$2,300.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$2,300.00	

Ref #: 679 / 5 Page 3

SECTION 8: Quality Management

8.1 Quality improvement program (QIP) description

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

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

The QIP description is reviewed and updated annually.

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

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

A complete copy of our QIP policy and procedure is available upon request by contacting Provider Services at **844-275-8750**.

8.2 Credentialing

To become a participating provider, 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 three years unless otherwise mandated by the state in which you practice).

Depending on the state in which you practice, UnitedHealthcare will review all current information relative to your license, sanctions, malpractice insurance coverage, etc. UnitedHealthcare will request a written explanation regarding any adverse incident and its resolution, and will request corrective action be taken to prevent future occurrences.

Before an applicant dentist is accepted as a participating provider, the dentist's credentials are evaluated. Initial facility site visits are required for some plans and/or markets. Please note that a site visit is required for each location. If a new location is added after initial contracting is completed, a site visit would be required for the new location before patients can be seen. Your Professional Networks Representative will inform you of any facility visits needed during the recruiting process. Offices must pass the facility review prior to activation.

The Dental Director and the Credentialing Committee review the information submitted in detail based on approved credentialing criteria. UnitedHealthcare will request a resolution of any discrepancy in credentialing forms submitted. Practitioners have the right to review and correct erroneous information and to be informed of the status of their application. Please refer to the Appendix of this Manual for additional details regarding practitioner rights.

Credentialing criteria are reviewed by advisory committees, which include input from practicing network providers to make sure that criteria are within generally accepted guidelines. You have the right to appeal any decision regarding your participation made by UnitedHealthcare based on information received during the credentialing or recredentialing process. To initiate an appeal of a credentialing or recredentialing decision,

please follow the instructions provided in the determination letter received from the Credentialing department.

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

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

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

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

Recredentialing requests are sent six months prior to the recredentialing due date. The CVO will make three attempts to procure a completed recredentialing application from the provider, and if they are unsuccessful, UnitedHealthcare will also make an additional three 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
- ☐ 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 six 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 Re-credentialing application
- ☐ Signed and dated Attestation
- ☐ Current copy of their state license
- ☐ Current copy of their Drug Enforcement Agency (DEA) certificate
- ☐ Current copy of their Controlled Dangerous Substance (CDS) certificate, if applicable
- ☐ Malpractice face sheet which shows their name on the certificate, expiration dates and limits – limits $1/3m
- ☐ Explanation of any adverse information, if applicable
- ☐ Current Medicaid ID (as required by state)

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

8.3 Site visits

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

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

8.4 Preventive health guideline

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

UnitedHealthcare's National Clinical Policy and Technology Committee reviews current professional guidelines and processes while consulting the latest literature, including but not limited to current ADA Current Dental Terminology (CDT), and specialty guidelines as suggested by organizations such as the American Academy

of Pediatric Dentistry, American Academy of Periodontology, American Association of Endodontists, American Association of Oral and Maxillofacial Surgeons, and the American Association of Dental Consultants. Additional resources include publications such as the Journal of Evidence-Based Dental Practice, online resources obtained via the Library of Medicine, and evidence-based clearinghouses such as the Cochrane Oral Health Group and Centre for Evidence Based Dentistry as well as respected public health benchmarks such as Healthy People 2020 and the Surgeon General's Report on Oral Health in America. Preventive health focuses primarily on the prevention, assessment for risk, and early treatment of caries and periodontal diseases, but also encompasses areas including prevention of malocclusion, oral cancer prevention and detection, injury prevention, avoidance of harmful habits and the impact of oral disease on overall health. Preventive health recommendations for children are intended to be consistent with American Academy of Pediatric Dentistry periodicity recommendations.

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

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

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

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

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

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

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

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

SECTION 9: Utilization Management Program

9.1 Utilization management

Through Utilization Management practices, UnitedHealthcare aims to provide members cost-effective, quality dental care through participating providers. By integrating data from a variety of sources, including individual Financial Analysis reporting, Utilization Review, claims data and individual audit reporting, UnitedHealthcare can evaluate group and individual practice patterns and identify those patterns which deviate from the norm.

By identifying and correcting aberrant provider practice patterns, we can not only reduce the overall impact of such behavior on the cost of care, but also improve the quality of dental care delivered.

9.2 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 percentage of procedures performed in any given category relative to total procedures are compared with benchmarks such as similarly designed UnitedHealthcare plans, to determine if utilization for that category is within expected levels. This method, which looks at the mix of procedures and incurred claims, was chosen in part because it is consistent with other forms of reporting at UnitedHealthcare. Aberrations might suggest either overutilization or underutilization. Variables which might influence utilization, such as plan design and/or population demographics, are taken into account. Additional analysis can determine whether the results are common throughout the group or caused by outliers.

9.3 Evaluation of utilization management data

Once the initial Utilization Management data is analyzed, if a dentist is identified as having potentially aberrant practice patterns, utilization may be reviewed at the individual claims level. For each specific dentist, an Audit Report may be run that identifies all procedures performed on all patients for a specified time period. For those dentists who practice at multiple sites, these reports are typically done on a site-by-site basis.

Examples of aberrant patterns could include upcoding, unbundling, miscoding, excessive treatments per patient (e.g., doing 15 restorations at one sitting), duplicate billing, or duplicate payments. Once completed, a sample of patients may be identified for chart audit. The number varies depending on the number of patients on the dentist's panel in the time period being studied and the severity of the problems noted.

9.4 Utilization review data results

Review findings are shared with individual practitioners in order to provide feedback relative to their peers as well as recommended follow-up.

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

- ☐ Provider Manual/Standards of Care
- ☐ Provider Training
- ☐ Continuing Education and Focus Groups
- ☐ Provider Newsflash

Finally, internal interventions may be indicated. These can include improvements to existing policies and procedures, specific interventions and creation of feedback mechanisms to make sure that corrections take place.

In all instances, practitioners will be provided with contact information that they can call to review results and ask any questions they may have.

9.5 Fraud and abuse

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

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

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

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

All Network Providers and third party contractors are expected to promptly report any perceived or alleged instances of fraud. Reporting may be made directly to the Compliance Helpline at 1-888-233-4877.

SECTION 10: Evidence-Based Education

10.1 Evidence-based dentistry and the Clinical Policy and Technology Committee

According to the ADA, Evidence-Based Dentistry can be 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."

The search for evidence usually begins with a clinical question. The process for defining that question can be described by the acronym P.I.C.O., which stands for:

- **P**roblem or **P**opulation
- **I**ntervention under Investigation
- How it is being **c**ompared
- The expected **o**utcome

In trying to find the answers to a given clinical question, evidence is gathered in the form of information, typically from scientific journals. It is important to keep in mind though, that not all "evidence" is created equal. The "ladder of evidence" is as follows:

- Anecdote/expert opinion
- Case study
- Case series
- Retrospective study
- Randomized controlled trial (RCT)
- Systematic review (a review of RCTs)

Of course, systematic reviews or randomized controlled trials are not available to answer all clinical questions we might have. This is why we indicate that we are using the "best available current evidence." Searching for evidence, we can consult a variety of sources including.

- Electronic indices — Medline®, PubMed®, Cochrane Library, National Guideline Clearinghouse, (AHRQ)
- Hand search of the scientific literature
- Reference listings in other articles
- Alternative sources — thesis, dissertations, conference reports, abstracts, unpublished studies (often referred to as the "gray literature")

Once data is collected, we want to review its usefulness in answering our question(s):

- How the study was designed
- How subjects for the study were chosen and grouped
- How statistics were applied – did it lead to the correct conclusions

Sometimes a technique called meta-analysis is used. Meta-analysis is used when describing combining the analysis, and summarizing the results of, several individual studies into one analysis. Systematic reviews often make use of meta-analysis.

Once we have reviewed our data, we need to interpret the evidence, considering the strength of that evidence, limitations of the review, implications for additional research and clinical implications. Ideally, we also want to build consensus — bringing different expertise and opinions into the interpretation and working toward buy-in from as many stakeholders as possible.

How can evidence-based dentistry be used? It can be used in clinical practice to:

- ☐ Define a clinical problem or question
- ☐ Search for the best evidence
- ☐ Evaluate the evidence
- ☐ Determine how it would apply to the patient
- ☐ Determine treatment

At UnitedHealthcare, we use evidence-based guidelines as the foundation of many of our own clinical efforts, including:

- ☐ Practice guidelines, parameters and algorithms based on evidence and consensus
- ☐ Comparing dentist quality and utilization data against guidelines
- ☐ Chart auditing, site visits, credentialing

The development of evidence-based guidelines and technology recommendations at DBP is the job of our Clinical Policy and Technology Committee.

The Committee consists of a mixture of employed and participating dentists. The participating dentists represent several specialties including general practice, endodontics, periodontics and oral surgery. In addition, we have access to academic institutions and other professional experts.

The Committee meets quarterly and reviews the evidence-based literature, making recommendations on clinical practice guidelines and new technologies. Whenever possible, we review and adopt existing guidelines and scientific literature from sources such as specialty societies, guidelines clearinghouses such as the Cochrane Oral Health Group and National Guideline Clearinghouse, government agencies such as AHRQ and NIDCR, electronic sites such as PubMed and the Centre for Evidence-Based Dentistry, and evidence-based journals such as the Journal of Evidence-Based Dental Practice.

Determinations are shared with dentists in our provider newsletter Newsflash, and become part of our business functions, including our clinical programs, utilization management and claims criteria, marketing and underwriting collateral, and this Manual.

Recommendations can result in new products or enhanced benefits for members. Recent examples include: our current medical-dental outreach program which focuses in 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-based dentistry is a methodology to help reduce variation and determine “what works.” It can be used on the individual patient, practice, plan or population levels, and helps to ensure that our clinical programs and policies are grounded in science.

SECTION 11: Governing Administrative Policies

11.1 Appointment scheduling standards

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

- ☐ **Emergency appointments**
  Immediately or within 24 hours
- ☐ **Urgent care appointments**
  Within 3 days
- ☐ **Routine care appointments**
  Offered within 45 days of the request

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

- ☐ A true emergency is defined as services required for treatment of severe pain, swelling, bleeding or immediate diagnosis and treatment of unforeseen dental conditions which if not immediately diagnosed and treated, would lead to disability or death.
- ☐ Urgent Care appointments would be needed if a patient is experiencing excessive bleeding, pain or trauma.
- ☐ Providers are encouraged to schedule members appropriately to avoid inconveniencing the members with long wait times in excess of thirty (30) minutes. Members should be notified of anticipated wait times and given the option to reschedule their appointment.

Dental offices that operate by "walk-in" or "first come, first served" appointments must meet the above state mandated or plan requirements, and are monitored for access and waiting times, where applicable.

Missed appointments

Offices should inform patients of office policies relating to missed appointments and any fees that may be incurred as a result.

11.2 Emergency coverage

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

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

11.3 New associates

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

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

If you have any questions or need to receive a copy of our Provider Application packet, please contact our Provider Services Line at **1-800-822-5353**.

11.4 Change of address, phone number, email, fax or tax identification number (TIN)

When there are demographic changes within your office, it is important to notify us as soon as possible so that we may update our records. This supports accurate claims processing as well as helps to make sure that member directories are up-to-date.

Changes should be submitted to:

UnitedHealthcare
Government Programs – Provider Operations
2300 Clayton Road
Suite 1000
Concord, CA 94520

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

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

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

If you have any questions, don't hesitate to contact Provider Services for guidance.

11.5 Office conditions

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

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

11.6 Sterilization and asepsis-control fees

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

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

11.7 Recall system

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

11.8 Transfer of dental records

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

11.9 Nondiscrimination

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

11.10 Cultural Competency

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

UnitedHealthcare 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.

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

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

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

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

SECTION 12: Plan Specific Information

12.1 Plan-specific information

UnitedHealthcare Community Plan offers the following product for the Medicare Special Needs population:

☐ UnitedHealthcare Dual Complete

There are no patient copayments or coinsurance for covered services. Covered services are paid at 100% of the provider's fee schedule amount for that service, subject to additional requirements in the provider agreement and contained in this Manual.

APPENDIX A: Attachments

13.1 Medicare Overview

Medicare is a federal program enacted in 1965 and administered by the Centers for Medicare and Medicaid Services (CMS). Generally, Medicare is available for people age 65 or older, or younger people with disabilities.

Medicare generally does not cover dentistry. However, health plans may choose to cover specific services. This varies from state to state and plan to plan.

13.2 Fraud, Waste & Abuse Training

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

(a) Provide detailed information about the Federal False Claims Act,

(b) Cite administrative remedies for false claims and statements,

(c) Reference state laws pertaining to civil or criminal penalties for false claims and statements, and

(d) With respect to the role of such laws in preventing and detecting fraud, waste and abuse in federal health care programs, include as part of such written policies, detailed provisions regarding care providers policies and procedures for detecting and preventing fraud, waste and abuse.

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

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

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

13.3 Practitioner Rights Bulletin

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

To review your information

This is specific to the information the Plan has utilized to evaluate your credentialing application and includes information received from any outside source (e.g., malpractice insurance carriers; state license boards) with the exception of references or other peer-review protected information.

To correct erroneous information

If, in the event that the credentialing information you provided varies substantially from information obtained from other sources, we will notify you in writing within fifteen (15) business days of receipt of the information. You will have an additional fifteen (15) business days to submit your reply in writing; within two (2) business days will send a written notification acknowledging receipt of the information.

To be informed of status of your application

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

To appeal adverse Committee Decisions

1. Providers applying for initial credentialing do not have appeal rights, unless required by State regulation.
2. Providers rejected for re-credentialing based on a history of adverse actions, and who have no active sanctions, have appeal rights only in states that require them or due to Quality of Care concerns against DBP members. An appeal, if allowed, must be submitted within 30 days of the date of the rejection letter. The provider has the right to be represented by an attorney or another person of the provider's choice.
3. Appeals are reviewed by Peer Review Committee (PRC). The PRC panel will include at least one member who is of the same specialty as the provider who is submitting the appeal.
4. PRC will consider all information and documentation provided with the appeal and make a determination to uphold or overturn the Credentialing Committee's decision. The PRC may request a corrective action plan, a Site Visit, and/or chart review.
5. Within ten days of making a determination, the PRC will send the provider, by certified mail, written notice of its final decision, including reasons for the decision.

Credentialing Supervisor
Credentialing Department
2300 Clayton Road
Suite 1000
Concord, CA 94520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