Dental Provider Manual

for UnitedHealthcare Community Plan of Maryland

UnitedHealthcare®

Contents

Introduction—Who We Are

Section 1: **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 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 **1-800-508-2069.**

If you have any questions or concerns about the information contained within this Manual, please contact the UnitedHealthcare Provider Services team at **1-800-508-2069.**

Unless otherwise specified herein, this Manual is effective on October 1, 2019 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 2019 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: 1-800-508-2069 Hours: 9 a.m.-6 p.m. (ET) Monday-Friday	Online uhcproviders.com	Interactive Voice Response (IVR) System Phone: 1-800-508-2069 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 1471 Milwaukee WI 53201	**1-800-508-2069**	GP133	Within 180 days	ADA* Claim Form, 2012 version or later
Claim Appeals	**PTE/Preauthorizations:** UnitedHealthcare PO Box 1427 Milwaukee, WI 53201	**1-800-508-2069**	GP133	Within 90 days from the date of payment decision	ADA Claim Form Provider narrative supporting appeal
Corrected Claims	**Provider Disputes / Corrected Claims:** UnitedHealthcare P.O. Box 541 Milwaukee, WI 53201	**1-800-508-2069**	N/A	Within 90 days from receipt of payment	ADA Claim Form Reason for requesting adjustment or resubmission
UnitedHealthcare Member Appeals & Grievances	**Member Appeals and Grievances:** UnitedHealthcare P. O. Box 31364 Salt Lake City, UT 84131-0364	**1-800-318-8821** **TTY 711**	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—1-800-508-2069**

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

To use the website, please go to **uhcproviders.com** and register as a participating user. For assistance, please call **1-800-508-2069.**

Section 3: **Patient Eligibility Verification Procedures**

3.1 **Member Eligibility**

Member eligibility or dental benefits may be verified online or via phone.

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

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

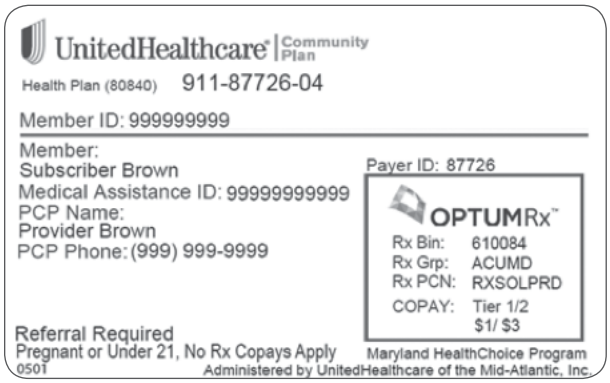
3.2 **Member Identification Card**

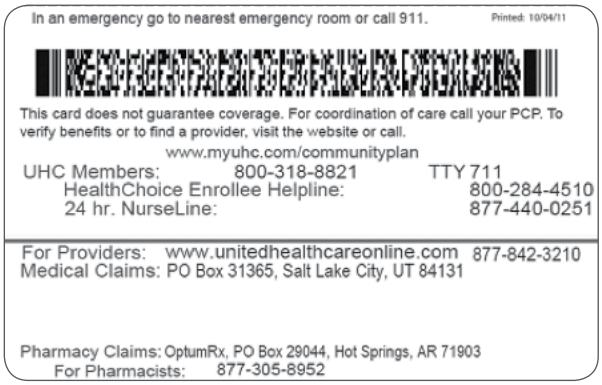
Members are issued an identification (ID) card by UnitedHealthcare Community Plan. There will not be separate dental cards for UnitedHealthcare Community Plan members. The ID cards are customized with the UnitedHealthcare Community Plan logo and include the toll-free customer service number for the health 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 **uhcproviders.com** or contact the dental Provider Services line at **1-800-508-2069**.

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 **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 **1-800-508-2069** during normal business hours for assistance with website issues.

UnitedHealthcare also offers an Interactive Voice Response (IVR) system; simply call **1-800-508-2069**. 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

Section 4: **Member Benefits / Exclusions & Limitations**

4.1 **Covered Services for UnitedHealthcare Maryland Medicaid HealthChoice Program**

Provider Quick Covered Services Reference Guide for the UnitedHealthcare Community Plan

Value added adult dental benefit services for members age 21 and over are covered under this plan. Pregnant Women and Former Foster Youth (ages 21-26) are excluded. It includes preventive and diagnostic services. The plan has a $750.00 maximum annual benefit. Covered services are paid at 100% of the provider fee schedule amount with no deductible or copay amount.

Should you have any questions regarding the benefits, please contact the Dental Provider Services Department at **1-800-508-2069**.

Code	Description	Age Limits	Frequency/Limitation	Auth Required	Docs Required
D0120	Periodic Oral Evaluation - Established Patient	21+	1 per 6 months		
D0140	Limited Oral Evaluation - Problem Focused	21+	1 per 12 months		
D0150	Comprehensive Oral Evaluation - New Or Established Patient	21+	1 per 1 lifetime		
D0220	Intraoral - Periapical First Radiographic Image	21+	1 per 1 calendar year		
D0230	Intraoral - Periapical Each Additional Image	21+	7 per 1 calendar year		
D0270	Bitewing - Single Radiographic Image	21+			
D0272	Bitewings - Two Radiographic Images	21+			
D0273	Bitewings - Three Radiographic Images	21+	1 per 1 calendar year		
D0274	Bitewings - Four Radiographic Images	21+	1 per 1 calendar year		
D0277	Vertical Bitewings - 7 To 8 Radiographic Images	21+	1 per 36 months		
D0330	Panoramic Radiographic Image	21+	1 per 60 months		
D1110	Prophylaxis - Adult	21+	1 per 6 months		
D2140	Amalgam - One Surface, Primary Or Permanent	21+	1 per 12 months		
D2150	Amalgam - Two Surfaces, Primary Or Permanent	21+	1 per 12 months		
D2160	Amalgam - Three Surfaces, Primary Or Permanent	21+	1 per 12 months		
D2161	Amalgam - Four Or More Surfaces, Primary Or Permanent	21+	1 per 12 months		
D2330	Resin-Based Composite - One Surface, Anterior	21+	1 per 12 months		
D2331	Resin-Based Composite - Two Surfaces, Anterior	21+	1 per 12 months		
D2332	Resin-Based Composite - Three Surfaces, Anterior	21+	1 per 12 months		
D2335	Resin-Based Composite - Four Or More Surfaces Or Involving Incisal Angle	21+	1 per 12 months		
D2391	Resin-Based Composite - One Surface, Posterior	21+	1 per 12 months		
D2392	Resin-Based Composite - Two Surfaces, Posterior	21+	1 per 12 months		
D2393	Resin-Based Composite - Three Surfaces, Posterior	21+	1 per 12 months		
D2394	Resin-Based Composite - Four Or More Surfaces, Posterior	21+	1 per 12 months		
D7140	Extraction, Erupted Tooth Or Exposed Root	21+	1 per 1 lifetime		

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 **1-800-508-2069** 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. Services rendered by Out of Network Provider
6. Costs for optional services
7. Any dental procedure not directly associated with dental disease.
8. 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.
9. 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.
10. Expenses for dental procedures begun prior to the covered person's eligibility with the plan.
11. 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.
12. 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.
13. Charges for failure to keep a scheduled appointment without giving the dental office proper notification.

4.3 Appeals, State Fair Hearings, and Complaints (Grievances)

Your Right to Appeal

Providers may have members that want to file a grievance, appeal, or request a State Fair Hearing. Providers may assist or instruct members on how to do so. These processes are explained in detail in the Member Handbook.

Excerpts from the Member Handbook are provided below for your reference. Please note that the Member Handbook may be updated, so for the most current information, please refer to the Member Handbook.

Adverse Benefit Determination, Complaints and Grievances

Adverse Benefit Determination.

An adverse benefit determination is when an MCO does any of the following:

- Denies or limits a requested service based on type or level of service, meeting medical necessity, appropriateness, setting, effectiveness;
- Reduces, suspends, or terminates a previously authorized service;

- Denies partial or full payment of a service;
- Fails to make an authorization decision or to provide services in a timely manner;
- Fails to resolve a grievance or appeal in a timely manner;
- Does not allow members living in a rural area with only one MCO to obtain services outside the network; or
- Denies a member's request to dispute a financial liability, including cost sharing, copayments, coinsurance, and other member financial liabilities.

Once an MCO makes an adverse benefit determination, you will be notified in writing at least 10 days before the adverse benefit determination goes into effect. You will be given the right to file an appeal and can request a free copy of all of the information the MCO used when making their determination.

Complaints

If you disagree with the MCO or provider about an adverse benefit determination, this is called a complaint. Examples of complaints include reducing or stopping a service you are receiving, being denied a medication not on the preferred drug list, or having a preauthorization for a procedure denied.

Grievances

If your complaint is about something other an adverse benefit determination, this is called a grievance. Examples of grievances include quality of care, not being allowed to exercise your rights, not being able to find a doctor, trouble getting an appointment, or not being treated fairly by someone who works at the MCO or at your doctor's office.

If you file a grievance and it is:

- About an urgent medical problem you are having, it will be solved within 24 hours.
- About a medical problem but it is not urgent, it will be solved within 5 days.
- Not about a medical problem, it will be solved within 30 days

Appeals

If your complaint is about a service you or a provider feels you need but the MCO will not cover, you can ask the MCO to review your request again. This request for a review is called an appeal.

If you want to file an appeal, you have to file it within 60 calendar days from the date that you receive the letter saying the MCO would not cover the service you wanted.

Your doctor can also file an appeal for you if you sign a form giving him or her permission. Other people can also help you file an appeal, like a family member or a lawyer.

When you file an appeal, be sure to let the MCO know of any new information that you have that will help them make a decision. The MCO will send you a letter letting you know that they received your appeal within five business days. While your appeal is being reviewed, you can still send or deliver any additional information that you think will help the MCO make a decision.

When reviewing your appeal, the MCO reviewers:

- Will be different from the medical professionals who made the previous decision;
- Will not be a subordinate of the reviewers who made the previous decision;
- Will have the appropriate clinical knowledge and expertise to perform the review;
- Will review all information submitted by the member or representative regardless if this information was submitted for the previous decision; and
- Will make a decision about your appeal within 30 calendar days.

The appeal process may take up to 44 days if you ask for more time to submit information or the MCO needs to get additional information from other sources. The MCO will call and send you a letter within two days if they need additional information.

If your doctor or MCO feels that your appeal should be reviewed quickly due to the seriousness of your condition, you will receive a decision about your appeal within 72 hours.

If your appeal does not need to be reviewed quickly, the MCO will try to call you and send you a letter letting you know that your appeal will be reviewed within 30 days.

If your appeal is about a service that was already authorized, the time period has not expired, and you were already receiving, you may be able to keep getting the service while your appeal is under review. You will need to contact the MCO's Member Services at **1-800-318-8821**, TTY **711**, Monday through Friday 8:00 a.m. to 7:00 p.m. ET and request to keep getting services while your appeal is reviewed. You will need to contact Member Services within 10 days from when the MCO sent the determination notice or before the intended effective date of the determination. If you do not win your appeal, you may have to pay for the services that you received while the appeal was being reviewed.

Once the review is complete, you will receive a letter informing you of the decision. If the MCO decides that you should not receive the denied service, the letter will tell you how to ask for a State Fair Hearing.

How to File a Complaint, Grievance or Appeal

To submit a complaint or grievance, you can contact the MCO's Member Services at 1-800-318-8821, Monday through Friday 8:00 a.m. to 7:00 p.m. ET. If you need auxiliary aids or interpreter services, let the Member Services representative know (hearing impaired members can use the Maryland Relay Service, **711**). The MCO's customer service representatives can assist you with filing a complaint, grievance, or appeal.

You can request to file an appeal verbally but will need to confirm the appeal request in writing, unless it is an expedited resolution request. To file the appeal in writing, the MCO can send you a simple form that you can complete, sign, and mail back. The MCO can also assist you in completing the form if you need help. You will also be given the opportunity to give the MCO your testimony and factual arguments prior to the appeal resolution.

If you need a copy of the MCO's official internal complaint procedure, call MCO Member Services at **1-800-318-8821, TTY 711**, Monday through Friday 8:00 a.m. to 7:00 p.m. ET.

The State's Complaint/Appeal Process

Getting Help From the HealthChoice Help Line.

If you have a question or complaint about your health care and the MCO has not solved the issue to your satisfaction, you can ask the State for help. The HealthChoice Help Line (**1-800-284-4510**) is open Monday through Friday between 8:00 a.m. and 5:00 p.m. When you call the Help Line, you can ask your question or explain your problem to one of the Help Line staff, who will:

- Answer your questions;
- Work with the MCO to resolve your problem; or
- Send your complaint to a Complaint Resolution Unit nurse who may:
  - Ask the MCO to provide information about your case within five days;
  - Work with your provider and MCO to assist you in getting what you need;
  - Help you to get more community services, if needed; or
  - Provide guidance on the MCO's appeal process and when you can request a State Fair Hearing.

Asking the State to Review the MCO's Decision.

If you appealed the MCO's initial decision and you received a written denial, you have the opportunity for the State to review your decision. This is called an appeal.

You can contact the HealthChoice Help Line at **1-800-284-4510** and tell the representative that you would like to appeal the MCO's decision. Your appeal will be sent to a nurse in the Complaint Resolution Unit. The Complaint Resolution Unit will attempt to resolve your issue with us in 10 business days. If it cannot be resolved in 10 business days, you will be sent a notice that gives you your options.

When the Complaint Resolution Unit is finished working on your appeal, you will be notified of their findings.

- If the State thinks the MCO should provide the requested service, it can order the MCO to give you the service; or
- If the State thinks that the MCO does not have to give you the service, you will be told that the State agrees with the MCO.

- If you do not agree with the State's decision, which you will receive in writing, you will again be given the opportunity to request a State Fair Hearing.

Types of State Decisions You Can Appeal.

You have the right to appeal three types of decisions made by the State. When the State:

- Agrees with the MCO that we should not cover a requested service;
- Agrees with the MCO that a service you are currently receiving should be stopped or reduced; or
- Denies your request to enroll in the Rare and Expensive Case Management (REM) Program.

Continuing Services During the Appeal.

There are times when you may be able to keep getting a service while the State reviews your appeal. This can happen if your appeal is about a service that was already authorized, the time period for the authorization as not expired, and you were already receiving the service. Call the HealthChoice Help Line (**1-800-284-4510**) for more information. If you do not win your appeal, you may have to pay for the services that you received while the appeal was being reviewed.

Fair Hearings.

To appeal one of the State's decisions, you must request that the State file a notice of appeal with the Office of Administrative Hearings on your behalf. The request for a State Fair Hearing must be submitted no later than 120 days from the date of the MCOs notice of resolution.

The Office of Administrative Hearings will set a date for the hearing based on the type of decision being appealed.

- If the appeal is about the MCO reducing or not giving you a service because both the State and MCO thinks you do not have a medical need for the service, the Office of Administrative Hearings will set a hearing date within 20 days of the day you file your appeal with the Office of Administrative Hearings. The Office of Administrative Hearings will make its decision on the case within 30 days of the date of the hearing.
- You can ask for an expedited appeal. If the State thinks your hearing should be held more quickly due to the seriousness of your health condition, a hearing will be held and a decision will be made within 72 hours.
- For all other appeals, the Office of Administrative Hearings will set a hearing date within 30 days of the day you file your appeal with the Office of Administrative Hearings. The Office of Administrative Hearings will make its decision on the case within 30 days of the date of the hearing.

The Board of Review/Judicial Appeal

- If the Office of Administrative Hearings decides against you, you may appeal to the State's Board of Review. You will get the information on how to appeal to the Board of Review with the decision from the Office of Administrative Hearings.
- If the Board of Review decides against you, you may appeal to the Circuit Court.

Reversed Appeal Resolutions

If the MCO reverses a denial, termination, reduction, or delay in services, that were not provided during the appeal process, the MCO will have to provide the services no later than 72 hours from the date it receives the reverse appeal notice.

If the MCO reverses a denial, termination reduction, or delay in services that a member was receiving during the appeal process, the MCO will pay for the services received during the appeal process.

If you need to appeal a service covered by the State, follow the directions provided in the adverse determination letter.

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:

1-800-508-2069
UnitedHealthcare MD Appeals
PO Box 1427
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 **Payment for Non-covered Services:**

When non-covered services are provided for Medicaid 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.

5.2 **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.

Section 6: **Claim Submission Procedures**

6.1 **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

As of January 1, 2018, all providers billing for services provided to Maryland HealthChoice recipients must be actively enrolled with the Maryland Department of Health (MDH). For more information, please contact MDH at 1-844-4MD-PROV (1-844-463-7768) or visit health.maryland.gov/ePREP

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 **1-855-586-1419** 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

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 claims should be submitted within 180 days from the date of service.

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.

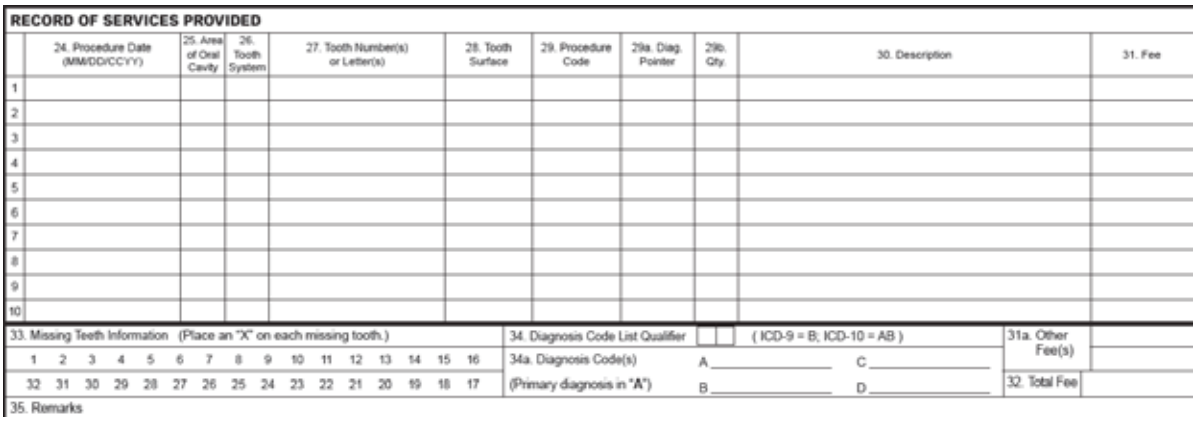
By report procedures

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 _____ C _____

B _____ 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.

6.2 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 **Community Plan 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.

6.3 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.

6.4 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.

6.5 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. See sample of EOB in section 6.9c.

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 for any additional payment along with primary payer's Explanation of Benefits (EOB).

6.6 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 ninety (90) 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.

6.7 Claim Adjudication & Periodic Overview

Claim Processing Standards:

- 100% 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.

6.8 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

OTHER INSURANCE AMOUNT - Amount paid by other carriers

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

6.9 Provider Remittance Advise Sample (Page 1)

UnitedHealthcare Dental

Payee ID: 941 Payee Name: Martin Pittman Remittance Date: 12/20/2010

UnitedHealthcare Dental **Please address questions to:**

UnitedHealthcare Dental

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 Dental
Attn: Appeals Coodinator

IMPORTANT NOTICE: Effective with claims and pre-authorizations received July 5, 2010 and later, in order to maintain HIPAA compliance, only ADA 2006 Dental Claim forms will be accepted when submitting claims and pre-authorizations. All other forms, including ADA forms from years prior to 2006, 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 2006 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

6.9.a Provider Remittance Advise Sample (Page 2)

UnitedHealthcare Dental

Payee ID: 941 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

6.9.c Explanation Of Benefits Sample (Page 1)

UnitedHealthcare Community Plan

United Healthcare Community Plan
6220 Old Dobbin Lane
Columbia, MD 21045

01/01/2018

JOHN DOE
2416 SPECIFIC TER
BALTIMORE, MD 20833

THIS IS NOT A BILL. YOU CANNOT BE BILLED FOR THE BALANCE OF ANY COVERED SERVICE.

EXPLANATION OF BENEFITS

Why am I getting this? We are writing to let you know that your provider will not be paid for the service (s) listed in the enclosed explanation of benefits.

How did you make this decision? The enclosed explanation of benefits includes the reason(s) these services did not pay. If you would like a free copy of any documents or information used in this decision, please call UnitedHealthcare Member Services at 1-800-318-8821 (TTY 711) Monday-Friday, 8 a.m. to 7 p.m., EST.

Next Steps: You may want to share a copy of this decision with your provider so you and your provider can discuss next steps. If your provider requested payment for these services, UnitedHealthcare has notified your provider of this decision.

Questions or need help? Please read the Appeal and Grievance Rights attachment to learn more about your appeal rights. If your provider would like to talk to a United Healthcare Community Plan representative about this decision, please have them call 1-877-842-3210. If you have questions, you can call United Healthcare Community Plan at 1-800-318-8821 (TTY 711), Monday-Friday, 8 a.m. to 7 p.m., EST or the HealthChoice Help Line at
1-800-284-4510.

Enclosures:
Explanation of Benefits
Appeal and Grievance Rights
Non-Discrimination Statement
Language Accessibility Statement

6.9.c Explanation Of Benefits Sample (Page 2)

Appeal and Grievance Rights	
What is an appeal?	An appeal is a review by the MCO or the Maryland Department of Health (the Department) when you are dissatisfied with a decision that impacts your care.

Why would I appeal?	Examples of reasons to file an appeal include:
	• UnitedHealthcare Community Plan denies covering a service your providerorders/prescribes for you. The reasons a service might be denied include:
	  o The treatment is not needed for your condition, or would not help you in diagnosing your condition.
	  o Another more effective service could be provided instead.
	  o The service could be offered in a more appropriate setting, such as a provider's office instead of the hospital.
	• UnitedHealthcare Community Plan limits, reduces, suspends, or stops a service that you are already receiving. For example:
	  o You have been getting physical therapy for a hip injury and you have reached the frequency of physical therapy visits allowed.
	  o You have been prescribed a medication, it runs out, and you do not receive any more refills for the medication.
	• UnitedHealthcare Community Plan denies all or part of payment for a service you've received.
	• UnitedHealthcare Community Plan fails to provide services in a timely manner, as defined by the Department (for example, it takes too long to authorize a service you or your provider requested).
	• UnitedHealthcare Community Plan denies your request to speed up (or expedite) the resolution about a medical issue.

What is a grievance?	A grievance is when you express dissatisfaction with your UnitedHealthcare Community Plan or provider.
Why would I file a grievance?	Examples of reasons to file an administrative grievance include: • Your provider's office was dirty, understaffed, or difficult to access. • The provider was rude or unprofessional. • You cannot find a conveniently located provider for your health care needs. • You are dissatisfied with the help you received from your provider's staff or UnitedHealthcare Community Plan. Examples of reasons to file a medical grievance include: • You are having issues with filling your prescriptions or contacting your provider. • You do not feel you are receiving the right care for your condition. • UnitedHealthcare Community Plan is taking too long to resolve your appeal or grievance about a medical issue. • UnitedHealthcare Community Plan denies your request to expedite your appeal about a medical issue.

6.9.c Explanation Of Benefits Sample (Page 3)

Filing an Appeal	
How do I appeal?	You have options. You or your authorized representative may appeal UnitedHealthcare Community Plan's decision within 60 days from the date of the denial notice. To ask for an appeal, call 1-800-318-8821 (TTY 711) or write to Appeals Department, UnitedHealthcare Community Plan, P.O. Box 31364, Salt Lake City, UT 84131-0364. UnitedHealthcare Community Plan will send you a notice to confirm receipt of the appeal. For assistance with the MCO appeal process, call the HealthChoice Help Line at 1-800-284-4510. You may also appeal UnitedHealthcare Community Plan's decision with the Department. To ask for the Department's assistance, call the HealthChoice Help Line at 1-800-284-4510.
What is an authorized representative?	An authorized representative is someone who has written permission to act or speak on your behalf, like a family member, a provider, or a lawyer. You can also represent yourself in the appeal. UnitedHealthcare Community Plan will accept any written documentation, signed and dated by you, stating that you intend to name an authorized representative for your appeal.
How do I get the information the MCO used to make its decision?	Your denial notice will explain how UnitedHealthcare Community Plan made its decision, including the information it considered. You may request any of the following information from UnitedHealthcare Community Plan, free of charge, to help with your appeal by calling UnitedHealthcare Community Plan at 1-800-318-8821 (TTY 711): • Your medical records • Any benefit provision, guideline, protocol, or criterion UnitedHealthcare Community Plan used to make its decision • Oral interpretation and written translation assistance • Assistance with filling out UnitedHealthcare Community Plan's appeal forms You may also call the HealthChoice Help Line at 1-800-284-4510 for help with filing a stronger appeal, seeking care alternatives, and learning about your rights and responsibilities.
How long does an appeal take to resolve?	UnitedHealthcare Community Plan will make a decision within 30 days from the date you appeal. You or UnitedHealthcare Community Plan may ask for up to 14 additional days to gather information to resolve the appeal. If UnitedHealthcare Community Plan requests an extension, the plan will send you a letter and call you and your provider. If you need more time to gather information to help UnitedHealthcare Community Plan make a decision, your or your representative may call UnitedHealthcare Community Plan at 1-800-318-8821 (TTY 711) and ask for an extension.

6.9.c Explanation Of Benefits Sample (Page 4)

How can I receive a faster decision on my appeal?	You can receive a faster decision if your provider tells UnitedHealthcare Community Plan you have an emergency medical condition. Ask your provider to call 1-877-842-3210 for an expedited review. If UnitedHealthcare Community Plan agrees to an expedited review, UnitedHealthcare Community Plan will call you or your provider within 24 hours of the decision to expedite and resolve the appeal within 72 hours. If UnitedHealthcare Community Plan denies your expedited review request, UnitedHealthcare Community Plan will call you and your provider and resolve the appeal in 30 days.
Can I continue receiving services during the appeal?	If this decision is a denial or reduction of ongoing services, you may be able to continue receiving these services during the appeal process by calling UnitedHealthcare Community Plan at 1-800-318-8821 (TTY 711) within 10 days of getting your denial letter. If UnitedHealthcare Community Plan or the Department upholds the decision, you may have to pay for the cost of the services received during the appeal process.
I disagree with the appeal result. How can I request a State fair hearing?	A State fair hearing is a review of your appeal by a representative of Maryland. You have the right to request a State fair hearing within 120 days of UnitedHealthcare Community Plan making a decision about the appeal, if you disagree with the result. You can also request a State fair hearing if UnitedHealthcare Community Plan does not resolve your appeal by the decision date on your notice. To learn more about State fair hearings and your options, please call the HealthChoice Help Line at 1-800-284-4510.
Filing a Grievance	
How do I file a grievance?	You can file a grievance with UnitedHealthcare Community Plan or the Department. To file a grievance with UnitedHealthcare Community Plan, call 1-800-318-8821 (TTY 711) or write to UnitedHealthcare Community Plan Grievance & Appeals Department, P.O. Box 31364, Salt Lake City, UT 84131-0364. UnitedHealthcare Community Plan will confirm the grievance in writing and send you a notice when it is resolved. To file a grievance with the Department, call the HealthChoice Help Line at 1-800-284-4510. A representative will assist you.
When can I file a grievance?	You may file a grievance at any time.
How long does it take to resolve a grievance?	For administrative grievances, you will receive a resolution no later than 30 days from the date of filing your grievance. For medical grievances, you will receive a resolution within 24 hours if it is an emergency and within 5 days if it is not an emergency. When necessary, UnitedHealthcare Community Plan may ask for up to 14 additional days. If UnitedHealthcare Community Plan needs more time, UnitedHealthcare Community Plan will notify you.

6.9.c Explanation Of Benefits Sample (Page 5)

EXPLANATION OF BENEFITS

Member Name: JOHN DOE
Member ID: 00000000000 00
Claim Number: 19000111111111
Provider Name: Jane Doe
Provider NPI: 0000000000
Office Location: 14 Sallizvurie Ave, Balrtimore, MD 21801-4120

ITEM	DATE OF SERVICE	PROCEDURE	TOOTH	BILLED AMOUNT	ALLOWED AMOUNT	PAID AMOUNT	OTHER INSURANCE	PATIENT PAY
1	01/01/2018	D1110, Prophylaxis - Adult		$70.00	$0.00	$0.00	$0.00	$0.00

ITEM: 1 Exception Code: 1067 Provider contract is not effective on date of service.

****YOUR PROVIDER CANNOT BILL YOU FOR SERVICES COVERED BY THE HEALTHCHOICE PROGRAM. THIS AMOUNT MAY INCLUDE ADDED SERVICES NOT COVERED BY THE PROGRAM.**

6.9.c Explanation Of Benefits Sample (Page 6)

UnitedHealthcare Community Plan

Nondiscrimination Statement

It is the policy of UnitedHealthcare Community Plan not to discriminate on the bass of race, color, national origin, sex, age or disability. UnitedHeathcare Community Plan has adopted an internal grievance procedure providing for prompt and equitable resolution of complaints alleging any action prohibited Section 1557 of the Affordable Care Act (42 USC. 18116) and regulations at 45 CFR part 92, issued by the U.S. Department of Health and Human Services. Section 1557 prohibits discrimination on the basis of race, color, national age or disability in certain health programs and activities. Section 1557 and its implementing regulations may be examined in the office of Civil Rights Coordinator who has been designated to coordinate efforts of UnitedHeathcare Community Plan to comply with Section 1557.

Any person who believes someone has been subjcted to discrimination on the basis of race, color, national origin, sex, age or disablity may file a grievance under this procedure. It is against the law for UnitedHealthcare Community Plan to retaliate against anyone who opposes discrimination, files a grievance, or participates in the investigtion of a grievance.

You can send a complaint to:

Civil Rights Coordinator
UnitedHealthcare Civil Rights Grieveance
P.O. Box 30608
Satt Lake City, UTAH 84130
UHC_Civil_Rights@uhc.com

Procedure:

- Grievances must be submitted to the Section 1557 Coordinator within 60 days of the date the person filing the grievance becomes aware of the alleged discriminatory action.
- A complaint must in writing containing the name and address of the person filing it . The complaint must state the problem or action alleged to be discriminatory and the remedy or relief sought.
- The Section 1557 Coordinator (or her/his desingee) shall conduct an investigation of the complaint. This investigation may be informal, but it will be thorough, affording all interested persons an opportunity to submit evidence relevant to complaint. The Section 1557 Coordinator will maintain the files and records of UntedHealthcare Community Plan relating to such grievances. To extent possible, and in accordance with applicable law the Section 1557 Coordinator will take appropriate steps to preserve confidentiality of files and records relating to grievances and will share them only with those who have a need to know.
- The Section 1557 Coordinator will issue a written decision on the grievance, basedd on a preponderance of evidence, no later than 30 days after its filling, including a notice to the complainant of their right to pursue further administrative or legal remedies.

6.9.c Explanation Of Benefits Sample (Page 7)

The availability and use of this grievance procedure does not prevent a person from pursuing other legal or administrative remedies, including filing a complaint of discrimination on the basis of race, color, national origin, sex, age or disability in court or the U.S. Department of Health and Human Services, Office for Civil Rights. A person can file a cornplaint of discrimination electronically through the Office for Civil Rights Complaint Portal, which is available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf** by mail or phone at:

U.S. Department of health and Human Services
200 Independence Avenue SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-868-1019, 1-800-537-7697 (TDD)

Complaint forms are available at: **http://www.hhs.gov/ocr/office/file/index.html**. Such complaints must be filed within 180 days of the date of the alleged discrimination.

UnitedHealthcare Community Plan will make appropriate arrangements to ensure that individuals with disabilities and individuas with limited English proficiency are provided auxiliary aids and services or language assistance services, respectively, if needed to participate in this grievance process. Such arrangements may include, but are not limited to, providing qualified interpreters, providing taped cassettes of material for individuals with low vision, or assuring a barrier-free location for proceedings. The Section 1557 Coordinator will be responsible for such arrangements.

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6.9.c Explanation Of Benefits Sample (Page 8)

UnitedHealthcare Community Plan

Declaraci6n Antidiscriminatoria

La politica de UnitedHealthcare Community Plan es la de no discriminar en base a la raza, color, nacionalidad, sexo, edad o discapacidad. UnitedHealthcare Community Plan ha adoptado un procedimiento interno en casos de agravios para proveer una pronta y justa resoluci6n a reclamaciones en las cuales se alegue cualquier acci6n prohibida por la Secci6n 1557 del Acta de Cuidados Asequibles (Affordable Care Act - 42 U.S.C. 18116) y la implementaci6n de sus regulaciones en 45 CFR parte 92, emitidas por el Departamento de Salud y Recursos Humanos de los Estados Unidos (U.S. Department of Health and Human Services). La Secci6n 1557 prohibe la discriminaci6n en bases de la raza, el color, la nacionalidad, el sexo, la edad o la discapacitaci6n en ciertos programas de salud y de actividades. La Secci6n 1557 y sus regulaciones implementadas pueden ser examinadas en la oficina del Coordinador de los Derechos Civiles, quien es una persona que ha sido designada para coordinar los esfuerzos de UnitedHealthcare Community Plan para cumplir con los requisitos de la Secci6n 1557.

Cualquier persona que crea que alguien ha sido discriminado en base a su raza, color, nacionalidad, sexo, edad o discapacidad puede presentar una reclamaci6n siguiendo este procedimiento. Es contra la ley que UnitedHealthcare Community Plan tome represalias en contra de cualquier persona que se oponga a la discriminaci6n, presente una reclamaci6n o participe en una investigaci6n acerca de una acci6n discriminatoria.

Usted puede enviar una queja a:
Civil Rights Coordinator
UnitedHealthcare Civil Rights Grievance
P.O. Box 30608
Salt Lake City, UTAH 84130
UHC_Civil_Rights@uhc.com

Procedimiento:

- Las reclamaciones deben presentarse ante el Coordinador de la Secci6n 1557 dentro de los primeros 60 dias, a partir de la fecha en que la persona que presenta la reclamaci6n tom6 consciencia de ser objeto de una posible acci6n discriminatoria.
- Una reclamaci6n debe presentarse por escrito y contener el nombre y la direcci6n de la persona que la presenta. La reclamaci6n debe declarar cual es el problema o la posible acci6n discriminatoria y cual es la soluci6n o asistencia que se desea obtener.
- El Coordinador de la Secci6n 1557 (o la persona que se designe) podra conducir una investigaci6n acerca de esta reclamaci6n. Esta investigaci6n puede ser informal, pero sera exhaustiva, ofreciendo a todas las personas interesadas una oportunidad para presentar evidencias relevantes a la reclamaci6n. El Coordinador de la Secci6n 1557 conservara en su poder todos los expedientes y records de UnitedHealthcare Community Plan relativos a tales reclamaciones. En la medida posible y de acuerdo a las leyes vigentes aplicables,

6.9.c Explanation Of Benefits Sample (Page 9)

el Coordinador de la Secci6n 1557 tomara todas las acciones necesarias para preservar la confidencialidad de los expedientes y records relativos a las reclamaciones y compartira la informaci6n solamente con aquellas personas que tengan la necesidad de conocer esa informaci6n.

- El Coordinador de la Secci6n 1557 emitira una decisi6n acerca de la reclamaci6n, basandose en la preponderancia de la evidencia, no mas tarde de 30 dias a partir de la fecha en que se present6 esta reclamaci6n y se incluira una notificaci6n para el demandante acerca de su derecho para proseguir con esta reclamaci6n por medio de otras resoluciones legales o administrativas.

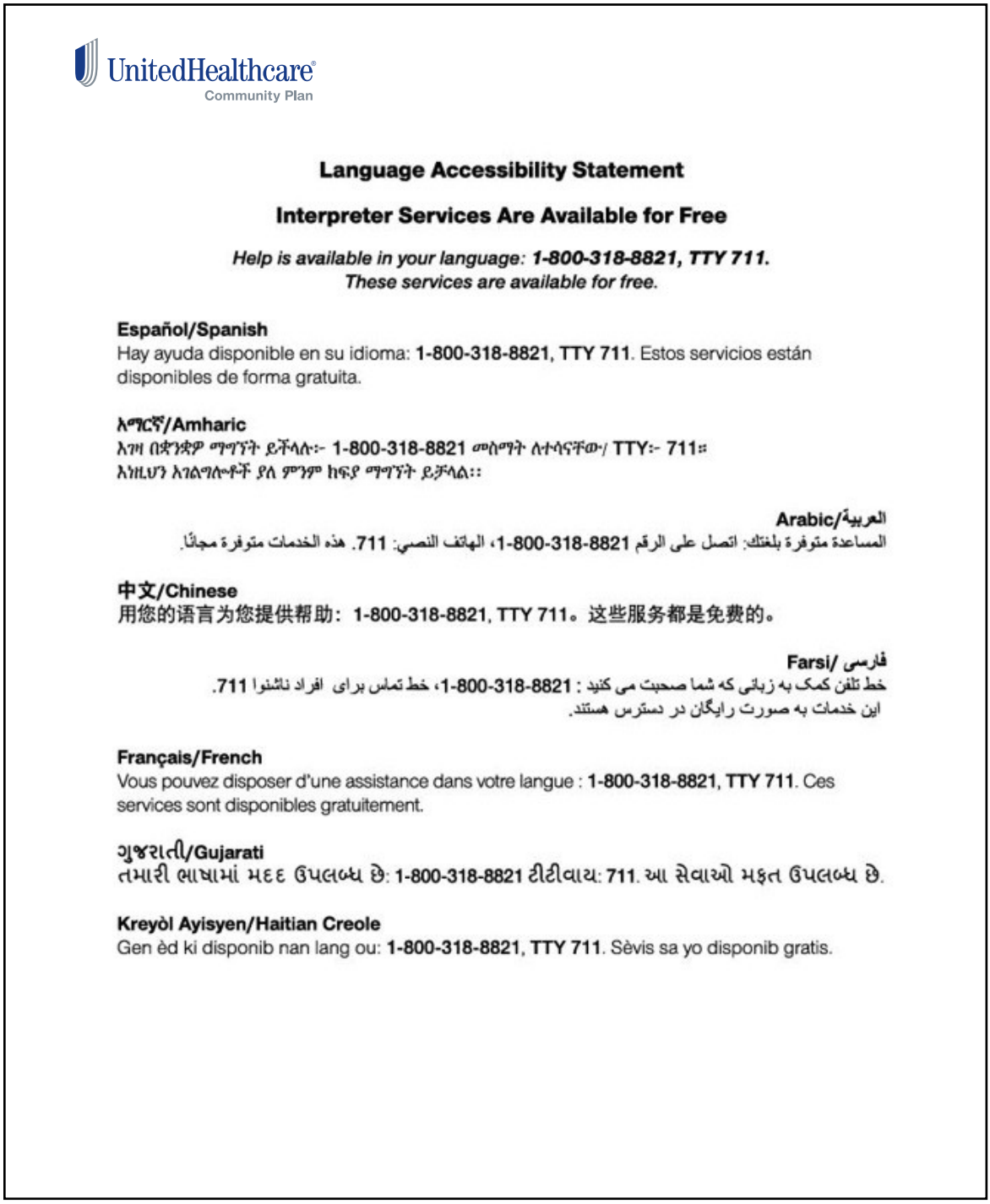
La disponibilidad y el uso de este procedimiento de reclamaciones no le impide a la persona que la presenta, proseguir con otras reclamaciones legales o administrativas, incluyendo la presentaci6n de una reclamaci6n por discriminaci6n basada en la raza, color, nacionalidad, sexo, edad o discapacidad en la corte o ante el Departamento de Salud y Recursos Humanos de los Estados Unidos, Oficina de los Derechos Civiles (U.S. Department of Health and Human Services, Office for Civil Rights). Una persona puede presentar una reclamaci6n por discriminaci6n electr6nicamente a traves del portal de la Oficina de Reclamaciones para los Derechos Civiles (Office for Civil Rights Complaint Portal), disponible en: **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf** o hacerlo por correo a la direcci6n:

U.S. Department of Health and Human Services
200 Independence Avenue SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-868-1019, 1-800-537-7697 (TDD)

Las formas para las reclamaciones se encuentran disponibles en: **http://www.hhs.gov/ocr/office/file/index.html**. Estas reclamaciones deben presentarse dentro de los primeros 180 dias a partir de la fecha en que esta posible acci6n discriminatoria tuvo lugar.

UnitedHealthcare Community Plan llevara a cabo todos los arreglos necesarios para asegurar que a las personas con discapacidades o aquellas personas con un limitado dominio del idioma ingles se les provea con apoyos auxiliares y servicios o asistencia en el lenguaje, respectivamente, si existe la necesidad de que estas personas tengan que participar en este procedimiento de reclamaci6n. Tales arreglos pueden incluir, pero no estar limitados a, proveer interpretes calificados, proveer casetes conteniendo el material para aquellos individuos con problemas de visi6n o asegurando localidades existentes para los procedimientos que sean libres de barreras que impidan el acceso a los procedimientos. El Coordinador de la Secci6n 1557 sera la parte responsable para esos arreglos.

6.9.c Explanation Of Benefits Sample (Page 10)



UnitedHealthcare®
Community Plan

Language Accessibility Statement

Interpreter Services Are Available for Free

Help is available in your language: 1-800-318-8821, TTY 711.
These services are available for free.

Español/Spanish
Hay ayuda disponible en su idioma: **1-800-318-8821, TTY 711**. Estos servicios están disponibles de forma gratuita.

አማርኛ/Amharic
እገዛ በቋንቋዎ ማግኘት ይችላሉ፦ **1-800-318-8821** መስማት ለተሳናቸው/ **TTY፦ 711**።
እነዚህን አገልግሎቶች ያለ ምንም ክፍያ ማግኘት ይቻላል።

Arabic/العربية
المساعدة متوفرة بلغتك: اتصل على الرقم **1-800-318-8821**، الهاتف النصي: **711**. هذه الخدمات متوفرة مجانًا.

中文/Chinese
用您的语言为您提供帮助：**1-800-318-8821, TTY 711**。这些服务都是免费的。

Farsi/ فارسی
خط تلفن کمک به زبانی که شما صحبت می کنید : **1-800-318-8821**، خط تماس برای افراد ناشنوا **711**.
این خدمات به صورت رایگان در دسترس هستند.

Français/French
Vous pouvez disposer d'une assistance dans votre langue : **1-800-318-8821, TTY 711**. Ces services sont disponibles gratuitement.

ગુજરાતી/Gujarati
તમારી ભાષામાં મદદ ઉપલબ્ધ છે: **1-800-318-8821** ટીટીવાય: **711**. આ સેવાઓ મફત ઉપલબ્ધ છે.

Kreyòl Ayisyen/Haitian Creole
Gen èd ki disponib nan lang ou: **1-800-318-8821, TTY 711**. Sèvis sa yo disponib gratis.

6.9.c **Explanation Of Benefits Sample (Page 11)**

Igbo
Ọrụ Ndị Ọkọwa Okwu Dị N'efu Enyemaka dị n'asụsụ gị: **1-800-318-8821, TTY 711**. Ọrụ ndị a dị n'efu.

한국어/Korean
사용하시는 언어로 지원해드립니다: **1-800-318-8821, TTY 711**. 이 서비스는 무료로 제공됩니다.

Português/Portuguese
Está disponível ajuda no seu idioma: **1-800-318-8821, TTY 711**. Estes serviços são disponibilizados gratuitamente.

Русский/Russian
Помощь доступна на вашем языке: **1-800-318-8821, TTY 711**. Эти услуги предоставляются бесплатно.

Tagalog
Makakakuha kayo ng tulong sa inyong wika: **1-800-318-8821, TTY 711**. Ang mga serbisyong ito ay makukuha ng libre.

Urdu/اردو
آپ کی زبان میں مدد دستیاب ہے: 1-800-318-8821، ٹی ٹی وائی: 711۔ یہ خدمات مفت میں دستیاب ہیں۔

Tiếng Việt/Vietnamese
Có hỗ trợ ngôn ngữ của quý vị: **1-800-318-8821, TTY 711**. Các dịch vụ này được cung cấp miễn phí.

Yorùbá/Yoruba
Ìrànlọ́wọ́ wà ní àrọ́wọ́tó ní èdè rẹ: **1-800-318-8821, TTY 711**. Àwọn iṣẹ́ yìí wà ní àrọ́wọ́tó lọ́fẹ̀ẹ́.

Bassa
U nla kosna mahola ni hop won I nsinga ini: **1-800-318-8821, TTY 711**. Ngui nsaa wogui wo.

Section 7: **Quality Management**

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

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

1. To measure, monitor, trend and analyze the quality of patient care delivery against performance goals and/or recognized benchmarks.
2. To foster continuous quality improvement in the delivery of patient care by identifying aberrant practice patterns and opportunities for improvement.
3. To evaluate the effectiveness of implemented changes to the QIP.
4. To reduce or minimize opportunity for adverse impact to members.
5. To improve efficiency, cost effectiveness, value and productivity in the delivery of oral health services.
6. To promote effective communications, awareness and cooperation between members, participating providers and the Plan.
7. To comply with 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 **1-855-812-9210.**

7.2 **Credentialing**

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

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

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

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

sure that criteria are within generally accepted guidelines. You have the right to appeal any recredentialing decision regarding your participation made by UnitedHealthcare based on information received during the recredentialing process. Appeals do not apply to initial credentialing providers unless state law dictates otherwise. To initiate an appeal of a recredentialing decision, follow the instructions provided in the determination letter received from the Credentialing Department. Appeals will be accepted and reviewed for states with appeal rights.

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

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

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

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

Recredentialing requests are sent 6 months prior to the recredentialing due date. The CVO will make 3 attempts to procure a completed recredentialing application from the provider, and if they are unsuccessful, UnitedHealthcare will also make an additional 3 attempts, at which time if there is no response, a termination letter will be sent to the provider as per their provider agreement.

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

Initial credentialing

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

Recredentialing

- Completed Recredentialing application
- Signed and dated Attestation
- Current copy of their state license
- Current copy of their Drug Enforcement Agency (DEA) certificate
- Current copy of their Controlled Dangerous Substance (CDS) certificate, if applicable

- Malpractice face sheet which shows their name on the certificate, expiration dates and limits— limits $1/3m
- Explanation of any adverse information, if applicable
- Current Medicaid ID (as required by state)

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

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

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

If you are new to CAQH ProView, visit **ADA.org/godigital** 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.

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.

7.3 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.

7.4 Preventive Health Guideline

The UnitedHealthcare approach to preventive health is a multi-focused strategy which includes several integrated areas. Preventive health focuses primarily on the prevention, assessment for risk, and early treatment of caries and periodontal diseases, but also encompasses areas including prevention of malocclusion, oral cancer prevention and detection, injury prevention, avoidance of harmful habits and the impact of oral disease on overall health. We have a long history of working with customers on education and outreach programs focusing on wellness, oral health management and the relationship between oral disease and overall health.

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

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

Caries Management begins with a complete evaluation including an assessment for risk. X-ray periodicity – X-ray examination should be tailored to the individual patient based on the patient's health history and risk assessment/vulnerability to oral disease and should follow current professionally accepted dental guidelines necessary for appropriate diagnosis and monitoring.

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

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

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

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

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

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

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

Section 8: **Utilization Management Program**

8.1 **Utilization Management**

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

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

8.2 **Community Practice Patterns**

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

Significant variation might suggest either 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.

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:

- Provider Manual/Standards of Care
- Provider Training
- Continuing Education
- Provider News Bulletins

8.5 **Utilization Review**

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

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

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

Utilization review is completed based on the following:

- To ascertain that the procedure meets our clinical criteria for necessary dental services, which is approved by the 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.

8.6 **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, 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 1-800-455-4521.

Section 9: **Evidence-Based Education**

9.1 **Evidence-based Dentistry & the Clinical Policy & Technology Committee**

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 United Healthcare, it ensures that our clinical programs and policies are grounded in science. This can result in new products or enhanced benefits for members. Recent examples include: our current medical-dental outreach program which focuses on identifying those with medical conditions thought to be impacted by dental health, early childhood caries programs, oral cancer screening benefit, implant benefit, enhanced benefits for periodontal maintenance and pregnant members, and delivery of locally placed antibiotics.

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

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

Evidence is found in a variety of sources including:

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

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

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

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

Section 10: **Governing Administrative Policies**

10.1 **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
- **Urgent care appointments**. . . . . Within 24 hours
- **Routine care appointments**. . . . . Offered within 30 calendar 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.

10.2 **Missed Appointments**

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

10.3 **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.

10.4 **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, contact our Provider Services Line at **1-855-812-9210.**

10.5 **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 Relations
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 the changes apply.

UnitedHealthcare reserves the right to conduct an on-site 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.

10.6 **Office Conditions**

Your 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.

10.7 **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.

10.8 **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.

10.9 **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.

10.10 **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.

10.11 **Cultural Competency**

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

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

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

This website contains valuable materials that will assist dental providers and their staff to become culturally competent: **http://www.hrsa.gov/culturalcompetence/index.html**

APPENDIX A: **Attachments**

A.1 **Fraud, Waste and Abuse Training**

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

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

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

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

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

A.2 **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 we 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 recredentialing 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 1 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 10 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
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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 UnitedHealthcare, Inc.

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