Dental Provider Manual

National Pacific Dental
A UnitedHealthcare Company

Revised 2/24/2025

United Healthcare® | NPD® National Pacific Dental

Contents

Section 1: Introduction — who we are

Welcome to National Pacific Dental, Inc., a UnitedHealthcare Company

This Provider Manual (the "Manual") is designed as a comprehensive reference guide focusing on Dental Health Maintenance Organizations (DHMO) plans. Here you will find the tools and information needed to successfully administer the National Pacific Dental (NPD) DHMO plans. As changes and new information arise, updates to the manual will be posted on the Provider Portal along with the latest version of the manual. Sign into **UHCdental.com** and select Manuals/Other Supporting Documents under Quick Links.

Our Commercial Preferred Provider Organization (PPO) plan requirements are contained in a separate Provider Manual. If you support our Commercial PPO plan and need that Manual, please log into the Provider Portal at **UHCdental.com** or contact Provider Services at **1-800-822-5353**.

This manual is being provided in accordance with your executed agreement. If you have any questions or concerns about the information contained within this Provider Manual, please contact the National Pacific Dental Provider Services team at **1-800-232-0990**.

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

Provider Online Academy

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

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

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

Addresses and phone numbers

National Pacific Dental Claims
c/o UnitedHealthcare Dental
P.O. Box 30567
Salt Lake City, UT 84130-0576

Provider Services 1-800-232-0990

Dallas Independent School District Only 1-800-996-7519

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

Payor ID 52133

Section 2: Products

2.1 Products

Product name / client name	Plan name / copay schedule	Product ID	Agreement ID	Minimum guarantee	Specialty referral	Plan type
United Healthcare	Plan 150	D0011884	SCFG00000214	Yes	Prior-Auth	Commercial
Cirrus Polaris	Plan 120C	D0012046	SCFG00000214	Yes	Prior-Auth	Commercial
United Healthcare	Plan 120C	D0012046	SCFG00000214	Yes	Prior-Auth	Commercial
United Healthcare	Plan 130C	D0012129	SCFG00000214	Yes	Prior-Auth	Commercial
United Healthcare	Plan 140C	D0012130	SCFG00000214	Yes	Prior-Auth	Commercial
Cirrus Polaris	Plan 140C	D0012131	SCFG00000214	Yes	Prior-Auth	Commercial
United Healthcare	Plan 140C	D0012131	SCFG00000214	Yes	Prior-Auth	Commercial
United Healthcare	Plan 120C	D0012148	SCFG00000214	Yes	Prior-Auth	Commercial
Lincoln Financial Group	Plan PLTX620	D0012170	SCFG00000214	Yes	Prior-Auth	Commercial
Lincoln Financial Group	Plan PLTX620	D0012171	SCFG00000214	Yes	Prior-Auth	Commercial
Lincoln Financial Group	Plan PLTX620C	D0012172	SCFG00000214	Yes	Prior-Auth	Commercial
Lincoln Financial Group	Plan PLTX620C	D0012173	SCFG00000214	Yes	Prior-Auth	Commercial
Lincoln Financial Group	Plan PLTX622	D0012175	SCFG00000214	Yes	Prior-Auth	Commercial
Lincoln Financial Group	Plan PLTX622C	D0012177	SCFG00000214	Yes	Prior-Auth	Commercial
Lincoln Financial Group	Plan PLTX624C	D0012181	SCFG00000214	Yes	Prior-Auth	Commercial
Lincoln Financial Group	Plan PLTX626C	D0012184	SCFG00000214	Yes	Prior-Auth	Commercial
Cirrus Polaris	Plan 130C	D0012191	SCFG00000214	Yes	Prior-Auth	Commercial
United Healthcare	Plan 130C	D0012191	SCFG00000214	Yes	Prior-Auth	Commercial
United Healthcare	Plan 150	D0012196	SCFG00000214	Yes	Prior-Auth	Commercial
Cirrus Polaris	Plan 110C	D0012205	SCFG00000214	Yes	Prior-Auth	Commercial
United Healthcare	Plan 110C	D0012205	SCFG00000214	Yes	Prior-Auth	Commercial
Cirrus Polaris	Plan 150C	D0012220	SCFG00000214	Yes	Prior-Auth	Commercial
United Healthcare	Plan 150C	D0012220	SCFG00000214	Yes	Prior-Auth	Commercial
United Healthcare	Plan 130	D0012241	SCFG00000214	Yes	Prior-Auth	Commercial
Cirrus Polaris	Plan 140	D0012245	SCFG00000214	Yes	Prior-Auth	Commercial
United Healthcare	Plan 140	D0012245	SCFG00000214	Yes	Prior-Auth	Commercial
Cirrus Polaris	Plan 140	D0012278	SCFG00000214	Yes	Prior-Auth	Commercial
United Healthcare	Plan 140	D0012278	SCFG00000214	Yes	Prior-Auth	Commercial
United Healthcare	Plan 120	D0012431	SCFG00000214	Yes	Prior-Auth	Commercial
Cirrus Polaris	Plan 150C	D0012441	SCFG00000214	Yes	Prior-Auth	Commercial
United Healthcare	Plan 150C	D0012441	SCFG00000214	Yes	Prior-Auth	Commercial
Cirrus Polaris	Plan 110	D0012453	SCFG00000214	Yes	Prior-Auth	Commercial
United Healthcare	Plan 110	D0012453	SCFG00000214	Yes	Prior-Auth	Commercial
Cirrus Polaris	Plan 110C	D0012515	SCFG00000214	Yes	Prior-Auth	Commercial
United Healthcare	Plan 110C	D0012515	SCFG00000214	Yes	Prior-Auth	Commercial
Cirrus Polaris	Plan 130	D0012965	SCFG00000214	Yes	Prior-Auth	Commercial

Product name / client name	Plan name / copay schedule	Product ID	Agreement ID	Minimum guarantee	Specialty referral	Plan type
United Healthcare	Plan 130	D0012965	SCFG00000214	Yes	Prior-Auth	Commercial
United Healthcare	Plan 110	D0015700	SCFG00000214	Yes	Prior-Auth	Commercial
USS	Plan 130	D0018632	SCFG00000214	Yes	Prior-Auth	Commercial
USS	Plan 130	D0023631	SCFG00000214	Yes	Prior-Auth	Commercial
Morgan White Group	Plan 350	D1000115	SCFG00000169	No	Prior-Auth	Commercial
Pacific Dental Benefits	Plan 350	D1000115	SCFG00000169	No	Prior-Auth	Commercial
Morgan White Group	Plan 350 I	D1000117	SCFG00000183	No	Prior-Auth	Commercial
Pacific Dental Benefits	Plan 350 I	D1000117	SCFG00000183	No	Prior-Auth	Commercial
United Healthcare	Plan 350 I	D1000117	SCFG00000183	No	Prior-Auth	Commercial
Morgan White Group	Plan 550DH	D1000121	SCFG00000183	No	Prior-Auth	Commercial
Morgan White Group	Plan 450	D1000172	SCFG00000170	No	Prior-Auth	Commercial
Pacific Dental Benefits	Plan 450	D1000172	SCFG00000170	No	Prior-Auth	Commercial
Morgan White Group	Plan 550DH	D1000183	SCFG00000171	No	Prior-Auth	Commercial
United Healthcare	Plan 550	D1000431	SCFG00000171	No	Prior-Auth	Commercial
United Healthcare	Plan 450	D1000435	SCFG00000170	No	Prior-Auth	Commercial

2.2 Plan benefits/patient charges

National Pacific Dental utilizes the most current American Dental Association (ADA) CDT procedure codes as the basis for our plan's procedure codes. All National Pacific Dental plans identify the procedure code, provide a description of the procedure, and list the patient's financial responsibility (co-payment).

All procedures listed on the member's plan are covered at the co-payment amount specified when appropriate. The co-payment listed on the member's plan, applies for specialty care services when coverage of benefits is pre-authorized by National Pacific Dental. Please refer to the member's plan for specific information.

Dental procedures not listed and not comparable to procedures on the member's plan are available to the member at your usual and customary fee.

All copayments from the member should be collected by your facility at the time Dental treatment is performed.

Section 3: Capitation overview

3.1 Capitation

Capitation is an alternative to the traditional PPO/Indemnity insurance system. Under a capitation arrangement, a comprehensive set of dental benefits is provided to the members who have selected a General Dentist as their Primary Care Provider (PCP). The General Dentist is compensated monthly at a predetermined fixed rate. The fixed rate, known as a capitation fee or PMPM (per member per month) is paid for a specific period, monthly. The General Dentist assumes the responsibility for providing basic dental services and the maintenance of health is unique to the capitation dental plan.

How it works:

1. A capitation roster is mailed in the first week of each month. The roster details the capitation being paid for each covered member.
2. The member's eligibility is typically effective the first day of the month.
3. It is important that your facility verify member eligibility prior to treatment.
4. If a member does not show on the roster, we offer several ways to verify eligibility.
   - NPD website ..... **UHCdental.com**
   - Provider Services **1-800-232-0990**
   - Integrated Voice Response (IVR) **1-800-822-5353**
5. Copayments are due and should be collected from the member at the time services are rendered. Refer to the member's specific dental plan/copayment schedule.
6. Submit general dentistry utilization by submitting an ADA claim form for all plans.
7. If you need to refer the member to a specialist, please follow the Specialty Care Referral Guidelines found in Section 6 of this manual.
8. Capitation checks are mailed with the monthly roster. If the office mailing address is different from primary (location) address, the capitation checks will be mailed to the mailing address and the capitation roster will be mailed to the primary (location) address.

Enrollment – primary care dentist site selection:

At the time of enrollment, each employee of a group receives an enrollment form to complete. Included in the form is a section to select a primary care dentist. A primary care dentist must be selected by each member/dependent. Therefore, each employee and each of their dependents (spouse/children), must choose a primary care dentist.

3.2 Capitation roster

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

"A" – Active	Patient eligible	Internal Info only not viable for provider .
"N" – Not Eligible	Patient not eligible	Contact NPD with patient information to verify status
"T" – Transferred	Patient eligible in another NPD office	Contact NPD with patient information to verify or change office assignment

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

Section 4: Patient eligibility verification process

4.1 Member eligibility verification

Prior to rendering services, you must verify the member's eligibility. Eligibility may be verified 1 of 3 ways:

1. Interactive Voice Response (IVR) System
2. Provider portal at **UHCdental.com**
3. Provider Services Representative

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

4.2 Integrated Voice Response System 1-800-822-5353

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

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

4.3 Website UHCdental.com

The National Pacific Dental website, **UHCdental.com**, offers helpful tools to assist with verifying eligibility, pre-authorization, claim status, remittance, procedure level pricing, fee schedules, benefit information, provider search and much more 24 hours a day, 7 days a week.

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

Section 5: Patient access

As a participating dentist in the NPD network, you have agreed to offer appointments to members using standards applicable to non-network patients. A dentist should not refuse to accept patients into his/her practice or deny service to patients because of the patient's race, creed, color, sex, insurance coverage, health, or national origin. Furthermore, you have agreed to provide the standards of oral health care provided to the public at large, and will abide by the **Clinical Practice Guidelines** set forth by NPD.

You have agreed to offer appointments to members without no unreasonable waiting periods for appointments, or waiting periods for services for members once an appointment is made.

All members/covered dependents of an affiliated NPD plan should appear on your Capitation Roster, however, if a member claims to have benefits, but does not appear on your current roster, you should immediately contact Customer Service to verify the member's/dependent's eligibility.

5.1 Appointment scheduling

The Texas Department of Insurance required dental professionals to meet specific appointment and availability standards. These standards help ensure members of National Pacific Dental have the best opportunities for quality care when they need it.

Listed below are guidelines for appointment scheduling:

- **Initial appointments** should be offered within three (3) calendar weeks unless the patient has requested a specific time for the appointment limiting his/her availability.
- **Existing patient visits** should be offered for basic services within six (6) calendar weeks.
- **Routine hygiene visit**s should be available within 16 calendar weeks. Each facility is required to have a recall system in place.
- **Emergency appointments** should be offered within 24-hours.
- **Reception wait time** should be 30 minutes or less

After-hours access standard requirement

All Primary Care Dentists are required to have active after-hours mechanisms (answering machine, answering service or cell phone) available for emergency contact information or instructions 24 hours a day 7 days a week.

If using call forwarding or a 24-hour answering service to receive calls from patients after regular business hours, the service must be able to reach the provider or a covering dentist.

It is acceptable to have a recorded message that provides patients with a phone number or pager number for the patient to contact their dentist, dentist staff, or a covering dentist. An after-hours message that directs members to call 911 or go to the nearest emergency room in case of dental emergency does not meet our standards.

Broken appointments

A broken appointment is defined as an appointment cancelled with less than 24-hours notification to your office or a failed appointment.

NPD understands that the time your facility reserves for our members is very valuable to your practice and broken appointments make it difficult to maintain an efficient work schedule. All Evidence of Coverage information provided to members discusses broken appointments and stresses the importance of keeping scheduled appointments, arriving on time, and canceling appointments with a minimum of 24-hours notice.

National Pacific Dental plans allow the facility to charge a broken appointment fee to the member if this is a standard policy for all patients in the provider office .

5.2 Panel closure

You reserve the right to request your office limit enrollment by being placed on closed status, meaning no new patients are allowed to select you as their primary care dentist. You must allow thirty (30) days for the change in status to become effective.

Your request must be submitted in writing to the address, fax, or email below. Your office has the ability to reopen the office to new members by logging into **UHCdental.com** and choosing the Self Service Portal.

National Pacific Dental – RMO
ATTN: 400-Provider Services
P.O. Box 30567
Salt Lake City, UT 84130
Fax: 1-855-363-9691
Email: dbpprvfx@uhc.com

NPD reserves the right to place your office on closed status for non-compliance of any of the requirements of the Texas Department of Insurance.

5.3 Member transfers

When a member requests a transfer of primary care dental office assignment

A member can change his selected dental facility by:

- Calling the Integrated Voice Response (IVR)
- Calling National Pacific Dental Customer Services Department and requesting a transfer to another facility. The Customer Service Associate will assist the member with locating another practice in a specific area if requested.
- Written request to National Pacific Dental Customer Services Department.

When a dentist requests a transfer of primary care dental office assignment

A Primary Care Dentist can request that a member be transferred to another facility if:

- The member is uncooperative.
- The member refuses to abide by the contracting dentist's treatment plan.
- There is a breakdown in the doctor/patient rapport.
- There is any verbal or physical abuse or threat of abuse to the dentist and/or staff.

- The member does not pay incurred co-payment or other charges for dental services
- The member used another person's identification card to obtain services
- The member knowingly supplies false information to NPD or the provider

All requests to have a member transferred out of your facility for Texas Plans should be submitted in writing to the member and copied to National Pacific Dental, as per the requirements of the Texas State Board of Dental Examiners.

Your dental office is responsible for providing copies of all the member's records, including x-rays, at the recommended TSBDE fee.

5.4 Outreach programs

National Pacific Dental may at times, or when deemed necessary, disseminate written materials to members and inform them of the availability and importance of preventive dental procedures and the importance of early intervention of various treatments. To help members become aware of the need for good dental health, NPD will inform members and providers of any local health fair programs and community outreach programs that have, as a component, preventive dental health programs. NPD also encourages members to participate in these programs. NPD may at times make monetary contributions to these programs to reach a broader member base and encourage more members to seek preventive dental health services than would otherwise occur without this effect.

Section 6: Specialty care referral guidelines

The National Pacific Dental (NPD) specialty care referral process is intended to allow the Primary Care Dentist (PCD) the opportunity to coordinate specialty services for his or her members while ensuring that the specialist's time is spent providing only the services which dictate specialty attention. This objective is for the member to receive quality, cost-effective dental care.

To locate an NPD participating specialty care provider, the member should contact Customer Service for direction.

Important: The Primary Care Dentist may not "direct refer" for specialty care.

Specialty referrals are not required for children under the age of 8 to see a pediatric dentist. Children under age 8 who need services of a specialist beyond a pediatric dentist must still obtain a specialty referral. To locate an in-network Pediatric Dentist, instruct the member to contact Customer Services.

Specialty care referral form

It is critical that the PCD complete the entire NPD Specialty Care Referral Form and to provide any supportive documentation needed to coordinate the referral. See Appendix: Attachments for a sample of the referral form. The NPD Specialty Referral Form can also be obtained on the provider portal by signing into **UHCdental.com** and selecting Manuals/Other Supporting Documents under Quick Links.

The Specialist must have a copy attached to his/her claim for reimbursement. Failure to complete this form is an inconvenience to the specialist and the patient. Specialists may not accommodate patients who do not have a referral form or an authorization number from NPD. These patients may be sent back to the PCD's office for the form.

Specialty care referral criteria

To be considered for specialty care coverage, the following criteria must by met:

- The patient must be eligible in the Primary Care Dental Office (PCD) when services are rendered
- A National Pacific Dental (NPD) network specialty care provider must provide treatment

Primary dental office responsibilities

1. Determine that the patient has treatment needs that meet the Specialty Care Referral Criteria listed later in this section by Specialty Type. Note: Some referrals require the Primary Care Dentist to submit materials and perform basic services before a referral can be processed or allowed.
2. Verify the procedure(s) is a covered benefit according to the patient's benefit schedule. Non-covered procedures may be referred to a Specialist, however, the patient is responsible for all fees related to non-covered services and the patient must be informed, in advance of this financial responsibility. It is not necessary to complete an NPD Specialty Care Referral Form for non-covered procedures.
3. Give the completed Specialty Care Referral form to the patient with any related radiographs and/or other clinical documentation attached. All appropriate radiographs must be made available for the Specialty Care Provider. A full mouth series (FMX) and periodontal chart, including probing is required for periodontal referrals.
4. Instruct the patient to contact NPD's Customer Service Department for an authorization number and direction to an NPD Specialist, as indicated on the Specialty Referral Form.

- Referrals are for "Consultation Only" – no other treatment requests will be initially authorized.
- Medical conditions or other case-specific circumstances that may require exception to the standard process, must be submitted with proper written documentation with the request for any exception.

Emergency cases may be coordinated by a phone call to National Pacific Dental (NPD) Customer Service Department.

Member responsibilities

1. Member is required to call NPD to get authorization number
2. NPD will provide member with direction to an NPD specialist

Specialist responsibilities

1. Verify eligibility by calling NPD Provider Services before starting any dental procedure.
2. If additional services beyond consultation and/or palliative treatment of pain is needed, contact NPD Provider Services Department.
3. For non-emergency treatment, the Specialty Care Provider is required to submit an itemized treatment plan on a Universal Claim Form (Attending Dentist's Statement) for review for pre-determination. Send the pre-determination to:

   National Pacific Dental
   c/o UnitedHealthcare Dental
   P.O. Box 30552
   Salt Lake City, UT 84130-0552
4. If during the course of authorized treatment, it is determined that additional treatment is needed over and above the approved treatment, the specialist is required to submit an additional request for preauthorization.
5. Specialty Care Provider may contact patient to schedule an appointment for treatment upon receipt of an approved predetermination.
6. Collect all applicable copayment(s).
7. Payment for unauthorized referral claims will be denied.

All treatment including but not limited to emergency approvals for treatment are subject to retrospective review where treatment may be recoded to reflect the more appropriate ADA code/procedure. Treatment deemed not to be appropriate procedures for specialty care may be sent back to the PCD for patient care.

Section 7: Claim submission procedures

7.1 Claim/Encounter submission options

National Pacific Dental requires its offices to submit utilization information for every patient seen as required by state rules and regulations. ADA Claim Forms or Encounter Reports should be submitted electronically or by mail, and sent to the Claims Department address listed below:

National Pacific Dental
C/O UnitedHealthcare Dental
P.O. Box 30567
Salt Lake City, UT 84130-0567

7.1.a Paper claims

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

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. Refer to Section 11 Exclusions and Limitations to find the recommendations for dental services.

7.1.b Electronic claims

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

If you wish to submit claims electronically, please contact your clearinghouse to initiate this process. If you do not currently work with a clearinghouse, you may sign up with one to initiate this process. The provider portal at **UHCdental.com** also offers the feature to directly submit your claims online through the provider portal. Refer to Section 4.3 Website for more information on how to register as a participating user.

7.1.c Encounter reporting

Encounter reporting or utilization data is an integral part of our Quality Management Program. The data collected validates the volume and frequency of dental care delivered.

To make utilization reporting easier and consistent, all Encounter Reports must include the following:

- Subscriber Name
- Subscriber ID
- Subscriber Date of Birth
- Group Name or Number
- Patient's Full Name

- Relationship to Subscriber
- ADA Code Performed
- Tooth # / Quadrant
- Surface
- Treating Dentist Name
- Dentist Tax I.D. for Billing
- Physical Address

7.2 Claim payments

National Pacific Dental will make payment for covered services rendered to members no later than the 45th day after receipt of a non-electronic claim and within 30 days of receiving an electronically submitted claim. All claims must be received with reasonable documentation necessary for National Pacific Dental to process the claim within these time frames.

7.3 Unbundling of procedures

National Pacific Dental will not allow the separating of dental procedures into component parts with individual charges so that the cumulative charge of the components is greater than the total charge to patients. This unbundling of procedures will not be honored or allowed under any circumstances under any NPD plan. All procedures will be "re-bundled" and paid accordingly.

7.4 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 ADA or visiting the ADA store at **engage.ada.org**.

7.5 Coordination of benefits (COB)

When a patient has coverage under more than one dental plan, the plans should be coordinated to maximize the patient's combined benefit. The combined benefit could be more than the single benefit associated with any of the individual plans. However, the patient should not be reimbursed an amount greater than the total fee charged.

In administering COB, one plan will be primary (i.e., its benefits are determined before those of the other plan and without considering the other plan's benefits) and the other plan will be secondary (i.e., its benefits are determined after those of the other plan and may be reduced because of the other plan's benefits). At no time should a provider submit charges to a secondary earner that are greater than the amount for which the patient is responsible according to their primary coverage.

While industry guidelines for determination of primary versus secondary coverage are provided, carriers and providers of care must keep in mind that according to Federal Code 1094, Title 10: a government plan is always considered the secondary plan when involved in a COB process. Examples of government plans include Medicare, Medicaid or any plan receiving government funding.

In order to determine which plan is primary, the following rules have been established:

1. If the other plan does not have a COB provision similar to this one, then that plan shall be primary.
2. If both plans have COB provisions, the plan covering the patient as a Subscriber is determined before those of the plan, which covers the patient as a Dependent.
3. Dependent Child/Parents not separated or divorced

The rules for the order of benefits for a dependent child when the parents are not separated or divorced are as follows:

1. The benefits of the plan of the parent whose birthday falls earlier in a year are determined before those of the plan of the parent whose birthday falls later in the year.
2. If both parents have the same birthday, the benefits of the plan which covered the parent longer are determined before those of the plan which covered the other parent for a shorter period of time;
3. The word “birthday” refers only to month and day in a calendar year, not the year in which the person was born;
4. If the other plan does not follow the birthday rule, but instead has a rule based upon the gender of the parent; and if, as a result, the plans do not agree on the order of benefits, the rule based upon the gender of the parent will determine the order of benefits.

When coordinating benefits between two capitation plans, the following rules apply:

In the case where the dental provider participates with both of the capitation plans and both of the capitation plans are administered by the same managed care company, the patient should be charged in accordance with the lesser of the two co-payment schedules and the dentist should submit a claim for additional payment (if applicable) in accordance with the guidelines set forth by the capitation plan.

In the case where the dentist participates with both of the capitation plans and the capitation plans are NOT administered by the same Managed Care Company, the patient should be charged in accordance with the plan that has been determined as the primary plan. The dentist should submit a claim for additional payment (if applicable) in accordance with the guidelines set forth by the primary plan.

When the dentist submits a claim for additional payment (if applicable) to the secondary plan, the claim must include an explanation of benefits (EOB) from the primary plan. If the secondary plan is a NPD plan, there will not be any additional payment to the dentist if the combined payment from the patient and the primary plan to the dentist is equal to or greater than the amount guaranteed to the dentist by NPD.

When coordinating benefits between a capitated plan and an indemnity plan where the capitated plan is primary, the following rules apply:

The dentist should submit the patient co-payment as specified by the capitation plan to the indemnity plan. The patient is responsible for paying the difference between the amount reimbursed by the indemnity plan and their co-payment (see Example 2).

The dentist should submit the patient co-payment as specified by the capitation plan to the indemnity plan. The patient is responsible for paying the difference between the amount reimbursed by the indemnity plan and their co-payment. The dentist should then submit a claim for additional payment (if applicable) to the capitated plan in accordance with their contract (see Example 3).

When coordinating benefits between a capitated plan and an indemnity plan where the indemnity plan is primary, the following rules apply:

The dentist should submit the regular office fee to the indemnity plan. The patient pays the difference between the fee submitted to the indemnity plan and the amount reimbursed by the indemnity plan, or their co-payment according to the capitated plan, whichever is less (see Example 4 and 4A).

The dentist should submit the regular office fee to the indemnity plan. The patient pays the difference between the fee submitted to the indemnity plan and the amount reimbursed by the indemnity plan, or their co-payment according to the capitated plan, whichever is less. The dentist should then submit the regular office fee in the form of a claim for additional payment (if applicable) to the capitation plan to include an explanation of benefits (EOB) from the indemnity plan. If the secondary plan is a NPD plan, there will not be any additional payment to the dentist if the combined payment from the patient and the primary indemnity plan to the dentist is equal to or greater than the amount guaranteed to the dentist by NPD (see Example 5).

Examples

Two capitated plans; regardless of which one is primary versus secondary and assuming the dentist participates in both plans.

Example 1: The dentist is a primary provider	
Member co-payment under first capitated plan:	$350.00
Member co-payment under second capitated plan:	$300.00

The patient should be charged in accordance with the lesser of the two co-payment schedules. In this example, the patient is responsible for a $300.00 co-payment.

Capitated plan is primary and the indemnity plan is secondary

Example 2: The dentist is a primary provider	
Member co-payment under capitated plan:	$350.00
Indemnity plan pays:	-200.00
Balance:	$150.00

The dentist should submit the patient co-payment as specified by the capitation plan ($350.00) to the indemnity plan. The patient is responsible for paying the difference between the amount reimbursed by the indemnity plan ($200.00) and their co-payment. In this example, the patient is responsible for a $150.00 co-payment.

Example 3: The provider is a specialist	
Member co-payment under capitated plan:	$300.00
Indemnity plan pays:	-150.00
Balance:	150.00
Dentist's guarantee with NPD	$350.00

The dentist should submit the patient co-payment as specified by the capitation plan ($300.00) to the indemnity plan. The patient is responsible for paying the difference between the amount reimbursed by the indemnity plan ($150.00) and their co-payment. In this example, the patient is responsible for a $150.00 co-payment. The dentist should then submit a claim for additional payment to NPD. Additional payment from NPD will not be made to the dentist if the combined payment ($300.00) from the patient

($1 X 0.00) and the indemnity plan ($150.00) to the dentist is equal to or greater than the amount guaranteed to the dentist ($350.00) by NPD. In this example, there would be an additional payment from NPD to the dentist for $50.00.

Indemnity plan is primary and the capitated plan is secondary

Example 4: The dentist is a primary provider	
Regular Office Fee:	$500.00
Indemnity Plan Pays:	-400.00
Balance After Indemnity Payment:	100.00
Member Co-payment under Capitated Plan:	$350.00

The dentist should submit the regular office fee ($500.00) to the Indemnity Carrier. The patient pays the difference between the fee submitted to the indemnity plan and the amount reimbursed by the indemnity plan ($400.00), or their co-payment according to the capitated plan ($350.00), whichever is less. In this example, the patient is responsible for the $100.00 balance.

Example 4A: The dentist is a primary provider	
Regular Office Fee:	$500.00
Indemnity Plan Pays:	-250.00
Balance after Indemnity Payment	250.00
Member Co-payment under Capitated Plan:	$350.00

The dentist should submit the regular office fee ($500.00) to the Indemnity Carrier. The patient pays the difference between the fee submitted to the indemnity plan and the amount reimbursed by the indemnity plan ($250.00) OR their co-payment according to the capitated plan ($350.00), whichever is less. In this example, the patient is responsible for the $250.00 balance.

Example 5: Provider is a Specialist	
Regular Office Fee:	$500.00
Indemnity Plan Pays	-0.00
Balance:	500.00
Member Co-payment under Capitated Plan:	300.00
Specialist's Guarantee with NPD:	$400.00

The Specialist should submit the regular office fee ($500.00) to the Indemnity Carrier. The patient pays the difference between the fee submitted to the Indemnity plan and the amount reimbursed by the Indemnity plan ($0.00) or, their co-payment according to the capitated plan ($300.00), whichever is less. In this example, the patient is responsible for a $300.00 co-payment.

The Specialist should then submit the regular office fee in the form of a claim for additional payment (if applicable) to the capitation plan and include an explanation of benefits (EOB) from the indemnity plan. If the secondary plan is a NPD Plan, there will not be any additional payment to the Specialist if the combined payment ($300.00) from the patient ($300.00) and the primary indemnity plan ($0.00) to the specialist is equal to or greater than the amount guaranteed to the Specialist ($400.00) by National Pacific Dental. In this example, there would be an additional payment from NPD to the Specialist for $100.00.

7.6 Termination of benefits

Should a member become ineligible, benefits will continue through the last day of the month (verify specific employer benefit office).

- All crown or bridge work in progress must be completed if the tooth has been prepped.
- Any partial or full denture must be completed if the final impression has been taken.
- On every tooth upon which work has been started, the procedure must be completed.
- Root canal therapy, in progress, should be completed at the same co-payment. This excludes any final or permanent restoration.

The member is financially responsible for the co-payment listed on the plan in effect at the time of termination for all services initiated prior to termination.

7.7 Right to appeal

If you believe that your claim has not been paid correctly, you may send a written appeal to National Pacific Dental. Any written appeal should include the member's name and subscriber ID, the reason for your appeal and any other information you feel might help us in reviewing your claim. The appeal should be mailed directly to:

National Pacific Dental, c/o UnitedHealthcare
Dental Attention: Claim Appeals/Complaints
P.O. Box 30569
Salt Lake City, UT 84130

7.8 Adverse determination

Providers may contact Provider Services at **1-800-232-0990** to communicate directly with a Dental Consultant or appropriate Utilization Review Agent regarding an adverse determination.

Section 8: Office administration

8.1 New associates

A credentialing application must be submitted for each new dentist to initiate the credentialing process for new associates prior to any treatment being rendered to eligible NPD members. See Section 10.2 Credentialing for more information on the credentialing process. In addition, your office is required to notify NPD in writing in the event that any dentist terminates his or her employment and will no longer be treating NPD members.

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

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

Requests for change will need to include an outline of the old information as well as the changes that are being requested. This should include the TIN(s) and/or Provider names for all associates to whom the changes apply. Providers may utilize the Demographic Change Form found in Appendix A.4.

Changes may be submitted through the provider self-service portal at **UHCdental.com**. Some requests may need to be made in writing with corresponding and/or backup documentation. For example, a tax identification number (TIN) change would require submission of a copy of the new W-9 and a new Provider Agreement, versus an office closing notice where we would need the notice submitted in writing on office letterhead.

Examples of changes requiring notification within 30 days of the change to National Pacific Dental:

- The status as to whether the participating provider is accepting new patients or not
- The address(es) of the office location where the participating provider currently practices
- The phone number(s) of the office location where the participating provider currently practices
- The email address of the participating provider
- If the participating provider is still affiliated with the listed provider groups
- The specialty of the participating provider
- The license(s) of the participating provider
- The tax identification number used by the participating provider. Tax identification number updates require a new provider agreement to be completed
- The NPI(s) of the participating provider
- The language spoken/written by the participating provider or the staff
- The ages services by the participating provider
- Office hours (7 days a week)

Changes should be submitted to:

National Pacific Dental – RMO
ATTN: 400-Provider Services
P.O. Box 30567

Salt Lake City, UT 84130
Fax: 1-855-363-9691
Email: dbpprvfx@uhc.com

Credentialing updates should be sent to:

Email: **dbpcredsupport@uhc.com**
National Pacific Dental Credentialing
2300 Clayton Road, Suite 1000
Concord, CA 94520

A Participating Provider is expected to review, update provider records and attest to the information available to National Pacific Dental members, including the information listed below, on no less than a quarterly basis. You are responsible for notifying NPD of these changes for all participating providers within your office.

If you have any questions, contact Provider services at **1-800-232-0990** for guidance.

8.3 Office conditions

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

8.4 Sterilization and asepsis control

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

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

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

8.6 Transfer of dental records

A dentist shall furnish copies of dental records to a patient who requests his or her dental records. At the patient's option, the copies may be submitted to the patient directly or to another Texas dental licensee who will provide treatment to the patient. Requested copies, including radiographs, shall be furnished within 30 days of the date of the request. The copies may be withheld until copying costs have been paid. Records shall not be withheld based on a past due account for dental care or treatment previously rendered to the patient. Copies of dental records submitted in accordance with a request under this

section shall be legible and all copies of dental x-rays shall be of diagnostic quality. Non-diagnostic quality copies of dental x-rays shall not fulfill the requirements of this section .

- A dentist providing copies of patient dental records is entitled to a reasonable fee for copying which shall be no more than $25 for the first 20 pages and $0.15 per page for every copy thereafter
- Fees for radiographs, which if copied by a radiograph duplicating service, may be equal to actual cost verified by invoice
- Reasonable costs for radiographs duplicated by means other than by a radiograph duplicating service shall not exceed the following charges:
  - A full mouth radiograph series: $15
  - A panoramic radiograph: $15
  - A lateral cephalometric radiograph: $15
  - A single extra-oral radiograph: $5
  - A single intra-oral radiograph: $5

8.7 Cultural competency

Cultural competence is of great importance in 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.

National Pacific Dental recognizes that the diversity of American society has long been reflected in our member population. National Pacific Dental 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 disparities.

National Pacific Dental 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.

Section 9: Specialty referral criteria

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

Pediatric dentistry

The NPD Primary Care Dentist is expected to provide routine dental care for children. Coverage of benefits for a contracting pediatric dentist or other specialist may be indicated when one or more of the following conditions exist:

- Down's Syndrome
- Mental/ physical disadvantage
- Deafness
- Autism
- Multiple Sclerosis
- Other severe medical problems as documented in writing by a licensed treating physician
- "Baby Bottle Syndrome" - rampant early childhood caries
- Root canal therapy on permanent teeth with incomplete root formation
- Other conditions/syndromes where formation of the teeth is incomplete or inadequate and complex restoration or removal of most of the teeth will be necessary
- An attempt to treat the child has been unsuccessful due to fear or anxiety, the child's inability to cooperate, or extensive treatment that makes such treatment unsafe for the patient or provider. The attempt should be documented on the referral form and include the specific date and circumstances.

National Pacific Dental will not reimburse the Specialty Care Provider for children age 8 or older who:

- Are not physically and/or mentally handicapped or medically compromised,
- Cannot be managed by the primary dentist due to lack of patient cooperation.

Endodontic

The National Pacific Dental Primary Care Dentist should provide routine endodontic procedures on any tooth deemed restorable, when pulpal disease is diagnosed and the member agrees to save the tooth. The following services should be completed by the general dentist (PCD).

- Pulpal diagnosis including (pulp testing).
- Uncomplicated root canal therapy (single and multiple canals).
- Root canal therapy on teeth that have had previous pulpotomies and whose canals are not totally calcified or obliterated.
- Emergency endodontic care (open, medicate, open and drain, pulpectomy, pulpotomy).

The following conditions are considered reasonable for referral to an endodontist:

- Apicoectomy
- Internal or external root resorption (anterior and posterior)
- Calcified canals

- Severe root and/or canal curvature
- Broken instrument in the canal
- Re-treatment of teeth with previous root canal therapy if the procedure is a benefit under the member's plan

Non-covered endodontic services by a specialist may include but are not limited to:

- Services rendered without referral authorized by NPD.
- Teeth requiring root canal therapy as a result of accident or trauma. The member may be covered under their major medical insurance.
- Teeth with a poor, guarded or hopeless periodontal or endodontic prognosis.
- Teeth that cannot be adequately restored.
- Teeth that are non-functional and for which no future function is treatment planned.
- Endodontic consultations for treatments or services that are not covered benefits.
- Routine root canals for anterior teeth and bicuspids without complications

Medical referrals

If a patient has a medical history or a physical condition which require the need of monitoring by a specialist:

- A letter from the patient's physician/general dentist must describe the basis for care by a specialist.
- The primary dentist must make a diagnosis or verify the condition.

As with all referrals, with the exception of referral to a Pediatrict Dentist noted in the Pediatric Dentistry Section, the member must be directed to Customer Service for authorization and direction to the appropriate specialist.

Oral surgery

The National Pacific Dental (NPD) contracted Primary Care Dentist should perform routine oral surgery, including simple extractions (7111, 7140), surgical extractions (7210), soft tissue impactions (7220), alveolectomies (7310, 7311, 7320, 7321) and post-operative care.

Benefits are not available for asymptomatic, non-pathological impactions. The NPD dentist should evaluate each case carefully and discuss findings with the member before deciding upon a course of treatment. If the dentist decides that he/she is inadequately prepared to perform partial or bony impactions, unusual sequence and non-routine post operative complications, the NPD dentist may request referral of the member for specialty care.

Referrals for consideration may include but are not limited to:

- Extraction of symptomatic bony, symptomatic partial bony or symptomatic soft tissue impactions with complications.
- Multiple extractions of (4) or more teeth to be extracted on same date of service excluding third molars.
- Symptomatic surgical extraction of erupted and non-erupted teeth, when determined to be beyond the scope of the Primary Care Dentist

- Surgical removal of residual roots when such extraction is expected to be complicated and beyond the scope of general dentistry.

NPD will not cover the following services by a specialist:

- Services rendered without referral from the primary dentist and authorization from NPD Customer Service or its Dental Director.
- Extraction of teeth requiring removal as a result of accidental, intentional injury or trauma. The member may be covered under their major medical insurance.
- Asymptomatic extractions with no pathology.
- Extractions deemed to be within the scope of the PCD without complications including but not limited to:
  - Extractions 7111, 7140
  - Surgical extractions 7210
  - Soft tissue extractions 7220
  - Alveloectomies 7310, 7311, 7320, 7320

Periodontal

Treatment goals

Once periodontal disease has been identified, the goals of treatment are the following:

- Arrest and control the progress of the disease.
- Maintain the periodontal tissues in an easily maintainable state.
- Treat, repair or regenerate the supporting periodontal structures, which include bone, gingival tissue, and periodontal ligaments.

Treatment phases

To achieve these goals, there are three phases of professional periodontal treatment:

- Initial cleaning, scaling and root planing.
- Surgery is indicated when deep pockets remain after extensive cleaning sessions. The depth of these pockets must be reduced by eliminating the bacterial plaque and calculus subgingivally. The surgery permits reduction of inflammation, healing and reattachment of the periodontal attachment.
- Maintenance. This procedure is instituted following periodontal therapy and continues at varying intervals, determined by clinical evaluation of the dentists.

Criteria

1. Comprehensive Periodontal Screening and Recording (PSR) must be completed by PCD and include but is not limited to:
   - **a.** Periodontal classification (Type I – IV)
   - **b.** A full mouth series of at least 14 x-rays.
   - **c.** Six-point periodontal probing (three points on buccal/cheek side and three on lingual/tongue side)
     - **i.** distofacial
     - **ii.** facial

iii. mesiofacial
iv. distolingual
v. lingual
vi. mesiolingual

d. Completion of periodontal charting

- Gingival and mucogingival lines
- Pocket measurements
- Areas of mucogingival involvement
- Furcation involvement
- Abnormal frenal attachments
- Mobility

2. Evaluation and treatment recommendations to be presented to patient include but is not limited to:

a. Determination of referral to Periodontist made at this time.

b. Patients with Type I, II or III periodontal conditions are to have scaling and root planing performed by their PCD. The scaling required may be localized and site specific.

c. Patients with Type IV periodontal conditions may be referred to a Periodontist with authorization from NPD

d. Re-evaluation should be performed by the PCD 4-6 weeks following the last quadrant of scaling and root planing (minimum 4 weeks – maximum 3 months).

The Primary Care Dentist is expected to render comprehensive periodontal treatment on Case Types I, II & III.

Periodontal Health	Type I Gingivitis	Type II Early Periodontitis	Type III Moderate Periodontitis	Type IV Severe Periodontitis
No bleeding Pink tissue with stippling and knife edge margins	No bone loss Inflammation, bleeding and/or suppuration. Loss of stippling	Slight bone loss (<10%) without furcation involvement	Moderate to severe bone loss (10-40%) with beginning furcation	Severe bone loss (>40%) with furcation involvement
1-2 mm sulcus depths	Inflammatory pocketing only	3-4 mm pocketing	5-6 mm pocketing	7+ mm pocketing
	0 mobility	0 mobility	+1 & +2 mobility	+3 & +4 mobility

The following conditions may be recommended for referral to a periodontal specialist:

1. Consultation

2. Post consultation treatment to be performed by a Periodontist may be authorized for the following cases when diagnosed as Type IV:

a. Scaling and root planing

b. Gingival flap surgery

c. Mucogingival surgery

d. Osseous surgery

e. Periodontal maintenance – once per 6 months after active periodontal therapy

3. Post consultation treatment to be performed by a Periodontist may be authorized for cases not diagnosed as Type IV:

a. Distal or proximal wedge procedure

b. Crown lengthening

c. Gingivectomy, in limited situations, when deemed to be beyond the scope or skill of the PCD

Primary Care Dentist Referral Procedures for Periodontal Services:

1. Prepare NPD Specialty Care Referral Form

- Referrals are for "Consultation Only" – no other treatment requests will be initially authorized before the consultation is completed.
  - Medical conditions or other case-specific circumstances that may require exception to the standard referral process must be submitted with proper written documentation with the request for any exception. Exceptions will be evaluated on a case by case basis and permitted only when the referral request clearly demonstrates need for the referral. Emergency cases may be coordinated by phone call to an NPD Referral Coordinator.

2. Referral requests for Scaling and Root Planing or Gingival Flap Procedure must include required attachments/documentation including:

a. Periodontal classification

b. Full mouth periodontal charting that includes:

- Gingival and mucogingival levels
- Pocket measurements, full 6 point probing
- Areas of mucogingival involvement
- Furcation involvement
- Abnormal frenum attachments
- Tooth mobility
  - Copy of progress notes (treatment records) or PCD notes/comments providing case type IV diagnosis.
- Oral health care instruction
- Assessment of patient's home care, skills and knowledge
- Determination of prognosis
  - X-rays are not required but are recommended for use by the Dental Director in making the referral recommendation.

3. Referral requests for Osseous Surgery or Gingivectomy must include required attachments/documentation including:

a. A copy of most recent periodontal charting (full 6 point probings)

b. Copy of progress notes (treatment records) or NPD Periodontal Status Sheet documenting:

- Dates scaling and root planing completed

- › Full mouth periodontal charting 1 to 3 months following initial periodontal scaling and root planing to evaluate patient's healing and response to initial therapy.
- › Dentist and/or RDH notes/comments
  - Oral health care instruction
  - Assessment of patient's home care, skills and knowledge
  - Determination of prognosis

c. X-rays are not required but are recommended for use unless specifically requested by Dental Director.

d. May be submitted with initial referral request at PCD's discretion

e. NPD Periodontal Status Sheet will be faxed, emailed or mailed to PCD.

4. Give member-patient white and yellow copy of Referral Form to give to the specialist

Periodontist claims submission:

NPD will **not** compensate a Specialist for the following conditions:

- Services rendered without the referral from Primary Care Dentist or direction from NPD
- Services rendered to treat teeth with questionable, guarded or poor prognosis. This type of case should be referred back to the primary dentist; and the patient should be informed that the plan will cover these teeth for extraction and prosthetic replacement.
- Class I, II, and III periodontal scaling and root planning (4341, 4342) without unusual circumstances.

In line with the current CDT, the Plan considers that a claim for procedure code D4341, Scaling and Root Planing, must contain four (4) diseased and treatable areas to be considered a full quadrant. Quadrants with three (3) or less diseased and treatable areas should be coded D4342.

Claims for procedure code D4260, Osseous Surgery, must contain at least four (4) areas with pocket depths measurements of five (5)mm or more. Three (3) areas or less with pocket depth measurements of five (5)mm or more should be coded D4261.

Gingival flap surgery should be submitted in the same manner.

Additionally, the Plan reserves the right to combine teeth in the same arch meeting these criteria into one quadrant, when there are eight or fewer teeth remaining in the arch.

Orthodontic

The NPD Primary Care Dentist is not required to provide orthodontic care except for space maintenance. Not all members have orthodontic coverage and should be referred to Customer Service to determine coverage and referral to a participating provider. If coverage is not included, please do not use a specialty referral form.

The final result of orthodontic treatment should be directed towards the attainment of an optimal end-result for each patient with regard to dentition, supporting bone relationship, interdigitation, contact points, overbite and over jet to achieve esthetic improvement and stability of attained correction. Active orthodontic treatment should be followed with retention appliances and supervision to help assure stability of correction.

National Pacific Dental does not cover orthodontic treatment in the following conditions*:

- For periodontally compromised teeth.
- To correct congenital anomalies
- To correct or treat TMJ
- To alter tilted teeth for permanent prosthetic placement
- To correct bruxism
- To increase vertical dimension

*Refer to the Exclusions and Limitations Section as well as the Clinical Practice Guidelines

Specialist as primary provider

In some instances, it may be necessary for a specialist to become the primary care provider for a member. The criteria for which this member should be allowed to use a specialist as a primary provider includes but is not limited to:

1. A minor or adult with diminished mental capabilities who presents a behavior management problem that a general practitioner would be incapable of caring for;
2. A minor or adult with severe, systemic or chronic medical problems that require more extensive monitoring with equipment not likely to be found in a general dental practice;

In order to allow for this situation, the Primary Care Dentist must refer the member with a written request to NPD's Dental Director, at the following address: National Pacific Dental, 2000 West Loop South, Suite 2010, Houston, TX 77027, explaining the circumstances for the referral. In addition, the Specialist must agree to assume responsibility for the treatment of the member in question and the member or designated representative must sign an agreement to that affect. The effective date of the designation of a non-primary care physician specialist as an enrollee's PCP may not be applied retroactively.

The Credentialing Committee must approve the specialist if the specialist is not currently a panel provider. The Plan will respond to the request for the Specialist as Primary Provider within thirty (30) days. The PCP's compensation may not be reduced prior to the effective date of the non-primary care physician specialist's new designation as PCD.

Section 10: Quality management

10.1 Quality Improvement Program (QIP) description

The foundation of National Pacific's Quality Assurance Department lies with the Quality Improvement Program (QIP). The Quality Improvement Program (QIP) functions as an integrated activity within NPD, providing a mechanism for monitoring quality issues. The scope of the QIP encompasses both clinical care and administrative services provided to internal and external customers. External and internal customers are defined as members, practitioners, employer groups and governmental agencies. This includes interactions internally with the Provider Relations, Customer Services, and Marketing Departments, and Practitioners, along with external customers.

The fundamental goal of the QIP, in partnership with the NPD network, is to ensure access to care which meets or exceeds standards of care within the local community. The QIP assists providers in upgrading their practices in such areas as record keeping and infection control. Additional goals of the program are as follows:

- Develop the highest quality dental provider network,
- Identify any areas of the dental practice which may need improvement and offer potential solutions to the problems,
- Provide a system that allows the provider and the members to have questions, inquiries, complaints, or disputes evaluated and resolved,
- Analyze statistical data to ensure efficient utilization and overall improvement of the member's dental health.

The following are areas that are included in the Quality Improvement Program and compose the requirements for all network providers:

- **Credentialing** - All applicants will be expected to maintain current documents, pass a facility evaluation and exhibit quality standards of practice.
- **Re-credentialing** - Providers are re-credentialed every 36 months. Each applicant for re-credentialing will be assessed for policy compliance, complaint ratio, accessibility and retrospective utilization review.
- **Complaint Procedure** - The complete complaint process is outlined including the process for appeal.
- **Peer Review** - All providers are subject to peer review. While the primary function is to monitor the panel, peer review can also be used by the provider for assistance with policies that may be unclear.
- **Disciplinary Procedures** - The process by which an action may be taken against a provider when a provider is non-compliant with Plan policies.
- **Utilization Review** - Utilization is reviewed retrospectively to track and trend care given to the membership.
- **Employee Policies** - A brief description of the required policies and procedures for all provider offices.

10.2 Credentialing

To become a participating provider in National Pacific Dental'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).

National Pacific Dental will review all current information relative to your license, sanctions, malpractice insurance coverage, etc. NPD will request a written explanation regarding any adverse incident and its resolution and will request corrective action be taken to prevent future occurrences.

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

You have the right to appeal any credentialing decision if your practice is in a state that allows for credentialing Appeals which is based on information received during the credentialing process. If you practice in a state that allows for Appeals, to initiate an appeal of a recredentialing decision, follow the instructions provided in the determination letter received from the Credentialing Committee Coordinator.

National Pacific Dental 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 NPD. 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, NPD 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, NPD 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:

Initial credentialing

- Completed Texas State Application
- Signed and dated Attestation
- Current copy of state license
- Current copy of Drug Enforcement Agency (DEA) certificate
- Current copy of Controlled Dangerous Substance (CDS) certificate

- Current copy of Sedation and/or General Anesthesia certificates, if applicable
- Copy of 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 name on the certificate, expiration dates and limits – limits $1/3m
- Explanation of any adverse information, if applicable
- Five years' work history in month/date format with no gaps; if there is a gap of 6 months or more, an explanation of the gap should be submitted

Recredentialing

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

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

We also accept the Council for Affordable Quality Healthcare (CAQH) process for credentialing/recredentialing application submissions.

National Pacific Dental is committed to supporting the American Dental Association (ADA) and CAQH 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, visit ADA.org/godigital to get started.

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

10.3 Provider complaint procedure

Dispute resolution:

If a dispute arises between a provider and NPD, the provider must submit written notification to NPD at the address below. Upon receiving the notification, NPD will respond within 30 days. If the dispute cannot be resolved the provider has the right to bring the issue to Arbitration.

Grievance procedures:

A provider location must immediately notify NPD of any grievances asserted by our members. In addition, contracted providers must participate in all grievance resolution procedures of NPD. The provider office must post a notice for NPD members regarding the process for resolving complaints.

The notice must include the toll-free number of the Texas Department of Insurance for filing complaints and Texas State Board of Dental Examiners.

Texas Department of Insurance

P.O. Box 149104
Austin, TX 78714-9104
Phone: 1-800-252-3439
Fax: 1-512-475-1771

Texas State Board of Dental Examiners

333 Guadalupe St., Ste 3-800
Austin, TX 78701
Phone: 512-463-6400
Fax: 1-512-463-7452

10.4 Peer review

The Peer Review Committee meets monthly if there is business to discuss, reviews and makes determinations for all clinical quality issues related to individual dentists. The Committee consists of licensed dentists, representatives from the Plan and the Dental Director who is a nonvoting member. The responsibilities of this committee are to review complaints determined by the Dental Director to be of a severe nature, review utilization trends retrospectively, make determinations on credentialing/re-credentialing applications, and ensure providers are providing the standard of care clinically.

10.5 Disciplinary procedures

National Pacific Dental's major focus is to gather data to establish realistic baselines and identify chronic quality of care deficiencies. If deficiencies are identified through grievances, telephone logs, member satisfaction surveys and/or retrospective utilization reviews, the Dental Director refers identified providers that exceed acceptable thresholds to the Quality Improvement Committee who make corrective action recommendations.

NPD may find it necessary to place a provider office on frozen status or probation. Violations requiring action may include:

1. Repeated inappropriate charges.
2. Major inadequacies in patient records.
3. More than 3% of total members assigned, submitting written complaints.
4. Refusal to comply with NPD's Quality Improvement Plan.

The procedure for placing an office on frozen status or probation is as follows:

1. The Dental Director sends notification correspondence, including corrective actions needed for compliance.
2. The office is closed to new enrollment.
3. When the office becomes compliant, the office will be reopened to new enrollment.
4. If the non-compliance continues, the Quality Improvement Committee will re-review the case and make recommendations.
5. If the QI Committee determines that a provider should be terminated, upon approval of the Board of Directors, the Dental Director will notify the office.

National Pacific Dental will give notice of its intent to terminate the contract and reasons for that cause. The provider has the right to appeal the termination by requesting a hearing with the Texas Dental Director and the Quality Improvement Committee prior to the termination date. This appeal should be requested in writing to the Dental Director. Termination will be utilized when the deficiencies are numerous, ongoing or NPD determines that correction is impossible, highly unlikely, or allowing the facility to provide care may endanger members.

Serious quality deficiencies resulting in the suspension or termination of the provider will be reported by the Dental Director to the State Board of Dental Examiners along with any action taken by National Pacific Dental.

10.6 Utilization review

Office utilization is reviewed retrospectively by the Dental Director. This review is critical in determining the appropriateness of treatment, the lack of treatment or over treatment. The Director will consider patient mix, office location and other criteria to fully use utilization data.

Encounter information

By contract, NPD requires its offices to submit utilization information for every patient seen as required by state rules and regulations. This information is reviewed to evaluate the treatment being rendered to our members. Under the direction of NPD's Dental Director, provider-reporting patterns are reviewed quarterly to analyze treatment patterns in all phases of dentistry. The Dental Director may call upon other licensed dentists, including specialists, to assist in any evaluation of clinical performance. Any outlier numbers are identified and analyzed. Comparisons to norms are made based on standard deviations and adequacy of treatment. If outliers are found, corrective actions are recommended.

Utilization indicators

On no less than a quarterly basis, the following utilization indicators are tracked and trended:

- Ratio of scaling and root planing to prophylaxes
- Scaling and root planing per 100 members
- Initial exams per 100 members
- Periodic exams per 100 members
- Prophylaxes per 100 members
- Sealants per 100 children
- Fluoride treatment per 100 children

The indicators are also evaluated by age-appropriate standards and usage. NPD places a high emphasis on dental health and the prevention of dental disease. The above indicators are key indicators of preventive dental care.

Provider profiles

In conjunction with the re-credentialing schedule, the following indicators are reviewed retrospectively, to further monitor for over or underutilization:

Crowns vs. Fillings	1:4	20% to 80%
SRP vs. Prophylaxis	1:6	14% to 84%
Fixed vs. Removable Prosthetics	2:1	67% to 33%
Examination vs. Prophylaxis	1:1	50% to 50%
Crowns vs. Build-up	3.5:1	78% to 22%
Endodontics vs. Extraction	1:4	20% to 80%

Providers may request profile information by written request.

10.7 Employee policies

In accordance with Texas Civil Statutes, Title 71, Chapter 9, Articles 4543-4590 and Texas Administrative Code Chapters 101-125, each provider must have a written policy that addresses the afore-mentioned areas of law regarding non-dentist dental personnel employed in your office. In addition, each provider must also have documentation that each dental personnel have a valid and current license or registration with the state to perform permitted duties.

Section 11: Exclusions and Limitations

Limitations of Benefits

The following are the limitation of benefits, unless otherwise specifically listed as a covered benefit on this

1. PERIODIC ORAL EVALUATION - Limited to 1 time per 6 months.
2. INTRAORAL COMPLETE SERIES OR PANOREX - Limited to 1 time in any 2-year period.
3. BITEWING RADIOGRAPHS - Limited to 1 series of 4 films per 6 months.
4. DENTAL PROPHYLAXIS - Limited to 1 time per 6 months.
5. FLUORIDE TREATMENTS - Limited to 1 time per calendar year.
6. SCALING AND ROOT PLANING - Limited to 4 quadrants per calendar year.
7. PERIODONTAL MAINTENANCE PROCEDURES - Limited to 1 time per 6 months, following active therapy, exclusive of gross debridement.
8. REMOVABLE PROSTHETICS/FIXED PROSTHETICS/CROWNS, INLAYS AND ONLAYS - Replacement of complete dentures, and fixed and removable partial dentures or crowns if damage or breakage was directly related to provider error. This type of replacement is the responsibility of the Dentist. If replacement is Necessary because of patient noncompliance, the patient is liable for the cost of replacement.
9. CROWNS - Retainers/Abutments - Limited to 1 time per tooth per 5 years.
10. CROWNS - Restorations - Limited to 1 time per tooth per 5 years. Covered only when a filling cannot restore the tooth.
11. TEMPORARY CROWNS - Restorations - Limited to 1 time per tooth per 5 years. Covered only when a filling cannot restore the tooth.
12. INLAYS/ONLAYS - Retainers/Abutments - Limited to 1 time per tooth per 5 years.
13. INLAYS/ONLAYS - Restorations - Limited to 1 time per tooth per 5 years. Covered only when a filling cannot restore the tooth.
14. STAINLESS STEEL CROWNS - Limited to 1 time per tooth per 5 years. Covered only when a filling cannot restore the tooth.
15. CROWNS, FIXED BRIDGES, AND IMPLANTS - The maximum benefit within a 12 month period is any combination of 7 crowns or pontics (artificial teeth that are part of a fixed bridge). If more than 7 crowns and/ or pontics are done for a Member within a 12 month period, the dentist's fee for any additional crowns within that period would not be limited to the listed Copayment but instead can reflect the Dentist's Billed Charges
16. POST AND CORES - Covered only for teeth that have had root canal therapy.
17. ADJUSTMENTS TO FULL DENTURES, PARTIAL DENTURES, BRIDGES OR CROWNS - Limited to repairs or adjustments performed more than 6 months after the initial insertion
18. INTRAVENOUS SEDATION OR GENERAL ANESTHESIA – Administration of I.V. sedation or general anesthesia is limited to covered oral surgical procedures involving 1 or more impacted teeth (soft tissue, partial bony or complete bony impactions).

19. ADJUNCTIVE - Pre-Diagnostic Test that aids in detection of mucosal abnormalities including premalignant and malignant lesion, not to include cytology or biopsy procedures - Limited to 1 time per year, to Covered Persons over the age of 30.
20. REPLACEMENT OF COMPLETE DENTURES, FIXED OR REMOVABLE PARTIAL DENTURES, CROWNS, INLAYS, ONLAYS, AND IMPLANTS, IMPLANT CROWNS, IMPLANT PROSTHESIS - Replacement of complete dentures, fixed or removable partial dentures, crowns, inlays, onlays, and implant crowns, implant prostheses previously submitted for payment under the plan is limited to 1 time per tooth per 5 years from initial or supplemental placement This includes retainers habit appliances and any fixed or removable orthodontic appliances
21. All Specialty Referral Services Must Be: (A) Pre-Authorized by us; and (B) Coordinated by a Covered Person's PCD. Any Covered Person who elects specialist care without prior referral by his or her PCD and approval by us is responsible for all charges incurred.
    - In order for specialty services to be Covered by this plan, the following referral process must be followed:
    - A Covered Person's PCD must coordinate all Dental Services.
    - When the care of a Network Specialist Dentist is required, the Covered Person's PCD must contact us and request authorization.
    - If the PCD's request for specialist referral is denied, the PCD and the Covered Person will be notified of the reason for the denial. If the service in question is a Covered service, and no limitations or exclusions apply, the PCD may be asked to perform the service.
    - Covered Person who receives authorized specialty services must pay all applicable Copayments associated with the services provided. When we authorize specialty dental care, a Covered Person will be referred to a Network Specialist Dentist for treatment. The Network includes Network Specialist Dentists in: (a) endodontics; (b) oral surgery; (c) pediatric dentistry; and (d) orthodontics; and (e) periodontics, located in the Covered Person's Service Area. If there is no Network Specialist Dentist in the Covered Person's Service Area, we will refer the Covered Person to a Non-Participating Specialist of our choice. Except for Emergency Dental Services, in no event will we cover dental care provided to a Covered Person by a specialist not preauthorized by us to provide such services.
    - Covered Person's financial responsibility is limited to applicable Copayments. Copayments are listed in the Covered Person's Schedule of Covered Dental Services

Exclusion of Benefits

The following procedures and services are excluded and not Covered Services, unless otherwise specifically listed as a covered benefit on this Plan's Schedule of Benefits:

1. Dental Services that are not Necessary
2. Any Dental Services or Procedures not listed in the Schedule of Covered Dental Services
3. Any Dental Procedure not performed in a participating dental setting. An exception is made for Emergency Dental Care, as defined in this Evidence of Coverage
4. Any Dental Procedure not directly associated with dental disease.
5. Procedures related to the reconstruction of a patient's correct vertical dimension of occlusion (VDO)

6. Any service done for cosmetic purposes that is not listed as a Covered cosmetic service in the Schedule of Covered Dental Services
7. Costs for non-dental services related to the provision of dental services in hospitals, extended care facilities, or Member's home are not covered. When deemed necessary by the Primary Care Dentist, the Member's physician, and authorized by the Plan, covered dental services that are delivered in an inpatient or outpatient hospital setting are covered as indicated in the Schedule of Benefits
8. Setting of facial bony fractures and any treatment associated with the dislocation of facial skeletal hard tissue.
9. Replacement of a lost, missing or stolen appliance or prosthesis or the fabrication of a spare appliance or prosthesis
10. Placement of fixed partial dentures solely for the purpose of achieving periodontal stability
11. Fixed or removable prosthodontic restoration procedures for complete oral rehabilitation or reconstruction
12. Services for injuries or conditions covered by Worker's Compensation or employer liability laws, and services that are provided without cost to the Covered Person by any municipality, county, or other political subdivision. This exclusion does not apply to any services covered by Medicaid or Medicare
13. Dental Services otherwise Covered under the Contract, but rendered after the date individual Coverage under the Contract terminates, including Dental Services for dental conditions arising prior to the date individual Coverage under the Contract terminates
14. Treatment of benign neoplasms, cysts, or other pathology involving benign lesions, except excisional removal. Treatment of malignant neoplasms or Congenital Anomalies of hard or soft tissue, including excision.
15. Any Covered Person request for: (a) specialist services or treatment which can be routinely provided by the PCD; or (b) treatment by a specialist without referral from the PCD and our approval
16. Drugs/medications, obtainable with or without a prescription, unless they are dispensed and utilized in the dental office during the patient visit.
17. Services related to the temporomandibular joint (TMJ), either bilateral or unilateral. Upper and lower jaw bone surgery (including that related to the temporomandibular joint). No Coverage is provided for orthognathic surgery, jaw alignment, or treatment.
18. Any endodontic, periodontal, crown or bridge abutment procedure or appliance requested, recommended or performed for a tooth or teeth with a guarded, questionable or poor prognosis.
19. Dental services received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country.
20. Any implant procedures performed which are not listed as Covered implant procedures in the Schedule of Covered Dental Services.
21. Treatment which requires the services of a pediatric specialist, after the Covered Person's 8th birthday without a specialty referral and authorization

Orthodontic Exclusions and Limitations

If you require the services of an orthodontist, a referral must first be obtained. If a referral is not obtained prior to the commencement of orthodontic treatment, the member will be responsible for all costs associated with any orthodontic treatment. If you terminate coverage after the start of orthodontic treatment you will be responsible for any additional charges incurred for the remaining orthodontic

1. The following are not Covered orthodontic benefits:
   - Extractions required for orthodontic purposes
   - Surgical orthodontics or jaw repositioning
   - Myofunctional therapy
   - Cleft palate
   - Micrognathia
   - Macroglossia
   - Hormonal imbalances
   - Orthodontic retreatment when initial treatment was rendered under this plan or for changes in orthodontic treatment necessitated by any kind of accident
   - Palatal expansion appliances
   - Replacement or repair of lost, stolen or broken appliances or appliances damaged due to the neglect of the Covered Person
2. If a treatment plan is for less than 24 Months, then a prorated portion of the full Copayment shall apply.
3. If Covered Person's dental eligibility ends, for whatever reason, and the Covered Person is receiving orthodontic treatment under the plan, the remaining cost for that treatment will be prorated at the orthodontist's usual fees over the number of months of treatment remaining. The Covered Person will be responsible for the payment of this balance under the terms and conditions pre-arranged with the orthodontist.
4. If the Covered Person has the orthodontist perform a "diagnostic work-up" (a consultation and diagnosis) and then decides to forgo the treatment program, the Covered Person will be charged a $50 consultation fee, plus any lab costs incurred by the orthodontist.
5. One orthodontic benefit under this plan is available per lifetime, per Covered Person. A Covered Person may access this benefit for either Interceptive Orthodontic Treatment or Comprehensive Orthodontic Treatment, or both. If both interceptive treatment and comprehensive treatment are necessary, and both are completed within a 24 Month period, the Copayments listed will apply. If both are necessary and active treatment for both extends beyond 24 Months, the provider is obligated to accept the plan Copayment only for the first 24 Months of active therapy. The provider may charge usual and customary fees for active treatment extending beyond the 24 Month benefit period.

Appendix A : Attachments

A.1.a Capitation Summary sample

20241113DBP,INC. CAPITATION20241101

United Healthcare | National Pacific Dental

CAPITATION SUMMARY

Sheet: Page 3 of 5
Cap Period: 11/01/2024 - 11/30/2024
Run Date: 11/01/2024
Tax ID Number:
Payee ID Number

DENTAL OFFICE
ADDRESS
CITY, STATE ZIP

Practitioner Name	Practitioner Number	Number of Active Mbrs	Prior Balance	Current Capitation Amount	Retro Capitation Amount	Capitation Adjustments	Total Capitation
DENTIST NAME	000123456789	5	$0.00	$16.10	-$3.40	$0.00	$12.70
DENTIST NAME	000987654321	21	$0.00	$71.62	$0.00	$0.00	$71.62
	TOTALS	26	$0.00	$87.72	-$3.40	$0.00	$84.32

A.1.b Capitation Roster sample

United Healthcare | National Pacific Dental

PATIENT ROSTER

Sheet: Page 5 of 5
Cap Period: 11/01/2024 - 11/30/2024
Run Date: 11/01/2024
Tax ID Number:
Payee ID Number:

DENTAL OFFICE
ADDRESS
CITY, STATE ZIP

Member Name	Susbscriber ID	Mbr #	Client Name	Elig Stat	Effective Date	Prior Balance	Current Capitation Amount	Retro Capitation Amount	Capitation Adjustment Amount	Total Capitation	Adj Reason Code	Agreement ID
SAMPLE	XXXXXX	00	LINCOLN FINANCIAL GROUP	N	11/01/24	$0.00	$0.00	-$3.40	$0.00	-$3.40		
SAMPLE	XXXXXX	01	United Healthcare	A	11/01/24	$0.00	$3.38	$0.00	$0.00	$3.38		SCFG00000215
			Total Active Members	26		$0.00	$87.72	-$3.40	$0.00	$84.32		
			Total Non Eligible and Transferred Members	1								

A.2 Provider Remittance Advice sample

20230921B03
JFC6
5044 28964

JFC6 [362,237] 3 of 4

[EP-EP]

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

Underwritten by:
National Pacific Dental, Inc.

EXPLANATION OF DENTAL PLAN REIMBURSEMENT THIS IS NOT A BILL

Page 3 of 3
Date: 09/21/2023

DENTAL OFFICE NAME
STREET ADDRESS
CITY, STATE ZIP

PROVIDER OR MBR NAME AND ID NO; PROVIDER NETWORK STATUS; GROUP NO; CLAIM NO ADA CODE DESCRIPTION	DATE OF SERVICE	TOOTH NO	AMOUNT CLAIMED	AMOUNT ALLOWED	DEDUCT APPLIED	OTHER INS	PATIENT RESP	AMOUNT PAID	EOB CODE
DENTIST NAME NPI Submitted: 1234567890 MEMBER NAME 55555555555; In Network; 55555555; 123456789012									
ADA CODE D0120 periodic oral evaluation	09/18/23	01 32	$76.00	$0.00	$0.00	$0.00	$0.00	$0.00	
ADA CODE D1110 prophylaxis - adult	09/18/23	01 32	$125.00	$15.00	$0.00	$0.00	$0.00	$15.00	PSS
ADA CODE D1206 topical application of fluoride varnish	09/18/23	01 32	$66.00	$0.00	$0.00	$0.00	$0.00	$0.00	
ADA CODE D0431 adjunctive pre-diagnostic test that aids in detection of mucosal abnormalities including premalignant and malignant lesi	09/18/23	01 32	$79.00	$79.00	$0.00	$0.00	$79.00	$0.00	DP2
SUB-TOTAL			$346.00	$94.00	$0.00	$0.00	$79.00	$15.00	

Notes:

DP2 Service denied. Does not meet the frequency requirements of the plan.

PSS The charge exceeds the allowable rate for this service

Plan underwritten by National Pacific Dental, Inc.

	AMOUNT CLAIMED	AMOUNT ALLOWED	DEDUCT APPLIED	OTHER INS	PATIENT RESP	AMOUNT PAID
TOTAL	$346.00	$94.00	$0.00	$0.00	$79.00	$15.00

DEN-PEOB1

A.3 Specialty Care Referral Form — page 1

Specialty Referral Request Form

UnitedHealthcare

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

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

SERVICES REQUESTED FOR REFERRAL & SPECIALIST CLAIM FOR SERVICES RENDERED

Proc. Code	Tooth/ Quad/arch	Description of Procedure	Date of Service	Charge

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

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

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

SPECIALTY REFERAL REQUEST INSTRUCTIONS:

MEMBER – Call Customer Service at 1-800-232-0990 and request an authorization.
SPECIALIST – Attach a copy of this referral when you submit your pre-determination and mail to P.O. Box 30552, Salt Lake City, UT 84130

NAT-4006 M51486 9/13 - National Pacific Dental

White – Specialist Canary – Member Pink – General Dentist

A.3 Specialty Care Referral Form — page 2

SPECIALTY CARE REFERRAL GUIDELINES

THE GENERAL DENTIST CANNOT REFER DIRECTLY TO A SPECIALIST, THE GENERAL DENTIST MUST COMPLETE THE SPECIALIST REFERRAL FORM AND GIVE IT TO THE MEMBER WITH ALL SUPPORTIVE DOCUMENTATION REQUIRED TO COORDINATE THE REFERRRAL. THE MEMBER WILL CONTACT CUSTOMER SERVICE TO PROCESS THE REFERRAL TO THE SPECIALIST.

The Customer Service Department WILL NOT process a referral to a Specialist if the member does not have a referral form and appropriate x-rays/documentation in hand to take to the Specialist.

General Dentist Instructions: To prevent any delay in processing, it is critical that the General Dentist **complete the entire NPD Specialty Care Referral Form** in full per requirements of the specific referral type request (preauthorization/emergency). Include all of the following information necessary to review the referral request:

- Specific ADA Procedure Codes
- Tooth numbers or Quadrants
- X-Rays, Photographs
- Other Reasons (Notes -if you feel there is additional information that needs to be relayed)
- Periodontal Probing

Member Instructions:
The Member will contact Customer Service at **800-232-0990** to request processing of the referral and authorization to a participating Specialist.

Specialist Instructions for Non-Emergency Treatment:
After determining the diagnosis and treatment required, the Specialty Care Provider will submit an itemized treatment plan (ADA Universal Claim Form) attached to the Specialty Referral Request Form including all pertinent supporting documentation listed above. The pre-determination request is sent to:

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

EMERGENCY SPECIALTY REFERRAL GUIDELINES

There may be circumstances when it will be necessary to refer a member to a specialist to receive emergency treatment. However, the Plan, expects the general dentist to provide proper stabilization of any situations or conditions to allow the Plan to conduct its review of requests for Specialist Care. In many cases it may be appropriate for the general dentist to treat the emergency himself.

A dental emergency is considered to be:
Acute pain, fever, swelling, infection and/or, any condition, which a reasonable person under the circumstances believes, if left untreated may result in disability, death, or the delay of treatment would be medically inadvisable.

For such situations, treatment should be limited to services necessary for:
Relief of pain, control of bleeding, treatment of swelling, treatment of infection, and/or stabilization of trauma and related emergency conditions.

General Dentist and Member Instructions:
Follow the same instructions as listed above.

Specialist Instructions for Emergency Referral Requests:
If a Member has been referred to your office for an Emergency Referral, after determining the diagnosis and treatment required, call Customer Service at **800-232-0990** to coordinate and for authorization for the treatment required to relieve the patient of pain.

After treatment has been completed; please send the claim for payment with supporting documentation:

National Pacific Dental
c/o UnitedHealthcare Dental
Attn: Claims
PO BOX 30567
Salt Lake City, UT 84130-0567

Please refer to your Provider Manual for complete Specialist Referral Guideline Instruction

A.4 Demographic Change Form

Provider Information Demographic Change Submission Form

United Healthcare | Dental Benefit Providers

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

Providers: To ensure your claims are processed correctly and on a timely basis, if you have had any changes to your demographic information, please ensure you submit your demographic changes **PRIOR** to submitting your claim(s) and within 30 days of the change taking place. For real-time updates and to reduce turn around times by 3-5 days, please visit the Self Service section after registration and log-in on **uhcdental.com**

Please check **ALL** the demographic items that **need** to be updated and complete all sections as appropriate. Please submit completed form using one of the methods to the right on this box:

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

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

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

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

Current Name:	(Last)	(First)
New Name:	(Last)	(First)

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

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

☐ Please check box if ***updating practice name or address***

PRACTICE LOCATION:

(Only complete applicable fields)

Previous Practice Name:	**New Practice Name:**
Previous Physical Address: (Suite #)	**New Physical Address:** (Suite #)
(City) (State) (Zip)	(City) (State) (Zip)

☐ Please check box if ***updating mailing address***

REMITTANCE ADDRESS:

(Only complete applicable fields)

☐ Please check box if ***remit is same as office location***

Previous Remit Address: (Suite #)	**New Remit Address** (Suite #)
(City) (State) (Zip)	(City) (State) (Zip)

ADDITIONAL DEMOGRAPHIC INFORMATION

(Only complete applicable fields)

Languages Spoken Other Than English:	**Directory Office website:**	**Directory Email Address:**
Phone Number:	**Fax Number:**	**Internal Email Address:**

New Office Hours:	Mon	Tue	Wed	Thu	Fri	Sat	Sun

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

Provider(s) associated with the requested change: _____

Notice*** ***Effective Date*** *may be different than the date of signature on this form. Please be sure your effective date reflects the actual date the change took place.*

AUTHORIZED SIGNATURE: **DATE:**

WPN: Prov W9 Rev Oct 2024

Appendix B: Member rights and responsibilities

Member's rights and responsibilities

National Pacific Dental recognizes that in order to provide access to quality care and service, the staff and members must acknowledge the existence of shared obligations based on the member's rights and responsibilities. National Pacific Dental carefully describes member rights and responsibilities in the Evidence of Coverage. The type of member rights and responsibilities include, but are not limited to:

The member's rights

- Have access and availability to care.
- Be provided information regarding contracting dentists.
- Be provided information regarding National Pacific Dental services, benefits and specialty referral process.
- Be treated with respect, dignity and recognition of their need for privacy and confidentially.
- Participate in making decisions regarding their course of treatment.
- Express grievances and be informed of the complaint and appeal process.

The members responsibilities

- Treat National Pacific Dental contracting dentists, dentist's office staff and National Pacific Dental staff with respect and courtesy.
- Keep scheduled appointments or contact the dental office twenty-four (24) hours in advance to cancel an appointment.
- Cooperate with the National Pacific Dental contracting dentist in following a prescribed course of treatment.
- Make applicable co-payments at the time of service.
- Notify National Pacific Dental of changes in family status.

The Customer Services Department is available during regular business hours at National Pacific Dental's toll free telephone number 1-800-232-0990 to respond to member inquiries and complaints, assist in securing emergency dental treatment and second opinions, and transfer eligibility from one office to another.

Member complaint procedure

National Pacific Dental is dedicated to providing high quality, personalized, comprehensive dental benefits to all Members in a manner which strengthens the dentist-patient relationship. NPD recognizes the need to have a Complaint Procedure to ensure timely, responsive, and fair resolution, which meets all policies and procedures of the Company and all Texas Department of Insurance requirements.

Registering a complaint

Any member, or person representing a member, who is not satisfied, may register a complaint either verbally or in writing. Those members who register a verbal complaint are given a form requesting additional information.

Complaint procedure

Once a verbal or written complaint has been received from a member, the complaint process has been initiated. The following procedures are followed:

1. The member receives acknowledgement of the complaint and a thirty-day (30) timeframe for the resolution of said complaint begins.
2. The dental office(s) in question will be contacted and asked to respond to the complaint with appropriate records, x-rays, clinical records, and billing ledgers. It is very important that the provider responds to the complaint in the requested time frame.
3. All the submitted information is presented to the Complaint Review Committee, chaired by the Dental Director.
4. Before the thirty-day timeframe is up, the Committee will render a decision and the member and provider will be notified in writing of the determination. This letter is specific to the contractual or clinical reasons for the determination.
5. Should the member disagree with the Committee resolution, the member may appeal the decision.
6. An appeal panel is appointed within 25 days of receipt of the request for appeal. The provider may be asked to submit additional information for the appeal panel. The procedures for the appeal panel follow the requirements of the Texas Department of Insurance and the policies of National Pacific Dental.
7. Within 5 days of the final determination of the appeal panel, the member will be notified of the recommendation.
8. At any time the member may directly contact the Texas Department of Insurance regarding a complaint.