NATIONAL PACIFIC DENTAL

A UnitedHealthcare Dental Company

PROVIDER MANUAL

Revised April 2010

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INTRODUCTION

Purpose:

The purpose of this Manual is to provide you and your office staff with the information needed to effectively administrate the benefits of eligible National Pacific Dental (NPD) member-patients in your dental facility. This Manual also serves as an addendum to your Provider Agreement. As a NPD Network Provider, you are a working partner with us in the delivery of dental managed healthcare. Our goal, as the "Plan" is to deliver the highest level of service to your NPD patients. Your responsibility, as the "Provider" is to deliver a comparable level of service to your NPD patients. We believe that the information contained within this Manual will assist you in realizing the company's mission, as well as meet your individual administrative needs.

Corporate Mission Statement:

To help people live their lives to the fullest.

Vision:

To be a constructive and transformational force in the health care system.

Important Phone Numbers:

Provider Services 800-232-0990		**Dallas ISD Only** 800-996-7519		**Integrated Voice Response (IVR) System** 800-822-5353
Hours:	**7:00 a.m. to 10:00 p.m. (CST), Monday through Friday IVR Systems – 24 hours a day, 7 days a week**			

All documents regarding the recruitment and contracting of providers, payment arrangements and detailed product information (including but not limited to the application, attachments, contract and supplemental documentation) are confidential proprietary information that may not be disclosed by any other individual and/or third party without the express written consent of National Pacific Dental, A UnitedHealthcare Dental Company.

QUICK REFERENCE GUIDE

Member Eligibility Rosters and Capitation Checks

- Mailed to each Network Provider at the end of the current month for eligibility for the next month.
  - Example: Members eligible for January, Mailed the first week of January
- Current month capitation checks contains retroactive reimbursements, when applicable

New Patients

- Eligibility and benefit verification for new patients can be made by calling the NPD Customer Service Department at 800-232-0990.
  - Customer Service Hours – 7:00 a.m. to 10:00 p.m., Monday through Friday
  - Website – http//uhcdental.com
  - Integrated Voice Response (IVR) System – 1-800-822-5353

Provider Assignment

- Enrolled members/dependents are required to contact NPD Customer Service Department to select a Primary Care Dentist.

Copayments

- It is recommended that you collect the applicable copayment from your member/ patients at the time of service.
  - Member copayments are listed in the group's Schedule of Benefits.
  - Standard Plan Schedules of Benefits are included at the end of this manual.

Specialty Referrals

- As the Member's Primary Care Provider, your office is required to complete the Specialty Referral Request Form – for full instructions see Section 3 of this manual.

- Give the Patient Copy to the member/patient and instruct them to call NPD's Customer Service Department.

- Retain the General Dentist Copy (pink) in the patient's chart.

- It is **mandatory** that all specialty referral requests be authorized; any unauthorized treatment will not be reimbursed and the member is not to be charged.

Utilization Reporting

- You are requested to submit utilization information on an approved ADA Claim form and submitted to the Claims Department address, as stated in Section 4.

CAPITATION

Under a capitation arrangement, a comprehensive set of dental benefits is provided to the Member 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 dentist assumes the responsibility for providing basic dental services to maintain the oral health of the Member. The emphasis placed on preventive dental services and the maintenance of health is unique to the prepaid dental plan.

Here is how it works:

- A new capitation roster is mailed in the first week of each month. The roster details the capitation being paid for each covered Member.
- The Member's eligibility is typically effective the first day of the month.
- It is important that your facility verify Member eligibility prior to treatment.
- If a Member does not show on the roster, we offer several ways to verify eligibility.
- Co-payments are due and should be collected from the Member at the time services are rendered. Refer to the Members specific dental plan/schedule.
- Submit general dentistry encounters using an ADA Claim Form for each visit.
- If you need to refer the Member to a specialist, please follow the "Specialty Referral Guidelines" provided in Section 3.
- For National Pacific Dental, capitation checks are mailed with the monthly roster.

How to Read your Roster from National Pacific Dental, Inc.

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.

Status	Description	Instructions
"A" – Active	Patient Eligible	Locate AGREEMENT ID on eligibility list and refer to fee schedule for co-payments (Ex: SCFG00000185)
"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

Member Eligibility

Eligibility may be verified using one of the following methods:

- **Integrated Voice Response (IVR) System** Up-to-the-minute information, 7 days a week. 24 hours a day, by simply calling the NPD's Integrated Voice Response (IVR) system at 1-800-822-5353.

- Please have the following information available when you call:
    - Member name, or
    - Member subscriber identification number
- The system will prompt you for information. If assistance is needed a Customer Service Representative will assist you during business hours (Monday through Friday 7:00 a.m. to 10:00 p.m., CST)

- **Internet website**
    - For Dentists who have Internet access, NPD will coordinate information on our website, http//uhcdental.com
    - Once you have registered on our provider website at http//uhcdental.com, you can verify your patients' eligibility online.
    - The Dentist Services link provides current information on eligibility, claims status, fee schedules, and more.
    - To access the site, you will need to register. Registration is a simple, 4 step process:
        - Provide the practice name and dentist's tax ID
        - Validate your address
        - Read and accept the user agreement
        - Create a user ID and password
- **Provider/Customer Service**
    - 1-800-232-0990

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**.**

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.

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 United Healthcare Dental Attention: Claim Appeals/Complaints, P.O. Box 30569 Salt Lake City, UT 84130.

ADVERSE DETERMINATION

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

CURRENT DENTAL TERMINOLOGY (CDT)

NPD recognizes the most current ADA code book (CDT) on dental procedures and nomenclature. National Pacific Dental feels it critical that NPD panel dentists uniformly use these codes to report accurate and precise treatment rendered to the patient.

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

LIMITING ENROLLMENT

You reserve the right to request your office limit enrollment by being placed on closed status, meaning that 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 attention of the Provider Relations Department. A writte request is also required to reopen the office to new members. 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.

APPOINTMENT OF MEMBERS

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 (refer to Section Two).

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.

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.

APPOINTMENT SCHEDULING

National Pacific Dental Standards

National Pacific Dental (NPD) created specific standards for access to care and our Quality Assurance Department monitors appointment availability as an indicator of compliance with those standards. Listed below are guidelines for appointment scheduling:

- Initial appointments should be offered within three (3) weeks unless the patient has requested a specific time for the appointment limiting his/her availability.
- Subsequent appointments should also be offered for basic services within eight (8) weeks.
- Recall appointments should be offered to all members. Each facility is required to have a recall system in place.
- Recall appointments should be available within four (4) months.
- *Emergency appointments should be offered in 24-hours or less. All Primary Care Dentists (are required to provide 24-hour emergency access to members who have selected their facility.

***An emergency is defined as services rendered for relief o f acute pain, bleeding, infection, swelling, fever or conditions which may result in disab ility or death and where delay of treatment would be medically inadvisable. Some conditions may require immediate care.**

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 b roken appointment fee to the member if this is a standard policy for all patients in the provider office.

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 **(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.

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 Co-payments from the member should be collected by your facility at the time Dental treatment is performed.

*** PLEASE REFER TO THE MEMBER'S PLAN FOR EXCLUSIONS AND LIMITATIONS PRIOR TO QUOTING THE MEMBER'S PAYMENT RESPONSIBILITIES. KEEP ALL PLAN INFORMATION IN SECTION SEVEN OF THIS BINDER.**

VERIFICATION OF ELIGIBILITY

The member's dental benefits are typically effective the first day of the month. It is crucial that your facility verify the following information prior to providing dental services to a National Pacific Dental member. There are several ways to verify eligibility.

- Monthly Capitation Report
- Customer Service Department 800-232-0990
- Integrated Voice Response (IVR) – 800-822-5353
- http//uhcdental.com

UTILIZATION SUBMISSION

How to Submit Data

ADA Claim Forms

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

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

Encounter data is important to submit regularly as it provides necessary information to evaluate member co-payment, capitation and/or group premium adjustments. For more information see Section 4.

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.

Member transfers before the 20th of the month become effective the first day of the following month.

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 FACILITY IS RESPONSIBLE FOR PROVIDING COPIES OF ALL OF THE MEMBER'S RECORDS, INCLUDING X-RAYS, AT THE RECOMMENDED TSBDE FEE.

Requested copies including radiographs shall be furnished within thirty (30) days of the date of the request, provided however, that copies need not be released until payment of copying cost have been made.

- A dentist providing copies of patient 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 x-ray duplicating service, nay be equal to actual costs verified by invoice;
- Reasonable costs for radiographs duplicated by means other than by an x-ray duplicating service shall not exceed the following charges:
  - A full mouth series: $15.00
  - A panoramic x-ray: $15.00
  - A lateral cephalogram: $15.00
  - A single extra-oral x-ray: $5.00
  - A single intra-oral x-ray: $5.00

Health Information Portability and Accountability Act of 1996 ("HIPAA"):

National Pacific Dental has implemented procedures and policies to comply with HIPAA's federal requirements. These procedures and policies cover the evaluation of how we receive and process claims/service encounters, how we respond to inquiries or complaints, how we prepare analytical reports and how we distribute contractually required information to employer groups, providers and regulators. NPD policies and procedures strive to protect the confidentiality of Protected Health Information ("PHI"), to limit the non-authorized disclosure and use of PHI and to acknowledge an individual's right to access their own PHI, to know who else has accessed it, and to correct errors.

If, as a health care provider, you transmit any Protected Health Information electronically, you are also required to comply with HIPAA regulations. Providers are considered "covered entities" by definition in the HIPAA regulations. Business Associate Agreements do not apply between two covered entities. NPD's expectation is that you will manage PHI in a confidential manner.

Under HIPAA regulations, the exchange of PHI for common dental operations such as the purpose of payment or issues of quality of care, do not require a Business Associate Agreement.

We have found several websites that be of help to providers and staff for your general reference:

http://www.hipaacomply.com
http://aspe.os.dhhs.gov/adminimp
http://www.hhs.gov/ocr/hippa
http://www.hippaa.org

In the event your NPD member/patients have questions regarding HIPAA, please forward them to our Customer Service Department. You or the members of your office staff may contact NPD's Quality Assurance Department and ask for the 'Compliance Officer for National Pacific Dental'.

American Recovery and Reinvestment Act of 2009 (ARRA)

http://www.tdi.state.tx.us/consumer/cpmrecoveryact.html

CLINICAL PRACTICE GUIDELINES

Introduction

The following guidelines have been adopted as an overall guide to clinical dental care. They are in no way intended to supercede the Texas Dental Practice Act, Texas Occupations Code, Rules and Regulations of the Texas State Board of Dental Examiners , Texas Administrative Code and the Texas Insurance Code. The guidelines have been received by National Pacific Dental's Director Of Health Services, submitted to and approved by the Quality Improvement Committee, and submitted to and approved by the Board of Directors of National Pacific Dental.

The practice guidelines are for informational purposes for the dental provider, and will be referred to in a general way, in judging clinical appropriateness and competence. The Quality Improvement Committee and Peer Review Committee will be using the guidelines to assess and measure clinical competencies, dental procedure outcomes, access to dental care, and compliance with the standards of National Pacific Dental (NPD), the Texas Insurance Code, and the Texas Board of Dental Examiners. When appropriate, these same standards will be employed to judge clinical competencies in grievances and disputes regarding clinical issues.

The guidelines will be reviewed annually by the Quality Improvement Committee, and any changes required due to advances in dentistry or changes in laws, rules, and regulations, will be made with appropriate input from the provider panel, the dental literature, Texas Dental Schools and American Dental Association, and affiliated state and local dental societies. All changes will be submitted and approved by the National Pacific Dental Board of Directors.

This section contains clinical practice guidelines on the following:

- History and Clinical Examination
- Radiographs
- Diagnosis
- Treatment Plan
- Endodontics
- Periodontics
- Oral Surgery
- Operative Dentistry
- Crowns and Fixed Partial Prosthodontics
- Removable Partial Prosthodontics
- Complete Denture Prosthodontics
- Pediatric dentistry
- Orthodontics
- Infection Control
- Emergency Guidelines
- Preventive Dentistry Guidelines

HISTORY AND CLINICAL EXAMINATION

The role of the patient's medical/dental history and clinical evaluation is to record pertinent information that will aid in the development and execution of a treatment plan that follows a logical, cost effective management of the appropriate treatment of the patient. The evaluation must include the overall physical mental and dental evaluation of the patient. This evaluation should be performed at the time of the initial visit for treatment as well as the time of any new need for dental treatment.

The dental history should be noted with special emphasis placed on the patient's chief complaint presented at the initial visit. Further, a baseline evaluation of the entire oral cavity, general health of the patient, mental state, and past medical problems should be documented, noted, initialed by the dentist and signed at the end of the baseline evaluation.

A coherent dental record system must be used. The patient's progress must be permanently documented in records, using appropriate forms with complete dental charting through out the patient evaluation, treatment and follow-up care. The dental record system must include at least the following:

1. Legible, understandable and organized dental records.
2. All entries must be in ink and signed/dated by the treating provider. Hygienist/and/or assistant
3. Dental x-rays should be mounted, identified, dated and retained with each patient chart.
4. A recall system, including a broken appointment follow-up system, to inform patients to schedule or reschedule dental appointments.

Charting

The dental history and clinical examination records or charts should contain those elements eluded to and endorsed by the Rules and Regulations of the State Board of Dental Examiners, Minimum Standard of Care which may contain but are not limited to the following:

- Caries;
- Restorations, defective or acceptable;
- Missing teeth;
- Endodontic status;
- Periodontal status including patient hygiene; based on probing and screening;
- Existing conditions including location and measurement of pockets, etiologic factors, TMJ history; mobile teeth,
- Occlusal trauma and horizontal and vertical bone loss evidenced by x rays;
- Description of the general health and appearance of the neck, lips, gingiva, oral mucosal membranes, tongue, pharynx;
- Evidence of attrition and erosion, bruxism or clenching, harmful habits should be noted;
- Incipient and other types of lesions should be recorded.
- Patient willingness to participate with treatment; comments/dissatisfaction.
- Each patient should receive a cancer screening and referral to the appropriate specialist for evaluation and care of suspicious areas suspected of being malignant. Areas of concern should be documented in the patient's chart along with treatment and referrals.

Medical History

The general medical history should be dated and signed by the patient or parent/guardian. The dentist should sign and date the history each time it is reviewed. All health histories should, at minimum, contain the following information:

Allergies	Sensitivities	Recent Illnesses
Recent Surgery	Hepatitis	Immunodeficiency
Prolonged Bleeding	Stroke	High Blood Pressure
Heart Disease	Pregnancy	Murmurs
Current Medications	Liver/Kidney Disease	Diabetes
Chronic Disease	Smoking Habits	Drug Dependency
Nervous Disorders	Radiation Therapy	Reaction to Anesthetics
Implants	Rheumatic Fever	Lung Disease/tuberculosis
Joint Replacements	Latex allergies	Infectious Diseases/AIDS

Osteoporosis Lupus

Medical alerts should be noted on the health question medical history, marked clearly on the top of the dental records, as well as being marked in an obvious place in the patient chart.
The medical and dental history, should be updated no less than annually and signed by the attending dentist. Baseline observations should be recorded for comparison with future observations as the patient returns for periodic examination and treatment.

Based upon review of the medical history, and completion of the physical evaluation, the physical status of the patient may be graded in accord with the American Society of Anesthesiologists' classification:

Class 1: A normal health patient for an elective procedure
Class 2: A patient with mild systemic disease that limits activity but is not incapacitating.
Class 3: A patient with severe systemic disease that limits activity but is not incapacitating.
Class 4: A patient with an incapacitating disease that is a constant threat to life.
Class 5: A moribund patient who is not expected to survive for 24 hours with or without the operation

RADIOGRAPHS

A full radiographic series should not be taken more than once every 2 years unless there are specific indications for more frequent examinations. An attempt should be made to obtain any previous series. A bitewing film series would not be taken more than once in a 12-month period unless there are specific indications for more frequent examinations**.** Radiographs should be kept on file for reference in subsequent evaluations and treatment, and should be reviewed on a regular basis, considering not only proposed treatment, but also treatment performed in the past.

- All radiographs should be properly exposed, developed, mounted and dated.
- All radiographs should be of acceptable diagnostic quality:
    1. Films exhibit no fog.
    2. No discoloration, stain or foreign body images are present.
    3. Film density is acceptable.
    4. Films reproduce geographic areas desired.
    5. Images should not be elongated, foreshortened or cone-cut.
    6. Interproximal surfaces should minimally overlap.
    7. Interproximal bone crest should not have adjacent tooth superimposition.
- A sufficient number of x-rays to diagnose and monitor existing dental and periodontal conditions.

Films must be taken in compliance with: state and federal regulations for radiation standards. . Only properly trained and, licensed or certified personnel may be permitted to operate X-ray equipment. . X-ray equipment must be inspected at regular intervals, no less often than required by regulation or recommended by the manufacturer. Lead aprons with thyroid collars must be used for patient protection. Providers using digital x-rays equipment should follow the manufacturer's recommendations for patient safety.

DIAGNOSIS

Diagnosis consists of the determination of the cause of the patient's dental problem and its classification into a category of disease or dysfunction. It is based upon the findings of the history and clinical examination, including the type of pain if any, stimuli that induce or relieve the pain, and duration of pain.

Diagnostic aids include, but are not limited to radiographs as well as study models (casts); electrical and/or thermal pulp tests, percussion, palpation, transillumination, and analysis of saliva, blood, urine,

cytology and biopsy, as necessary. Laboratory screening tests are utilized when suggested by the dental and medical history or physical evaluation.

INFORMED CONSENT OF A TREATMENT PLAN

No matter how thorough the clinical examination, how accurate the diagnosis, or how rational the treatment plan, there will be times the patient refuses to accept part or all of the recommended treatment. There may also be times when the patient requests a form of treatment that, in the best judgment of the attending dentist, would be neglectful or injurious to his or her dental health and function.

A patient cannot be forced to comply with a recommended course of treatment. Likewise, a dentist cannot be forced by the patient to perform services that are contrary to the patient's best interest. If this sort of disagreement occurs, the dentist must make the patient fully aware of his/her diagnosis and recommendations and record the patient's response completely in the patient's permanent record. A written informed consent should be presented to the patient listing the Risks, Benefits, Alternatives and Risks of no treatment. The informed consent should then be signed by the patient, and/or guardian, provider and witnessed by a third party. The following should be explained fully to the patient by the Provider:

- Reason for treatment
- Diagnosis
- Prognosis without treatment
- Alternative plans of treatment
- Nature of care and treatment
- Inherent risks
- Expectancy of success following treatment

The dentist must manage patient expectations and accomplishment of the treatment plan in the long-term interests of the patient. Therefore, each treatment plan should indicate clearly the planned step-by-step progression, and the expected overall duration of the treatment plan.

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 and/or treatment deemed not to be procedures for specialty care may be sent back to the PCD for appropriate care.

ENDODONTICS - Includes local anesthetics and x-rays, where necessary, as part of the normal procedure.

The NPD Primary Care Dentist (PCD) is expected to provide routine endodontic procedures on *any tooth deemed restorable* if the member prefers to save the tooth. Non-routine endodontic procedures should be referred to a specialist (see the specialty referral section for more details).

Examination of the endodontic patient should include an evaluation of the area causing . Clinical tests to evaluate and treat the endodontic patient include but are not limited to thermal, electric, percussion, palpation, and mobility may be used Treatment planning should include the strategic importance of the tooth or teeth considered for treatment, the prognosis, and such other factors as excessively curved canals, periodontal disease, occlusion, tooth fractures, and calcified or occluded canals. Teeth that are predisposed to fracture following endodontic treatment should be adequately protected.

Success or failure of endodontic therapy is not solely related to the technique that is utilized. Immediate post-operative radiographs are helpful in evaluating the techniques of endodontic treatment but long-term success of the treatment is determined by follow-up examinations continued for a minimum of two years following treatment. The examination must included periapical radiographs, clinical examination, and a record of the presence or absence of symptoms.
Endodontic cases that lie outside the knowledge and experience (beyond the scope) of the treating dentist should be referred for consultation and/ or treatment.

The following are not acceptable for referral to an endodontist:

- Anterior and bicuspid endodontia without complications.
- Third molar endodontia in otherwise intact dentition without complication
- Crown lengthening (if a listed benefit)
- Endondontia on teeth of questionable restorability or dental value

PERIODONTICS

The clinical examination of the periodontal patient should record the presence or absence of the inflammatory and non-inflammatory abnormalities (usually manifested by the color and texture of the gingival tissues), the condition and stability of the dentition and the depth of periodontal pockets. Radiographs are used to evaluate the condition and amount of alveolar bone in conjunction with manual probing and measurements of pockets.

Children and adolescents should be screened for evidence of periodontal disease. Adult patients should be examined, probed and charted to provide baseline information of the periodontal condition and informed of the presence of any periodontal disease. A notation should be made in the patient's record whether or not the dentist treats the condition, refers the patient, or the patient does not elect treatment at that time.

It is the policy of National Pacific Dental that the general attending dentist perform all full mouth debridements and Class I, II, and III scaling and root planings in preparation for the patient to be sent to the specialist. In addition, pocket measurements and a full mouth series of at least 14 x-rays should be taken and sent with the patient to an approved NPD specialist.

Existing conditions should be recorded and should include:

- Location and measurement of pockets
- Etiologic factors
- Mobile teeth
- Occlusal trauma

Following treatment, clinical examination should evidence:

- Healthy tissues
- Absence of inflammation
- Acceptable gingival form
- Absence of bacterial plaque or calculus
- A non-traumatic occlusion

The patient should be trained in skills for plaque control procedures. A follow-up program for evaluation of the success of treatment, continuous supportive therapy and maintenance program should be established.

- Patients should be recalled for periodic prophylaxis and periodontal evaluation depending on their individual rate of plaque and calculus formation.

- The condition of the periodontal tissues, the depth of pockets and the course of treatment should be recorded on appropriate charts periodically.

ORAL SURGERY

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

Asymptomatic, non-pathologic impactions need not be routinely extracted. The NPD Primary Care Dentist (PCD) should evaluate each case carefully with the member before deciding on a course of treatment

If the NPD PCD decides that he/she is inadequately prepared to perform partial or complete bony impactions, unusual sequence and non-routine post-operative complications, then the NPD PCD should consider referring the member to an oral surgeon. **The member must contact Customer Service for referral to a participating oral surgery provider.**

Appropriate referral situations may include:

- Surgical procedures on endodontically treated teeth, including extraction with complications
- Biopsies of suspected lesions;
- Extractions of third molars if documentation indicates *pain, pathology and difficulty beyond the capabilities of the Primary Care Dentist;*

Inappropriate referral situations due to contract language, benefit restriction or long-term prognosis include:

- Extractions for orthodontic purposes;
- Extractions that are non-pathologic or asymptomatic;
- Extractions of immature teeth;
- Extractions of erupted third molars;
- Non-surgical root tip recovery

Therapeutic Measures

Dental extractions are based on a clearly recorded diagnosis for which extraction is the treatment choice for the dentist and patient. Extractions may be indicated in the presence of non-restorable caries, untreatable periodontal disease not amenable to endodontic therapy, or when overriding medical conditions which provide compelling justification to eliminate existing or potential sources of oral infection.

OPERATIVE DENTISTRY

The dentist's choice of restorative material for a given patient depends upon the nature and extent of the defect to be restored, its location in the tooth and in the mouth, the stress distribution expected during mastication and the esthetic requirements.

The patient's age, health, general condition, and hygiene of the oral cavity, as well as the patient's wishes and attitude must also be considered in the dentist's choice of restorative material.

CROWNS AND FIXED PARTIAL PROSTHODONTICS

A thorough history and clinical examination leading to the diagnosis of the patient's general and oral condition must be completed before establishing a treatment plan. Care must be exercised when placing crowns so the hardness of the material used is compatible with that of the opposing dentition. Since many of the features of evaluation in crowns and fixed partial prosthodontics are common to all of dental practice, they will not be discussed in detail in this section. Only those aspects that have specific importance for this area will be included. The following information relates to benefit coverage, not appropriateness of care.

- Crowns, bridges and dentures are not to be replaced within a five-year period from initial placement.
- Single unit cast metal and/or ceramic restorations and crowns are covered only when the tooth cannot be adequately restored with other restorative materials.
- Crown build ups including pins are only allowable as a separate procedure in the exceptional instance where extensive tooth structure is lost and the need for a substructure can be demonstrated;
- Replacement of long standing missing tooth or teeth is excluded from coverage in an otherwise stable dentition;
- Any unit beyond five units of fixed prosthodontics per arch is considered full mouth reconstruction and not a covered benefit.

A final restoration of a tooth or teeth that requires endodontic and/or periodontal treatment should be postponed until a favorable prognosis for the retention of the tooth or teeth has been established.

The patient's age, health, and general condition of the oral cavity, as well as the patient's wishes and attitude must also be considered.

Crown(s) must be incorporated in the treatment plan in the appropriate sequence in relation to endodontic, periodontic, and surgical procedures.

REMOVABLE PARTIAL PROSTHODONTICS

Removable partial prostheses are indicated when the initial history, clinical examination and diagnosis reveal conditions that contraindicated replacement of missing teeth with fixed prosthetic appliances, or when individual patient factors preclude fixed prosthetic restorations.

- A removable partial denture is normally not indicated for a single tooth replacement as a permanent restoration, or as a replacement of non-functional second and third molars.

- Properly constructed fixed restorations are usually more physiologically and psychologically acceptable to the patient. Conditions that may contraindicate fixed restorations are:

    1. Replacement of two or more missing teeth when distal abutment tooth is missing
    2. Replacement of missing teeth in cases of periodontal involvement for remaining teeth with unfavorable prognosis

COMPLETE DENTURE PROSTHODONTICS

Complete dentures are the restoration of last resort. They are indicated as a treatment procedure only when the prognosis for the remaining teeth is hopeless, or when all upper or lower teeth have been removed.

Since many of the features of complete denture prosthodontics are common to all of dental practice, they will not be discussed in detail in this section.

Acrylic or plastic is acceptable material for artificial denture teeth. The same guidelines should apply to immediate complete dentures, if they are a listed benefit, as to complete dentures. The dentist has the responsibility of informing the patient of the necessity for modifying the immediate denture at periodic intervals to compensate for tissue changes that may occur.

PEDIATRIC DENTISTRY

Principles and practices of prevention should be employed, such as dietary counseling and plaque control. Topical fluorides should be applied at least annually as part of the prophylaxis, and dietary fluorides should be prescribed where the water supplies are deficient**.** Application of sealants and fluoride varnishes may be utilized where appropriate.

It is expected that the Primary Care Dentist will render care to all children. NPD recommends appointments for children with apparent behavioral problems be scheduled early in the day. The NPD Primary Care Dentist may also consider oral pre-medication or nitrous oxide sedation for these children. Requests for referral to a specialist may be made for those children who remain disruptive and/or would be traumatized by remaining under the care of the general dentist. Refer to Section Three: Specialty Care Referral Guidelines for assistance.

In specific cases, the pedodontic specialist can become the primary provider. Patients with documented uncontrollable behavior and/or documented mental or physical handicaps may be eligible for the specialist as the primary provider. Refer to the section on specialty referrals for more in depth explanation.

ORTHODONTICS

NPD Primary Care Dentists are not expected to provide orthodontic care except for space maintenance. Some members have orthodontic coverage and some do not. Please refer to a member's specific plan.

Candidates for orthodontic treatment should be in good oral health and have good habits of oral hygiene Of particular importance is the timing of treatment which may be initiated in the deciduous dentition, the mixed dentition or the adult dentition. Orthodontics may be completed in one or more phases of treatment.

A satisfactory result in orthodontics is dependent upon the combination of professional skill and patient cooperation during all phases of treatment considering the age of the patient, the severity of the presenting malocclusion, the desired treatment objectives, as well as individual osteogenic patterns occurring during treatment.

Covered benefits for orthodontics include:

- Routine 24-month orthodontic cases
- Consult individual member plans

RECOMMENDATION FOR INFECTION CONTROL AND ENVIRONMENTAL GUIDELINES

All dental health care workers shall comply with the universal precautions, as recommended for dentistry by the Centers for Disease Control, and THSC 85.202. Providers are expected to adhere to the CDC guidelines on Oral Health, American Dental Association on Infection Control and OSHA Standards for Dentistry

For the protection of the staff and patients gloves must be worn when touching blood, saliva or mucous membranes, and when examining oral lesions. Hands must be rewashed and re-gloved before performing procedures on another patient. Dentists, hygienists and chair side assistants must wear surgical masks and protective eyewear.

All participating dental offices must comply with applicable OSHA, State and Local regulations regarding infection control. It is expected that all customary aseptic procedures will be followed in the office, including but not limited to the following:

- Sterilization of all instruments by means of an autoclave or chemclave that is fully functional with temperature gauge and timer and tested with biological strips on a weekly basis
- Storage of sterilized instruments in sealed bags and dated to prevent contamination.
- Use of sterile syringe and needle for each patient; and protection of the syringe needle from becoming contaminated during a single anesthetic procedure when it may be needed for multiple applications on the same patient (for example, by recapping the needle or by placing the syringe in a sterile field.)
- The office, including operatories, must be clean, organized and well maintained.
- All containers must be labeled as to content and expiration date if applicable.

Please consult Section Four of this manual for more detailed Quality Assurance information.

EMERGENCY GUIDELINES

The dentist agrees to provide his or her National Pacific Dental enrollees immediate care in health-threatening emergency cases, and to provide 24-hour emergency accessibility. A true emergency is defined as services required for treatment of severe pain, swelling, bleeding or immediate diagnosis and treatment of unforeseen dental conditions which if not immediately diagnosed and treated, would lead to disability or death.

Emergency appointments should be scheduled within 24 hours and the patient should be informed that only the emergency will be treated at that time. The 24-hour emergency coverage can be provided by making arrangements for such coverage with another dental office, but the patient's National Pacific Dental Primary Care Dentist remains responsible for the cost. Information regarding emergency specialty referrals can be found in Section Three: Referral Process.

A portable oxygen supply and positive flow valve must be available in each office as well as an emergency kit with appropriate medications for in-office emergency situations with no exemptions. Medications should be checked at regular intervals and replaced at the expiration date. All Texas dentists must be certified in cardiopulmonary resuscitation (CPR) techniques.

If the enrollee is more than 75 miles from his or her National Pacific Dental dentist's office when the emergency occurs, National Pacific Dental will reimburse the patient for emergency and stabilization services only provided by some other office up to the limit specified by the subscriber's contract. The subscriber's evidence of coverage brochure should be checked.

Each office shall have an emergency action policy. This policy is to be a written policy by which the staff is instructed to perform specific tasks during certain defined emergencies including obtaining outside assistance, if necessary. The policy is to be available at all times in an appropriate and conspicuous location known to all employees.

PREVENTIVE DENTISTRY GUIDELINES

It is the policy of National Pacific Dental to provide a benefit for professionally recognized effective preventive service. The Plan is to improve the oral health of its members by fostering good oral health preventive practices through education, early detection and treatment of disease, consistent monitoring of the members health and habits, and delivery of services to treat existing conditions.

National Pacific Dental Network Providers will be expected to:

Examination: Provide routine examinations for members to identify dental concerns as early as possible.

Routine Prophylaxis: Providers are encouraged to provide routine prophylaxis services in accordance with the definitions of the ADA's CDT (current version). Providers should make decisions about the appropriateness of routine prophylaxis after screening, evaluating and documenting the periodontal status of the member. Providers are expected to provide home care education and any other preventive device such as fluoride.

Caries Prevention: Providers should provide a program of plaque control geared to an individual's susceptibility to caries. For cavity susceptible individuals, we recommend x-rays every 6 months and annually for the remaining population. *The placement of sealants and fluoride varnishes for children of cavity prone years is strongly encouraged.*

Periodontal Disease Prevention: Providers are encouraged to provide a comprehensive program including oral health maintenance, documentation, diagnosis and treatment.

Oral Diseases: Providers are expected to perform an oral cancer screening.

Other Preventive Concerns: Preservation of primary teeth, space maintenance, education to reduce "baby bottle tooth decay" syndrome, eruption of permanent dentition and adverse health habits such as smoking, dipping or chewing of tobacco.

MEDICAL EMERGENCY KIT POLICY

MEDICAL EMERGENCY KIT REMINDER:

National Pacific Dental (NPD) would like to remind all Network Dentists that it is the policy of NPD and the Texas State Board of Dental Examiners that each dental office possess and maintain a Medical Emergency kit and equipment for emergencies that may occur in the Dental Office. NPD's policy is that each office must possess an emergency kit that meets the minimum standards recommended by the American Dental Association (ADA). Through evidenced based studies, the ADA recognizes that patients, parents, staff members and non-patients in dental waiting rooms have the same statistical rate as the general public for being the subject of an emergency situation. These factors have been considered in the analysis by the ADA. NPD recognizes that as a first responder and medical professional, dental providers need to be prepared to assist in any emergency regardless of whether it is related to drugs that have been injected by a dentist during a dental procedure. Each item in the emergency kit shall be maintained and replaced prior to its expiration date. No office or specialty is exempt from this requirement.

The Council on Scientific Affairs recommends the minimum kit to be:

1. Epinephrine 1:1000 (injectable)
2. Histamine-Blocker (injectable)
3. Oxygen with Positive Pressure
4. Nitroglycerin (Sublingual Tablet or Aerosol Spray)
5. Bronchodilator (Asthma inhaler)
6. Sugar
7. Aspirin

It is the policy of National Pacific Dental to inspect new offices on entry to the plan and other network offices on any required office visit to ensure that the office is compliant with the stated policy.

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 PCD office is not to directly refer to a specialist.**

It is critical that the PCD complete the entire NPD Specialty Care Referral Form (Referral Form can be found on the UHC portal) and to provide any supportive documentation needed to coordinate the referral. (See Section Six: Sample Forms) The Specialist must have the white 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. 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

a. 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.

b. 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.

c. All appropriate radiographs must then be made available for the Specialty Care Provider. A full mouth series (FMX) and periodontal chart, including probings is required for periodontal referrals.

d. Give the Specialty Care Referral to the patient with any related radiographs and/or other clinical documentation attached.

e. Instruct the patient to contact NPD's Customer Service Department for direction to an NPD Specialist, as indicated on the Specialty Referral Form.

1. Referrals are for "Consultation Only" – no other treatment requests will be initially authorized.
2. 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 a National Pacific Dental (NPD) Referral Coordinator.

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.

Specialist Responsibilities

a. Verify eligibility by calling NPD Customer Service before starting any dental procedure.
b. If additional services beyond consultation and/or palliative teatment of pain is needed, contact the Specialty Referral Coordinator.
c. 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 United Healthcate Dental
P.O. Box 30552
Salt Lake City, UT 84130-0552

d 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.
e. Specialty Care Provider may contact patient to schedule an appointment for treatment upon receipt of an approved pre-determination.
f. Collect all applicable copayment(s).
g. Payment for unauthorized referral claims will be denied.

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 the following:

- Services rendered without authorization and proper direction from Customer Service or its Dental Director,
- Children over eight years of age 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.

EMERGENCY REFERRALS

In certain instances it may be necessary to refer a National Pacific Dental member to a contracting specialist for emergency dental services. Emergency dental services are defined as treatment for the relief of acute pain, bleeding, infection, fever, swelling or conditions which may result in disability or death and when delay of treatment would be medically inadvisable.

In such instances, the contracting **Primary Care Dentist** should:

- Verify eligibility.
- Examine the member.
- Take appropriate radiographs.
- Render an accurate diagnosis.
- Develop an emergency treatment plan that is appropriate for the diagnosis and consistent with the overall treatment plan for the member.
- Perform any appropriate palliative treatment to alleviate pain and/ or improve the condition of the member.
- Contact National Pacific Dental for emergency referral direction
- Give the appropriate records to the member to hand carry to the specialist appointment

National Pacific Dental will, during normal business hours:

- Verify eligibility.
- Verify benefits.
- Assist the patient in selecting a contracted specialist
- Assist the member with the appointment if necessary.
- Provide the referring dentist with an authorization number.

AUTHORIZATION FOR EMERGENCY REFERRALS IS VALID FOR 48 HOURS.

ALL DOCUMENTATION FOR EMERGENCY REFERRALS IS SUBJECT TO RETROSPECTIVE REVIEW FOR COVERAGE.

ENDODONTIC REFERRALS

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, the memb er must be directed to Customer Service for authorization and direction to the appropriate specialist.

ORAL SURGERY REFERRALS

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 REFERRAL

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)
   - (1) distofacial
   - (2) facial
   - (3) mesiofacial
   - (4) distolingual
   - (5) lingual
   - (6) 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*
    a. Referrals are for "Consultation Only" – no other treatment requests will be initially authorized before the consultation is completed.
        1. 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
                a. 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
                b. 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.
    2. 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 REFERRAL

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.

QUALITY ASSURANCE

Quality Improvement Program (QIP)

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.

During the credentialing phase of all prospective dentists' applications an initial on-site evaluation of the dental facility must be completed prior to becoming a part of the NPD provider network. These evaluations are scheduled in advance and are designed to cause minimal disruption to the prospective provider and staff. The on-site review is comprised of the following areas:

Dental Facility Review - The Dental Facility Review evaluates the overall appearance and administrative procedures of the practice. Such items as after-hour patient access, appointment waiting times, recall system and display of credentials are evaluated

Sterilization and Safety Review - Ensures overall compliance of the dental office to the standards established by OSHA are met. Such areas as radiology, staff protection, sterilization techniques and infection control, disposal of hazardous materials and emergency protocols are evaluated.

The prospective dentist receives a follow-up letter summarizing the results of the review. Suggestions may be made for overall improvement. Should the results of the review reveal any major deficiencies or an unacceptable overall evaluation, the dentist is given a specific time frame in which to make necessary corrective actions. A follow-up evaluation is scheduled to review the defined problematic areas. Failure at this point to correct any deficiencies may result in the denial of participation in the network.

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.

DENTAL FACILITY REVIEW

Dental Facility Assessment Criteria

The following criteria are used for conducting the facility assessment and completing the form.

Office Appearance and Access:

Exterior and common areas must be well maintained.
The grounds of the surrounding building must be clear of obstructions and clean. The interior of the building must be well maintained and clean. There should be handicap access to parking, building entrance, office entrance, bathroom entrance and water fountains. There should be an elevator available if the office is above the first floor.

Emergency exits must be accessible and well marked.
There must be clear, unobstructed access to all exit doors at all times (OSHA). Fire extinguishers should be available and checked routinely. All exits must be clearly marked and illuminated.

Office must be clean.
Reception areas must be clean and well kept. Eating drinking, smoking, applying cosmetics and handling contact lenses in areas where there is a potential for occupational exposure, such as the dental laboratory or sterilization area is prohibited.

Restrooms must be clean and convenient.
Restrooms must be accessible to all patients, clean, sanitary and adequately supplied with paper goods and soap for hand washing.

Treatment rooms must be clean and well kept.
All surfaces must be kept clean and able to be disinfected at minimum. All hazardous waste must be stored in receptacles that are clean, in good condition and marked as "Biohazards". Rooms should be clean, free of clutter and well organized.

Equipment must be in good condition and appropriately marked.

Equipment must be in good working order and not pose a safety hazard to the patient or staff. Caution x-ray signs should be posted as well as any microwave "in use" sign, when appropriate. An emergency kit must be available and current. A nitrous oxide recovery system should be used.

Policies for staff members should be readily available and procedures on how a patient may contact the TDI and the State Board of Dental Examiners should be displayed in the office should a patient wish to register a complaint against the dental office.

A written policy that addresses the law regarding non-dentist dental personnel employed by a dental office should be available for inspection. In addition documentation should be available that ensures dental personnel have a valid and current license or registration with the state to perform permitted duties. Information for members to contact the Texas Department of Insurance and the Texas State Board of Dental Examiners must be displayed in the office should a member wish to submit a complaint against the dental office.

STERILIZATION PROCESS AND SAFETY REVIEW

Sterilization Criteria

All items used intra-orally are to be routinely sterilized by autoclave, dry heat, chemical vapor/gas or disposables.

A sterilization process should always be followed.

The sterilization process must be organized. Steps for organized sterilization should include:

- Heavy-duty gloves should be used when handling soiled instruments.
- Remove instruments from operatory and place in a container of water or disinfectant/detergent as soon as possible after use.
- Place instruments in a covered ultrasonic cleaner to increase efficiency of cleaning, reduce handling and minimize the chance of hand injuries.
- Hand scrub instruments to remove any remaining debris.
- Sterilized instruments should be stored in dated sterilization bags.

Process indicators must be used. (CDC recommended)

Documentation of weekly spore testing must be maintained. (ADA and CDC recommended)

Documentation indicates spore testing is done weekly.

Disposable items/instruments must be discarded after each use.

All work surfaces must be wiped down after each use with EPA registered disinfectants or disposable covers must be used.

The CDC recommends all surfaces that may have been contaminated with patient material should be cleaned after each patient. Surfaces should be wiped with a germicidal agent. Disposable covers should be used for handles, switches, headrests and bracket tray covers.

Sealed bags/ trays, packets or cassettes must be used for storage of sterilized instruments.

Personal Protective Equipment Worn In The Treatment Area:

Gloves and masks should be worn and changed between each patient.
Eye protection with solid shields should be worn.

Clinic jackets/lab coats (disposable protective clothing should be worn).

Office Emergency Procedures:

The dental office should develop and initiate a plan to handle medical emergencies.
Emergency kits should be updated regularly and staff trained in emergency procedures.
The dental office must provide portable oxygen that can be delivered under positive pressure.
The dentist and appropriate personnel must have current CPR certification.

Compliance with OSHA and/or EPA Regulations:

The dental office must maintain a current written exposure control plan.
The dental office must maintain a hazard communication program.
The dental office must follow appropriate waste disposal (sharps, needle recapping, bio-hazardous waste).

Radiographic Equipment:

X-Ray unit(s) must have current radiological safety certifications and registration.
Lead aprons with cervical collars are to be used.

Appointment Scheduling Recall System:

Adequate time should be scheduled to complete an adult cleaning prophylaxis. An appointment can be scheduled for a separate appointment to complete the examination and x-rays for patients of record.

IN CASES OF COR RECTIVE ACTION OR GRIEVANCE INVESTIGATION FACILITY EVALUATIONS, INCLUDING PATIENT CHART AUDITS MAY BE PERFORMED UPON REQUEST OF THE QUALITY ASSURANCE DEPARTMENT.

The Quality Improvement Committee shall have the authority to make recommendations to the Quality Assurance Department for the following corrective actions when it is determined that the areas of accessibility, excessive transfers for cause, credentialing investigations, type or number of member grievances, unsatisfactory member survey results do not meet acceptable standards or exceed established thresholds:

1. Improve provider communication
2. Support Provider education
3. Close provider status to further member enrollments
4. Revisit (perform on-site review) within a minimum timeframe of 6 months
5. Sanction of category of service
6. Additional provider recruitment
7. Practice management training
8. Provider termination (termination for cause)

CREDENTIALING

Every dentist interested in joining NPD provider network is sent a recruitment package. The recruitment package includes basic information, a Provider Application and sample patient co-payment schedules. Upon joining the NPD network, providers are furnished with the Provider Manual, which outlines dental policy and administrative guidelines. These policies include the requirement that the provider have written policies in accordance with statutory requirements for licensure, delegation and supervision of dental hygienist and dental assistants.

The Network Recruiter is responsible for securing the following information and documentation prior to acceptance by National Pacific Dental as a contracting dentist.

Credentialing Verification

Copies of the following must be included:

- Copies of current dental license. License must be in good standing.
- DEA Certificate.
- State Controlled Substance Certificate (DPS)
- Proof of current Professional Liability Insurance Coverage. Minimum requirements at contracted level.
- Work history for the last 5 years.
- Radiology Certificate (if applicable)
- Malpractice history is reviewed.
- Primary source verification from the provider's dental school

Credentialing Query

National Pacific Dental will conduct a query of the National Practitioners Data Bank and the Board of Dental Examiners to verify status.

Provider Agreement

The Provider Agreement must be signed and dated and shall not be materially altered.

RE-CREDENTIALING

Re-credentialing is conducted triennially and includes a review of the following:

Credentials Verification (Current copies of the following must be included):

Dental License
Professional Liability Coverage
DEA Certificate
DPS Certificate
Radiology Certificate (if applicable)
Primary source verification of any new specialty board, if applicable

Credential Query

National Pacific Dental will conduct a query of the National Practitioners Data Bank and the Board of Dental Examiners.

Re-credentialing Non-Responders

Failure to respond to re-credentialing requests may result in termination.

Provider Participation Activation

When a dental office meets all of the afore-mentioned criteria, the office is given a unique Provider ID Number and placed in the network as a participating provider.

Accepted offices are subject to all facets of the National Pacific Dental QI plan. The components of the QI plan are:

- Grievance Review
- Access Surveys
- Customer Surveys
- Provider Surveys
- Retrospective Utilization Review
- Retrospective Specialty Referral Review

Grievance Review
Grievances are reviewed individually by the Complaint Review Committee. All providers are expected to participate with this process in providing information to the Committee in the requested time-frames. The complete complaint process will be detailed in the following section.

Access Surveys
The current access standard used by NPD is one (1) provider (primary or specialist) within seventy-five (75) miles of the member's home or location of the employer. The current requirement is that 100% of the membership has access within 75 miles to a primary care provider. The standard member to provider ratio is 2,000 lives to one Full Time Equivalent (FTE) provider. NPD will monitor this on a quarterly basis and add providers as necessary to maintain prescribed access standards. NPD has established a written system to monitor and evaluate accessibility to care, including systems to address problems that develop. Appointment availability is monitored through periodic visits by Provider Relations Representatives, telephone surveys and during Quality Improvement on-site audits. Non-discriminatory appointment booking for the Plan's members is required.

Customer Surveys
Customer Satisfaction Surveys are performed on no less than an annual basis. The information received is calculated to identify patterns and trends and to determine if any action is required. The results are presented to the Quality Improvement Committee for review. On a periodic basis, the survey results are assessed for patient complaints, member requests to change practitioner and/or facilities, and member disenrollments to evaluate overall plan service. Any significant deficiencies are referred to the Dental Director for evaluation.

Provider Surveys
On no less than an annual basis, National Pacific Dental will provide a Provider Survey to all panel providers for evaluation of services and membership. It is the intention to provide an avenue for dentists to contribute their experiences to assist in the evaluation of overall plan service.

Retrospective Utilization Review
National Pacific Dental will review retrospectively, utilization provided by the dentist. This will allow analysis of over or under utilization and potential trends in changing procedures and their usage.

Retrospective Specialty Referral Review
National Pacific Dental will monitor and review the numbers and procedure types of specialty referrals. All providers are expected to handle routine dental procedures. Referrals will be monitored for potential abuse or potential increases in the specialty network.

ACCESS TO CARE

National Pacific Dental requests that participating providers adhere to the Texas Department of Insurance guidelines with respect to a patient's access to care. TDI states that participating primary care providers coverage shall be available and accessible to enrollees 24 hours per day, 7 days per week within the DHMO service area.

Understandably, the general dentist cannot be in the office at all times. However, some means of contacting the dentist, dentist staff, or a covering dentist, must be available to the member at all times. A covering dentist is acceptable provided the dentist is licensed in the state he/she practices and has agreed to accept the member's respective co-payments a payment in full. If such an arrangement is not reached, the assigned general dentist will be responsible for any claim arising from the incident. Further, it is unacceptable to send members to another provider in the NPD network without that provider's consent. NPD's policy is that all emergencies are to be seen within 24 hours or same day, if life threatening. If you encounter problems with emergency coverage, please contact Provider Relations for assistance.

If a member's emergency involves a condition which has been previously treated by a specialist, it is the specialist's responsibility to ensure that acceptable provisions for emergency coverage to treat that condition have been made. If a specialist determines that the member's condition requires the attention of another specialist, the specialist should refer the member back to the primary dentist. The Specialty Referral Guidelines and process should be followed. Specialists may not refer directly to other specialists.

The following are acceptable office policies concerning emergencies for assigned members:

- A recorded message that provides members with a phone number or pager number that can be used to contact their dentist, dentist staff, or a covering dentist.
- Call forwarding or a 24-hour answering service.
- Any other approved device or method that ensures the member is aware that a prompt response is forth coming.

Failure to comply with these TDI standards for emergency coverage may result in a claim that will be the responsibility of the assigned provider. Office emergency procedures will be verified annually. Lack of an appropriate policy will require immediate correction.

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) time-frame 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 respond 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 time limit 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.

PROVIDER COMPLAINT PROCEDURE

Dispute Resolution:
In the event that 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: 800-252-3439
Fax: 512-475-1771

Texas State Board of Dental Examiners
333 Guadalupe St., Ste 3-800
Austin, TX 78701
Phone: 512-463-6400
Fax: 512-463-7452

PEER REVIEW

A subcommittee of the Quality Improvement Committee comprises an Advisory/Credentialing Committee. The Advisory Committee consists of licensed dentists, representatives from Provider Relations and the Plan. The Dental Director is a non-voting member of the Advisory/Credentialing Committee. The function of this committee is to review policies and procedures, review all information presented to the providers, review complaints determined by the Dental Director to be of a severe nature, review

utilization trends retrospectively, approve the credentialing/re-credentialing process, define and monitor the accessibility of the providers and provide clinical advice.

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 on-site audits, 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 it's 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.

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 take into account 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 under utilization:

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

Providers may request profile information by written request.

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.

ENCOUNTER INFORMATION

Service encounter information is a critical part of an NPD provider's responsibilities. Information regarding services rendered to NPD members/patients is entered into NPD's Utilization Management Database and is used in the development of premium rates and provider reimbursement, as well as in the analysis of utilization trends and outcomes. It is important that encounter data on every member be mailed to NPD's claims department address for each date of service. This data is required to be submitted on ADA claim forms.

SPECIALTY CARE REFERRAL FORM

The National Pacific Dental Specialty Care Referral Form is to be filled out by the Primary Care Dentist. This form along with supporting x-rays, periodontal charting, etc. is to be submitted to the NPD Claims address. The following information **must** be filled in:

Primary Care (General Practice) Dentist

- Signature date of referral
- Member Subscriber ID #
- Patient Name
- Employer (of member)
- Provider Name
- Provider Address
- Specialty
- Comments/Services Requested
    - Be specific – indicate "Consultation only" – if appropriate or needed treatment and tooth number.
    - Why the patient requires treatment by a specialist,

Specialist

- Date of First Appointment
- Treatment Rendered

National Pacific Dental must authorize <u>all</u> referrals to a dentist whose practice is limited to specialty care. A member who does not obtain the appropriate authorization may have services not considered for payment. The primary care dentist may not "direct refer" for specialty care.

Coordination of Benefits

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:

A. 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.
B. 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;
C. The word "birthday" refers only to month and day in a calendar year, not the year in which the person was born;
D. 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: 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.

TERMINATION OF BENEFITS

When benefits are terminated:

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.

Unless provided elsewhere in the plan description, the following Limitations and Exclusions apply to benefits coverage with National Pacific Dental.

LIMITATIONS

Below are the limitations that are applicable to this Plan:

1. Crowns, bridges and dentures (including immediate dentures) are not to be replaced within a five-year period from initial placement and only if it is unsatisfactory and cannot be made satisfactory by reline or repair;

2. Partial dentures are not to be replaced within any five year period from initial placement, unless necessary due to natural tooth loss where the addition or replacement of teeth to the existing partial is not feasible;

3. Denture relines are limited to one per denture during any 12 consecutive months;

4. Treatment is generally limited to conventional techniques and does not include hemisection, implants, over-dentures and grafting;

5. The plan allows a treatment plan up to five units of crown or bridgework per arch. Upon the sixth unit, the Plan considers the treatment to be full-mouth reconstruction. The patient is responsible for fees incurred for anything beyond the fifth unit at usual and customary fees;

6. Periodontal treatments (root planing/subgingival curettage) are limited to four quadrants during any 12 consecutive months;

7. A full mouth x-ray is defined as a minimum of 6 periapical films plus bite wing x-rays or panorex plus bite wing x-rays on the same date of service;

8. Sealant benefits include the application of sealants on posterior teeth with no decay, with no restorations and with the occlusal surface intact, up to age fourteen when the treating dentist determines necessity. Sealant benefits do not include the repair or replacement of a sealant on any tooth within three years of its application;

9. Single unit cast metal and/or ceramic restorations and crowns are covered only when the tooth cannot be adequately restored with other restorative materials. Crown build ups including pins are only allowable as a separate procedure in the exceptional instance where extensive tooth structure is lost and the need for a substructure can be demonstrated by written report and x-rays;

   Cosmetic dental care is limited to composite restorations on posterior teeth, if a listed benefit, when a Plan dentist determines treatment to be appropriate dental care. All other cosmetic procedures are excluded from coverage.

EXCLUSIONS

The following dental procedures and services are not included in the Plan:

1. Hospital or ambulatory facility administered dental services; general anesthesia; intravenous and inhalation sedation; services of a special anesthesiologist; prescription drugs or other related hospital or ambulatory facility fees;

2. Dental conditions arising out of and due to enrollee's employment or for which Worker's Compensation is payable. Services that are provided to the enrollee by state government or agency thereof, or are provided without cost to the enrollee by any municipality, county or other subdivision;

3. Treatment required by reason of war;

4. Treatment of fractures and dislocations;

5. Loss or theft of fixed and removable prosthetics (crowns, bridges, full or partial dentures);

6. Dental expenses incurred in connection with any dental procedures started after termination of eligibility for coverage; and dental expenses incurred for treatment in progress prior to Member's eligibility with National Pacific Dental (e.g.: teeth prepared for crowns, root canals in progress, fixed and removable prosthetics);

7. Any service that is not specifically listed as a covered expense;

8. Procedures, appliances or restorations to replace developmentally missing teeth or other developmental conditions; developmental malformations (including but not limited to cleft palate, enamel hypoplasia, fluorosis, jaw malformations, anodontia) and the removal/replacement of supernumerary teeth;

9. Treatment/removal of malignancies, cysts over 1.25 centimeters, tumors or neoplasms;

10. Dispensing of drugs/medications in a dental office;

11. Treatment as a result of accidental injury. Accidental injury is defined as damage to the hard and soft tissues of the oral cavity resulting from external forces to the mouth;

12. Cases which in the professional opinion of two (2) National Pacific Dental attending dentists, or the NPD Dental Director, determine that a satisfactory result cannot be obtained or where the prognosis is poor or guarded;

13. Dental services received from any dental office other than a National Pacific Dental dental office, unless expressly authorized in writing by National Pacific Dental or as cited under "Emergency Dental Services";

14. Elective procedures, including but not limited to the removal of impacted asymptomatic teeth, extractions for orthodontic purposes, surgical orthodontic procedures and crown exposure;

15. Implant placement or removal, appliances placed on or services associated with implants, including but not limited to prophylaxis and periodontal treatment;

16. Crown lengthening procedures unless specifically covered on fee schedule

17. Replacement of long standing missing tooth or teeth (usually 5 years or more) in an otherwise stable dentition;

18. Dental services and treatments for restoring tooth structure loss from wear, bruxism, attrition and/or erosion; changing or restoring vertical dimension; and full-mouth reconstruction to enhance occlusion; diagnosis and/or treatment of the temporomandibular joint (TMJ);

19. Dental services not performed in the National Pacific Dental general dental office because of physical, medical or behavioral limitations of eligible dependents/members over the age of eight years. This exclusion shall not apply to an enrollee who is unable to undergo dental treatment in an office setting or undergo local anesthesia due to a documented physical, mental, or medical reason as determined by the enrollee's physician or the dentist providing dental care.

Orthodontic Exclusions and Limitations:

1. Orthodontic treatment must be provided by a contracting National Pacific Dental dentist.

2. Plan benefits shall cover 24 months of usual and customary orthodontic treatment and an additional 24 months of retention. Treatment extending beyond such time periods will be subject to a per-office-visit charge.

3. The following are not included as orthodontic benefits:

    a. Repair or replacement of lost or broken appliances
    b. Re-treatment of orthodontic cases
    c. Treatment in progress at inception of eligibility
    d. Changes in treatment necessitated by an accident
    e. Treatment involving:

        A. Maxillo-facial surgery, myofunctional therapy, cleft palate, micrognathia, macroglossia
        B. Surgically exposing impacted teeth (i.e. maxillary cuspids)
        C. Hormonal imbalances or other factors affecting growth or developmental disturbances
        D. Treatment related to temporomandibular joint disorders
        E. Lingually placed direct bonded appliances and arch wires ("invisible braces")
        F. Functional appliances that are used in conjunction with fixed appliances

4. The retention phase of treatment shall include the construction, placement and adjustment of retainers.

2000 West Loop South
9th Floor
Houston, TX 77027
Phone: 800-822-5353

CAPITATION SUMMARY

Sheet: 1 of 2
Cap Period: 09/01/09-09/30/2009
Run Date: 08/29/09
Check No: 00001234
Tax Id Number: 123456789
Payee Id Number: 000000123456

2566473G2d020870001

DOCTORS/FACILITY NAME
ADDRESS
CITY, ST ZIP CODE

Practitioner Name	Practitioner Number	Number of Active Mbs	Prior Balance	Current Capitation Amount	Retro Capitation Amount	Capitation Adjustments	Total Capitation
LAST NAME, FIRST NAME	000000123456	7	0.00	27.61	0.00	0.00	27.61
	TOTALS	7	0.00	27.61	0.00	0.00	27.61

2000 West Loop South
9th Floor
Houston, TX 77027
Phone: 800-822-5353

2566473G2d020870001

DOCTORS/FACILITY NAME
ADDRESS
CITY, ST ZIP CODE

PATIENT ROSTER

Sheet: 2 of 2
Cap Period: 09/01/09-09/30/2009
Run Date: 08/29/09
Check No: 00001234
Tax Id Number: 123456789
Payee Id Number: 000000123456

Member Name	Subscriber Id	Mbr #	Client Name	Elg Stat	Effective Date	Prior Balance	Current Capitation Amount	Retro Capitation Amount	Capitation Adjustment Amount	Total Capitation	Adj Reason Code	Agreement Id
LAST NAME, FIRST NAME	123456789	02	United Healthcare	A	09/01/2009	0.00	4.36	0.00	0.00	4.36		SCFG00000170
LAST NAME, FIRST NAME	123456789	00	United Healthcare	A	09/01/2009	0.00	4.36	0.00	0.00	4.36		SCFG00000170
LAST NAME, FIRST NAME	123456789	01	United Healthcare	A	09/01/2009	0.00	4.36	0.00	0.00	4.36		SCFG00000170
LAST NAME, FIRST NAME	123456789	03	United Healthcare	A	09/01/2009	0.00	4.36	0.00	0.00	4.36		SCFG00000170
LAST NAME, FIRST NAME	123456789	04	United Healthcare	A	09/01/2009	0.00	4.36	0.00	0.00	4.36		SCFG00000170
LAST NAME, FIRST NAME	987654321	00	United Healthcare	A	09/01/2009	0.00	1.81	0.00	0.00	1.81		SCFG00000168
LAST NAME, FIRST NAME	621495755	01	United HealthCare	A	09/01/2009	0.00	4.00	0.00	0.00	4.00		SCFG00000169
			Total Active Members		7	0.00	27.61	0.00	0.00	27.61		
			Total Non Eligible and Transferred Members									

This is confidential material and is proteced by HIPAA. Please keep this list in a secure place.
Patient Rosters are only printed for members belonging to capitated plans.
Eligibility Status: A – Active, N – Non Eligible, T - Transfer

Specialty Referral Request Form

United Healthcare Dental®

NPD® National Pacific Dental — A UnitedHealthcare Dental Company

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 30567, Salt Lake City, UT 84130-0537

NAT-4006 (6/08)

White – Specialist Canary – Member Pink – General Dentist

Dear Doctor,

As required by Texas Department of Insurance regulations, National Pacific Dental (NPD) is obligated to continually monitor access to dental care delivered by our providers. To make this process as simple as possible, we now are pleased to be able to offer two ways of responding to this request. **You may complete this form and fax or mail it to us**. Please respond in the next fifteen (15) days. Thank you for your cooperation.

National Pacific Dental, A United HealthCare Dental Company
NETWORK OPERATION
FAX No. (925) 363-6099
2300 Clayton Rd, Ste 1000
Concord, CA 94520

Practitioner ID: «Pr_ID» **County: «County»** **Date: 04/01/2009**

AVERAGE PATIENT WAIT UNTIL NEXT AVAILABLE APPOINTMENT:

Assume four (4) different patients call today, each for a different type of appointment, as listed below. Each patient CAN TAKE ANY APPOINTMENT TIME OR DAY and NEEDS THE SOONEST AVAILABLE APPOINTMENT. For each question, fill in [only one] numbered box to show how long each patient will wait from today until the DATE of that patient's appointment. Please answer once for each of the questions below:

1. **Patient #1:** A new patient scheduled for Exam
   (1) **[ ]** Less than 3 calendar weeks (2) **[ ]** 3 calendar weeks (3) **[ ]** More than 3 calendar weeks

2. **Patient #2:** An existing patient scheduled for Exam
   (2) **[ ]** Less than 6 calendar weeks (2) **[ ]** 6 calendar weeks (3) **[ ]** More than 6 calendar weeks

3. **Patient #3:** Another existing patient scheduled for a hygiene visit
   (3) **[ ]** Less than 16 weeks (2) **[ ]** 16 weeks (3) **[ ]** More than 16 weeks

4. **Patient #4:** Emergency Visit:
   (1) **[ ]** Less than 24 hours (2) **[ ]** 24 hours (3) **[ ]** More than 24 hours

AVERAGE PATIENT WAITING TIME TO BE SEATED:

5. If a patient arrives on time for an appointment, usually how long does the patient wait in the reception area?
   (1) **[ ]** 30 minutes or less (2) **[ ]** 30 minutes (3) **[ ]** Over 30 minutes

6. If a patient arrives on time for an appointment, usually how long does the patient wait to be seen in operatory?
   (1) **[ ] 15** minutes or less (2) **[ ] 15** minutes (3) **[ ]** Over 15 minutes

Dentists Staffing Changes:

7. Has there been a change in the dentists employed at your office? **Yes [ ]** **No [ ]**
   If Yes, please list the names of ALL the dentists currently employed at your office.

COMPLETED BY: _____ **DATE:** _____

Instructions:
a. **Complete** and **Sign** the survey.
b. **Mail (or Fax)** the survey back to the above address. Thank you for your cooperation.

NPD kindly requests that you provide a current fax number.

Fax Number: _____