Dental Provider Manual

UnitedHealthcare Community Plan of Kentucky

Provider Services: 1-877-897-4941

January 2024

UnitedHealthcare® | Dental Benefit Providers®

Contents

Section 1: Introduction — who we are

Welcome to UnitedHealthcare Community Plan

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

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

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

This Provider Manual (the "Manual") is designed as a comprehensive reference guide for the dental plans in your area, primarily UnitedHealthcare Community Plan Medicaid and Medicare plans. Here you will find the tools and information needed to successfully administer UnitedHealthcare plans. As changes and new information arise, it will be uploaded on the portal at **UHCdental.com/medicaid** under State specific alerts and resources.

Our Commercial program plan requirements are contained in a separate Provider Manual. If you support one of our Commercial plans and need that Manual, please contact Provider Services at **1-800-822-5353**.

If you have any questions or concerns about the information contained within this Manual, please contact the UnitedHealthcare Community Plan Provider Services team at the telephone number listed on the cover of this document.

Unless otherwise specified herein, this Manual is effective the date found of the cover of this document for dental providers currently participating in the UnitedHealthcare Community Plan's network, and effective immediately for newly contracted dental providers.

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

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

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

Provider Online Academy

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

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

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

Section 2: Patient eligibility verification procedures

2.1 Member eligibility

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

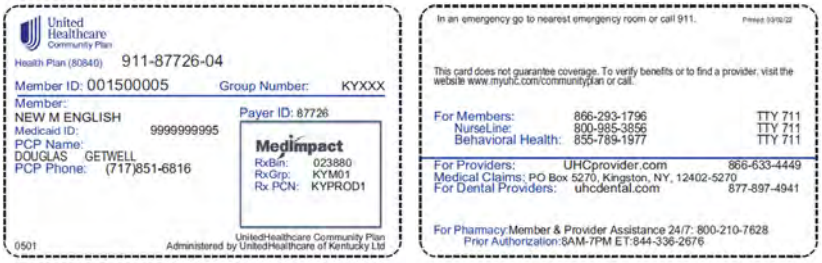
We receive daily updates on member eligibility and can provide the most up-to-date information available.

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

2.2 Identification card

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

A member ID card is not a guarantee of payment. It is the responsibility of the provider to verify eligibility at the time of service. To verify a member's dental coverage, go to **UHCdental.com/medicaid** or contact the dental Provider Services line at the telephone number listed on the cover of this document. A sample ID card is provided below. The member's actual ID card may look slightly different.



2.3 Eligibility verification

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

The username and password that are established during the registration process will be used to access the website. One username and password are granted for each payee ID number.

UnitedHealthcare Community Plan also offers an Interactive Voice Response (IVR) system for eligibility verification; please see section A.4 of this manual to see details of the IVR system. The IVR is available 24 hours a day, 7 days a week.

2.4 Quick reference guide

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

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

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

You want to:	Provider Services Line—1-877-897-4941 Dedicated Service Representatives Hours: 8 a.m.-6 p.m. (EST) Monday-Friday	Online UHCdental.com/medicaid	Interactive Voice Response (IVR) System and Voicemail Hours: 24 hours a day, 7 days a week
Ask a Benefit/Plan Question (including prior authorization requirements)	✓	✓	
Ask a question about your contract	✓		
Changes to practice information (e.g., associate updates, address changes, adding or deleting addresses, Tax Identification Number change, specialty designation)	✓	✓	
Inquire about a claim	✓	✓	✓
Inquire about eligibility	✓	✓	✓
Inquire about the In-Network Practitioner Listing	✓	✓	✓
Nominate a provider for participation	✓	✓	
Request a copy of your contract	✓		
Request a Fee Schedule	✓	✓	
Request an EOB	✓	✓	
Request an office visit (e.g., staff training)	✓		
Request benefit information	✓	✓	
Request documents	✓	✓	
Request participation status change	✓		

2.5 Provider Portal / Dental Hub

The UnitedHealthcare Community Plan website at **UHCdental.com/medicaid** offers many time-saving features including **eligibility verification, benefits, claims submission and status, print remittance information, claim receipt acknowledgment and network specialist locations.** The portal is also a helpful content library for **standard forms, provider manuals, quick reference guides, training resources,** and more.

To use the website, go to **UHCdental.com/medicaid** and register or log-in for Dental Hub as a participating user. Online access requires only an internet browser, a valid user ID, and a password once registered. There is no need to download or purchase software.

To register on the site, you will need information on a prior paid claim or a Registration code. To receive your Registration code and for other Dental Hub assistance, call Provider Services.

2.6 Integrated Voice Response (IVR) system — 1-877-897-4941

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

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

Section 3: Office administration

3.1 Office site quality

UnitedHealthcare Community Plan and affiliates monitor complaints for quality of services (QOS) concerning participating care providers and facilities. Complaints about you or your site are recorded and investigated. We conduct appropriate follow-up to assure that members receive care in a safe, clean and accessible environment. For this reason, UnitedHealthcare Community Plan has set Clinical Site Standards for all primary care provider office sites to help ensure facility quality.

UnitedHealthcare Community Plan requires you and your facilities meet the following site standards:

- Clean and orderly overall appearance.
- Available handicapped parking and handicapped accessible facilities.
- Available adequate waiting room space and dental operatories for providing member care.
- Privacy in the operatory.
- Clearly marked exits.
- Accessible fire extinguishers.

3.2 Office conditions

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

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

3.3 Sterilization and infection control fees

Dental office infection control programs must meet the minimum requirements based on the Centers for Disease Control & Prevention's (CDC) guiding principles of infection control. All instruments should be sterilized where possible. Masks and eye protection should be worn by clinical staff where indicated; gloves should be worn during every clinical procedure. The dental office should have a sharps container for proper disposal of sharps. Disposal of medical waste should be handled per OSHA and state guidelines.

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

3.4 Recall system

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

3.5 Transfer of dental records

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

3.6 Office hours

Provide the same office hours of operation to UnitedHealthcare Community Plan members as those offered to commercial members.

3.7 Protect confidentiality of member data

UnitedHealthcare Community Plan members have a right to privacy and confidentiality of all health care data. We only give confidential information to business associates and affiliates who need that information to improve our members' health care experience. We require our associates to protect privacy and abide by privacy law. If a member requests specific medical record information, we will refer the member to you. You agree to comply with the requirements of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and associated regulations. In addition, you will comply with applicable state laws and regulations.

UnitedHealthcare Community Plan uses member information for treatment, operations and payment. UnitedHealthcare Community Plan has safeguards to stop unintentional disclosure of protected health information (PHI). This includes passwords, screen savers, firewalls and other computer protection. It also includes shredding information with PHI and all confidential conversations. All staff is trained on HIPAA and confidentiality requirements.

3.8 Provide access to your records

You shall provide access to any medical, financial or administrative records related to services you provide to UnitedHealthcare Community Plan members within 14 calendar days of our request. We may request you respond sooner for cases involving alleged fraud and abuse, a member grievance/appeal, or a regulatory or accreditation agency requirement. Maintain these records for six years or longer if required by applicable statutes or regulations.

3.9 Inform members of advance directives

Members have the right to make their own health care decisions. This includes accepting or refusing treatment. They may execute an advance directive at any time. An advance directive is a document in which the member makes rules around their health care decisions if they later cannot make those decisions.

Several types of advance directives are available. You must comply with all applicable state law requirements about advance directives.

Members are not required to have an advance directive. You cannot provide care or otherwise discriminate against a member based on whether they have executed one. Document in a member's medical record whether they have executed or refused to have an advance directive.

If a member has one, keep a copy in their medical record. Or provide a copy to the member's PCP. Do not send a copy of a member's advance directive to UnitedHealthcare Community Plan.

If a member has a complaint about non-compliance with an advance directive requirement, they may file a complaint with the UnitedHealthcare Community Plan medical director, the physician reviewer, and/or the state survey and certification agency.

3.10 Participate in quality initiatives

You shall help our quality assessment and improvement activities. You shall also follow our clinical guidelines, member safety (risk reduction) efforts and data confidentiality procedures.

UnitedHealthcare Community Plan clinical quality initiatives are based on optimal delivery of health care for particular diseases and conditions. This is determined by United States government agencies and professional specialty societies.

3.11 New associates

As your practice expands and changes and new associates are added, you must contact us within 10 calendar days to request an application so that we may get them credentialed and set up as a participating provider.

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

If you have any questions or need to receive a copy of our provider application packet, please contact Provider Services at the telephone number listed on the cover of this document.

3.12 Change of address, phone number, email address, fax or tax identification number

When there are demographic changes within your office, you must notify us at least 10 calendar days prior to the effective date of the change. This supports accurate claims processing as well as helps to make sure that member directories are up-to-date.

Changes should be submitted to:

UnitedHealthcare – RMO
ATTN: 224-Prov Misc Mail WPN
PO BOX 30567
SALT LAKE CITY, UT 84130

Fax: 1-855-363-9691
Email: **dbpprvfx@uhc.com**

Credentialing updates should be sent to:

2300 Clayton Road
Suite 1000
Concord, CA 94520

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

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

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

If you have any questions, don't hesitate to contact Provider Services at the telephone number listed on the cover of this document for guidance.

Section 4: Patient access

4.1 Appointment scheduling standards

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

- **Urgent care appointments** Within 48 hours
- **Routine care appointments** Offered within 30 calendar days of the request

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

Urgent care appointments would be needed if a patient is experiencing excessive bleeding, pain or trauma.

Providers are encouraged to schedule members appropriately to avoid inconveniencing the members with long wait times. Members should be notified of anticipated wait times and given the option to reschedule their appointment.

4.2 Emergency coverage

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

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

4.3 Specialist referral process

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

To obtain a list of participating dental network specialists, go to our website at **UHCdental.com**. Click "Find a Dentist" on the top right and then choose "Medicaid Plans" to search by location. You may also contact Provider services on the telephone number listed on the cover of this document.

4.4 Missed appointments

Enrolled Participating Providers are not allowed to charge Members for missed appointments.

If your office mails letters to Members who miss appointments, the following language may be helpful to include:

- "We missed you when you did not come for your dental appointment on month/date. Regular check-ups are needed to keep your teeth healthy."
- "Please call to reschedule another appointment. Call us ahead of time if you cannot keep the appointment. Missed appointments are very costly to us. Thank you for your help."

Contacting the Member by phone or postcard prior to the appointment to remind the individual of the time and place of the appointment may help to decrease the number of missed appointments.

The Centers for Medicare and Medicaid Services (CMS) interpret federal law to prohibit a Provider from billing Medicaid and CHIP Members for missed appointments. In addition, your missed appointment policy for UnitedHealthcare members cannot be stricter than that of your private or commercial patients.

4.5 Nondiscrimination

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

Section 5: Utilization Management program

5.1 Utilization Management

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

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

5.2 Community practice patterns

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

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

5.3 Evaluation of utilization management data

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

5.4 Utilization Management analysis results

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

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

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

5.5 Utilization review

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

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

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

Utilization review is completed based on the following:

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

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

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

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

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

- Systematic review and meta-analysis
- Randomized controlled trials (RCT)
- Retrospective studies
- Case series
- Case studies

Anecdotal/expert opinion (including professional society statements, white papers and practice guidelines) Evidence is found in a variety of sources including:

- Electronic database searches such as Medline®, PubMed®, and the Cochrane Library.
- Hand search of the scientific literature
- Recognized dental school textbooks
- Evidence based dentistry can be used clinically to guide treatment decisions, and aid health plans in the development of benefits. At UnitedHealthcare Community Plan, we use evidence as the foundation of our efforts, including:
- Practice guidelines, parameters and algorithms based on evidence and consensus.
- Comparing dentist quality and utilization data
- Conducting audits and site visits
- Development of dental policies and coverage guidelines

The Dental Clinical Policy and Technology Committee (DCPTC) is responsible for developing and evaluating the inclusion of evidence-based practice guidelines, new technology and the new application of existing technology in the UnitedHealthcare Community Plan dental policies, benefits, clinical programs, and business functions; to include, but not limited to dental procedures, pharmaceuticals as utilized in the practice of dentistry, equipment, and dental services. The DCPTC convenes

every other month and no less frequently than four times per year. The DCPTC is comprised of Dental Policy Development and Implementation Staff Members, Non-Voting Members, and Voting Members. Voting Members are UnitedHealth Group Dentists with diverse dental experience and business background including but not limited to members from Utilization Management and Quality Management.

Section 6: Quality management

6.1 Quality Improvement Program (QIP) description

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

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

The QIP description is reviewed and updated annually:

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

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

6.2 Credentialing

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

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

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

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

Dental Benefit Providers contracts with an external Credentialing Verification Organization (CVO) to assist with collecting the data required for the recredentialing process. The CVO will occasionally contact our contracted providers to collect outstanding credentialing information.

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

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

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

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

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

Initial credentialing

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

Recredentialing

- Completed Recredentialing application
- Signed and dated Attestation
- Current copy of their state license
- Current copy of their Drug Enforcement Agency (DEA) certificate
- Current copy of their Controlled Dangerous Substance (CDS) certificate, if applicable
- Current copy of their Sedation and/or General Anesthesia certificates, if applicable
- Copy of their Sedation and/or General Anesthesia training certificate/diploma, if applicable
- Signed and dated Sedation and/or General Anesthesia Attestation, if applicable

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

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

6.3 Site visits

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

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

UnitedHealthcare Dental, Dental Benefit Providers, reserves the right to conduct an on-site inspection prior to and any time during the effectuation of the contract of any Mobile Dental Facility or Portable Dental Operation bound by the "Mobile Dental Facilities Standard of Care Addendum."

6.4 Preventive health guideline

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

UnitedHealthcare Community Plan's National Clinical Policy and Technology Committee reviews current professional guidelines and processes while consulting the latest literature, including, but not limited to, current ADA Current Dental Terminology (CDT), and specialty guidelines as suggested by organizations such as the American Academy of Pediatric Dentistry, American Academy of Periodontology, American Association of Endodontists, American Association of Oral and Maxillofacial Surgeons, and the American Association of Dental Consultants. Additional resources include publications such as the Journal of Evidence-Based Dental Practice, online resources obtained via the Library of Medicine, and evidence-based clearinghouses such as the Cochrane Oral Health Group and Centre for Evidence Based Dentistry as well as respected public health benchmarks such as the Surgeon General's Report on Oral Health in America. Preventive health focuses primarily on the prevention, assessment for risk, and early treatment of caries and periodontal diseases, but also encompasses areas including prevention of malocclusion, oral cancer prevention and detection, injury prevention, avoidance of harmful habits and the impact of oral disease on overall health. Preventive health recommendations for children are intended to be consistent with American Academy of Pediatric Dentistry periodicity recommendations.

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

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

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

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

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

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

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

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

6.5 Addressing the opioid epidemic

Combating the opioid epidemic must include prevention, treatment, recovery and harm reduction. We engage in strategic community relationships and approaches for special populations with unique risks, such as pregnant women and infants. We use our robust data infrastructure to identify needs, drive targeted actions, and measure progress. Finally, we help ensure our approaches are trauma-informed and reduce harm where possible.

Brief summary of framework

Prevention: Prevent Opioid-Use Disorders before they occur through pharmacy management, provider practices, and education.

Treatment: Access and reduce barriers to evidence-based and integrated treatment.

Recovery: Support care management and referral to person-centered recovery resources.

Harm Reduction: Access to Naloxone and facilitating safe use, storage, and disposal of opioids.

Strategic community relationships and approaches: Tailor solutions to local needs.

Enhanced solutions for pregnant mom and child: Prevent neonatal abstinence syndrome and supporting moms in recovery.

Enhanced data infrastructure and analytics: Identify needs early and measure progress.

Increasing education & awareness of opioids

It is critical you are up-to-date on the cutting edge research and evidence-based clinical practice guidelines. We keep Opioid Use Disorders (OUD) related trainings and resources available on our provider portal to help ensure you have the information you need, when you need it. For example, state-specific Behavioral Health Toolkits are developed to provide access to clinical practice guidelines, free substance use disorders/OUD assessments and screening resources, and other important

state-specific resources. Additionally, Pain Management Toolkits are available and provide resources to help you identify our members who present with chronic physical pain and may also be in need of behavioral health services to address the psychological aspects of pain. Continuing education is available and includes webinars such as, "The Role of the Health Care Team in Solving the Opioid Epidemic," and "The Fight Against the Prescription Opioid Abuse Epidemic." While resources are available, we also work to help ensure you have the educational resources you need. For example, our Drug Utilization Review Provider Newsletter includes opioid trends, prescribing, and key resources.

Access these resources at **UHCprovider.com**. Click "Resources" on the top right. Then click "Drug Lists and Pharmacy". There you will see an Opioid Programs and Resources - Community Plan (Medicaid) link which provides tools and education.

Prevention

We are invested in reducing the abuse of opioids, while facilitating the safe and effective treatment of pain. Preventing OUD before they occur through improved pharmacy management solutions, improved care provider prescribing patterns, and member and care provider education is central to our strategy.

UnitedHealthcare Community Plan has implemented a 90 MED supply limit for the long-acting opioid class. The prior authorization criteria coincide with the CDC's recommendations for the treatment of chronic non-cancer pain. Prior authorization applies to all long-acting opioids. The CDC guidelines for opioid prevention and overdose can be found at this link, **https://www.cdc.gov/drugoverdose/prevention/index.html**.

6.6 COVID-19 information and resources

UnitedHeathcare's goal is to provide current information and resources related to the COVID-19 pandemic. A broad range of information and resources may be found at this link **https://www.uhcprovider.com/en/resource-library/news/Novel-Coronavirus-COVID-19.html**.

Section 7: Fraud, waste, and abuse training

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

- Provide detailed information about the Federal False Claims Act,
- Cite administrative remedies for false claims and statements,
- Reference state laws pertaining to civil or criminal penalties for false claims and statements, and
- With respect to the role of such laws in preventing and detecting fraud, waste and abuse in federal health care programs, include as part of such written policies, detailed provisions regarding care providers policies and procedures for detecting and preventing fraud, waste and abuse.

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

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

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications-Items/MLN4649244

Section 8: Governance

8.1 Provider rights bulletin

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

To review your information

You may review any information the plan has utilized to evaluate your credentialing application, including information received from any outside source (e.g., malpractice insurance carriers; state license boards), with the exception of references or other peer-review protected information.

To correct erroneous information

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

To be informed of status of your application

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

To appeal adverse committee decisions

In the event you are denied participation or continued participation, you have the right to appeal the decision in writing within 30 days of the date of receipt of the rejection/denial letter and is applicable to certain states.

UnitedHealthcare Dental
Credentialing Department
2300 Clayton Road
Suite 1000
Concord, CA 94520
Phone: **1-855-918-2265**
Fax: **1-844-881-4963**

8.2 Quality of care issues

A provider who has demonstrated behavior inconsistent with the provision of quality of care is subject to review, corrective action, and/or termination. Questions of quality-of-care may arise for, but are not limited to, the following reasons:

- Chart audit reveals clear and convincing evidence of under- or over utilization, fraud, upcoding, overcharging, or other inappropriate billing practices.
- Multiple quality-of-care related complaints or complaints of an egregious nature for which investigation confirms quality concerns.
- Malpractice or disciplinary history that elicits risk management concerns.

Note: A provider cannot be prohibited from the following actions, nor may a provider be refused a contract solely for the following:

- Advocating on behalf of an enrollee
- Filing a complaint against the MCO
- Appealing a decision of the MCO
- Providing information or filing a report pursuant to PHL4406-c regarding prohibition of plans
- Requesting a hearing or review

We may not terminate a contract unless we provide the practitioner with a written explanation of the reasons for the proposed contract termination and an opportunity for a review or hearing as described below.

- Cases which meet disciplinary or malpractice criteria are initially reviewed by the Credentialing Committee. Other quality-of-care cases are reviewed by the Peer Review Committee.
- The Committees make every effort to obtain a provider narrative and appropriate documents prior to making any determination.
- The Committees may elect to accept, suspend, unpublish, place a provider on probation, require corrective action or terminate the provider.
- The provider will be allowed to continue to provide services to members for a period of up to sixty (60) days from the date of the provider's notice of termination.
- The Hearing Committee will immediately remove from our network any provider who is unable to provide health care services due to a final disciplinary action. In such cases, the provider must cease treating members upon receipt of this determination.

8.3 Appeals process

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

- Providers are notified in writing of their appeal rights within fifteen (15) calendar days of the Committee's determination. The letter will include the reason for denial/termination; notice that the provider has the right to request a hearing or review, at the provider's discretion, before a panel appointed by UnitedHealthcare; notice of a thirty (30)-day time frame for the request; and, a time limit for the hearing date, which must be held within thirty (30) days after the receipt of a request for a hearing.
- The Hearing will be scheduled within thirty (30) days of the request for a hearing.
- The Hearing Committee includes at least three members appointed by UnitedHealthcare, who are not in direct economic competition with the provider, and who have not acted as accuser, investigator, fact-finder, or initial decision-maker in the matter. At least one person on the panel will be the same discipline or same specialty as the person under review. The panel can consist of more than three members, provided the number of clinical peers constitute one-third or more of the total membership.
- The Hearing Committee may uphold, overturn, or modify the original determination. Modifications may include, but are not limited to, placing the provider on probation, requiring completion of specific continuing education courses, requiring site or chart audits, or other corrective actions.
- The decision of the Hearing Committee is sent to the provider by certified letter within thirty (30) calendar days.
- Decisions of terminations shall be effective not less than thirty (30) days after the receipt by the provider of the Hearing Panel's decision.
- In no event shall determination be effective earlier than sixty (60) days from receipt of the notice of termination.

Note: A provider terminated due to a case involving imminent harm to patient care, a determination of fraud, or a final disciplinary action by a state licensing board or other governmental agency that impairs the health care professional's ability to practice is not eligible for a hearing or review.

8.4 Cultural competency

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

UnitedHealthcare Community Plan recognizes that the diversity of American society has long been reflected in our member population. UnitedHealthcare Community Plan acknowledges the impact of race and ethnicity and the need to address varying risk conditions and dental care disparities. Understanding diverse cultures, their values, traditions, history and institutions is

integral to eliminating dental care disparities and providing high-quality care. A culturally proficient health care system can help improve dental outcomes, quality of care and contribute to the elimination of racial and ethnic health disparities.

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

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

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

Section 9: Claim submission procedures

9.1 Claim submission options

9.1.a Paper claims

To receive payment for services, practices must submit claims via paper or electronically. When submitting a paper claim, dentists are required to submit an American Dental Association (ADA) Dental Claim Form (2019 version or later). If an incorrect claim form is used, the claim cannot be processed and will be returned.

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

Refer to Section 9.2 for more information on claims submission best practices and required information. Appendix A will provide you with the appropriate claims address information to ensure your claims are routed to the correct resource for payment.

9.1.b Electronic claims

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

If you wish to submit claims electronically, please contact your clearinghouse to initiate this process. If you do not currently work with a clearinghouse, you may either sign up with one to initiate this process. The UnitedHealthcare Community Plan website (**UHCdental.com/medicaid**) also offers the feature to directly submit your claims online through the provider portal / Dental Hub. Refer to Section 2.5 for more information on how to register as a participating user.

9.1.c Electronic payments

ePayment Center replaced the current electronic payment and statement process for UnitedHealthcare Dental Government Program Plans.

The ePayment center is an online portal which will allow you to enroll in electronic delivery of payments and electronic remittance advice (ERA).

Through the ePayment Center, we will continue to offer a no-fee Automated Clearing House (ACH) delivery of claim payments with access to remittance files via download. Delivery of 835 files to clearinghouses is available directly through the ePayment Center enrollment portal.

ePayment Center allows you to:

- Improve cash flow with faster primary payments and speed up secondary filing/patient collections
- Access your electronic remittance advice (ERA) remotely and securely 24/7
- Streamline reconciliation with automated payment posting capabilities
- Download remittances in various formats (835, CSV, XLS, PDF)
- Search payments history up to 7 years

To register:

1. Visit **UHCdental.epayment.center/register**
2. Follow the instructions to obtain a registration code
3. Your registration will be reviewed by a customer service representative and a link will be sent to your email once confirmed

4. Follow the link to complete your registration and setup your account
5. Log into **UHCdental.epayment.center**
6. Enter your bank account information
7. Select remittance data delivery options
8. Review and accept ACH Agreement
9. Click "Submit"
10. Upon completion of the registration process, your bank account will undergo a prenotification process to validate the account prior to commencing the electronic fund transfer delivery. This process may take up to 6 business days to complete

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

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

The Zelis Payments advantage:

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

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

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

9.2 Claim submission requirements and best practices

Claims for Kentucky Medicaid members will be denied if National Provider Identifier (NPI) numbers or taxonomy codes are missing or their registration with the state is not current. The following list of questions and answers will guide you in fulfilling NPI and taxonomy requirements and help ensure claims can be promptly adjudicated.

Frequently asked questions

- **What is the Kentucky Department of Medicaid Services (KDMS) Master Provider File?** The Master Provider File holds records of registered rendering NPI and taxonomy codes, and Billing/Payee NPI and taxonomy codes. The Kentucky Department of Medicaid Services (KDMS) maintains and distributes the Master Provider File to all managed care organizations (MCOs) for verification.
- **Why would my claim be denied due to NPI numbers or taxonomy codes?** If the provider's rendering NPI, rendering taxonomy code and the practice's Billing/Payee NPI does not appear on the KDMS Master Provider File, the claim will deny. Also, if the provider's registration with the state was not effective on the Date of Service, the claim will deny.
- **How do I verify that my rendering NPI and taxonomy code and my practice's Billing/Payee NPI and taxonomy code are on the KDMS Master Provider File and are currently registered and valid?** You can verify or update your information on the Kentucky Medicaid Partner Portal at **chfs.ky.gov**. You may also call the KDMS Enrollment Department at 877-838-5085 and speak with a representative.

9.2.a Dental claim form required information

The most current Dental ADA claim form (2019 or later) must be submitted for payment of services rendered.

One claim form should be used for each patient and the claim should reflect only 1 treating dentist for services rendered. The claims must also have all necessary fields populated as outlined in the following:

Header information

Indicate the type of transaction by checking the appropriate box: Statement of Actual Services.

Subscriber information

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

Patient information

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

Primary payer information

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

Other coverage

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

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

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

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

Billing dentist or dental entity

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

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

Treating dentist and treatment location

List the following information regarding the dentist that provided treatment:

- Certification — Signature of dentist and the date the form was signed

- Name (use name provided on the Practitioner Application)
- License number
- TIN (or SSN)
- Address (street, city, state, ZIP code)
- Phone number
- NPI
- Rendering provider taxonomy

Record of services provided

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

Missing teeth information

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

Remarks section

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

ICD-10 instructions

RECORD OF SERVICES PROVIDED

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

33. Missing Teeth Information (Place an "X" on each missing tooth.)	34. Diagnosis Code List Qualifier ☐☐ (ICD-10 = AB)	31a. Other Fee(s)	
1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16	34a. Diagnosis Code(s) A _____ C _____		
32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17	(Primary diagnosis in "**A**") B _____ D _____	32. Total Fee	
35. Remarks			

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

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

34 **Diagnosis Code List Qualifier:** Enter the appropriate code to identify the diagnosis code source:
B = ICD-9-CM **AB** = ICD-10-CM (as of Oct. 1, 2013)

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

34a **Diagnosis Code(s):** Enter up to 4 applicable diagnosis codes after each letter (A.-D.). The primary diagnosis code is entered adjacent to the letter "A."

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

By Report procedures

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

Using current ADA codes

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

Supernumerary teeth

UnitedHealthcare recognizes tooth letters "A" through "T" for primary teeth and tooth numbers "1" to "32" for permanent teeth. Supernumerary teeth should be designated by using codes AS through TS or 51 through 82. Designation of the tooth can be determined by using the nearest erupted tooth. If the tooth closest to the supernumerary tooth is # 1 then the supernumerary tooth should be charted as #51, likewise if the nearest tooth is A the supernumerary tooth should be charted as. These procedure codes must be referenced in the patient's file for record retention and review. Patient records must be kept for a minimum of 7 years.

Insurance fraud

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

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

Invalid or incomplete claims:

If claims are submitted with missing information, incomplete or outdated claim forms, the claim will be rejected or returned to the provider and a request for the missing information will be sent to the provider. For example, if the claim is missing a tooth number or surface, a letter will be generated to the provider requesting this information.

9.2.b Coordination of Benefits (COB)

Our benefits contracts are subject to coordination of benefits (COB) rules. We coordinate benefits based on the member's benefit contract and applicable regulations.

UnitedHealthcare Community Plan is the payer of last resort. Other coverage should be billed as the primary carrier. When billing UnitedHealthcare Community Plan as a secondary payer, submit the primary payer's Explanation of Benefits or remittance advice with the claim.

9.2.c Timely submission (Timely filing)

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

All adjustments or requests for reprocessing must be made within 365 days from date of service, or date of eligibility posting, only if the initial submission time period has been met. An adjustment can be requested in writing or telephonically.

Secondary claims must be received within 180 calendar days of the primary payer's determination (see section 9.2.b).

Refer to the Quick Reference Guide for address and phone number information.

9.3 Timely payment

- 90% of all clean claims will be paid or denied within 30 calendar days of receipt.
- 99% of all clean claims will be paid or denied within 45 calendar days of receipt.

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

9.4 Provider remittance advice

9.4.a Explanation of dental plan reimbursement (remittance advice)

The Provider Remittance Advice is a claim detail of each patient and each procedure considered for payment. Use these as a guide to reconcile member payments. As a best practice, it is recommended that remittance advice is kept for future reference and reconciliation.

Below is a list and description of each field:

PROVIDER NAME AND ID NUMBER- Provider Name and ID number – Treating dentists name, Practitioner ID number (NPI National Provider Identifier, TIN Tax Identification Number)

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

AMOUNT BILLED - Amount submitted by provider

AMOUNT PAYABLE - Amount payable after benefits have been applied

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

OTHER INSURANCE - Amount payable by another carrier

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

NET AMOUNT (Summary Page) - Total amount paid

PATIENT NAME

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

PATIENT DOB

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

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

ENCOUNTER NUMBER - Claim reference number

BENEFIT LEVEL - In or out-of-network coverage

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

DOS - Dates of Service: Dates that services are rendered/performed

CDTCODE - Current Dental Terminology - Procedure code of service performed

TOOTH NO. - Tooth Number procedure code of service performed (if applicable)

SURFACE(S) - Tooth Surface of service performed (if applicable)

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

QTY OR NO. OF UNITS

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

PAYABLE AMOUNT - Contracted amount

COPAY AMOUNT - Member responsibility

COINSURANCE AMOUNT - Member responsibility of total payment amount

DEDUCTIBLE AMOUNT - Member responsibility before benefits begin

PATIENT PAY - Amount to be paid by the member

OTHER INSURANCE AMOUNT - Amount paid by other carriers

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

EXCEPTION CODES - Codes that explain how the claim was adjudicated

9.4.b Provider Remittance Advice sample (page 1)

UnitedHealthcare KY Medicaid

Payee ID: 55555 Payee Name: Dental Office Name Remittance Date: 10/20/2017

UnitedHealthcare

Please address questions to:

UnitedHealthcare KY Medicaid
PO Box 1427
Milwaukee, WI 53201

Contact: UnitedHealthcare Community Plan - Provider Services
Phone: (855)934-9818
Fax:

Dental Office Name
Street Address
City, State ZIP

Current Period:	**10/20/2017**
Payee ID:	55555
Phone:	(555)555-5555
Fax:	(555)555-5555
Tax ID:	555555555

Remittance Summary

Fee For Service:	**$2,164.33**
Budget Allocation:	**$0.00**
Capitation:	**$0.00**
Case Fees:	**$0.00**
Additional Compensation:	**$0.00**
Prior Period Recovery and other Payee Adjustments:	**$0.00**
Total:	**$2,164.33**

What if I do not agree with this decision?
If you do not agree with the denial, you may appeal. You may appeal within 90 calendar days after the payment, denial or recoupment of a timely claim submission. Administrative appeals should be sent to the address below.
UnitedHealthcare Community Plan
P.O. Box 1427
Milwaukee, WI 53201
If you have any questions, please call Provider Customer Services at 855-934-9818

Ref #: 34143 / 169 Page 1

9.4.c Provider Remittance Advice sample (page 2)

UnitedHealthcare KY Medicaid

Payee ID: 55555 Payee Name: Dental Office Name Remittance Date: 10/20/2017

Fee For Service Summary

Dental Office Name
Street Address
City, State ZIP

Provider / ID	Location / ID	Amount Billed	Amount Payable	Patient Pay	Other Insurance	Prior Mo. Adj	Net Amount
Provider Name/ 55555	Dental Office Name / 55555	$4,785.00	$1,870.84	$0.00	$0.00	$0.00	$1,870.84
Provider Name / 55555	Dental Office Name / 55555	$1,110.00	$109.37	$0.00	$0.00	$0.00	$109.37
Provider Name / 55555	Dental Office Name / 55555	$450.00	$184.12	$0.00	$0.00	$0.00	$184.12
	Totals:	**$6,345.00**	**$2,164.33**	**$0.00**	**$0.00**	**$0.00**	**$2,164.33**

Ref #: 34143 / 170 Page 2

9.4.d Provider Remittance Advice sample (page 3)

UnitedHealthcare KY Medicaid

Payee ID: 55555 Payee Name: Dental Office Name Remittance Date: 10/20/2017

Services Detail

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

Patient Name: Last, First Name
Subscriber/Member: 555555555 / 00
DOB: 00/00/0000
Office Reference No: 555555555
Provider Name: Last, First Name
Provider NPI: 5555555555
Plan: UnitedHealthcare Kentucky
Product: UHC KY Medicaid
Encounter #: **55555555555555**
Referral #:
Referral Date:
Benefit Level: In Network

ITM	DOS	CODE	POS	BILLED QTY	BILLED AMOUNT	ALLOWED QTY	ALLOWED AMOUNT	PAY %	PAYABLE AMOUNT	COPAY AMOUNT	COINS AMOUNT	DEDUCT AMOUNT	PATIENT PAY	OTHER INSUR	NET AMOUNT	PAY CODE
1	10/16/17	D2740 4	11	1	$885.00	0	$0.00	100.00 %	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	FFS
2	10/16/17	D2954 4	11	1	$225.00	1	$109.37	100.00 %	$109.37	$0.00	$0.00	$0.00	$0.00	$0.00	$109.37	FFS
					$1,110.00		**$109.37**		**$109.37**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$109.37**	

ITEM: 1 Exception Code: 1096 Service Authorization not Found.

Patient Name: Last, First Name
Subscriber/Member: 555555555 / 00
DOB: 00/00/0000
Office Reference No: 555555555
Provider Name: Last, First Name
Provider NPI: 5555555555
Plan: UnitedHealthcare Kentucky
Product: UHC KY Medicaid Adult
Encounter #: **55555555555555**
Referral #:
Referral Date:
Benefit Level: In Network

ITM	DOS	CODE	POS	BILLED QTY	BILLED AMOUNT	ALLOWED QTY	ALLOWED AMOUNT	PAY %	PAYABLE AMOUNT	COPAY AMOUNT	COINS AMOUNT	DEDUCT AMOUNT	PATIENT PAY	OTHER INSUR	NET AMOUNT	PAY CODE
1	10/12/17	D2392 29 DO	11	1	$135.00	1	$71.84	100.00 %	$71.84	$0.00	$0.00	$0.00	$0.00	$0.00	$71.84	FFS
2	10/12/17	D7140 30	11	1	$160.00	1	$52.28	100.00 %	$52.28	$0.00	$0.00	$0.00	$0.00	$0.00	$52.28	FFS
					$295.00		**$124.12**		**$124.12**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$124.12**	

Patient Name: Last, First Name
Subscriber/Member: 555555555 / 00
DOB: 00/00/0000
Office Reference No: 555555555
Provider Name: Last, First Name
Provider NPI: 5555555555
Plan: UnitedHealthcare Kentucky
Product: UHC KY Medicaid Adult
Encounter #: **55555555555555**
Referral #:
Referral Date:
Benefit Level: In Network

ITM	DOS	CODE	POS	BILLED QTY	BILLED AMOUNT	ALLOWED QTY	ALLOWED AMOUNT	PAY %	PAYABLE AMOUNT	COPAY AMOUNT	COINS AMOUNT	DEDUCT AMOUNT	PATIENT PAY	OTHER INSUR	NET AMOUNT	PAY CODE
1	10/12/17	D0120 00	11	1	$50.00	1	$0.00	100.00 %	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	FFS
2	10/12/17	D0220 00	11	1	$25.00	1	$9.58	100.00 %	$9.58	$0.00	$0.00	$0.00	$0.00	$0.00	$9.58	FFS
3	10/12/17	D0230 00	11	1	$20.00	1	$7.98	100.00 %	$7.98	$0.00	$0.00	$0.00	$0.00	$0.00	$7.98	FFS
4	10/12/17	D0274 00	11	1	$50.00	1	$21.63	100.00 %	$21.63	$0.00	$0.00	$0.00	$0.00	$0.00	$21.63	FFS
5	10/12/17	D2392 13 DO	11	1	$135.00	1	$71.84	100.00 %	$71.84	$0.00	$0.00	$0.00	$0.00	$0.00	$71.84	FFS
					$280.00		**$111.03**		**$111.03**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$111.03**	

ITEM: 1 Exception Code: 1039 This service is not covered under the plan.

Patient Name: Last, First Name
Subscriber/Member: 555555555 / 00
DOB: 00/00/0000
Office Reference No: 555555555
Provider Name: Last, First Name
Provider NPI: 5555555555
Plan: UnitedHealthcare Kentucky
Product: UHC KY Medicaid
Encounter #: **55555555555555**
Referral #:
Referral Date:
Benefit Level: In Network

ITM	DOS	CODE	POS	BILLED QTY	BILLED AMOUNT	ALLOWED QTY	ALLOWED AMOUNT	PAY %	PAYABLE AMOUNT	COPAY AMOUNT	COINS AMOUNT	DEDUCT AMOUNT	PATIENT PAY	OTHER INSUR	NET AMOUNT	PAY CODE
1	10/12/17	D0150 00	11	1	$55.00	1	$39.66	100.00 %	$39.66	$0.00	$0.00	$0.00	$0.00	$0.00	$39.66	FFS
2	10/12/17	D0210 00	11	1	$125.00	1	$40.72	100.00 %	$40.72	$0.00	$0.00	$0.00	$0.00	$0.00	$40.72	FFS
3	10/12/17	D1120 00	11	1	$60.00	1	$21.95	100.00 %	$21.95	$0.00	$0.00	$0.00	$0.00	$0.00	$21.95	FFS
4	10/12/17	D1208 00	11	1	$25.00	1	$11.98	100.00 %	$11.98	$0.00	$0.00	$0.00	$0.00	$0.00	$11.98	FFS
					$265.00		**$114.31**		**$114.31**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$114.31**	

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9.5 Overpayment

If you find an overpaid claim, notify us of the overpayment immediately. Send us the overpayment within the time specified in your Agreement. If your payment is not received by that time, we may apply the overpayment against future claim payments in accordance with our Agreement and applicable law.

If you prefer us to recoup the funds from your next payment, call Provider Services.

If you prefer to mail a refund, send an Overpayment Return Check to:

UnitedHealthcare Community Plan Overpayment
P.O. Box 481
Milwaukee, WI 53201

Include the following information with the Overpayment Return Check:

- Name and contact information for the person authorized to sign checks or approve financial decisions
- Member identification number (e.g., ACC, DD, ALTCS EPD)
- Date of service
- Original claim number (if known)
- Date of payment
- Amount paid
- Amount of overpayment
- Overpayment reason
- Check number

9.6 Tips for successful claims resolution

- Do not let claim issues grow or go unresolved.
- Call Provider Services if you can't verify a claim is on file.
- Do not resubmit validated claims on file unless submitting a corrected claim with the required indicators.
- File adjustment requests and claims disputes within contractual time requirements.
- If you must exceed the maximum daily frequency for a procedure, submit the medical records justifying medical necessity. If you have questions, call Provider Services.
- UnitedHealthcare Community Plan is the payer of last resort. This means you must bill and get an EOB from other insurance or source of health care coverage before billing UnitedHealthcare Community Plan. Secondary claims must be received within 180 calendar days from the date of service, even if the primary carrier has not made payment.
- When submitting appeal or reconsiderations requests, provide the same information required for a clean claim. Explain the discrepancy, what should have been paid and why.

9.7 Payment for non-covered services

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

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

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

Please note: It is recommended that benefits and eligibility be confirmed by the provider before treatment is rendered. Members are held harmless and cannot be billed for services that are covered under the plan.

9.8 Radiology requirements

Guidelines for providing radiographs are as follows:

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

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

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

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

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

9.9 Corrected claim submission guidelines

When should I submit a corrected claim?

A corrected claim should ONLY be submitted when an original claim or service was PAID based upon incorrect information.

A Corrected Claim must be submitted in order for the original claim to be adjusted with the correct information. As part of this process, the original claim will be recouped and a new claim processed in its place with any necessary changes.

On the other hand, if a claim or service originally denied due to incorrect or missing information, or was not previously processed for payment, DO NOT submit a corrected claim. Denied services have no impact on member tooth history or service accumulators, and, as such, do not require reprocessing.

What scenarios are subject to the corrected claim process?

A corrected claim should only be submitted if the original service(s) PAID based on incorrect information.

Some examples of correction(s) that need to be made to a prior PAID claim are:

- Incorrect Provider NPI or location
- Payee Tax ID
- Incorrect Member
- Procedure codes
- Services originally billed and paid at incorrect fees (including no fees)
- Services originally billed and paid without primary insurance

How do I submit a corrected claim?

- Electronically – Clearing House
- Electronically – Dental Hub (**only if original claim was submitted on the Dental Hub. If original claim was not submitted on the Dental Hub, another method should be utilized**)

- Provider Web Portal (PWP)
- Paper

Electronic submission are the most efficient and preferred method. If Providers do not have access to electronic submissions, and need to submit on paper, the following steps are required.

- Must be submitted to the Corrected Claims PO Box for proper processing and include the following:
  - Current version of the ADA form and all required information
  - The ADA form must be clearly noted “Corrected Claim”
  - In the remarks field (Box 35) on the ADA form indicate the original paid encounter number and record all corrections you are requesting to be made.

NOTE: If all information does not fit in Box 35, please attach an outline of corrections to the claim form.

What scenarios ARE NOT subject to the corrected claim process?

A corrected claim should not be submitted if the original claim or service(s) which are the subject of the correction denied or were not previously submitted.

Some examples of items that are not considered claim corrections are:

- Any request to “Reprocess” a claim with no changes being made. This includes requests to reprocess a claim based on a new authorization being obtained.
- Any changes being made to a claim or service that denied for any reason such as missing tooth, quad, or arch information, incorrect code, age inappropriate code being billed, missing primary EOB, incorrect provider, etc.
- Any request to recoup a denied service. You DO NOT need to recoup a denied service as denied services are invalid and have no impact on member service/tooth history or accumulators.

If you received a claim or service denial due to missing/incomplete/incorrect information or you have since obtained authorization for services, please submit a new claim with the updated information per your normal claim submission channels. Timely filing limitations apply when a denied claim is being resubmitted with additional information for processing.

If you received a claim or service denial which you do not agree with, including denials for no authorization, please refer to your provider handbook for the proper method for submitting an appeal or reprocess request.

What happens if I submit a corrected claim to the wrong PO box or don’t include the required documentation?

Following the above guidelines will allow you to receive payment as expediently as possible. Failure to follow these guidelines may result in unnecessary delay and/or rejection of your submission. As a reminder the Corrected Claim mailing address is found below.

Submit to:
Corrected Claims
PO Box 481
Milwaukee, WI 53201

Appendices for the State of Kentucky

Appendix A: Resources and services — how we help you

Addresses and phone numbers

Need:	Address:	Phone Number:	Payer I.D.:	Submission Guidelines:	Form(s) Required:
Claim Submission (initial)	Claims: P.O. Box 193 Milwaukee, WI 53201	**1-877-897-4941**	GP133	Within 365 calendar days from the date of service For secondary claims, within 30 calendar days from the primary payer determination	ADA* Claim Form, 2019 version or later
Corrected Claims	Corrected Claims: P.O. Box 481 Milwaukee, WI 53201	**1-877-897-4941**	N/A	Within 365 days from date of service.	ADA Claim Form Reason for requesting adjustment or resubmission
Claim Appeals (Appeal of a denied or reduced payment)	Claim Appeals: P.O. Box 6 Milwaukee, WI 53201	**1-877-897-4941**	N/A	Within 60 days after the claim determination	Supporting documentation, including claim number is required for processing.
Prior Authorization Requests	Pre-authorizations: P.O. Box 1333 Milwaukee, WI 53201	**1-877-897-4941**	GP133	N/A	ADA Claim Form – check the box titled: Request for Predetermination / Preauthorization section of the ADA Dental Claim Form
Member Benefit Appeal for Service Authorization (Appeal of a denied or reduced service)	UnitedHealthcare Community Attn: Appeals and Grievances Unit P.O. Box 31364 Salt Lake City, UT 84131-0364	**1-866-293-1796**	N/A	Within 60 calendar days from the date of the adverse benefit determination	N/A

Appendix B: Member benefits/exclusions and limitations

For the most updated member benefits, exclusions, and limitations please visit our website at **UHCdental.com/medicaid**. We align benefit design to meet all regulatory requirements by Kentucky Medicaid and the Kentucky Legislature including the Kentucky Medicaid Provider Billing Manual, the Kentucky Medicaid Dental Fee Schedule, and 907 KAR 1:026.

B.1 Exclusions & limitations

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

With the exception of medically necessary EPSDT services for children under the age of 21, any service not listed as a covered service in the benefit grids (Section B.2) is excluded.

Please call Provider Services at **1-877-897-4941** if you have any questions regarding frequency limitations.

General exclusions

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

B.2 Benefit grid

The following Benefit Grid contains all covered dental procedures and is intended to align to all State and Federal regulatory requirements; therefore, this Grid is subject to change. For the most updated member benefits, exclusions, and limitations please visit our website at **UHCdental.com/medicaid**.

Code	Description	Age limits	Frequency limits	Other limits	Pre/Post auth requirement
D0120	Periodic Oral Exam	0-999	1 Per 6 Months	D0120-D0180; 1 Per 1 Day	N
D0140	Limited Oral Evaluation - Problem Focused	0-999	1 Per 1 Day	D0120-D0180; 1 Per 1 Day	N
D0145	Oral Evaluation, Patient Under Three	0-2	1 Per 6 Months	D0120-D0180; 1 Per 1 Day	N
D0150	Comprehensive Oral Evaluation - New Or Established Patient	0-999	1 Per 12 Months	D0120-D0180; 1 Per 1 Day	N
D0160	Detailed And Extensive Oral Evaluation - Problem Focused, By Report	0-999	1 Per 1 Day	D0120-D0180; 1 Per 1 Day; Endodontics and Oral Surgeons only	N
D0170	Re-Evaluation - Limited, Problem Focused	0-999	1 Per 1 Day	D0120-D0180; 1 Per 1 Day	N
D0171	Re-Evaluation - Post Operative Office Visit	0-999	1 Per 1 Day	D0120-D0180; 1 Per 1 Day	N
D0180	Comprehensive periodontal evaluation	0-999	1 Per 1 Day	D0120-D0180; 1 Per 1 Day; Periodontics only	N
D0191	Assessment Of A Patient	0-20			N
D0210	Intraoral - Comprehensive Series of Radiographic Images	0-999	1 Per 24 Months		N
D0220	Intraoral - Periapical First Radiographic Image	0-999		D0220, D0230; 14 Per 12 Months	N
D0230	Intraoral - Periapical Each Additional Image	0-999		D0220, D0230; 14 Per 12 Months	N
D0270	Bitewing - Single Radiographic Image	0-999	4 Per 12 Months	D0270 - D0277; 4 Per 12 Months	N
D0272	Bitewings - Two Radiographic Images	0-999	2 Per 12 Months	D0270 - D0277; 4 Per 12 Months	N
D0273	Bitewings - Three Radiographic Images	0-999	1 Per 12 Months	D0270 - D0277; 4 Per 12 Months	N
D0274	Bitewings - Four Radiographic Images	0-999	1 Per 12 Months	D0270 - D0277; 4 Per 12 Months	N
D0277	Vertical Bitewings - 7 To 8 Radiographic Images	0-999	1 Per 12 Months	D0270 - D0277; 1 Per 12 Months	N
D0330	Panoramic Radiographic Image	0-999	1 Per 36 Months	5 and under	Y
D0340	2D Cephalometric Radiographic Image	0-999	1 Per 24 Months		N
D0472	Accession Of Tissue, Gross Examination	0-999			N
D0473	Accession Of Tissue, Gross And Microscopic Examination	0-999			N
D0474	Accession Of Tissue, Gross And Microscopic Examination	0-999			N
D0475	Decalcification Procedure	0-999			N
D0476	Special Stains For Microorganisms	0-999			N
D0477	Special Stains, Not For Microorganisms	0-999			N
D0478	Immunohistochemical Stains	0-999			N
D0479	Tissue In-Situ Hybridization, Including Transmission	0-999			N
D0482	Direct Immunofluorescence	0-999			N
D0484	Consultation On Slides Prepared Elsewhere	0-999			N
D0485	Consultation, Including Preparation Of Slides From Biopsy Material	0-999			N
D0486	Accession Of Transepithelial Cytologic Sample, Microscopic Examination	0-999			N
D1110	Prophylaxis - Adult	12-999	1 Per 6 Months	D1110-D1120; 1 Per 1 Day	N
D1120	Prophylaxis - Child	0-20	1 Per 6 Months	D1110-D1120; 1 Per 1 Day	N
D1206	Topical Application Of Fluoride Varnish	0-20	2 Per 12 Months		N
D1206	Topical Application Of Fluoride Varnish	21-999	2 Per 12 Months	Medical Necessity, documentation of high caries or root exposure	Y
D1208	Topical Application of Fluoride	0-20	2 Per 1 Accum Year		N

Code	Description	Age limits	Frequency limits	Other limits	Pre/Post auth requirement
D1321	Counseling for the Control and Prevention of Adverse Oral, Behavioral, and System	0-999	1 Per 6 Months		N
D1351	Sealant - Per Tooth	5-20	3 Per 1 Lifetime	Cannot be billed with any other restorative/fillings code	N
D1352	Preventive Resin Restoration	0-999	1 Per 1 Lifetime	Per Tooth Cannot be billed with any other restorative/fillings code	N
D1353	Sealant Repair - Per Tooth	0-20	1 Per 1 Lifetime	Per Tooth Cannot be billed with any other restorative/fillings code	N
D1354	Interim Caries Arresting Medicament Application - per tooth	0-999	2 Per 6 Months	Cannot be billed with any other restorative/fillings code	N
D1510	Space Maintainer - Fixed - Unilateral - per quadrant	0-20	1 Per 12 Months	D8210, D8220, D1510, D1516, D1517, D1520, D1526, D1527; 2 Per 12 Months	N
D1516	Space Maintainer - Fixed - Bilateral, maxillary	0-20	1 Per 12 Months	D8210, D8220, D1510, D1516, D1517, D1520, D1526, D1527; 2 Per 12 Months	N
D1517	Space Maintainer - Fixed - Bilateral, mandibular	0-20	1 Per 12 Months	D8210, D8220, D1510, D1516, D1517, D1520, D1526, D1527; 2 Per 12 Months	N
D1520	Space Maintainer - Removable - Unilateral - per quadrant	0-20	1 Per 12 Months	D8210, D8220, D1510, D1516, D1517, D1520, D1526, D1527; 2 Per 12 Months	N
D1526	Space Maintainer - Removable - Bilateral, maxillary	0-20	1 Per 12 Months	D8210, D8220, D1510, D1516, D1517, D1520, D1526, D1527; 2 Per 12 Months	N
D1527	Space Maintainer - Removable - Bilateral, mandibular	0-20	1 Per 12 Months	D8210, D8220, D1510, D1516, D1517, D1520, D1526, D1527; 2 Per 12 Months	N
D1551	Re-Cement Or Re-Bond Bilateral Space Maintainer - maxillary	0-20	1 Per 1 Day		N
D1552	Re-Cement Or Re-Bond Bilateral Space Maintainer - mandibular	0-20	1 Per 1 Day		N
D1553	Re-Cement Or Re-Bond Unilateral Space Maintainer - Per quadrant	0-20	1 Per 1 Day		N
D1556	Removal Of Fixed Unilateral Space Maintainer - Per quadrant	0-20	1 Per 12 Months		N
D1557	Removal Of Fixed Bilateral Space Maintainer - maxillary	0-20	1 Per 12 Months		N
D1558	Removal Of Fixed Bilateral Space Maintainer - mandibular	0-20	1 Per 12 Months		N
D2140	Amalgam - One Surface, Primary Or Permanent	0-999	1 Per 12 Months		N
D2150	Amalgam - Two Surfaces, Primary Or Permanent	0-999	1 Per 12 Months		N
D2160	Amalgam - Three Surfaces, Primary Or Permanent	0-999	1 Per 12 Months		N
D2161	Amalgam - Four Or More Surfaces, Primary Or Permanent	0-999	1 Per 12 Months		N
D2330	Resin-Based Composite - One Surface, Anterior	0-999	1 Per 12 Months		N
D2331	Resin-Based Composite - Two Surfaces, Anterior	0-999	1 Per 12 Months		N
D2332	Resin-Based Composite - Three Surfaces, Anterior	0-999	1 Per 12 Months		N
D2335	Resin-Based Composite - Four Or More Surfaces Or Involving Incisal Angle	0-999	1 Per 12 Months		N
D2390	Resin-Based Composite Crown, Anterior	0-20	1 Per 12 Months	Per tooth	N
D2391	Resin-Based Composite - One Surface, Posterior	0-999	1 Per 12 Months	Per tooth	N
D2392	Resin-Based Composite - Two Surfaces, Posterior	0-999	1 Per 12 Months	Per tooth	N
D2393	Resin-Based Composite - Three Surfaces, Posterior	0-999	1 Per 12 Months	Per tooth	N
D2394	Resin-Based Composite - Four Or More Surfaces, Posterior	0-999	1 Per 12 Months	Per tooth	N
D2710	Crown - Resin-Based Composite (Indirect)	0-999	1 Per 5 Years		N
D2721	Crown - Resin With Predominantly Base Metal	0-999	1 Per 5 Years		Y
D2740	Crown - Porcelain/Ceramic	0-999	1 Per 5 Years		Y
D2750	Crown - Porcelain Fused To High Noble Metal	0-999	1 Per 5 Years		Y
D2751	Crown - Porcelain Fused To Predominantly Base Metal	0-999	1 Per 5 Years		Y
D2752	Crown - Porcelain Fused To Noble Metal	0-999	1 Per 5 Years		Y

Code	Description	Age limits	Frequency limits	Other limits	Pre/Post auth requirement
D2790	Crown - Full Cast High Noble Metal	0-999	1 Per 5 Years		Y
D2791	Crown - Full Cast Predominantly Base Metal	0-999	1 Per 5 Years		Y
D2792	Crown - Full Cast Noble Metal	0-999	1 Per 5 Years		Y
D2799	Provisional Crown	0-999	1 Per 5 Years		Y
D2920	Re-Cement or Re-Bond Crown	0-999	1 Per 5 Years		N
D2928	prefabricated porcelain/ceramic crown – permanent tooth	0-999	1 Per 5 Years		N
D2930	Prefabricated Stainless Steel Crown - Primary Tooth	0-999	1 Per 5 Years	Per tooth per patient	N
D2931	prefabricated stainless steel crown – permanent tooth	0-999	1 Per 5 Years		N
D2932	Prefabricated Resin Crown	0-999	1 Per 5 Years		N
D2934	Prefabricated Esthetic Coated Stainless Steel Crown - Primary Tooth	0-11	1 per 12 Month; Per Patient per Tooth	Tooth Numbers 1-32, A-T; Surface Code M, O, D, B, L, F, I	Y
D2940	Protective Restoration	0-999		All Teeth (Teeth 1 through 32, A through T)	N
D2950	Core Buildup, Including Any Pins When Required	0-999	1 Per 5 Years		N
D2951	Pin Retention - Per Tooth, In Addition To Restoration	0-999	2 Per 1 Lifetime		N
D2954	Prefabricated Post And Core In Addition To Crown	0-999	1 Per 5 Years		N
D2990	Resin Infiltration of Incipient Smooth Surface Lesions	0-999	2 Per 1 Lifetime	Cannot be billed with any other restoration code	Y
D3110	Pulp Cap - Direct (Excluding Final Restoration)	0-20			N
D3220	Therapeutic Pulpotomy	0-20			N
D3310	Endodontic Therapy, Anterior Tooth (Excluding Final Restoration)	0-999	1 Per 1 Lifetime		Y
D3320	Endodontic Therapy Premolar Tooth (Excluding Final Restoration)	0-999	1 Per 1 Lifetime		Y
D3330	Endodontic Therapy, Molar tooth (Excluding Final Restoration)	0-999	1 Per 1 Lifetime		Y
D3346	Retreatment Of Previous Root Canal Therapy - Anterior	0-999	1 Per 1 Lifetime		Y
D3347	Retreatment Of Previous Root Canal Therapy - Premolar	0-999	1 Per 1 Lifetime		Y
D3348	Retreatment Of Previous Root Canal Therapy - Molar	0-999	1 Per 1 Lifetime		Y
D3351	Apexification / Recalcification - Initial Visit	0-16	1 Per 1 Lifetime		Y
D3352	Apexification / Recalcification - Interim	0-16	1 Per 1 Lifetime		Y
D3353	Apexification / Recalcification - Final Visit	0-16	1 Per 1 Lifetime		Y
D3410	Apicoectomy - Anterior	0-999	1 Per 1 Lifetime		Y
D3421	Apicoectomy - Premolar (First Root)	0-999	1 Per 1 Lifetime		Y
D3425	Apicoectomy - Molar (First Root)	0-999	1 Per 1 Lifetime		Y
D3426	Apicoectomy - (Each Additional Root)	0-999			Y
D3430	Retrograde Filling - Per Root	0-999	1 Per 1 Lifetime	Per Tooth	Y
D4210	Gingivectomy Or Gingivoplasty - Four Or More Contiguous Teeth	0-999	1 Per 12 Months		Y
D4211	Gingivectomy Or Gingivoplasty - One To Three Contiguous Teeth	0-999	1 Per 12 Months		Y
D4212	Gingevectomy/Gingivoplasty To Allow Access For Restorative Procedure, Per Tooth	0-999	1 Per 12 Months	Per Tooth	Y
D4240	Gingival Flap Procedure, Including Root Planing - Four Or More Contiguous Teeth	0-999	1 Per 12 Months		Y
D4241	Gingival Flap Procedure, Including Root Planing - One To Three Contiguous Teeth	0-999	1 Per 12 Months		Y
D4249	Clinical Crown Lengthening - Hard Tissue	0-999	1 Per 1 Lifetime	Per Tooth	Y
D4263	Bone Replacement Graft - First Site In Quadrant	0-999	1 Per 1 Lifetime	Per Tooth	Y
D4266	Guided Tissue Generation, Natural Teeth - Resorbable Barrier, Per Site	0-999	1 Per 36 Months	Per Tooth	Y
D4267	Guided Tissue Regeneration, Natural Teeth - Nonresorbable Barrier, Per Site	0-999	1 Per 36 Months	Per Tooth	Y
D4270	Pedicle Soft Tissue Graft Procedure	0-999	1 Per 1 Lifetime	Per Tooth	Y
D4273	Autogenous Connective Tissue Graft Proc, First Tooth, Implant Or Tooth Position	0-999	1 Per 1 Lifetime	Per Tooth	Y
D4277	Free Soft Tissue Graft Procedure (Including Donor Site Surgery) First	0-999	1 Per 1 Lifetime		Y

Code	Description	Age limits	Frequency limits	Other limits	Pre/Post auth requirement
D4322	Splint – intra-coronal natural teeth or prosthetic crowns	0-999	1 Per 5 Years		Y
D4323	Splint – extra-coronal natural teeth or prosthetic crowns	0-999	1 Per 5 Years		Y
D4341	Periodontal Scaling And Root Planing - Four Or More Teeth Per Quadrant	0-999	1 Per 12 Months		Y
D4342	Periodontal Scaling And Root Planing - One To Three Teeth Per Quadrant	0-999	1 Per 12 Months		Y
D4355	Full Mouth Debridement To Enable Comprehensive Periodontal Evaluation And Diagnosis	0-999			Y
D4381	Localized Delivery Of Antimicrobial Agents Via A Controlled Release Vehicle	0-999	1 Per 1 Lifetime	Per Tooth	Y
D4910	Periodontal Maintenance	0-999	1 Per 3 Months	4 Per 1 Accum Year	Y
D4920	Unscheduled Dressing Change (By Someone Other Than Treating Dentist Or Staff)	0-999	1 Per 1 Day		N
D5110	Complete Denture - Maxillary	0-999	1 Per 5 Years	1 per 5 years One prosthesis code per arch per 5 years	Y
D5120	Complete Denture - Mandibular	0-999	1 Per 5 Years	1 per 5 years One prosthesis code per arch per 5 years	Y
D5130	Immediate Denture - Maxillary	0-999	1 Per 5 Years	1 per 5 years One prosthesis code per arch per 5 years	Y
D5140	Immediate Denture - Mandibular	0-999	1 Per 5 Years	1 per 5 years One prosthesis code per arch per 5 years	Y
D5211	Maxillary Partial Denture - Resin Base	0-999	1 Per 5 Years	1 per 5 years One prosthesis code per arch per 5 years	Y
D5212	Mandibular Partial Denture - Resin Base	0-999	1 Per 5 Years	1 per 5 years One prosthesis code per arch per 5 years	Y
D5213	Maxillary Partial Denture - cast metal framework with resin denture bases	0-999	1 Per 5 Years	1 per 5 years One prosthesis code per arch per 5 years	Y
D5214	Mandibular Partial Denture - cast metal framework with resin denture bases	0-999	1 Per 5 Years	1 per 5 years One prosthesis code per arch per 5 years	Y
D5221	Immediate Maxillary Partial Denture – resin base	0-999	1 Per 5 Years	1 per 5 years One prosthesis code per arch per 5 years	Y
D5222	Immediate Mandibular Partial Denture – resin base	0-999	1 Per 5 Years	1 per 5 years One prosthesis code per arch per 5 years	Y
D5225	Maxillary Partial Denture - flexible base (including any retentive clasping mate	0-999	1 per 5 Accum Year Per Patient; more frequent for children under 21 if medically necessary due to growth	Prior Authorization Required for children if more than 1 needed in 5 year period	N
D5226	Mandibular Partial Denture - flexible base (including any retentive clasping mat	0-999	1 per 5 Accum Year Per Patient; more frequent for children under 21 if medically necessary due to growth	Prior Authorization Required for children if more than 1 needed in 5 year period	N
D5282	Removable Unilateral Partial Denture - one piece cast metal (including retentive/clasping materials, rests, and teeth) maxillary	0-999	1 Per 5 Accum Years	1 per 5 years One prosthesis code per arch per 5 years	Y
D5283	Removable Unilateral Partial Denture - one piece cast metal (including retentive/clasping materials, rests, and teeth) mandibular	0-999	1 Per 5 Accum Years	1 per 5 years One prosthesis code per arch per 5 years	Y

Code	Description	Age limits	Frequency limits	Other limits	Pre/Post auth requirement
D5284	Removable Unilateral Partial Denture – one piece flexible base (including retentive/clasping materials, rests, and teeth) – per quadrant	0-999	1 Per 5 Accum Years	One prosthesis code per arch per 5 years	Y
D5286	Removable Unilateral Partial Denture - One Piece Resin (Including retentive/clasping materials, rests, and teeth) – per quadrant	0-999	1 Per 5 Accum Years	One prosthesis code per arch per 5 years	Y
D5410	Adjust Complete Denture - Maxillary	0-999	1 Per 12 Months	Cannot be billed within 6 months of denture delivery	N
D5411	Adjust Complete Denture - Mandibular	0-999	1 Per 12 Months	Cannot be billed within 6 months of denture delivery	N
D5421	Adjust Partial Denture - Maxillary	0-999	1 Per 12 Months	Cannot be billed within 6 months of denture delivery	N
D5422	Adjust Partial Denture - Mandibular	0-999	1 Per 12 Months	Cannot be billed within 6 months of denture delivery	N
D5511	Repair Broken Complete Denture Base - Mandibular	0-999	1 Per 12 Months		N
D5512	Repair Broken Complete Denture Base - Maxillary	0-999	1 Per 12 Months		N
D5520	Replace Missing Or Broken Teeth - Complete Denture (Each Tooth)	0-999	1 Per 12 Months		N
D5621	Repair Cast Partial Framework - Mandibular	0-999	1 Per 12 Months		N
D5622	Repair Cast Partial Framework - Maxillary	0-999	1 Per 12 Months		N
D5630	Repair Or Replace Broken Retentive / Clasping Materials - Per Tooth	0-999	1 Per 12 Months		N
D5640	Replace Broken Teeth - Per Tooth	0-999	1 Per 12 Months		N
D5731	Reline Complete Mandibular Denture (direct)	0-999	1 Per 12 Months	Cannot be billed within 6 months of denture delivery	N
D5740	Reline Maxillary Partial Denture (direct)	0-999	1 Per 12 Months	Cannot be billed within 6 months of denture delivery	N
D5750	Reline Complete Maxillary Denture (indirect)	0-999	1 Per 36 Months	Cannot be billed within 6 months of denture delivery	N
D5751	Reline Complete Mandibular Denture (indirect)	0-999	1 Per 36 Months	Cannot be billed within 6 months of denture delivery	N
D5820	Interim Partial Denture (Including retentive clasping materials and teeth) - max	0-999	1 Per 60 Months		Y
D5821	Interim Partial Denture (Including retentive clasping materials and teeth) - man	0-999	1 Per 60 Months		Y
D5913	Nasal Prosthesis	0-999			Y
D5914	Auricular Prosthesis	0-999			Y
D5919	Facial Prosthesis	0-999			Y
D5931	Obturator Prosthesis, Surgical	0-999			Y
D5932	Obturator Prosthesis, Definitive	0-999			Y
D5934	Mandibular Resection Prosthesis With Guide Flange	0-999			Y
D5952	Speech Aid Prosthesis, Pediatric	0-13			Y
D5953	Speech Aid Prosthesis, Adult	14-999			Y
D5954	Palatal Augmentation Prosthesis	0-999			Y
D5955	Palatal Lift Prosthesis, Definitive	0-999			Y
D5988	Surgical Splint	0-999			Y
D5999	Unspecified Maxillofacial Prosthesis, By Report	0-999			Y
D6010	Surgical Placement Of Implant Body: Endosteal Implant	0-999	1 Per 1 Lifetime		Y
D6056	Prefabricated Abutment - Includes Modification And Placement	0-999	1 Per 1 Lifetime		Y
D6057	Custom Fabricated Abutment - Includes Placement	0-999	1 Per 1 Lifetime		Y
D6058	Abutment Supported Porcelain/Ceramic Crown	0-999	1 Per 1 Lifetime		Y
D6059	Abutment Supported Porcelain Fused To Metal Crown (High Noble Metal)	0-999	1 Per 1 Lifetime		Y
D6065	Implant Supported Porcelain/Ceramic Crown	0-999	1 Per 1 Lifetime		Y
D6066	Implant supported crown – porcelain fused to metal crown (titanium, titanium alloy)	0-999	1 Per 1 Lifetime		Y
D6081	Scaling and debridement	0-999	1 Per 1 Lifetime		Y

Code	Description	Age limits	Frequency limits	Other limits	Pre/Post auth requirement
D6103	Bone Graft For Repair Of Peri-Implant Defect - Not Including Flap Entry/Closure	0-999	1 Per 1 Lifetime		Y
D6104	Bone Graft At Time Of Implant Placement	0-999	1 Per 1 Lifetime		Y
D6190	Radiographic/Surgical Implant Index, By Report	0-999	1 Per 1 Lifetime		Y
D6211	Pontic - Cast Predominantly Base Metal	0-999	1 Per 5 Years		Y
D6240	Pontic - Porcelain Fused To High Noble Metal	0-999	1 Per 5 Years		Y
D6241	Pontic - Porcelain Fused To Predominantly Base Metal	0-999	1 Per 5 Years		Y
D6242	Pontic - Porcelain Fused To Noble Metal	0-999	1 Per 5 Years		Y
D6750	Retainer Crown - Porcelain Fused To High Noble Metal	0-999	1 Per 5 Years		Y
D6751	Retainer Crown - Porcelain Fused To Predominantly Base Metal	0-999	1 Per 5 Years		Y
D6752	Retainer Crown - Porcelain Fused To Noble Metal	0-999	1 Per 5 Years		Y
D6930	Re-Cement Or Re-Bond Fixed Partial Denture	0-999	1 Per 12 Months		N
D7111	Extraction, Coronal Remnants - Primary Tooth	0-999			N
D7140	Extraction, Erupted Tooth Or Exposed Root	0-999			N
D7210	Extraction, Erupted Tooth	0-999			N
D7220	Removal Of Impacted Tooth - Soft Tissue	0-999			Y
D7230	Removal Of Impacted Tooth - Partially Bony	0-999			Y
D7240	Removal Of Impacted Tooth - Completely Bony	0-999			Y
D7241	Removal Of Impacted Tooth - Completely Bony, Unusual Surgical Complications	0-999			Y
D7250	Removal Of Residual Tooth (Cutting Procedure)	0-999			N
D7251	Coronectomy - Intentional Partial Tooth Removal - Impacted Teeth Only	0-999	1 Per 1 Lifetime	Per Tooth	Y
D7260	Oroantral Fistula Closure	0-999			Y
D7270	Reimplantation And/Or Stabilization Of Accidentally Evulsed / Displaced Tooth	0-999			Y
D7280	Exposure of an Unerupted Tooth	0-999			Y
D7285	Incisional Biopsy Of Oral Tissue - Hard (Bone, Tooth)	0-999	1 Per 1 Day		Y
D7286	Incisional Biopsy Of Oral Tissue - Soft	0-999	1 Per 1 Day		Y
D7310	Alveoloplasty In Conjunction With Extractions - Four Or More Teeth	0-999	1 Per 1 Lifetime	D7310, D7320; 1 Per 1 Lifetime (Per Quadrant)	N
D7320	Alveoloplasty Not In Conjunction With Extractions - Four Or More Teeth	0-999	1 Per 1 Lifetime	D7310, D7320; 1 Per 1 Lifetime (Per Quadrant)	N
D7410	Excision Of Benign Lesion Up To 1.25 Cm	0-999			N
D7411	Excision Of Benign Lesion Greater Than 1.25 Cm	0-999			Y
D7471	Removal Of Lateral Exostosis (Maxilla Or Mandible)	0-999			Y
D7472	Removal Of Torus Palatinus	0-999	1 Per 1 Lifetime		Y
D7473	Removal Of Torus Mandibularis	0-999	1 Per 1 Lifetime		Y
D7510	Incision And Drainage Of Abscess - Intraoral Soft Tissue	0-999			N
D7520	Incision And Drainage Of Abscess - Extraoral Soft Tissue	0-999			N
D7530	Removal Of Foreign Body From Mucosa	0-999			N
D7550	Partial Ostectomy/Sequestrectomy For Removal Of Non-Vital Bone	0-999	1 Per 1 Lifetime		N
D7880	Occlusal Orthotic Device, By Report	0-999	1 Per 1 Lifetime		Y
D7910	Suture Of Recent Small Wounds Up To 5 Cm	0-999			Y
D7961	Buccal/Labial frenectomy (frenulectomy)	0-999	2 Per 1 Lifetime	D7961, D7962; 2 Per 1 Day (Per Arch)	Y
D7962	Lingual Frenectomy (frenulectomy)	0-999	1 Per 1 Lifetime	D7961, D7962; 2 Per 1 Day	Y
D8020	Limited Orthodontic Treatment Of The Transitional Dentition	0-20			Y
D8030	Limited Orthodontic Treatment Of The Adolescent Dentition	0-20			Y
D8070	Comprehensive Orthodontic Treatment Of The Transitional Dentition	0-20			Y
D8080	Comprehensive Orthodontic Treatment Of The Adolescent Dentition	0-20			Y

Code	Description	Age limits	Frequency limits	Other limits	Pre/Post auth requirement
D8210	Removable Appliance Therapy	0-20	2 Per 12 Months	D8210, D8220, D1510, D1516, D1517, D1520, D1526, D1527; 2 Per 12 Months	Y
D8220	Fixed Appliance Therapy	0-20	2 Per 12 Months	D8210, D8220, D1510, D1516, D1517, D1520, D1526, D1527; 2 Per 12 Months	Y
D8660	Pre-Orthodontic Treatment Examination To Monitor Growth And Development	0-20			N
D8670	Periodic Orthodontic Treatment Visit	0-20			Y
D8680	Orthodontic Retention (Removal Of Appliances, Place Retainers)	0-999			Y
D8698	Re-cement Or Re-bond Fixed Retainer - Maxillary	0-20	1 Per 1 Day		N
D8699	Re-cement Or Re-bond Fixed Retainer - Mandibular	0-20	1 Per 1 Day		N
D8701	Repair Of Fixed Retainer, Includes Reattachment - Maxillary	0-20	1 Per 4 Accum Years		N
D8702	Repair Of Fixed Retainer, Includes Reattachment - Mandibular	0-20	1 Per 4 Accum Years		N
D8703	Replacement Of Lost Or Broken Retainer - Maxillary	0-20	1 Per 4 Accum Years		N
D8704	Replacement Of Lost Or Broken Retainer - Mandibular	0-20	1 Per 4 Accum Years		N
D8999	Unspecified Orthodontic Procedure, By Report	0-20			Y
D9110	Palliative (Emergency) Treatment Of Dental Pain - Per Visit	0-999	1 Per 1 Day		N
D9222	Deep Sedation/General Anesthesia - First 15 Minutes	0-999	1 Per 1 Day		Y
D9223	Deep Sedation / General Anesthesia - Each subsequent 15 Minute Increment	0-999	5 Per 1 Day		Y
D9230	Inhalation Of Nitrous/Analgesia, Anxiolysis	0-999			N
D9239	Intravenous Moderate (Conscious) Sedation/Analgesia - First 15 Minutes	0-999	1 Per 1 Day		Y
D9243	Intravenous Moderate (Conscious) Sedation/Analgesia - Each Subsequent 15 Minute	0-999	5 Per 1 Day		Y
D9248	Non-Intravenous Conscious Sedation	0-999			N
D9410	House/Extended Care Facility Call	0-999			N
D9420	Hospital Or Ambulatory Surgical Center Call	0-999			N
D9610	Therapeutic Parenteral Drug, Single Administration	0-999	1 Per 1 Day		N
D9944	Occlusal Guard-hard appliance, full arch	0-999	1 Per 2 Years		Y
D9945	Occlusal Guard-soft appliance, full arch	0-999	1 Per 2 Years		Y
D9946	Occlusal Guard-hard appliance, partial arch	0-999	1 Per 2 Years		Y
D9995	Teledentistry - Synchronous; Real-Time Encounter	0-999	1 Per 1 Day		N
D9996	Teledentistry - Asynchronous; Information Stored And Forwarded To Dentist	0-999	1 Per 1 Day		N

Appendix C: Orthodontic treatment

C.1 General guidelines for orthodontic treatment

- Approved orthodontic treatment plans must be completed before the patient's 21st birthday.
- Services will not be authorized after Kentucky Medicaid eligibility has expired.
- As with all Medicaid services, a provider acknowledges compliance with all Medicaid requirements when he or she submits a claim for reimbursement.
- Orthodontic services that are performed solely for cosmetic purposes are not a benefit of Kentucky Medicaid.
- An approved authorization for orthodontic treatment is not a guarantee for payment. All orthodontic claims will be evaluated for all benefit rules and limitations including member eligibility, member age, etc.

C.2 Appliance therapy

Appliance therapy	
Prior Authorization is required for all appliance therapy codes (D8210, D8220)	
Eligible age group: 0-20	
CDT codes	
D8210	Removable Appliance Therapy
D8220	Fixed Appliance Therapy
Documentation required for prior authorization	
ADA 2012 or newer claim form with service codes noted	
Digital diagnostic models or Intra and extra oral digital photographs	
Panoramic x-ray	
Cephalometric radiographic image with tracings	
Treatment plan	
Treatment length	
2 per 12 months per recipient	
Criteria	
Documentation of thumb sucking or tongue thrusting or other pathological habit	

C.3 Interceptive orthodontic treatment

Interceptive orthodontic treatment	
Prior Authorization is required for all interceptive codes (D8060)	
Eligible age group: 0-20	
CDT codes	
D8010	limited orthodontic treatment of the primary dentition
D8020	limited orthodontic treatment of the transitional dentition
D8030	limited orthodontic treatment of the adolescent dentition
D8040	limited orthodontic treatment of the adult dentition
Documentation required for prior authorization	
ADA 2012 or newer claim form with service codes noted	
Digital diagnostic models or photos of models, and Intra and extra oral photographs	
Panoramic x-ray	
Cephalometric radiographic image with tracings	
Treatment plan and or the Orthodontic Treatment Approval Request Form for UnitedHealthcare Community Plan of Kentucky	
Treatment length	
The length of treatment for Interceptive Orthodontic Treatment is determined by individual patient medical necessity.	
Criteria	
Palatal expansion	

Interceptive orthodontic treatment
Correction of skeletal disharmonies of the primary/transitional dentition
Correction of anterior crossbite
Severe cuspid crowding/correction of inadequate space for cuspid eruption

C.4 Comprehensive orthodontic treatment

Comprehensive orthodontic treatment	
Prior Authorization is required for all comprehensive codes (D8070, D8080)	
Eligible age group: 0-20	
Comprehensive medically necessary orthodontic services are a covered benefit for members who have a severe, dysfunctional handicapping malocclusion or special medical conditions including, but not limited to cleft palate, post-trauma head injury involving the oral cavity, and/or skeletal anomalies involving the oral cavity.	
Covered benefits CDT codes	
D8070	Comprehensive orthodontic treatment of the transitional dentition
D8080	Comprehensive orthodontic treatment of the adolescent dentition
Documentation required for prior authorization	
ADA 2012 or newer claim form with service codes noted	
Digital diagnostic models or photos of models, and intra and extra oral photographs	
Panoramic x-ray	
Cephalometric radiographic image with tracings	
Treatment plan	
Orthodontic Treatment Approval Request Form for UnitedHealthcare Community Plan of Kentucky	
Treatment length	
One unit of D8070 or D8080 is issued for banding	
Total number of periodic treatment (D8670) visits not to exceed 22	
Completed Comprehensive Orthodontic cases will be eligible for D8680; authorization is required.	
Criteria	
Documentation demonstrates that patient meets the criteria described on The Orthodontic Treatment Approval Request Form for UnitedHealthcare Community Plan of Kentucky.	

C.5 Process to request a new comprehensive orthodontic treatment plan

A new comprehensive treatment plan requires authorization. To be considered for approval, please submit a request for D8080 or D8070. A Clinician will review the request and compare to the clinical criteria above. If you are approved for a new comprehensive orthodontic treatment plan, you will automatically be eligible to submit up to 22 D8670 claims. As with all approved authorizations, you and the member will receive a written copy of the approval for your records.

When the comprehensive orthodontic treatment plan is completed, you may request an authorization for D8680 to complete and receive the remaining payment for the case and move into the retention phase.

C.6 Process to request a completion of a transfer orthodontic treatment plan

If a member has already begun their comprehensive orthodontic treatment plan with another insurer or another provider, UnitedHealthcare will review the case to make a medical necessity determination for the remainder of the case.

To request an authorization for a transfer orthodontic treatment plan, please submit an authorization for D8999 and the remaining quantity of D8670s required to complete treatment. A clinician will evaluate the case to ensure the original banding met the clinical criteria for New Comprehensive Orthodontic Cases, and to determine the number of additional D8670s required to complete treatment.

Transfer orthodontic treatment	
Prior Authorization is required for all transfer orthodontic cases (D8999, D8670)	
Eligible age group: 0-20	
Covered benefits CDT codes	
D8999	Used to identify a Transfer Orthodontic Case
D8670	Periodic Orthodontic Treatment Visit
Documentation required for prior authorization	
ADA Form (paper or electronic) to include codes D8999 and D8670 with requested number of D8670 services to complete case	
Copy of EOB/remit showing paid banding from previous insurance or previous provider, whichever is applicable	
Payment history from prior insurance or prior provider	
Narrative of Medical Necessity	
Treatment length	
Based on medical necessity	
Criteria	
Transfer cases will be evaluated to ensure the original banding met the clinical criteria for New Comprehensive Orthodontic Cases, and to determine the number of additional D8670s required to complete treatment.	

United Healthcare | Dental Benefit Providers

Orthodontic Treatment Approval Request Form

for UnitedHealthcare Community Plan of Kentucky

Patient Name: _____DOB: _____

Documentation Requirements:

- ☐ Models or Digital equivalent
- ☐ Cephalometric x-rays
- ☐ Panoramic x-rays
- ☐ Intraoral and Extraoral Photos
- ☐ Narrative, including treatment plan notes

CRITERIA	DESCRIPTION	YES	NO
Deep Overbite	Severe overbite encompassing one (1) or more teeth in palatal impingement diagnosed by a lingual view of orthodontic models (stone or digital) showing palatal soft tissue contact.		
Anterior Open Bite	True Anterior Open Bite, Skeletal in nature that if left untreated will not resolve. Not including one or two teeth slightly out of occlusion or where the incisors have not fully erupted.		
Antero-Posterior Discrepancy	Class II and Class III Malocclusions that are at least 1 full tooth Class II or III.		
Anterior Crossbite	Anterior crossbite that involves more than 2 teeth within the same arch, a single tooth cross bite demonstrating obvious gingival stripping or severe dental attrition, or edge to edge crossbite with severe dental attrition due to a traumatic occlusion.		
Posterior Crossbite	Handicapping posterior transverse discrepancy, includes several posterior teeth 1 of which shall be a molar. Handicap demonstrated by Functional Shift, Facial Asymmetry, or complete buccal lingual cross bite.		
Posterior Open Bite	Significant Posterior open bite not involving partially erupted teeth or 1 or 2 teeth slightly out of occlusion.		
Impaction	Tooth will not erupt into the arch without orthodontic or surgical intervention. Impaction must demonstrate pathology or pose significant threat to the integrity of remaining dentition. Does not include third molars or teeth that will erupt ectopically.		
Extreme Overjet	Overjet in excess of 8mm.		
Facial Anomaly	Cleft palate or severe facial anomaly Has a congenital or developmental disorder giving rise to a handicapping malocclusion Has a significant facial discrepancy requiring a combined orthodontic and orthognathic surgery treatment approach Has developmental anodontia in which several congenitally missing teeth result in a handicapping malocclusion or arch deformation		
Trauma	Has trauma or injury resulting in severe misalignment of the teeth or alveolar structures and does not include simple loss of teeth with no other affects.		
Speech Pathology	A medically documented speech pathology resulting from the malocclusion as documented from a licensed medical provider or speech pathologist.		

Appendix D: Authorization for treatment

D.1 Dental treatment requiring authorization

To make sure that desirable quality of care standards are achieved and to maintain the overall clinical effectiveness of the program, there are times when prior authorization is required prior to the delivery of clinical services. These services may include specific restorative, endodontic, periodontic, prosthodontic and oral surgery procedures. For a complete listing of procedures requiring authorization, refer to the benefit grid.

Prior authorization means the practitioner must submit those procedures for approval with clinical documentation supporting necessity before initiating treatment.

For questions concerning prior authorization, dental claim procedures, or to request clinical criteria, please call the Provider Services Line.

You can submit your authorization request electronically, by paper through mail, or online at **UHCdental.com/medicaid**. All documentation submitted should be accompanied with ADA Claim Form and by checking the box titled: "Request for Predetermination/Preauthorization" section of the ADA Dental Claim Form to the address referenced in the appendix of this manual.

D.2 Authorization timelines

The following timelines will apply to requests for authorization:

- We will make a determination on standard authorizations within 2 days of receipt of the request. Written notification of denied determinations will be sent within 14 calendar days of receipt of the request.
- We will make a determination on expedited authorizations within 24 hours of receipt of the request. Written notification denied determinations will be sent within 2 business days of receipt of the request.
- Authorization approvals will expire 180 days from the date of determination.

D.3 Clinical criteria and documentation requirements for services requiring authorization

Prior authorization of treatment and emergency treatment 10/14/20 revision

When submitting for prior authorization / retrospective review of these procedures, please note the documentation requirements when sending in the information to Skygen Dental. Skygen Dental criteria utilized for medical necessity determination were developed from information collected from American Dental Association's Code Manuals, clinical articles and guidelines, as well as dental schools, practicing dentists, insurance companies, other dental related organizations, and local state or health plan requirements. The criteria Skygen Dental reviewers will look for in order to approve the request is listed below. Should the procedure need to be initiated under an emergency condition to relieve pain and suffering, you are to provide treatment to alleviate the patient's condition. However, to receive reimbursement for the treatment, Skygen Dental will require the same criteria / documentation be provided (with the claim for payment) and the same criteria be met to receive payment for the treatment.

When reviewing requests for services the following guidelines will be used: Treatment will not be routinely approved when functional replacement with less costly restorative materials, including prosthetic replacement, is possible. Dental work for cosmetic reasons or because of the personal preference of the member or provider is not within the scope of the Medicaid program.

Procedure	Procedure codes	Documentation (simplified for Skygen)	Criteria for approval	Auth
Panorex	D0330	0-5 Narrative of necessity	• 0-5 child requires documentation describing medical necessity	Prior
Fluoride varnish	D1206	21- 999 Narrative of necessity	• 21-999 requires a Narrative of necessity documenting root exposure, xerostomia, or high caries rate.	Prior Post
Application of caries arresting medicament - per tooth	D1354	0- 999 Narrative of necessity	• Caries risk assessment, Treatment plan, or Justification (time to treat, pt in ability to tolerate treatment, geographic constraints)	Prior Post
Crowns	D2721, D2740, D2750, D2751, D2752, D2790, D2791, D2792. D2710	Current x-rays Narrative of necessity if decay not evident on films	• Anterior endo teeth- . NOT indicated to only restore access opening • Anterior non endo teeth- 50% incisal edge / 4+ surfaces involved • Bicuspid – 1 cusp / 3+ surfaces involved • Molar – 2 cusps / 4+ surfaces involved • Minimum 50% bone support • No periodontal furcation • No sub-crestal caries • Clinically acceptable RCT (if performed) • Full coverage of primary tooth without a successor. • Symptomatic cracked tooth syndrome; not craze lines or not for cosmetic services.	Prior
Provisional Crown	D2799	Current x-rays Narrative of necessity	• Documentation describes medical necessity and provisional crown need for a minimum of 6 months. • Not to be used as a temporary crown for a routine prosthetic restoration. • See criteria for crowns.	Prior
Resin infiltration of incipient	D2990	Current x-rays	• Documentation supports medical necessity • Clinically appropriate lesion with minimal caries in dentin • Not allowed for only cosmetic purposes. • Not allowed with any other restorative code same tooth.	Prior
Endodontic Therapy	D3310, D3320, D3330	Current x-rays	**Covered in the following scenarios:** • A restorable mature, completely developed permanent or primary tooth with irreversible pulpitis, necrotic pulp or frank vital pulpal exposure • Teeth with radiographic periapical pathology • Primary teeth without a permanent successor • Trauma • When needed for prosthetic rehabilitation **Not covered in the following situations:** • Teeth with a poor long-term prognosis • Teeth with inadequate bone support or advanced or untreated periodontal disease • Teeth with incompletely formed root apices • Sargenti method used. • On a multirooted tooth with all canals not treated. • greater than 50% bone • no sub-crestal caries • Root Canal Fill Should be demonstrated radiographically to be free from void, less than 2mm short of the apex and not more than 1mm beyond	Prior Post
Retreatment Of Previous Root Canal Therapy	D3346, D3347, D3348	Current x-rays	• Tooth is sensitive to pressure and percussion or other subjective symptoms • Placement of a post has the potential to compromise the existing obturation or apical seal of the canal system • Minimum 50% bone support • No periodontal furcation • No sub-crestal caries • Evidence of apical pathology/fistula • Pain from percussion / temp	Prior Post
Apexification / Recalcification	D3351, D3352, D3353	Current x-rays Narrative of necessity	**Covered in the following scenarios:** • Incomplete apical closure in a permanent tooth root • External root resorption or when the possibility of external root resorption exists • Necrotic pulp, irreversible pulpitis or periapical lesion • For prevention or arrest of resorption • Perforations or root fractures that do not communicate with oral cavity **Not covered in the following situations:** • A tooth with a completely closed apex	Prior

Procedure	Procedure codes	Documentation (simplified for Skygen)	Criteria for approval	Auth
Retrograde Filling - Per Root	D3430	Current x-rays Narrative of necessity	• Periradicular pathosis and a blockage of the root canal system that could not be obturated by nonsurgical root canal treatment • Persistent Periradicular pathosis resulting from an inadequate apical seal that cannot be corrected non-surgically • Root perforations • Resorptive defects	Prior
Gingivectomy Or Gingivoplasty to allow access for restorative procedure per tooth.	D4210, D4211, D4212	Current x-rays Complete 6 point periodontal charting Narrative of necessity	• Must have chronic conditions or take medications that cause hypertrophic gingival growth. • Narrative including hx of non-surgical procedures and prognosis. • indicated for suprabony pockets exceeding 3mm to allow restorative access including root surface caries. • Not indicated when bone surgery is required for infrabony defects.	Prior
Scaling and Root Planning	D4341, D4342	• Panoramic x-ray or full series • Periodontal charting	**Covered in the following scenarios:** • Sub-Gingival Calculus and Bone Loss are evident on radiographs **Not covered in the following scenarios:** • For the removal of heavy deposits of calculus and plaque in the absence of clinical attachment loss • Gingivitis as defined by inflammation of the gingival tissue without loss of attachment (bone and tissue) • As a sole treatment for refractory chronic, aggressive or advanced Periodontal Diseases	Prior
Full mouth debridement	D4355	• Panoramic x-ray or full series • Narrative indicating pregnancy	**Covered only if ALL of the following scenarios are present:** • The member is pregnant • Heavy calculus is present on teeth and usually visible on radiographs • Due to the amount of calculus, plaque and debris, a comprehensive examination and diagnosis is not possible	Prior Post
Flap Procedures	D4240, D4241	Current x-rays Complete 6 point periodontal charting Narrative of necessity	• Must have chronic conditions or take medications that cause hypertrophic gingival growth. • The presence of moderate to deep probing depths • Moderate/severe gingival enlargement or extensive areas of overgrowth • Loss of attachment • The need for increased access to root surface and/or alveolar bone when previous non-surgical attempts have been unsuccessful • The diagnosis of a cracked tooth, fractured root or external root resorption when this cannot be accomplished by non-invasive methods • To preserve keratinized tissue in conjunction with osseous surgery	Prior
Clinical Crown Lengthening - Hard Tissue	D4249	Current x-rays Complete 6 point periodontal charting Narrative of necessity	• In an otherwise periodontally healthy area to allow a restorative procedure on a tooth with little to no crown exposure • To allow preservation of the biological width for restorative procedures • Fracture or caries extends apical to the attached gingival margin.	Prior
Bone Replacement Graft - First Site In Quadrant-retained natural tooth	D4263	Current x-rays Complete 6 point periodontal charting Narrative of necessity	• In an otherwise periodontally healthy area to correct an isolated periodontal defect • Infrabony/Intrabony vertical defects • Class II Furcation involvements	Prior
Guided Tissue Generation-natural teeth	D4266, D4267	Current x-rays Complete 6 point periodontal charting Narrative of necessity	• Intrabony/infrabony vertical defects • Class II Furcation involvements • In otherwise healthy periodontium, to enhance periodontal tissue regeneration and healing for mucogingival defects in conjunction with mucogingival surgeries	Prior
Tissue Graft Procedure	D4270, D4273, D4277	Current x-rays Complete 6 point periodontal charting Narrative of necessity	• Areas with less than 2 mm of attached gingiva • Unresolved sensitivity in areas of Recession • Progressive Recession or chronic inflammation	Prior
Splint intra-coronal and Extracoronal natural teeth or prosthetic crowns	D4322, D4323	Current x-rays periodontal charting Narrative of necessity	• Documentation indicates periodontal mobility Type 3 or 4 • Documentation shows completed periodontal therapy • Multiple teeth that have become mobile due to loss of alveolar bone loss and periodontium • Absence of active disease or inflammation • During surgical and healing phases of regenerative periodontal therapy **Not indicated for the following:** • Tooth transplantation • Trauma resulting in the reimplantation of completely avulsed tooth/teeth • Trauma resulting in displacement or fracture of tooth/teeth	Prior

Procedure	Procedure codes	Documentation (simplified for Skygen)	Criteria for approval	Auth
Localized Delivery Of Antimicrobial Agents Via A Controlled Release Vehicle	D4381	Panoramic or FMX Perio charting Previous scaling and root planing dates	• Periodontal disease with probing depths greater than or equal to 5 millimeters with active disease (bleeding upon probing, exudate, and inflammation) present. • Isolated periodontal defect - otherwise healthy periodontium	Prior
Periodontal Maintenance	D4910	Current x-rays Complete 6 point periodontal charting	**Covered in the following scenarios:** • To maintain the results of surgical and non-surgical periodontal treatment • As an extension of active periodontal therapy at selected intervals • Requires a history of D4341 or D4342. **Not covered in the following scenarios:** • If no history of scaling and root planing (SRP) or surgical procedures	Prior
Complete Dentures	D5110, D5120, D5130, D5140	Panoramic x-ray or FMX Date of prior placement	• Remaining teeth do not have adequate bone support or are not restorable • Existing denture greater than 5 years old and unserviceable (narrative must explain why any existing denture is not serviceable or cannot be relined or rebased)	Prior
Partial Dentures	D5211, D5212, D5213, D5214, D5221, D5222	Panoramic x-ray or FMX	• Replacing one or more anterior teeth • Replacing three or more posterior teeth (excluding 3rd molars) • Existing partial denture greater than 5 years old and unserviceable • Abutment teeth have greater than 50% bone support and are restorable • Absence of active periodontal disease or caries	Prior
Unilateral Partial Dentures	D5820, D5821, D5282, D5283, D5284, D5286	Panoramic x-ray or FMX	• Existing partial denture greater than 5 years old and unserviceable • Abutment teeth have greater than 50% bone support and are restorable • Absence of active periodontal disease or caries	Prior
Prosthetics	D5913, D5914, D5919, D5931, D5932, D5934, D5952, D5953, D5954, D5955, D5988, D5999	• Panoramic x-ray or full series • Narrative of Medical Necessity • Photographs	**Covered in the following scenarios:** • Must be provided by a board eligible or board-certified prosthodontist • Documentation describes accident, facial trauma, disease, facial reconstruction or other medical necessity need	Prior
Surgical Placement Of Implant Body	D6010	Panoramic x-ray or FMX	• Documentation shows healthy bone and periodontium. • Missing tooth • Healthy periodontium absence of inflammation • No unrestored caries • History good Oral hygiene • Edentulous bone adequate for implant osteointegration • Unable to wear RPD • FPD not indicated • Implant is limited to replacement of a single tooth	Prior
Prefabricated and custom abutments	D6056, D6057	Xray of implant History of D6010 PTE	• Documentation shows fully integrated and restorable implant • Appropriate crown / implant ratio • Healthy bone and periodontium surrounding surgical implant (see D6010)	Prior
Abutment supported crn	D6059	Xray of implant History of D6010	• Documentation shows fully integrated surgical implant with good crown / implant ratio • Healthy bone and periodontium surrounding surgical implant • Meets criteria for D6056, D6057 (see D6010)	Prior
Implant supported crowns	D6065, D6066	Xray of implant History of D6010	• Documentation shows fully integrated surgical implant with good crown / implant ratio • Healthy bone and periodontium surrounding surgical implant (see D6010) • D6056-6066 require approval of D6010	Prior
Scale and debridement of single implant in the presence of inflammation or mucositis without flap.	D6081	x-rays of implant Perio chart Narrative of necessity	• Documentation describes medical necessity • Not allowed n conjunction with D1110, D4910, or D4346	Prior
Bone graft for repair of peri-implant defect.	D6103	x-ray of implant Perio chart Narrative of necessity	• Documentation supports need for bone graft at implant site • Not allowed same day or within 12 months of implant placement	Prior
Bone graft at the time of implant placement	D6104	Current x-rays of area Narrative of necessity	• Documentation shows healthy bone and periodontium • Approved D6010	Prior
Radiographic/ surgical index by report	D6190	Narrative of necessity	• Documentation describes medical necessity for implant planning	Prior

Procedure	Procedure codes	Documentation (simplified for Skygen)	Criteria for approval	Auth
Bridges	D6211, D6240, D6241, D6242, D6750, D6751, D6752	Panoramic x-ray or FMX Dental charting indicating missing teeth	• Replacement of missing permanent teeth in which the Retainer/Abutment teeth have a favorable long-term prognosis • Replacement of one to two missing teeth in a Tooth Bounded Space • Minimum 50% bone support on abutments • No periodontal furcation on abutments • No sub-crestal caries on abutments • Clinically acceptable RCT on abutments • Unable to wear RPD • Replacement of existing fixed partial denture: • One of the abutment crowns is defective on existing bridge • One of the abutment crowns has recurrent decay on existing bridge • One of the abutment crowns needs root canal on existing bridge	Prior
Impacted Teeth	D7220, D7230, D7240, D7241	• Panoramic x-ray or full series • Narrative of Medical Necessity	**Covered in the following scenarios:** • Recurrent Infection (abscess, cellulitis, pericoronitis that does not respond to conservative treatment) • Non restorable caries, pulpal or periapical lesions or pulpal exposure • Tumor resection • Ectopic position/impinges on the root of an adjacent tooth/horizontal impacted, jeopardizing another molar **Not covered in the following scenarios:** • Asymptomatic Impactions Will Not Be Approved • For pain or discomfort related to normal tooth eruption • For prophylactic reasons other than an underlying medical condition • When a more conservative procedure can be performed • Less than 2/3 of the root developed	Prior Post
Surgical Removal of Residual Tooth Roots	D7250	• Radiographs of current area • Narrative of Medical Necessity	**Covered in the following scenarios:** • When tooth roots or fragments of tooth roots remain in the bone following a previous incomplete tooth extraction **Not covered in the following scenarios:** • Tooth decay resulting in the destruction of the dentition to the extent that only root tips remain (should be considered D7140 or D7210)	Prior Post
Coronectomy - Intentional Partial Tooth Removal - Impacted Teeth Only	D7251	• Panoramic x-ray or full series • Narrative of Medical Necessity	• Radiograph indicates removal of complete tooth would result in damage to the neurovascular bundle - not indicated for teeth with mobility, root surface caries - periapical pathology, or prophylactic reason, discomfort or pain related to normal tooth eruption.	Prior Post
Coronectomy - Intentional Partial Tooth Removal	D7251	Current panoramic x-ray Narrative of necessity	• When clinical criteria for extraction of impacted teeth is met • When the removal of complete tooth would likely result in damage to the neurovascular bundle	Prior Post
Oroantral Fistula Closure / Sinus Perforation	D7260	• Radiographs of current area • Narrative of Medical Necessity	**Covered in the following scenarios:** • An oroantral fistula will not heal spontaneously and must be surgically repaired	Prior
Reimplantation And/Or Stabilization Of Accidentally Evulsed / Displaced Tooth	D7270	• Current Post-Op X-ray • Narrative of necessity	**Covered in the following scenarios:** • Subluxation injuries to permanent teeth • Lateral Luxation injuries of primary and permanent teeth • Extrusion injuries of <3mm in an immature developing primary tooth • Avulsion of permanent teeth **Not covered in the following scenarios:** • Primary teeth if injury is severe or tooth is near exfoliation • Intrusion injuries to primary teeth when the apex is displaced toward the permanent tooth germ • Extrusion injuries of a primary tooth that is fully formed, mobile, and near exfoliation, or the child is unable to cope with an emergency situation	Prior Post
Surgical Access of an Un-erupted Tooth	D7280	• Radiographs of current area • Narrative of Medical Necessity	**Covered in the following scenarios:** • Limited to exposure of the tooth for orthodontic treatment **Not covered in the following scenarios:** • If member does not meet clinical criteria for comprehensive orthodontic treatment • For supernumerary teeth and third molars • When surgical access of impacted tooth would threaten vital structures • Individuals with unmanaged medical conditions that result in excessive bleeding, reduced resistance to infection, or poor healing response • For teeth that would erupt ectopically	Prior Post
Excision Of Benign Lesion Greater Than 1.25 Cm	D7411	• Narrative of Medical Necessity • Pathology Report	**Covered in the following scenarios:** • Documentation supports medical necessity **Not Covered in the following scenarios:** • Non-neoplastic conditions	Prior

Procedure	Procedure codes	Documentation (simplified for Skygen)	Criteria for approval	Auth
Removal of lateral Exostosis	D7471	• Panoramic x-ray • Narrative of Medical Necessity • Photographs	**Covered in the following scenarios:** • If a partial or complete denture cannot be adapted successfully to the alveolar ridge • When causing soft tissue trauma with existing removable appliances • For unusually large Exostoses that are prone to recurrent traumatic injury	Prior
Excision of Bone Tissue	D7472 – D7473	• Panoramic x-ray • Narrative of Medical Necessity • Photographs	Documentation supports medical necessity for fabrication of a prosthesis	Prior
Reduction of Dislocation and Management of TMJ Dysfunctions	D7880	Current x-rays Narrative of necessity	**Covered in the following Scenarios:** • Narrative, x-rays, or photos support medical necessity for procedure • Documentation supports history of TMJ pain / treatment efforts **Not Covered in the following scenarios:** • For bruxism, grinding or other occlusal factors	Prior
Suture Repairs	D7910	• Narrative of Medical Necessity	**Covered in the following scenarios:** • Documentation describes accident **Not covered in the following scenarios:** • Not for tooth extraction or to close surgical incision	Prior
Interceptive and Comprehensive Orthodontic Treatment	D8010, D8020, D8030, D8040, D8070, D8080	• Digital Models • Ceph x-rays • Pano x-rays • Intra/Extraoral Photos • Treatment Plan • Ortho Form	Documentation demonstrates that patient meets the criteria described on the Orthodontic Treatment Approval Request Form for UnitedHealthcare Community Plan of Kentucky.	Prior
Periodic Orthodontic Treatment Visit	D8670	• Approved Comprehensive Othodontic Treatment	Approved ortho banding for comprehensive orthodontic treatment or approved Ortho Continuity of Care Treatment Plan (D8999)	Prior
Removable Appliance Therapy	D8210	• Narrative of Medical Necessity	**Covered in the following scenarios:** • Documentation of thumb sucking or tongue thrusting habit **Not Covered in the following scenarios:** • Minor tooth guidance	Prior
Fixed Appliance Therapy	D8220	• Narrative of Medical Necessity	**Covered in the following scenarios:** • Documentation of thumb sucking or tongue thrusting habit **Not Covered in the following scenarios:** • Minor tooth guidance	Prior
Deep Sedation / General Anesthesia and Intravenous Moderate (Conscious) Sedation	D9222, 9223, D9239, D9243	Narrative of necessity	**Covered in the following scenarios:** • Clinical procedures of extensiveness or complexity or situations that require more than a local anesthetic • Uncooperative or unmanageable individuals for which other behavior management techniques are inappropriate or inadequate • Physical, cognitive, or developmental disabilities • Significant underlying medical condition • Allergy or sensitivity to Local Anesthesia • Lengthy restoration procedures for pediatric members • Individuals with extreme anxiety or fear • Severe infection that inhibits local anesthesia **Not Covered for the following scenarios:** • Electively requested by the member	Prior
Occlusal Guard	D9944, D9945, D9946	Narrarive of necessity	**Covered in the following scenarios:** • Bruxism or clenching either as a nocturnal parasomnia or during waking hours, resulting in excessive wear or fractures of natural teeth or restorations • To protect natural teeth when the opposing dentition has the potential to cause enamel wear such as the presence of porcelain or ceramic restorations **Not Covered for the following scenarios:** • For treatment of temporomandibular disorders or myofascial pain disfunction • As an appliance intended for orthodontic tooth movement	Prior

D.4 Appealing a denied authorization

Members have the right to appeal any fully or partially denied authorization determination. Denied requests for authorization are also known as “adverse benefit determinations.” An appeal is a formal way to share dissatisfaction with an adverse benefit determination.

As a treating provider, you may advocate for your patient and assist with their appeal. If you wish to file an appeal on the member's behalf, you will need their consent to do so.

You or the member may call or mail the information relevant to the appeal within 60 calendar days from the date of the adverse benefit determination.

Member Denied Authorization Appeal Mailing Address:

UnitedHealthcare Community
Attn: Appeals and Grievances Unit
P.O. Box 31364
Salt Lake City, UT 84131-0364
Toll-free: 866-293-1796 (TTY 711)

For standard appeals, if you appeal by phone, you must follow up in writing, ask the member to sign the written appeal, and mail it to UnitedHealthcare Community Plan. Expedited appeals do not need to be in writing.

The member has the right to:

- Receive a copy of the rule used to make the decision.
- Ask someone (a family member, friend, lawyer, health care provider, etc.) to help. The member may present evidence, and allegations of fact or law, in person and in writing.
- Review the case file before and during the appeal process. The file includes medical records and any other documents.
- Send written comments or documents considered for the appeal.
- Ask for an expedited appeal if waiting for this health service could harm the member's health.
- Ask for continuation of services during the appeal. However, the member may have to pay for the health service if it is continued or if the member should not have received the service. As the provider, you cannot ask for a continuation. Only the member may do so.

D.5 Appeal determination timeframe:

- We resolve a standard appeal 30 calendar days from the day we receive it.
- We resolve an expedited appeal 72 hours from when we receive it.

D.6 State Fair Hearing

A stare fair hearing lets members share why they think Kentucky Medicaid services should not have been denied, reduced or terminated.

Members have 120 days from the date on UnitedHealthcare Community Plan's adverse appeal determination letter.

The UnitedHealthcare Community Plan member may ask for a state fair hearing by writing a letter to:

Division of Program Quality and Outcomes
275 E. Main St. 6C-C
Frankfort, KY 40621

Phone: 1-502-564-9444
Fax: 1-502-564-0223
Email: ProviderMCOInquiry@ky.gov – Provider
Complaints: SB20@ky.gov – External Independent Review

The member may ask UnitedHealthcare Community Plan Customer Service for help writing the letter.

The member may have someone attend with them. This may be a family member, friend, care provider or lawyer. Written consent is required.

Processes related to reversal of our initial decision

If the state fair hearing outcome is to not deny, limit, or delay services while the member is waiting on an appeal, then we provide the services:

- As quickly as the member's health condition requires or
- No later than 72 hours from the date UnitedHealthcare Community Plan receives the determination reversal.

If the State Fair Hearing decides UnitedHealthcare Community Plan must approve appealed services, we pay for the services as specified in the policy and/or regulation.

Appendix E: Member rights and responsibilities

For the most updated information regarding Member Rights and Responsibilities, please review the Member Handbook at the following link: **UHCcommunityplan.com/KY**.

E.1 Member rights

Members of UnitedHealthcare Community Plan of Kentucky have a right to:

- Respect, dignity, privacy, confidentiality, accessibility and nondiscrimination.
- A reasonable opportunity to choose a PCP and to change to another provider in a reasonable manner.
- Consent for or refusal of treatment and active participation in decision choices.
- Ask questions and receive complete information relating to your medical condition and treatment options, including specialty care.
- Voice grievances and receive access to the grievance process, receive assistance in filing an appeal, and request a State Fair Hearing from UnitedHealthcare Community Plan of Kentucky and/or the Department.
- Timely access to care that does not have any communication or physical access barriers.
- Prepare Advance Medical Directives.
- Assistance with requesting and receiving a copy of your medical records.
- Timely referral and access to medically indicated specialty care.
- Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.
- Be furnished health care services in accordance with federal and state regulations.

E.2 Member responsibilities

Members of UnitedHealthcare Community Plan of Kentucky agree to:

- Work with their PCP to protect and improve their health.
- Find out how their health plan coverage works.
- Listen to their PCP's advice and ask questions when in doubt.
- Call or go back to their PCP if they do not get better or ask to see another provider.
- Treat health care staff with the respect they expect themselves.
- Tell us if they have problems with any health care staff by calling Member Services at 1-866-293-1796.
- Keep their appointments, calling as soon as they can if they must cancel.
- Use the emergency department only for real emergencies.
- Call their PCP when you need medical care, even if it is after-hours.

Dental Benefit Providers®