Dental Provider Manual

UnitedHealthcare Community Plan of Massachusetts

MA One Care

For MA SCO plan details visit the Medicare Advantage QRG.

Provider Services: 1-800-980-2986

January 1, 2026

United Healthcare® | Dental Benefit Providers®

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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 provider 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 **1-800-980-2986.**

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.

Unless otherwise specified herein, this Manual is effective the date found on the cover 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/provideracademy**.

Required trainings

To remain compliant with Massachusetts State requirements, participating providers with the Massachusetts One Care program are required to complete the Cultural Competency training annually by December 31.

To complete the trainings:

- Click **HERE** to go to the state-specific training page
- Choose Massachusetts and select "Cultural Competency and Americans with Disabilities Act - REQUIRED TRAINING"
- Click on "Start Course" and complete the Attestation
- After submitting the completed Attestation, click the "forward arrow" in the bottom right corner to advance to the next page

Section 2: Patient eligibility verification procedures

2.1 Member eligibility

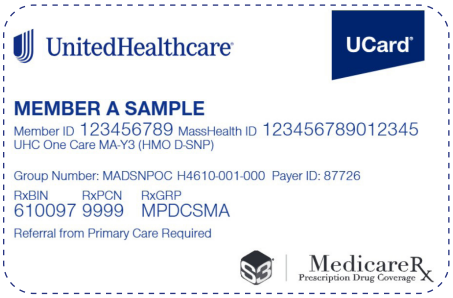
Member eligibility or dental benefits may be verified online or via phone.

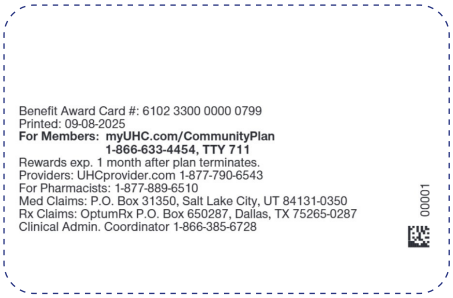
Important Note: Eligibility should be verified on the date of service. Verification of eligibility is not a guarantee of payment. Payment can only be made after the claim has been received and reviewed in light of eligibility, dental necessity and other limitations and/or exclusions. **Additional rules 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 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 manual. A sample ID card is provided below. The member's actual ID card may look slightly different.





2.3 Eligibility verification

Eligibility should be verified on the date of service. You can check eligibility on the Dental Hub at **UHCdental.com/medicaid** or via the Interactive Voice Response (IVR) system. Both options are 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 team is available during normal business hours to assist you with any questions you may have. They are trained to handle calls regarding 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– 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 Website UHCdental.com/medicaid

The UnitedHealthcare Community Plan website at **UHCdental.com/medicaid** offers valuable resources, including access to standard forms, provider manuals, quick reference guides, training materials, and network specialists search tools.

Additionally, you can register for the provider portal (Dental Hub) directly from the website. The Dental Hub provides a range of time-saving features including eligibility verification, benefit information, claims submission and status, remittance, and more. Visit **UHCdental.com/medicaid** to register or log in to the Dental Hub as a participating user.

To register for the Dental Hub, you will need a W-9 and a recently paid claim, or the verification code from your Welcome Letter. For additional assistance with the Dental Hub, call Provider Services.

2.6 Integrated Voice Response (IVR) system

We have a toll-free Integrated Voice Response (IVR) system that allows 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 procedure 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

You shall 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 new associates are added, you must contact us within 10 calendar days to request an application. This allows us to credential the associate and set them up as a participating provider.

It is important to remember associates cannot see members as participating providers until they are credentialed by our organization.

To request a provider application packet, visit **UHCdental.com/medicaid** > Join our network or contact Provider Services at the telephone number listed on the cover of this manual.

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

As a participating provider, it is important to notify us of any demographic changes within your practice. This ensures accurate claims processing and helps maintain up-to-date directories for members.

Requests for demographic changes must be submitted in writing with supporting documentation. For example, a TIN change requires a new W9, while an office closing notice must be on office letterhead. In addition, when making changes, the old information and the requested updates, including names, TINs, and Practitioner IDs for all affected associates must be provided.

Changes should be submitted to:

UnitedHealthcare – RMO
ATTN: 400-Provider Services
P.O. BOX 30567
SALT LAKE CITY, UT 84130

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

Credentialing updates should be sent to:

2300 Clayton Road
Suite 1000
Concord, CA 94520

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, contact Provider Services at the telephone number listed on the cover of this manual 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/medicaid**. Click "Find a Dentist" on the top right and then choose "Medicaid Plans" to search by location. You may also contact Provider Services at the telephone number listed on the cover of the manual.

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, applicants must complete the full credentialing process and receive approval from our Credentialing Committee. To maintain participation, all practitioners are required to undergo recredentialing - typically every three (3) years, unless otherwise mandated by state regulations.

Initial Credentialing

Before acceptance into the network, a dentist's credentials are thoroughly evaluated. UnitedHealthcare partners with SKYGEN Dental Hub to collect the necessary data for both credentialing and recredentialing. Timely responses to inquiries from SKYGEN or UnitedHealthcare are essential to ensure the process is completed efficiently.

Credentialing includes a review of the state license status, sanctions or disciplinary actions, malpractice insurance coverage, and other relevant professional credentials. If any adverse findings are identified, we will request a written explanation, including details of the incident, its resolution, and a corrective action plan to prevent recurrence.

For certain plans or markets, initial facility site visits may be required based on state-specific regulations. Each location must pass the facility review before activation. Your Professional Networks Representative will inform you if a site visit is necessary during the recruitment process.

The Credentialing Committee evaluates all submitted information against established criteria. These criteria are reviewed and approved with input from practicing network providers to ensure alignment with accepted industry standards. If discrepancies are found in submitted forms, UnitedHealthcare will request clarification or correction. Providers have the right to:

- Review and correct erroneous information
- Be informed of their application status

Recredentialing

Recredentialing is required to maintain participation and is a condition of your provider agreement. Failure to comply with the recredentialing process may result in termination for cause.

Recredentialing requests are sent several months before the due date. In the request, you will be directed to the SKYGEN Dental Hub to start the process. If SKYGEN cannot obtain a complete recredentialing packet, UnitedHealthcare will make additional outreach attempts. If there is no response, UnitedHealthcare will issue a termination letter to the provider.

In addition to the items verified in the initial credentialing process, UnitedHealthcare may also review provider performance measures, including:

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

For more details on credentialing, refer to the **Credentialing Guidelines** available at **UHCdental.com/resources**.

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

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** > Tools and resources > Resource library > Pharmacy resources > Drug lists and pharmacy > Opioid Programs and Resources - Community Plan (Medicaid).

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 **Preventing Opioid Overdose | Overdose Prevention | CDC**.

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.

https://www.uhcprovider.com/en/resource-library/patient-health-safety/cultural-competency.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 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 Dental Hub. Refer to Section 2.5 for more information on how to register as a participating user.

9.1.c Electronic payments

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

9.2.a Dental claim form required information

The 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 as it appears on dental license
- License number
- TIN (or SSN)
- Address (street, city, state, ZIP code)
- Phone number
- NPI

Record of services provided

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

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 ADA store at **engage.ada.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 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 six (6) years or longer if required by applicable statutes or regulations.

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 on the summary page:

PROVIDER/ID NUMBER - Treating dentist name and Practitioner ID number

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

AMOUNT BILLED - Amount submitted by provider

AMOUNT PAYABLE - Amount payable after benefits have been applied

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

OTHER INSURANCE - Amount payable by another carrier

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

NET AMOUNT - Total amount paid

Below is a list and description of each field on the services detail page:

PATIENT NAME

SUBSCRIBER/MEMBER NUMBER - Identifying number on the subscriber's ID card

DOB (Date of Birth) - Patient date of birth

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 (Date of Service) - Dates that services are rendered/performed

CODE - 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)

POS (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 - 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 MO Medicaid

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

UnitedHealthcare®

Please address questions to:

UnitedHealthcare MO 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 MO 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 MO 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 Missouri
Product: UHC MO 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 Missouri
Product: UHC MO 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 Missouri
Product: UHC MO 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 Missouri
Product: UHC MO 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:

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

Please note: 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.

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.

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.

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 logging into the Dental Hub at **UHCdental.com/medicaid**.

9.9 Corrected claim submission guidelines

A corrected claim should ONLY be submitted when an original claim or service was PAID based upon incorrect information. As part of the process, the original claim will be recouped, and a new claim processed in its place with any necessary changes.

Examples of correction(s) for 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

A corrected claim may be submitted using the methods below:

- Electronically through Clearing House

- Electronically through the Dental Hub
- Paper to the mailing address below

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

Electronic submission is 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 P.O. 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.

If a claim or service originally DENIED due to incorrect or missing information/authorization, 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. 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 the appeals language on the Provider Remittance Advice for guidance with the appeals process applicable to the state plan.

Appendices for the State of Massachusetts

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: UnitedHealthcare Dental Claims P.O. Box 637 Milwaukee, WI 53201	**1-800-980-2986**	GP133	Within 180 calendar days from the date of service For secondary claims, within 180 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	**1-800-980-2986**	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: UnitedHealthcare Dental Attn: Appeals Department P.O. Box 196 Milwaukee, WI 53201	**1-800-980-2986**	N/A	Within 60 days after the claim determination	Supporting documentation, including claim number is required for processing.
Prior Authorization Requests	Pre-authorizations: UnitedHealthcare Dental P.O. Box 700 Milwaukee, WI 53201	**1-800-980-2986**	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 your state's Medicaid and legislature included in your state's Medicaid Provider Billing Manual.

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.

Any service not listed as a covered service in the benefit grids (Appendix B.2) is excluded.

Please call Provider Services 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**.

For **MA SCO** plan details visit the **Medicare Advantage QRG**.

MA One Care benefit grid

Code	Description	Age limits	Frequency limits	Auth required
D0120	Periodic Oral Exam	21 - 999	2 per 1 Accum Year	N
D0140	Limited Oral Evaluation - Problem Focused	21 - 999	2 per 1 Accum Year	N
D0150	Comprehensive Oral Evaluation - New Or Established Patient	21 - 999	1 per 1 Lifetime	N
D0180	Comprehensive periodontal evaluation	21 - 999	1 per 1 Accum Year	N
D0190	Screening Of A Patient	21 - 999	2 per 1 Accum Year	N
D0191	Assessment Of A Patient	21 - 999	1 per 1 Accum Year	N
D0210	Intraoral - Comprehensive Series of Radiographic Images	21 - 999	1 per 3 Accum Year	N
D0220	Intraoral - Periapical First Radiographic Image	21 - 999		N
D0230	Intraoral - Periapical Each Additional Image	21 - 999		N
D0270	Bitewing - Single Radiographic Image	21 - 999	2 per 1 Accum Year	N
D0272	Bitewings - Two Radiographic Images	21 - 999	2 per 1 Accum Year	N
D0273	Bitewings - Three Radiographic Images	21 - 999	2 per 1 Accum Year	N
D0274	Bitewings - Four Radiographic Images	21 - 999	2 per 1 Accum Year	N
D0330	Panoramic Radiographic Image	21 - 999	1 per 3 Accum Year	N
D0340	2D Cephalometric Radiographic Image	21 - 999		N
D1110	Prophylaxis - Adult	21 - 999	2 per 1 Accum Year	N
D1354	Interim Caries Arresting Medicament Application - per tooth	21 - 999	2 per 1 Lifetime	N
D2140	Amalgam - One Surface, Primary Or Permanent	21 - 999	1 per 1 Lifetime	N
D2150	Amalgam - Two Surfaces, Primary Or Permanent	21 - 999	1 per 1 Lifetime	N
D2160	Amalgam - Three Surfaces, Primary Or Permanent	21 - 999	1 per 1 Lifetime	N
D2161	Amalgam - Four Or More Surfaces, Primary Or Permanent	21 - 999	1 per 1 Lifetime	N
D2330	Resin-Based Composite - One Surface, Anterior	21 - 999	1 per 1 Lifetime	N
D2331	Resin-Based Composite - Two Surfaces, Anterior	21 - 999	1 per 1 Lifetime	N
D2332	Resin-Based Composite - Three Surfaces, Anterior	21 - 999	1 per 1 Lifetime	N
D2335	Resin-Based Composite - Four or More Surfaces (Anterior)	21 - 999	1 per 1 Lifetime	N
D2391	Resin-Based Composite - One Surface, Posterior	21 - 999	1 per 1 Lifetime	N
D2392	Resin-Based Composite - Two Surfaces, Posterior	21 - 999	1 per 1 Lifetime	N
D2393	Resin-Based Composite - Three Surfaces, Posterior	21 - 999	1 per 1 Lifetime	N
D2394	Resin-Based Composite - Four Or More Surfaces, Posterior	21 - 999	1 per 1 Lifetime	N
D2721	Crown - Resin With Predominantly Base Metal	21 - 999	1 per 60 Month	N
D2740	Crown - Porcelain/Ceramic	0 - 999	1 per 60 Month	Y
D2751	Crown - Porcelain Fused To Predominantly Base Metal	21 - 999	1 per 60 Month	N
D2910	Re-Cement Or Re-Bond Inlay, Onlay, Veneer Or Partial Coverage Restoration	21 - 999		N
D2920	Re-Cement or Re-Bond Crown	21 - 999		N

Code	Description	Age limits	Frequency limits	Auth required
D2931	Prefabricated Stainless Steel Crown - Permanent Tooth	21 - 999		N
D2950	Core Buildup, Including Any Pins When Required	21 - 999	1 per 60 Month	N
D2951	Pin Retention - Per Tooth, In Addition To Restoration	21 - 999		N
D2954	Prefabricated Post And Core In Addition To Crown	21 - 999	1 per 60 Month	N
D2980	Crown Repair	21 - 999		N
D2999	Unspecified Restorative Procedure, By Report	21 - 999		Y
D3120	Pulp Cap - Indirect (Excluding Final Restoration)	21 - 999		N
D3310	Endodontic Therapy, Anterior Tooth (Excluding Final Restoration)	21 - 999	1 per 1 Lifetime	N
D3320	Endodontic Therapy Premolar Tooth (Excluding Final Restoration)	21 - 999	1 per 1 Lifetime	N
D3330	Endodontic Therapy, Molar tooth (Excluding Final Restoration)	21 - 999	1 per 1 Lifetime	N
D3346	Retreatment Of Previous Root Canal Therapy - Anterior	21 - 999		N
D3347	Retreatment Of Previous Root Canal Therapy - Premolar	21 - 999		N
D3348	Retreatment Of Previous Root Canal Therapy - Molar	21 - 999		N
D3410	Apicoectomy - Anterior	21 - 999	1 per 1 Lifetime	N
D3421	Apicoectomy - Premolar (First Root)	21 - 999	1 per 1 Lifetime	N
D3425	Apicoectomy - Molar (First Root)	21 - 999	1 per 1 Lifetime	N
D3426	Apicoectomy - Each Additional Root)	21 - 999		N
D4210	Gingivectomy Or Gingivoplasty - Four Or More Contiguous Teeth	21 - 999	1 per code per quadrant every 3 accum years	Y
D4211	Gingivectomy Or Gingivoplasty - One To Three Contiguous Teeth	21 - 999	1 per code per quadrant every 3 accum years	Y
D4341	Periodontal Scaling And Root Planing - Four Or More Teeth Per Quadrant	0 - 999	1 per code per quadrant every 3 accum years	Y
D4342	Periodontal Scaling And Root Planing - One To Three Teeth Per Quadrant	0 - 999	1 per code per quadrant every 3 accum years	Y
D4346	Scaling in moderate or severe gingival inflammation	21 - 999	2 per 1 Accum Year	N
D5110	Complete Denture - Maxillary	21 - 999	1 per 84 Month	N
D5120	Complete Denture - Mandibular	21 - 999	1 per 84 Month	N
D5211	Maxillary Partial Denture - Resin Base	21 - 999	1 per 84 Month	N
D5212	Mandibular Partial Denture - Resin Base	21 - 999	1 per 84 Month	N
D5511	Repair Broken Complete Denture Base - Mandibular	21 - 999		N
D5512	Repair Broken Complete Denture Base - Maxillary	21 - 999		N
D5520	Replace missing or broken teeth - complete denture (each tooth) - per tooth	21 - 999		N
D5611	Repair Resin Partial Denture Base - Mandibular	21 - 999		N
D5612	Repair Resin Partial Denture Base - Maxillary	21 - 999		N
D5621	Repair Cast Partial Framework - Mandibular	21 - 999		N
D5622	Repair Cast Partial Framework - Maxillary	21 - 999		N
D5630	Repair Or Replace Broken Retentive / Clasping Materials - Per Tooth	21 - 999		N
D5640	Replace missing or broken teeth - partial denture - per tooth	21 - 999		N
D5650	Add tooth to existing partial denture - per tooth	21 - 999		N
D5660	Add Clasp To Existing Partial Denture - Per Tooth	21 - 999		N
D5730	Reline Complete Maxillary Denture (Direct)	21 - 999	1 per 24 Month	N
D5731	Reline Complete Mandibular Denture (Direct)	21 - 999	1 per 24 Month	N

Code	Description	Age limits	Frequency limits	Auth required
D5750	Reline Complete Maxillary Denture (Indirect)	21 - 999	1 per 24 Month	N
D5751	Reline Complete Mandibular Denture (Indirect)	21 - 999	1 per 24 Month	N
D6780	Retainer Crown - 3/4 Cast High Noble Metal	21 - 999		N
D6791	Retainer Crown - Full Cast Predominantly Base Metal	21 - 999		N
D6999	Unspecified Fixed Prosthodontic Procedure, By Report	21 - 999		Y
D7111	Extraction, Coronal Remnants - PrimaryTooth	21 - 999		N
D7140	Extraction, Erupted Tooth Or Exposed Root	21 - 999		N
D7210	Extraction, Erupted Tooth	21 - 999		N
D7220	Removal Of Impacted Tooth - Soft Tissue	21 - 999		N
D7230	Removal Of Impacted Tooth - Partially Bony	21 - 999		N
D7240	Removal Of Impacted Tooth - Completely Bony	21 - 999		N
D7250	Removal Of Residual Tooth (Cutting Procedure)	21 - 999		N
D7251	Coronectomy - Intentional Partial Tooth Removal - Impacted Teeth Only	0 - 999	1 per 1 Lifetime	N
D7270	Reimplantation And/Or Stabilization Of Accidentally Evulsed / Displaced Tooth	21 - 999		N
D7310	Alveoloplasty In Conjunction With Extractions - Four Or More Teeth	21 - 999	1 per code per quadrant every 6 months	N
D7311	Alveoloplasty In Conjunction With Extractions - One To Three Teeth	21 - 999	1 per code per quadrant every 6 months	N
D7320	Alveoloplasty Not In Conjunction With Extractions - Four Or More Teeth	21 - 999	1 per code per quadrant every 6 months	N
D7321	Alveoloplasty Not In Conjunction With Extractions - One To Three Teeth	21 - 999	1 per code per quadrant every 6 months	N
D7340	Vestibuloplasty - Ridge Extension (Secondary Epithelialization)	21 - 999		Y
D7350	Vesibuloplasty - Ridge Extension (Including Soft Tissue Grafts)	21 - 999		Y
D7410	Excision Of Benign Lesion Up To 1.25 Cm	21 - 999		N
D7411	Excision Of Benign Lesion Greater Than 1.25 Cm	21 - 999		N
D7450	Removal Of Benign Odontogenic Cyst Or Tumor - Dia Up To 1.25 Cm	21 - 999		N
D7451	Removal Of Benign Odontogenic Cyst Or Tumor - Dia Greater Than 1.25 Cm	21 - 999		N
D7460	Removal Of Benign Nonodontogenic Cyst Or Tumor - Dia Up To 1.25 Cm	21 - 999		N
D7461	Removal Of Benign Nonodontogenic Cyst Or Tumor - Dia Greater Than 1.25 Cm	21 - 999		N
D7471	Removal Of Lateral Exostosis (Maxilla Or Mandible)	21 - 999	1 per code per arch every lifetime	N
D7472	Removal Of Torus Palatinus	21 - 999	1 per 1 Lifetime	N
D7473	Removal Of Torus Mandibularis	21 - 999	1 per 1 Lifetime	N
D7961	Buccal / Labial Frenectomy (Frenulectomy)	21 - 999		N
D7962	lingual frenectomy (frenulectomy)	21 - 999		N
D7963	Frenuloplasty	21 - 999		N
D7970	Excision Of Hyperplastic Tissue - Per Arch	21 - 999		N
D7999	Unspecified Oral Surgery Procedure, By Report	21 - 999		Y
D8680	Orthodontic Retention (Removal Of Appliances, Place Retainers)	21 - 999	1 per 1 Lifetime	Y
D8999	Unspecified Orthodontic Procedure, By Report	21 - 999		Y
D9110	Palliative (Emergency) Treatment Of Dental Pain - Per Visit	21 - 999		N
D9222	Deep Sedation/General Anesthesia - First 15 Minutes	21 - 999		N

Code	Description	Age limits	Frequency limits	Auth required
D9223	Deep Sedation / General Anesthesia - Each subsequent 15 Minute Increment	21 - 999		N
D9230	Inhalation Of Nitrous/Analgesia, Anxiolysis	21 - 999		N
D9239	Intravenous Moderate (Conscious) Sedation/Analgesia - First 15 Minutes	21 - 999		N
D9243	Intravenous Moderate (Conscious) Sedation/Analgesia - Each Subsequent 15 Minute	21 - 999		N
D9248	Non-Intravenous Conscious Sedation	21 - 999		N
D9310	Consultation - Diagnostic Service Provided By Dentist Or Physician	0 - 999	1 per 1 Lifetime	N
D9410	House/Extended Care Facility Call	21 - 999	1 per 1 Day	N
D9450	Case Presentation, Subsequent to Detailed and Extensive Treatment Planning	21 - 999	1 per 1 Day	N
D9920	Behavior Management, By Report	21 - 999		Y
D9930	Treatment Of Complications (Post Surgical) - Unusual Circumstances, By Report	21 - 999		Y
D9995	Teledentistry - Synchronous; Real-Time Encounter	21 - 999	1 per 1 Day	N
D9996	Teledentistry - Asynchronous; Information Stored And Forwarded To Dentist	21 - 999	1 per 1 Day	N
D9999	Unspecified Adjunctive Procedure, By Report	21 - 999		Y
T1013	Sign Language or Oral Interpretive Services	21 - 999	1 per 1 Day	N
T1015	FQHC Encounter Payment - ADA	21 - 999	1 per 1 Day	N

Appendix C: Authorization for treatment

C.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.

C.2 Authorization timelines

The following timelines will apply to requests for authorization:

- We will make a determination and send notification on standard authorizations within 7 calendar days of receipt of the request.
- We will make a determination and send notificaiton on expedited authorizations within 72 hours of receipt of the request.
- Authorization approvals will expire 180 days from the date of determination.

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

C.4 Peer-to-Peer Review

The treating provider can request a peer-to-peer review with the dental consultant within 60 calendar days of adverse benefit determination. The dental consultant conducting the peer-to-peer consultation will clearly identify what documentation the provider must provide to obtain approval of the specific item, procedure, or service; or a more appropriate course of action based upon accepted clinical guidelines. To make the request, call Provider Services at **1-800-980-2986** 8 a.m. - 6 p.m. (ET) Monday-Friday.

Note:

- Peer-to-peer review is only for prior authorizations. You must file an appeal for post authorization as the services have already been rendered and are not eligible for peer-to-peer.
- Peer-to-peer review is only valid within 60 days of issuance of denial. Providers who have appealed services are not eligible for a peer-to-peer request.

UnitedHealthcare will offer a peer-to-peer consultation within a mutually agreed upon time within 24 business hours of a provider's request for a peer-to-peer consultation.

C.5 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.

C.6 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.

C.7 State Fair Hearing

A state fair hearing lets members share why they think Massachusetts 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 to file for a State Fair Hearing.

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

Division of Program Quality and Outcomes
MassHealth
100 Hancock St.
6th Floor
Quincy, MA 02171

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.

C.8 Credentialing and Recredentialing Appeals

Appeals for credentialing / re-credentialing for disciplinary action is not applicable in your state.

Appendix D: Member rights and responsibilities

For the most updated information regarding Member Rights and Responsibilities, please review the Member Handbook.

D.1 Member rights

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

- Respect, dignity, privacy, confidentiality, accessibility and nondiscrimination.
- A reasonable opportunity to choose a Dentist 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 Massachusetts and/or the Department of Health and Human Services.
- 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.

D.2 Member responsibilities

Members of UnitedHealthcare Community Plan of Massachusetts agree to:

- Work with their Dentist to protect and improve their health.
- Find out how their dental plan coverage works.
- Listen to their Dentist's advice and ask questions when in doubt.
- Call or go back to their Dentist 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 **1-877-832-7730.**
- Keep their appointments, calling as soon as they can if they must cancel.
- Use the emergency department only for real emergencies.
- Call their Dentist when you need dental care, even if it is after-hours.

Dental Benefit Providers®