Dental Provider Manual

UnitedHealthcare Dental
Commercial PPO

Spring 2023

United Healthcare | Dental Benefit Providers®

Contents

Section 1: Introduction — who we are

Welcome to UnitedHealthcare®

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

UnitedHealthcare is committed to providing accessible, quality, comprehensive dental care 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.

UnitedHealthcare offers a portfolio of products to its members, your patients, as well as to its participating dental offices. Products include Preferred Provider Organization (PPO), Exclusive Provider Organization (EPO), In-Network Only (INO), Dental Health Maintenance Organization (DHMO), Discount Preferred Programs, Direct Compensation (DC) and various discounted Fee for Service (FFS) plans.

The products offered and how our plans are branded vary by market, based on how the products are licensed and the associated contracting entity.

This Provider Manual is designed as a comprehensive reference guide focusing on the PPO, EPO and INO plans referenced above. Here you will find the tools and information needed to successfully administer UnitedHealthcare plans. As changes and new information arise, we will send these updates to you. Please store these updates with this Provider Manual for future reference.

Our Medicaid, and many of our DHMO and Direct Compensation Plans, are summarized separately. If you support one of these plans and need a manual, please log into **UHCdental.com** with your Optum ID or contact our Provider Services team at **1-800-822-5353.**

This manual is being provided in accordance with your executed agreement. If you have any questions or concerns about the information contained within this Provider Manual, please contact the UnitedHealthcare provider services team at **1-800-822-5353.**

UHC On Air

UHC On Air is a source for 24/7 on demand video broadcasts created specifically for UHC Dental providers. UHC On Air provides instant access to content for providers, such as:

- Educational video resources,
- Interactive provider training materials,
- Onboarding content for new dentists,
- Up-to-date operational and clinical policy information,
- Market-specific programs, and
- Provider advocate profiles.

To access UHC On Air, log into **UHCdental.com** with your Optum ID, or you may use this link, **https://cx.uhc.com/content/uhc-provider/dentalprovidereducation/en.html**.

Section 2: Resources & services

2.1. Quick reference guides – addresses and phone numbers

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

Our Provider Servicing Team is available to assist you in plan administration. Call our toll-free number during normal business hours to speak with knowledgeable specialists. They are trained to address eligibility, claims, plan information and contract inquiries.

Refer to the table below for available resources based on type of inquiry.

You want to:	Provider Services Line – Dedicated Service Representatives Phone: 1-800-822-5353 Hours: 8 am–9 pm EST or 7 am–8 pm CST	Online: UHCdental.com	Interactive Voice Response (IVR) System Phone: 1-800-822-5353 Hours: 24 / 7
Inquire about a claim	✓	✓	✓
Ask a benefit / plan question (including prior authorization requirements)	✓	✓	✓
Inquire about eligibility	✓	✓	✓
Request an EOB	✓	✓	
Request a Fee Schedule	✓	✓	
Request a copy of your contract	✓		
Ask a question about your contract	✓		
Inquire about the In-Network Practitioner Listing	✓	✓	✓
Nominate a provider for participation	✓	✓	
Changes to Practice Information (e.g., associate updates, address changes, adding or deleting addresses, Tax Identification Number change, specialty designation, demographic updates)	✓	✓	
Request participation status change	✓		
Request documents	✓	✓	
Request benefit information	✓	✓	

Need:	Address	Phone Number	Payer I.D.	Submission Guidelines	Form(s) Required
Claim Submission (initial)	CLAIMS UnitedHealthcare P.O. Box 30567 Salt Lake City, UT 84130-0567	1-800-822-5353	52133 Claim Filing indicator: "CL"	Within 90 days of the date of service	ADA Claim Form, 2019 version or later
Prior Authorization Requests*	PTE/Preauthorizations UnitedHealthcare P.O. Box 30552 Salt Lake City, UT 84130-0567	1-800-822-5353	52133		ADA Claim Form – check the box titled: Request for Predetermination / Preauthoriza- tion section of the ADA Dental Claim Form
Claim Adjustment Request or Requests for Reprocessing	Adjustments/ Resubmissions UnitedHealthcare P.O. Box 30567 Salt Lake City, UT 84130-0567	1-800-822-5353	52133	Within 60 days from receipt of payment	ADA Claim Form Provider narrative Reason for requesting adjustment or resubmission
Claim Disputes	Provider Disputes UnitedHealthcare P.O. Box 30567 Salt Lake City, UT 84130-0567	1-800-822-5353	N/A	Within 60 days from receipt of payment	ADA Claim Form Written summary of appeal
Coordination of Benefits	Claims UnitedHealthcare P.O. Box 30567 Salt Lake City, UT 84130-0567	1-800-822-5353	52133	Within 90 days of the date of service	ADA Claim Form Primary Payer's EOB showing the amount paid by the primary payer
Member Complaints and Appeals	UnitedHealthcare P.O. Box 30569 Salt Lake City, UT 84130-0567	1-800-822-5353	N/A	N/A	N/A

2.2.A Integrated Voice Response (IVR) system 1-800-822-5353

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

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

2.2.B Website UHCdental.com

The UnitedHealthcare website, **UHCdental.com**, offers many time-saving features including eligibility verification, pre-authorization, claims submission and status, remittance, procedure level pricing, fee schedules, benefit information, provider search and much more 24 hours a day, seven days a week.

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

Through this site, you may also enroll in Electronic Payments and Statements, a free direct deposit service. To obtain the necessary forms and/or complete enrollment for these services, register and log in to **UHCdental.com**, go to Quick Links and click Electronic Payments and Statements. Also refer to section 2.3 Electronic Payments and Statements for more information.

We make it easy to get started

You can use our Online Guided Tour under the dentist site to take you through the registration process.

Once you have registered on our provider website at **UHCdental.com**, you can verify your patients' eligibility online with just a few clicks.

Please contact our Customer Service line if you have additional questions or need help registering on our website.

Note: Passwords are the responsibility of the dental office (see agreement during the registration process).

2.3. Electronic Payments and Statements

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**.

Section 3: Plan eligibility

Eligibility may be verified one of three ways:

1. At our website (**UHCdental.com**)
2. Through our Interactive Voice Response (IVR) available through the Provider Services line
3. By speaking with a Provider Services Representative

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

3.1 Member identification card

Members are issued an identification (ID) card to all recipients enrolled in benefits. When members of a family enroll, separate cards may be issued to each family member. The ID cards are customized with the Plan logo and include the toll-free customer service number. For DHMO plans, the primary care dentist name and telephone number is also included. ID cards also include the member's group ID number.

The ID card has instructions for both members (how to access care) and providers (eligibility verification). ID cards should be presented by members when services are rendered.

Presentation by a person with an ID card is not a guarantee of payment. It is the responsibility of the provider to verify eligibility at the time of service.

3.2 Eligibility verification

As outlined in your provider agreement, member eligibility must be verified prior to rendering services. This section contains helpful tips on how to establish eligibility through our Provider Servicing tools.

The Interactive Voice Response (IVR) system

Our Provider Services line provides IVR features that enable you to obtain up-to-the minute eligibility information with one quick telephone call. Eligibility may be verified for one or more members at a time by using either voice or touch-tone keypad, or a combination. This 24-hour-a-day, seven-day-a-week, toll-free access delivers immediate eligibility information directly by fax to your office.

The IVR is never busy, there is never a wait and is available 24 hours a day, seven days a week.
Provider services line: 1-800-822-5353

Important Note: A member's ID card is not proof of eligibility. 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.

It's easy to get started.

All you need is the following:

- A touch-tone phone
- The member's name, subscriber ID number and date of birth
- Your dental office fax number

When calling the Provider Services line, here's what you'll receive:

- Confirmation of the member's name
- Dependent information
- Plan details

Upon your request, our IVR system will automatically fax to your office all the information needed to effectively and efficiently serve your patients.

Use the touch-tone option if you are encountering problems with speech recognition.

3.3 Specialty care referral guidelines

No authorization is needed for participating dentists to refer members to a specialist.

If specialty care is necessary, please refer members to a participating specialist, whenever possible, as it will be less costly for the member. Members covered under an "in-network only" plan can only utilize their benefits when treated by a participating specialist.

You may obtain a listing of participating specialists in your area through our website, **UHCdental.com,** or by calling **1-800-822-5353** and using the Interactive Voice Response (IVR) system. If you are unable to locate a participating specialist in your area, contact a provider services representative at **1-800-822-5353** for assistance.

Section 4: Member benefits/exclusions & limitations

4.1.A Diagnostic services guidelines

For the most recent and up to date clinical policy criteria and documentation requirements please follow **UHCdental.com> RESOURCES> CLINICAL GUIDELINES**, or you may use this **LINK**.

Code	Description	Age	Frequencies and limitations	Clinical review req
DIAGNOSTIC				
Clinical Oral Evaluations				
D0120	Periodic oral evaluation – established patient	0 - 99	Limited to 2 times per consecutive 12 months.	N
D0140	Limited oral evaluation – problem focused	0 - 99	Periodic Oral Evaluation - Limited to 2 times per consecutive 12 months.	N
D0145	Oral evaluation for a patient under three years of age and counseling with primary caregiver	0 - 2	Limited to 2 times per consecutive 12 months. Not Covered if done in conjunction with other exams.	N
D0150	Comprehensive oral evaluation – new or established patient	0 - 99	Comprehensive Oral Evaluation - Limited to 2 times per consecutive 12 months. Not Covered if done in conjunction with other exams.	N
D0160	Detailed and extensive oral evaluation – problem focused, by report	0 - 99	Limited to 2 times per consecutive 12 months. Only 1 exam is Covered per date of service.	N
D0170	Re-evaluation – limited, problem focused (established patient; not post-operative visit)	0 - 99	Service Not Listed - Included in category for Limited or Detailed Oral Evaluation. Limited or Detailed Oral Evaluation. Limited to 2 times per consecutive 12 months. Only 1 exam is Covered per date of service.	N
D0180	Comprehensive periodontal evaluation – new or established patient	0 - 99	Comprehensive Periodontal Evaluation - new or established patient. Limited to 2 times per consecutive 12 months.	N
Radiographs / Diagnostic Imaging (Including Interpretation)				
D0210	Intraoral – complete series of radiographic images	0 - 99	Limited to 1 time per consecutive 36 months. Vertical bitewings can not be billed in conjunction with a complete series.	N
D0220	Intraoral – periapical first radiographic image	0 - 99		N
D0230	Intraoral – periapical each radiographic image	0 - 99		N
D0240	Intraoral – occlusal radiographic image	0 - 99		N
D0250	Extraoral – first radiographic image	0 - 99	Limited to 2 films per calendar year.	N
D0251	Extra-oral posterior dental radiographic image	0 - 99	Limited to 2 films per calendar year.	N
D0270	Bitewing – single radiographic image	0 - 99	Limited to 4 films per calendar year.	N
D0272	Bitewings – two radiographic image	0 - 99	Limited to 1 series of films per calendar year.	N
D0273	Bitewings – three radiographic image	0 - 99	Limited to 1 series of films per calendar year.	N
D0274	Bitewings – four radiographic image	0 - 99	Limited to 1 series of films per calendar year.	N
D0277	Vertical bitewings – 7 to 8 radiographic image	0 - 99	Limited to 1 time per consecutive 36 months. Vertical bitewings can not be billed in conjunction with a complete series.	N
D0320	Temporomandibular joint arthrogram, including injection	0 - 99	TMJ plans only; not generally covered on standard plans - Limited to 1 film per joint, total of 2 films per consecutive 12 months.	N
D0321	Other temporomandibular joint radiographic image	0 - 99	TMJ plans only; not generally covered on core standard plans - Limited to 1 film per joint, total of 2 films per consecutive 12 months.	N
D0322	Tomographic survey	0 - 99	TMJ plans only; not generally covered on standard plans - Limited to 1 film per joint, per consecutive 12 months.	N
D0330	Panoramic radiographic image	0 - 99	Limited to 1 time per consecutive 36 months.	N
D0340	Cephalometric radiographic image	0 - 18	Limited to 1 per consecutive 12 months. Can only be billed for orthodontics.	N
D0350	Oral/facial photographic images obtained intraorally or extraorally	0 - 99	Limited to 1 time per consecutive 36 months.	N
D0351	3D photographic image	0 - 99	Limited to 1 time per consecutive 36 months.	N
Test and Examinations				
D0414	Lab processing of microbial specimen to include culture and sensitivity studies.	0 - 99		N

Code	Description	Age	Frequencies and limitations	Clinical review req
DIAGNOSTIC				
D0415	Collection of microorganisms for culture and sensitivity	0 - 99		N
D0416	Viral culture	0 - 99		N
D0431	Adjunctive pre-diagnostic test that aids in detection of mucosal abnormalities including premalignant and malignant lesions, not to include cytology or biopsy procedures	0 - 99	Limited to 1 time per consecutive 12 months.	N
D0460	Pulp vitality tests	0 - 99	Limited to 1 charge per visit, regardless of how many teeth are tested.	N
D0470	Diagnostic casts	0 - 99	Limited to 1 time per consecutive 24 months.	N
D0601	Caries risk assessment and documentation, with a finding of low risk	0 - 99	Limited to 2 times per consecutive 12 months.	N
D0602	Caries risk assessment and documentation, with a finding of moderate risk	0 - 99	Limited to 2 times per consecutive 12 months.	N
D0603	Caries risk assessment and documentation, with a finding of high risk	0 - 99	Limited to 2 times per consecutive 12 months.	N

4.1.B Preventive services guidelines

For the most recent and up to date clinical policy criteria and documentation requirements please follow **UHCdental.com> RESOURCES> CLINICAL GUIDELINES**, or you may use this **LINK**.

Code	Description	Age	Frequencies and limitations	Clinical review req
PREVENTIVE				
Dental Prophylaxis				
D1110	Prophylaxis – adult	13 - 99	Limited to 2 times per consecutive 12 months.	N
D1120	Prophylaxis – child	2 - 12	Limited to 2 times per consecutive 12 months.	N
Topical Fluoride Treatment (Office Procedure)				
D1206	Topical application of fluoride varnish	0 - 15	Limited to Covered Persons under the age of 16 years, and limited to 2 times per consecutive 12 months.	N
D1208	Topical application of fluoride	0 - 15	Limited to Covered Persons under the age of 16 years, and limited to 2 times per consecutive 12 months.	N
Other Preventive Services				
D1351	Sealant – per tooth	4 - 15	Limited to Covered Persons under the age of 16 years and once per first or second permanent molar every consecutive 36 months.	N
D1352	Preventive resin restoration in a moderate to high caries risk patient – permanent tooth	0 - 15	Limited to Covered Persons under the age of 16 years and once per first or second permanent molar every consecutive 36 months.	N
D1353	Sealant repair – per tooth	4 - 15	Limited to Covered Persons under the age of 16 years and once per first or second permanent molar every consecutive 36 months.	N
Space Maintenance (Passive Appliances)				
D1510	Space maintainer – fixed – unilateral	0 - 15	12 sites total, for refractory pockets.	N
D1516	Space maintainer – fixed – bilateral, maxillary	0 - 15	Limited to Covered Persons under the age of 16 years, once per consecutive 60 months. Benefit includes all adjustments within 6 months of installation.	N
D1517	Space maintainer – fixed – bilateral, mandibular	0 - 15	Limited to Covered Persons under the age of 16 years, once per consecutive 60 months. Benefit includes all adjustments within 6 months of installation.	N
D1520	Space maintainer – removable – unilateral	0 - 15	Limited to Covered Persons under the age of 16 years, once per consecutive 60 months. Benefit includes all adjustments within 6 months of installation.	N
D1526	Space maintainer – removable – bilateral, maxillary	0 - 15	Limited to Covered Persons under the age of 16 years, once per consecutive 60 months. Benefit includes all adjustments within 6 months of installation.	N
D1527	Space maintainer – removable – bilateral, mandibular	0 - 15	Limited to Covered Persons under the age of 16 years, once per consecutive 60 months. Benefit includes all adjustments within 6 months of installation.	N
D1550	Re-cementation of space maintainer	0 - 15	Limited to 1 per consecutive 6 months after initial insertion.	N
D1555	Removal of fixed space maintainer	0 - 15		N
D1575	Distal shoe space maintainer - fixed unilateral	0 - 15	Limited to Covered Persons under the age of 16 years, once per consecutive 60 months. Benefit includes all adjustments within 6 months of installation.	N

4.1.C Restorative services guidelines

For the most recent and up to date clinical policy criteria and documentation requirements please follow **UHCdental.com> RESOURCES> CLINICAL GUIDELINES**, or you may use this **LINK**.

Code	Description	Age	Frequencies and limitations	Clinical review req
RESTORATIVE				
Amalgam Restorations (Including Polishing)				
D2140	Amalgam – one surface, primary or permanent	0 - 99	Multiple restorations on one surface will be treated as a single filling.	N
D2150	Amalgam – two surfaces, primary or permanent	0 - 99	Multiple restorations on one surface will be treated as a single filling.	N
D2160	Amalgam – three surfaces, primary or permanent	0 - 99	Multiple restorations on one surface will be treated as a single filling.	N
D2161	Amalgam – four or more surfaces, primary or permanent	0 - 99	Multiple restorations on one surface will be treated as a single filling.	N
Resin - Based Composite Restorations – Direct				
D2330	Resin-based composite – one surface, anterior	0 - 99	Multiple restorations on one surface will be treated as a single filling.	N
D2331	Resin-based composite – two surfaces, anterior	0 - 99	Multiple restorations on one surface will be treated as a single filling.	N
D2332	Resin-based composite – three surfaces, anterior	0 - 99	Multiple restorations on one surface will be treated as a single filling.	N
D2335	Resin-based composite – four or more surfaces or involving incisal angle (anterior)	0 - 99	Multiple restorations on one surface will be treated as a single filling.	N
D2390	Resin-based composite crown, anterior	0 - 99	Limited to 1 time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth. Not Covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.	Y
D2391	Resin-based composite – one surface, posterior	0 - 99	Alternate benefit. Enhanced Plans Only - Multiple restorations on one surface will be treated as a single filling.	N
D2392	Resin-based composite – two surfaces, posterior	0 - 99	Alternate benefit. Enhanced Plans Only - Multiple restorations on one surface will be treated as a single filling.	N
D2393	Resin-based composite – three surfaces, posterior	0 - 99	Alternate benefit. Enhanced Plans Only - Multiple restorations on one surface will be treated as a single filling.	N
D2394	Resin-based composite – four or more surfaces, posterior	0 - 99	Alternate benefit. Enhanced Plans Only - Multiple restorations on one surface will be treated as a single filling.	N
Gold Foil Restorations				
D2410	Gold foil – one surface	0 - 99	Gold Foil Restorations - Multiple restorations on one surface will be treated as a single filling.	N
D2420	Gold foil – two surfaces	0 - 99	Gold Foil Restorations - Multiple restorations on one surface will be treated as a single filling.	N
D2430	Gold foil – three surfaces	0 - 99	Gold Foil Restorations - Multiple restorations on one surface will be treated as a single filling.	N
Inlay/Onlay Restorations				
D2510	Inlay – metallic – one surface	0 - 99	Limited to 1 time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth. Not Covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.	N
D2520	Inlay – metallic – two surfaces	0 - 99	Limited to 1 time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth. Not Covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.	N
D2530	Inlay – metallic – three or more surfaces	0 - 99	Limited to 1 time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth. Not Covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.	N
D2542	Onlay – metallic – two surfaces	0 - 99	Limited to 1 time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth. Not Covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.	Y
D2543	Onlay – metallic – three surfaces	0 - 99	Limited to 1 time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth. Not Covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.	Y

Code	Description	Age	Frequencies and limitations	Clinical review req
RESTORATIVE				
D2544	Onlay – metallic – four or more surfaces	0 - 99	Limited to 1 time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth. Not Covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.	Y
Inlay/Onlay Restorations: Porcelain/Ceramic Inlays/Onlays Include All Indirect Ceramic and Porcelain Type Inlays/Onlays				
D2610	Inlay – porcelain/ceramic – one surface	0 - 99	Limited to 1 time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth. Not Covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.	N
D2620	Inlay – porcelain/ceramic – two surfaces	0 - 99	Limited to 1 time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth. Not Covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.	N
D2630	Inlay – porcelain/ceramic – three or more surfaces	0 - 99	Limited to 1 time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth. Not Covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.	N
D2642	Onlay – porcelain/ceramic – two surfaces	0 - 99	Limited to 1 time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth. Not Covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.	Y
D2643	Onlay – porcelain/ceramic – three surfaces	0 - 99	Limited to 1 time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth. Not Covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.	Y
D2644	Onlay – porcelain/ceramic – four or more surfaces	0 - 99	Limited to 1 time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth. Not Covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.	Y
Inlay/Onlay Restorations: Resin - Based Composite Inlays/Onlays Must UtilizeIndirect Technique				
D2650	Inlay – resin-based composite – one surface	0 - 99	Limited to 1 time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth. Not Covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.	N
D2651	Inlay – resin-based composite – two surfaces	0 - 99	Limited to 1 time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth. Not Covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.	N
D2652	Inlay – resin-based composite – three or more surfaces	0 - 99	Limited to 1 time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth. Not Covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.	N
D2662	Onlay – resin-based composite – two surfaces	0 - 99	Limited to 1 time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth. Not Covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.	Y
D2663	Onlay – resin-based composite – three surfaces	0 - 99	Limited to 1 time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth. Not Covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.	Y
D2664	Onlay – resin-based composite – four or more surfaces	0 - 99	Limited to 1 time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth. Not Covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.	Y
Crowns – Single Restorations Only				
D2710	Crown – resin-based composite (indirect)	0 - 99	Limited to 1 time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth. Not Covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.	Y
D2712	Crown – 3⁄4 resin-based composite (indirect)	0 - 99	Limited to 1 time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth. Not Covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.	Y
D2720	Crown – resin with high noble metal	0 - 99	Limited to 1 time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth. Not Covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.	Y
D2721	Crown – resin with predominantly base metal	0 - 99	Limited to 1 time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth. Not Covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.	Y
D2722	Crown – resin with noble metal	0 - 99	Limited to 1 time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth. Not Covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.	Y
D2740	Crown – porcelain/ceramic substrate	0 - 99	Limited to 1 time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth. Not Covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.	Y

Code	Description	Age	Frequencies and limitations	Clinical review req
RESTORATIVE				
D2750	Crown – porcelain fused to high noble metal	0 - 99	Limited to 1 time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth. Not Covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.	Y
D2751	Crown – porcelain fused to predominantly base metal	0 - 99	Limited to 1 time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth. Not Covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.	Y
D2752	Crown – porcelain fused to noble metal	0 - 99	Limited to 1 time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth. Not Covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.	Y
D2780	Crown – 3/4 cast high noble metal	0 - 99	Limited to 1 time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth. Not Covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.	Y
D2781	Crown – 3/4 cast predominantly base metal	0 - 99	Limited to 1 time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth. Not Covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.	Y
D2782	Crown – 3/4 cast noble metal	0 - 99	Limited to 1 time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth. Not Covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.	Y
D2783	Crown – 3/4 porcelain/ ceramic	0 - 99	Limited to 1 time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth. Not Covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.	Y
D2790	Crown – full cast high noble metal	0 - 99	Limited to 1 time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth. Not Covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.	Y
D2791	Crown – full cast predominantly base metal	0 - 99	Limited to 1 time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth. Not Covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.	Y
D2792	Crown – full cast noble metal	0 - 99	Limited to 1 time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth. Not Covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.	Y
D2794	Crown – titanium	0 - 99	Limited to 1 time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth. Not Covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.	Y
D2799	Provisional crown– further treatment or completion of diagnosis necessary prior to final impression	0 - 99	Limited to 1 time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth. Not Covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.	Y
Other Restorative Services				
D2910	Recement inlay, onlay, or partial coverage restoration	0 - 99	Re-Cement Inlays/Onlays, Crowns, Bridges and Post and Core - Limited to those performed more than 12 months after the initial insertion.	N
D2915	Recement cast or prefabricated post and core	0 - 99	Re-Cement Inlays/Onlays, Crowns, Bridges and Post and Core - Limited to those performed more than 12 months after the initial insertion.	N
D2920	Recement crown	0 - 99	Re-Cement Inlays/Onlays, Crowns, Bridges and Post and Core - Limited to those performed more than 12 months after the initial insertion.	N
D2921	Reattachment of tooth fragment, incisal edge or cusp	0 - 99	Repairs or Adjustments to Full Dentures, Partial Dentures, Bridges or Crowns - Limited to repairs or adjustments performed more than 12 months after the initial insertion. Limited to 1 per consecutive 6 months.	N
D2930	Prefabricated stainless steel crown – primary tooth	0 - 15	Limited to 1 time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth. Prefabricated esthetic coated stainless steel crown - primary tooth, are limited to primary anterior teeth.	N
D2931	Prefabricated stainless steel crown – permanent tooth	0 - 99	Limited to 1 time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth. Prefabricated esthetic coated stainless steel crown - primary tooth, are limited to primary anterior teeth.	N
D2932	Prefabricated resin crown	0 - 99	Limited to 1 time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth. Prefabricated esthetic coated stainless steel crown - primary tooth, are limited to primary anterior teeth.	N
D2933	Prefabricated stainless steel crown with resin window	0 - 99	Limited to 1 time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth. Prefabricated esthetic coated stainless steel crown - primary tooth, are limited to primary anterior teeth.	N

Code	Description	Age	Frequencies and limitations	Clinical review req
RESTORATIVE				
D2934	Prefabricated esthetic coated stainless steel crown – primary tooth	0 - 15	Limited to 1 time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth. Prefabricated esthetic coated stainless steel crown - primary tooth, are limited to primary anterior teeth.	N
D2940	Protective restoration	0 - 99	Sedative Filling - Covered as a separate benefit only if no other service, other than x-rays and exam, were performed on the same tooth during the visit.	N
D2941	Interim therapeutic restoration – primary dentition	0 - 99	Sedative Filling - Covered as a separate benefit only if no other service, other than x-rays and exam, were performed on the same tooth during the visit.	N
D2950	Core buildup, including any pins when required	0 - 99	Post and Cores - Covered only for teeth that have had root canal therapy.	Y
D2951	Pin retention – per tooth, in addition to restoration	0 - 99	Pin Retention - Limited to 2 pins per tooth; not covered in addition to cast restoration.	N
D2952	Post and core in addition to crown, indirectly fabricated	0 - 99	Post and Cores - Covered only for teeth that have had root canal therapy.	Y
D2953	Each additional indirectly fabricated post – same tooth	0 - 99	Post and Cores - Covered only for teeth that have had root canal therapy.	Y
D2954	Prefabricated post and core in addition to crown	0 - 99	Post and Cores - Covered only for teeth that have had root canal therapy.	Y
D2957	Each additional prefabricated post – same tooth	0 - 99	Post and Cores - Covered only for teeth that have had root canal therapy.	Y
D2975	Coping	0 - 99	Limited to 1 per tooth per consecutive 60 months. Not covered if done at the same time as a crown on same tooth.	Y
D2980	Crown repair necessitated by restorative material failure	0 - 99	Repairs or Adjustments to Full Dentures, Partial Dentures, Bridges or Crowns - Limited to repairs or adjustments performed more than 12 months after the initial insertion. Limited to 1 per consecutive 6 months.	N
D2981	Inlay repair necessitated by restorative material failure	0 - 99	Repairs or Adjustments to Full Dentures, Partial Dentures, Bridges or Crowns - Limited to repairs or adjustments performed more than 12 months after the initial insertion. Limited to 1 per consecutive 6 months.	N
D2982	Onlay repair necessitated by restorative material failure	0 - 99	Repairs or Adjustments to Full Dentures, Partial Dentures, Bridges or Crowns - Limited to repairs or adjustments performed more than 12 months after the initial insertion. Limited to 1 per consecutive 6 months.	N

4.1.D Endodontic services guidelines

For the most recent and up to date clinical policy criteria and documentation requirements please follow **UHCdental.com> RESOURCES> CLINICAL GUIDELINES**, or you may use this **LINK**.

Code	Description	Age	Frequencies and limitations	Clinical review req
ENDODONTICS				
Pulp Capping				
D3110	Pulp cap – direct (excluding final restoration)	0 - 99	Not Covered if utilized solely as a liner or base underneath a restoration.	N
D3120	Pulp cap – indirect (excluding final restoration)	0 - 99	Not Covered if utilized solely as a liner or base underneath a restoration.	N
Pulpotomy				
D3220	Therapeutic pulpotomy (excluding final restoration) – removal of pulp coronal to the dentinocemental junction and application of medicament	0 - 99	Limited to 1 time per primary or secondary tooth per lifetime.	N
D3221	Pulpal debridement, primary and permanent teeth	0 - 99	Limited to 1 time per tooth per lifetime. This procedure is not to be used when endodontic services are done on same date of service..	N
D3222	Partial pulpotomy for apexogenesis – permanent tooth with incomplete root development	0 - 99	Limited to 1 time per primary or secondary tooth per lifetime.	N
Endodontic Therapy on Primary Teeth				
D3230	Pulpal therapy (resorbable filling) – anterior, primary tooth (excluding final restoration)	0 - 15	Limited to 1 time per tooth per lifetime. Covered for anterior teeth only.	N
D3240	Pulpal therapy (resorbable filling) – posterior, primary tooth (excluding final restoration)	0 - 15	Limited to 1 time per tooth per lifetime. Covered for posterior teeth only.	N
Endodontic Therapy (Including Treatment Plan, Clinical Procedures and Follow - Up Care)				
D3310	Endodontic therapy, anterior tooth (excluding final restoration)	0 - 99	Limited to 1 time per tooth per lifetime. Dentist who performed the original root canal should not be reimbursed for the retreatment for the first 12 months.	N
D3320	Endodontic therapy, bicuspid tooth (excluding final restoration)	0 - 99	Limited to 1 time per tooth per lifetime. Dentist who performed the original root canal should not be reimbursed for the retreatment for the first 12 months.	N
D3330	Endodontic therapy, molar (excluding final restoration)	0 - 99	Limited to 1 time per tooth per lifetime. Dentist who performed the original root canal should not be reimbursed for the retreatment for the first 12 months.	N
D3331	Treatment of root canal obstruction; non-surgical access	0 - 99	Limited to 1 time per tooth per lifetime.	N
D3332	Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth	0 - 99	Limited to 1 time per tooth per lifetime.	N
D3333	Internal root repair of perforation defects	0 - 99	Limited to 1 time per tooth per lifetime.	N
Endodontic Retreatment				
D3346	Retreatment of previous root canal therapy – anterior	0 - 99	Dentist who performed the original root canal should not be reimbursed for the retreatment for the first 12 months.	Y
D3347	Retreatment of previous root canal therapy – bicuspid	0 - 99	Dentist who performed the original root canal should not be reimbursed for the retreatment for the first 12 months.	Y
D3348	Retreatment of previous root canal therapy – molar	0 - 99	Dentist who performed the original root canal should not be reimbursed for the retreatment for the first 12 months.	Y
Apexification/Recalcification				
D3351	Apexification/recalcification/pupal regeneration - initial visit (apical closure/calcific repair of perforations, root resorption, pulp space disinfection, etc.)	0 - 99	Limited to 1 time per tooth per lifetime.	N
D3352	Apexification/recalcification/pupal regeneration - interim medication visit (apical closure/calcific repair of perforations, root resorption, pulp space disinfection, etc.)	0 - 99	Limited to 1 time per tooth per lifetime.	N
D3353	Apexification/recalcification – final visit (includes completed root canal therapy – apical closure/ calcific repair of perforations, root resorption, etc.)	0 - 99	Limited to 1 time per tooth per lifetime.	N

Code	Description	Age	Frequencies and limitations	Clinical review req
ENDODONTICS				
Pulpal Regeneration				
D3355	Pulpal regeneration - initial visit	0 - 99	Limited to 1 time per tooth per lifetime.	N
D3356	Pulpal regeneration -interim medicament replacement	0 - 99	Limited to 1 time per tooth per lifetime.	N
D3357	Pulpal regeneration - completion of treatment	0 - 99	Limited to 1 time per tooth per lifetime.	N
Apicoectomy/Periradicular Services				
D3410	Apicoectomy/periradicular surgery – anterior	0 - 99	Limited to 1 time per tooth per lifetime.	Y
D3421	Apicoectomy/periradicular surgery – biscupid (first root)	0 - 99	Limited to 1 time per tooth per lifetime.	Y
D3425	Apicoectomy/periradicular surgery – molar (first root)	0 - 99	Limited to 1 time per tooth per lifetime.	Y
D3426	Apicoectomy/periradicular surgery – (each additional root)	0 - 99	Limited to 1 time per tooth per lifetime.	Y
D3427	Periradicular surgery without apicoectomy	0 - 99	Limited to 1 time per tooth per lifetime.	Y
D3430	Retrograde filling – per root	0 - 99	Limited to 1 time per tooth per lifetime.	Y
D3450	Root amputation – per root	0 - 99		Y
Other Endodontic Procedures				

4.1.E Periodontal services guidelines

For the most recent and up to date clinical policy criteria and documentation requirements please follow **UHCdental.com> RESOURCES> CLINICAL GUIDELINES**, or you may use this **LINK**.

Code	Description	Age	Frequencies and limitations	Clinical review req
PERIODONTICS				
Surgical Services (Including Usual Postoperative Care)				
D4210	Gingivectomy or gingivoplasty – four or more contiguous teeth or tooth bounded spaces per quadrant	14 - 99	Limited to 1 per quadrant or site per consecutive 36 months.	N
D4211	Gingivectomy or gingivoplasty – one to three contiguous teeth or tooth bounded spaces per quadrant	14 - 99	Limited to 1 per quadrant or site per consecutive 36 months.	N
D4230	Anatomical crown exposure – four or more contiguous teeth or tooth bounded spaces per quadrant	18 - 99	Limited to 1 per quadrant or site per consecutive 36 months.	Y
D4231	Anatomical crown exposure – one to three teeth or tooth bounded spaces per quadrant	18 - 99	Limited to 1 per quadrant or site per consecutive 36 months.	Y
D4240	Gingival flap procedure, including root planing – four or more contiguous teeth or tooth bounded spaces per quadrant	18 - 99	Limited to 1 per quadrant or site per consecutive 36 months.	N
D4241	Gingival flap procedure, including root planing – one to three contiguous teeth or tooth bounded spaces per quadrant	18 - 99	Limited to 1 per quadrant or site per consecutive 36 months.	N
D4245	Apically positioned flap	18 - 99	Limited to 1 per quadrant or site per consecutive 36 months.	N
D4249	Clinical crown lengthening – hard tissue	18 - 99	Limited to 1 per quadrant or site per consecutive 36 months.	Y
D4260	Osseous surgery (including flap entry and closure) – four or more contiguous teeth or tooth bounded spaces per quadrant	18 - 99	Limited to 1 per quadrant or site per consecutive 36 months.	Y
D4261	Osseous surgery (including flap entry and closure) – one to three contiguous teeth or tooth bounded spaces per quadrant	18 - 99	Limited to 1 per quadrant or site per consecutive 36 months.	Y
D4263	Bone replacement graft - first site in quadrant	18 - 99	Limited to 1 per quadrant or site per 36 months.	Y
D4264	Bone replacement graft – each additional site in quadrant	18 - 99	Limited to 1 per quadrant or site per 36 months.	Y
D4265	Biologic materials to aid in soft and osseous tissue regeneration	18 - 99	Limited to 1 per quadrant or site per consecutive 36 months.	Y
D4266	Guided tissue regeneration – resorbable barrier, per site	18 - 99	Limited to 1 per quadrant or site per consecutive 36 months.	Y
D4267	Guided tissue regeneration – nonresorbable barrier, per site (includes membrane removal)	18 - 99	Limited to 1 per quadrant or site per consecutive 36 months.	Y
D4268	Surgical revision procedure, per tooth	18 - 99	Limited to 1 per quadrant or site per consecutive 36 months.	Y
D4270	Pedicle soft tissue graft procedure	18 - 99	Limited to 1 per quadrant or site per consecutive 36 months.	Y
D4273	Autogenous connective tissue graft procedure (including donor and recipient surgical sites) first tooth, implant or edentulous tooth position in graft	18 - 99	Limited to 1 per quadrant or site per consecutive 36 months.	Y
D4274	Mesial/distal wedge procedure, single tooth (when not performed in conjunction with surgical procedures in the same anatomical area)	18 - 99	Limited to 1 per quadrant or site per 36 months.	Y
D4275	Non-autogenous connective tissue graft (including recipient site and donor material) first tooth, implant, or edentulous tooth position in graft	18 - 99	Limited to 1 per quadrant or site per consecutive 36 months.	Y
D4276	Combined connective tissue and double pedicle graft, per tooth	18 - 99	Limited to 1 per quadrant or site per consecutive 36 months.	Y
D4277	Free soft tissue graft procedure (including recipient and donor surgical sites) first tooth, implant, or edentulous tooth position in graft	18 - 99	Limited to 1 per quadrant or site per consecutive 36 months.	Y
D4283	Autogenous connective tissue graft procedure (including donor and recipient surgical sites) – each additional contiguous tooth, implant or edentulous tooth position in same graft site	18 - 99	Limited to 1 per quadrant or site per consecutive 36 months.	Y
D4285	Non-autogenous connective tissue graft procedure (including recipient surgical site and donor material) – each additional contiguous tooth, implant or edentulous tooth position in same graft site	18 - 99	Limited to 1 per quadrant or site per consecutive 36 months.	Y

Code	Description	Age	Frequencies and limitations	Clinical review req
PERIODONTICS				
Non-Surgical Periodontal Service				
D4320	Provisional splinting – intracoronal	0 - 99	Cannot be used to restore vertical dimension or as part of full mouth rehabilitation, should not include use of laboratory based crowns and/or fixed partial dentures (bridges). Exclusion of laboratory based crowns or bridges for the purposes of provisiona	N
D4321	Provisional splinting – extracoronal	0 - 99	Cannot be used to restore vertical dimension or as part of full mouth rehabilitation, should not include use of laboratory based crowns and/or fixed partial dentures (bridges). Exclusion of laboratory based crowns or bridges for the purposes of provisiona	N
D4341	Periodontal scaling and root planing – four or more teeth per quadrant	16 - 99	Limited to 1 time per quadrant per consecutive 24 months.	N
D4342	Periodontal scaling and root planing – one to three teeth per quadrant	16 - 99	Limited to 1 time per quadrant per consecutive 24 months.	N
D4346	Scaling in presence of generalized moderate or severe gingival inflammation	16 - 99	Limited to 2 times per consecutive 12 months.	N
D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis	16 - 99	Limited to once per consecutive 36 months.	N
D4381	Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth	16 - 99	Limited to 3 sites per quadrant, or 12 sites total, for refractory pockets, or in conjunction with scaling or root planing, by report.	Y
Other Periodontal Services				
D4910	Periodontal maintenance	16 - 99	Limited to 2 times per consecutive 12 months following active or adjunctive periodontal therapy, exclusive of gross debridement.	N
D4920	Unscheduled dressing change (by someone other than treating dentist or their staff)	0 - 99		N

4.1.F Removable prosthodontic services guidelines

For the most recent and up to date clinical policy criteria and documentation requirements please follow **UHCdental.com> RESOURCES> CLINICAL GUIDELINES**, or you may use this **LINK**.

Code	Description	Age	Frequencies and limitations	Clinical review req
REMOVABLE PROSTHODONTICS				
Complete Dentures (Including Routine Post - Delivery Care)				
D5110	Complete denture – maxillary	16 - 99	Limited to 1 per consecutive 60 months. No additional allowances for precision or semi-precision attachments.	N
D5120	Complete denture – mandibular	16 - 99	Limited to 1 per consecutive 60 months. No additional allowances for precision or semi-precision attachments.	N
D5130	Immediate denture – maxillary	16 - 99	Limited to 1 per consecutive 60 months. No additional allowances for precision or semi-precision attachments.	N
D5140	Immediate denture – mandibular	16 - 99	Limited to 1 per consecutive 60 months. No additional allowances for precision or semi-precision attachments.	N
Partial Dentures (Including Routine Post - Delivery Care)				
D5211	Maxillary partial denture – resin base (including retentive/clasping materials, rests and teeth)	0 - 99	Limited to 1 per consecutive 60 months. No additional allowances for precision or semi-precision attachments.	N
D5212	Mandibular partial denture – resin base (including retentive/clasping materials, rests and teeth)	0 - 99	Limited to 1 per consecutive 60 months. No additional allowances for precision or semi-precision attachments.	N
D5213	Maxillary partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	16 - 99	Limited to 1 per consecutive 60 months. No additional allowances for precision or semi-precision attachments.	N
D5214	Mandibular partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	16 - 99	Limited to 1 per consecutive 60 months. No additional allowances for precision or semi-precision attachments.	N
D5221	Immediate maxillary partial denture – resin base (including any conventional clasps, rests and teeth)	0 - 99	Limited to 1 per consecutive 60 months. No additional allowances for precision or semi-precision attachments.	N
D5222	Immediate mandibular partial denture – resin base (including any conventional clasps, rests and teeth)	0 - 99	Limited to 1 per consecutive 60 months. No additional allowances for precision or semi-precision attachments.	N
D5223	Immediate maxillary partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth	0 - 99	Limited to 1 per consecutive 60 months. No additional allowances for precision or semi-precision attachments.	N
D5224	Immediate mandibular partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	0 - 99	Limited to 1 per consecutive 60 months. No additional allowances for precision or semi-precision attachments.	N
D5225	Maxillary partial denture – flexible base (including any clasps, rests and teeth)	0 - 99	Limited to 1 per consecutive 60 months. No additional allowances for precision or semi-precision attachments.	N
D5226	Mandibular partial denture – flexible base (including any clasps, rests and teeth)	0 - 99	Limited to 1 per consecutive 60 months. No additional allowances for precision or semi-precision attachments.	N
D5282	Removable unilateral partial denture – one piece cast metal (including clasps and teeth), maxillary	16 - 99	Limited to 1 per consecutive 60 months. No additional allowances for precision or semi-precision attachments.	N
D5283	Removable unilateral partial denture – one piece cast metal (including clasps and teeth), mandibular	16 - 99	Limited to 1 per consecutive 60 months. No additional allowances for precision or semi-precision attachments.	N
Adjustments to Dentures				
D5410	Adjust complete denture – maxillary	16 - 99	Limited to repairs or adjustments performed more than 12 months after the initial insertion. Limited to 1 per consecutive 6 months.	N
D5411	Adjust complete denture – mandibular	16 - 99	Limited to repairs or adjustments performed more than 12 months after the initial insertion. Limited to 1 per consecutive 6 months.	N
D5421	Adjust partial denture – maxillary	0 - 99	Limited to repairs or adjustments performed more than 12 months after the initial insertion. Limited to 1 per consecutive 6 months.	N

Code	Description	Age	Frequencies and limitations	Clinical review req
REMOVABLE PROSTHODONTICS				
D5422	Adjust partial denture – mandibular	0 - 99	Limited to repairs or adjustments performed more than 12 months after the initial insertion. Limited to 1 per consecutive 6 months.	N
Repairs to Complete Dentures				
D5511	Repair broken complete denture base, mandibular	16 - 99	Limited to repairs or adjustments performed more than 12 months after the initial insertion. Limited to 1 per consecutive 6 months.	N
D5512	Repair broken complete denture base, maxillary	16 - 99	Limited to repairs or adjustments performed more than 12 months after the initial insertion. Limited to 1 per consecutive 6 months.	N
D5520	Replace missing or broken teeth – complete denture (each tooth)	16 - 99	Repairs or Adjustments to Full Dentures, Partial Dentures, Bridges or Crowns - Limited to repairs or adjustments performed more than 12 months after the initial insertion. Limited to 1 per consecutive 6 months.	N
Repairs to Partial Dentures				
D5611	Repair resin partial denture base, mandibular	16 - 99	Limited to repairs or adjustments performed more than 12 months after the initial insertion. Limited to 1 per consecutive 6 months.	N
D5612	Repair resin partial denture base, maxillary	16 - 99	Limited to repairs or adjustments performed more than 12 months after the initial insertion. Limited to 1 per consecutive 6 months.	N
D5621	Repair cast partial framework, mandibular	16 - 99	Limited to repairs or adjustments performed more than 12 months after the initial insertion. Limited to 1 per consecutive 6 months.	N
D5622	Repair cast partial framework, maxillary	16 - 99	Limited to repairs or adjustments performed more than 12 months after the initial insertion. Limited to 1 per consecutive 6 months.	N
D5630	Repair or replace broken retentive/ clasping materials	0 - 99	Repairs or Adjustments to Full Dentures, Partial Dentures, Bridges or Crowns - Limited to repairs or adjustments performed more than 12 months after the initial insertion. Limited to 1 per consecutive 6 months.	N
D5640	Replace broken teeth – per tooth	0 - 99	Repairs or Adjustments to Full Dentures, Partial Dentures, Bridges or Crowns - Limited to repairs or adjustments performed more than 12 months after the initial insertion. Limited to 1 per consecutive 6 months.	N
D5650	Add tooth to existing partial denture	0 - 99	Repairs or Adjustments to Full Dentures, Partial Dentures, Bridges or Crowns - Limited to repairs or adjustments performed more than 12 months after the initial insertion. Limited to 1 per consecutive 6 months.	N
D5660	Add clasp to existing partial denture	0 - 99	Repairs or Adjustments to Full Dentures, Partial Dentures, Bridges or Crowns - Limited to repairs or adjustments performed more than 12 months after the initial insertion. Limited to 1 per consecutive 6 months.	N
D5670	Replace all teeth and acrylic on cast metal framework (maxillary)	16 - 99	Repairs or Adjustments to Full Dentures, Partial Dentures, Bridges or Crowns - Limited to repairs or adjustments performed more than 12 months after the initial insertion. Limited to 1 per consecutive 6 months.	N
D5671	Replace all teeth and acrylic on cast metal framework (mandibular)	16 - 99	Repairs or Adjustments to Full Dentures, Partial Dentures, Bridges or Crowns - Limited to repairs or adjustments performed more than 12 months after the initial insertion. Limited to 1 per consecutive 6 months.	N
Denture Rebase Procedures				
D5710	Rebase complete maxillary denture	16 - 99	Limited to rebasing performed more than 6 months after the initial insertion. Limited to 1 time per consecutive 12 months.	N
D5711	Rebase complete mandibular denture	16 - 99	Limited to rebasing performed more than 6 months after the initial insertion. Limited to 1 time per consecutive 12 months.	N
D5720	Rebase maxillary partial denture	0 - 99	Limited to rebasing performed more than 6 months after the initial insertion. Limited to 1 time per consecutive 12 months.	N
D5721	Rebase mandibular partial denture	0 - 99	Limited to rebasing performed more than 6 months after the initial insertion. Limited to 1 time per consecutive 12 months.	N
D5730	Reline complete maxillary denture (chairside)	16 - 99	Limited to relining performed more than 6 months after the initial insertion. Limited to 1 time per consecutive 12 months.	N
D5731	Reline complete mandibular denture (chairside)	16 - 99	Limited to relining performed more than 6 months after the initial insertion. Limited to 1 time per consecutive 12 months.	N
D5740	Reline maxillary partial denture (chairside)	0 - 99	Limited to relining performed more than 6 months after the initial insertion. Limited to 1 time per consecutive 12 months.	N
D5741	Reline mandibular partial denture (chairside)	0 - 99	Limited to relining performed more than 6 months after the initial insertion. Limited to 1 time per consecutive 12 months.	N
D5750	Reline complete maxillary denture (laboratory)	16 - 99	Limited to relining performed more than 6 months after the initial insertion. Limited to 1 time per consecutive 12 months.	N
D5751	Reline complete mandibular denture (laboratory)	16 - 99	Limited to relining performed more than 6 months after the initial insertion. Limited to 1 time per consecutive 12 months.	N

Code	Description	Age	Frequencies and limitations	Clinical review req
REMOVABLE PROSTHODONTICS				
D5760	Reline maxillary partial denture (laboratory)	0 - 99	Limited to relining performed more than 6 months after the initial insertion. Limited to 1 time per consecutive 12 months.	N
D5761	Reline mandibular partial denture (laboratory)	0 - 99	Limited to relining performed more than 6 months after the initial insertion. Limited to 1 time per consecutive 12 months.	N
Interim Prosthesis				
D5810	Interim complete denture (maxillary)	16 - 99	Limited to 1 per consecutive 60 months. No additional allowances for precision or semi-precision attachments.	N
D5811	Interim complete denture (mandibular)	16 - 99	Limited to 1 per consecutive 60 months. No additional allowances for precision or semi-precision attachments.	N
D5820	Interim partial denture (maxillary)	0 - 99	Limited to 1 per consecutive 60 months. No additional allowances for precision or semi-precision attachments.	N
D5821	Interim partial denture (mandibular)	0 - 99	Limited to 1 per consecutive 60 months. No additional allowances for precision or semi-precision attachments.	N
Other Removable Prosthetic Services				
D5850	Tissue conditioning, maxillary	0 - 99	Limited to 1 time per consecutive 12 months.	N
D5851	Tissue conditioning, mandibular	0 - 99	Limited to 1 time per consecutive 12 months.	N
D5863	Overdenture - complete maxillary	16 - 99	Limited to 1 per consecutive 60 months. No additional allowances for precision or semi-precision attachments.	N
D5864	Overdenture - complete mandibular	16 - 99	Limited to 1 per consecutive 60 months. No additional allowances for precision or semi-precision attachments.	N
D5865	Overdenture - partial maxillary	16 - 99	Limited to 1 per consecutive 60 months. No additional allowances for precision or semi-precision attachments.	N
D5866	Overdenture - partial mandibular	16 - 99	Limited to 1 per consecutive 60 months. No additional allowances for precision or semi-precision attachments.	N
D5876	Add metal substructure to acrylic full denture (per arch)	16 - 99	Limited to rebasing performed more than 6 months after the initial insertion. Limited to 1 time per consecutive 12 months.	N

4.1.G Implant and fixed prosthetic services guidelines

For the most recent and up to date clinical policy criteria and documentation requirements please follow **UHCdental.com> RESOURCES> CLINICAL GUIDELINES**, or you may use this **LINK**.

Code	Description	Age	Frequencies and limitations	Clinical review req
IMPLANTS				
Surgical Services				
D6010	Surgical placement of implant body: endosteal implant	0 - 99	Buy-Up Only - Enhanced Plans Only: Limited to 1 time per consecutive 60 months.	Y
D6012	Surgical placement of interim implant body for transitional prosthesis: endosteal implant	0 - 99	Buy-Up Only - Enhanced Plans Only: Limited to 1 time per consecutive 60 months.	Y
D6013	Surgical placement of a mini-implant	0 - 99	Buy-Up Only - Enhanced Plans Only: Limited to 1 time per consecutive 60 months.	Y
D6040	Surgical placement: eposteal implant	0 - 99	Buy-Up Only - Enhanced Plans Only: Limited to 1 time per consecutive 60 months.	Y
D6050	Surgical placement: transosteal implant	0 - 99	Buy-Up Only - Enhanced Plans Only: Limited to 1 time per consecutive 60 months.	Y
Implant Supported Prosthetics: Supporting Structures				
D6051	Interim abutment	0 - 99	Buy-Up Only - Enhanced Plans Only: Limited to 1 time per consecutive 60 months.	Y
D6052	Semi-precision attachment abutment	0 - 99	Buy-Up Only - Enhanced Plans Only: Limited to 1 time per consecutive 60 months.	Y
D6055	Connecting bar – implant supported or abutment supported	0 - 99	Buy-Up Only - Enhanced Plans Only: Limited to 1 time per consecutive 60 months.	Y
D6056	Interceptive Orthodontic Treatment	0 - 99	Buy-Up Only - Enhanced Plans Only: Limited to 1 time per consecutive 60 months.	Y
D6057	Custom abutment – includes placement	0 - 99	Buy-Up Only - Enhanced Plans Only: Limited to 1 time per consecutive 60 months.	Y
Implant Supported Prosthetics: Single Crowns, Abutment Supported				
D6058	Abutment supported porcelain/ceramic crown	0 - 99	Buy-Up Only - Enhanced Plans Only: Limited to 1 time per consecutive 60 months.	Y
D6059	Abutment supported porcelain fused to metal crown (high noble metal)	0 - 99	Buy-Up Only - Enhanced Plans Only: Limited to 1 time per consecutive 60 months.	Y
D6060	Abutment supported porcelain fused to metal crown (predominantly base metal)	0 - 99	Buy-Up Only - Enhanced Plans Only: Limited to 1 time per consecutive 60 months.	Y
D6061	Abutment supported porcelain fused to metal crown (noble metal)	0 - 99	Buy-Up Only - Enhanced Plans Only: Limited to 1 time per consecutive 60 months.	Y
D6062	Abutment supported cast metal crown (high noble metal)	0 - 99	Buy-Up Only - Enhanced Plans Only: Limited to 1 time per consecutive 60 months.	Y
D6063	Abutment supported cast metal crown (predominantly base metal)	0 - 99	Buy-Up Only - Enhanced Plans Only: Limited to 1 time per consecutive 60 months.	Y
D6064	Abutment supported cast metal crown (noble metal)	0 - 99	Buy-Up Only - Enhanced Plans Only: Limited to 1 time per consecutive 60 months.	Y
D6094	Abutment supported crown – (titanium)	0 - 99	Buy-Up Only - Enhanced Plans Only: Limited to 1 time per consecutive 60 months.	Y
Implant Supported Prosthetics: Single Crowns, Implant Supported				
D6065	Implant supported porcelain/ceramic crown	0 - 99	Buy-Up Only - Enhanced Plans Only: Limited to 1 time per consecutive 60 months.	Y
D6066	Implant supported porcelain fused to metal crown (titanium, titanium alloy, high noble metal)	0 - 99	Buy-Up Only - Enhanced Plans Only: Limited to 1 time per consecutive 60 months.	Y
D6067	Implant supported metal crown (titanium, titanium alloy, high noble metal)	0 - 99	Buy-Up Only - Enhanced Plans Only: Limited to 1 time per consecutive 60 months.	Y
Implant Supported Prosthetics: Fixed Partial Denture Retainer, Abutment Supported				
D6068	Abutment supported retainer for porcelain/ceramic FPD	0 - 99	Buy-Up Only - Enhanced Plans Only: Limited to 1 time per consecutive 60 months.	Y
D6069	Abutment supported retainer for porcelain fused to metal FPD (high noble metal)	0 - 99	Buy-Up Only - Enhanced Plans Only: Limited to 1 time per consecutive 60 months.	Y

Code	Description	Age	Frequencies and limitations	Clinical review req
IMPLANTS				
D6070	Abutment supported retainer for porcelain fused to metal FPD (predominantly base metal)	0 - 99	Buy-Up Only - Enhanced Plans Only: Limited to 1 time per consecutive 60 months.	Y
D6071	Abutment supported retainer for porcelain fused to metal FPD (noble metal)	0 - 99	Buy-Up Only - Enhanced Plans Only: Limited to 1 time per consecutive 60 months.	Y
D6072	Abutment supported retainer for cast metal FPD (high noble metal)	0 - 99	Buy-Up Only - Enhanced Plans Only: Limited to 1 time per consecutive 60 months.	Y
D6073	Abutment supported retainer for cast metal FPD (predominantly base metal)	0 - 99	Buy-Up Only - Enhanced Plans Only: Limited to 1 time per consecutive 60 months.	Y
D6074	Abutment supported retainer for cast metal FPD (noble metal)	0 - 99	Buy-Up Only - Enhanced Plans Only: Limited to 1 time per consecutive 60 months.	Y
D6194	Abutment supported retainer crown for FPD – (titanium)	0 - 99	Buy-Up Only - Enhanced Plans Only: Limited to 1 time per consecutive 60 months.	Y
Implant Supported Prosthetics: Fixed Partial Denture Retainer, Implant Supported				
D6075	Implant supported retainer for ceramic FPD	0 - 99	Buy-Up Only - Enhanced Plans Only: Limited to 1 time per consecutive 60 months.	Y
D6076	Implant supported retainer for porcelain fused to metal FPD (titanium, titanium alloy, or high noble metal)	0 - 99	Buy-Up Only - Enhanced Plans Only: Limited to 1 time per consecutive 60 months.	Y
D6077	Implant supported retainer for cast metal FPD (titanium, titanium alloy, or high noble metal)	0 - 99	Buy-Up Only - Enhanced Plans Only: Limited to 1 time per consecutive 60 months.	Y
Other Implant Services				
D6080	Implant maintenance procedures, when prostheses are removed and reinserted, including cleansing removal of prosthesies, cleansing of prosthesis and abutments and reinsertion of prosthesis	0 - 99	Buy-Up Only - Enhanced Plans Only: Limited to 1 time per consecutive 60 months.	N
D6081	Scaling and debridement in the presence of inflammation or mucositis of a single implant	0 - 99	Buy-Up Only - Enhanced Plans Only: Limited to 1 time per consecutive 60 months.	Y
D6085	Provisional implant crown	0 - 99	Buy-Up Only - Enhanced Plans Only: Limited to 1 time per consecutive 60 months.	Y
D6090	Repair implant supported prosthesis, by report	0 - 99	Buy-Up Only - Enhanced Plans Only: Limited to 1 time per consecutive 60 months.	Y
D6091	Replacement of semi-precision or precision attachment (male or female component) of implant/abutment supported prosthesis, per attachment	0 - 99	Buy-Up Only - Enhanced Plans Only: Limited to 1 time per consecutive 60 months.	N
D6092	Recement implant/abutment supported crown	0 - 99	Buy-Up Only - Enhanced Plans Only: Limited to 1 time per consecutive 60 months.	N
D6093	Recement implant/abutment supported fixed partial denture	0 - 99	Buy-Up Only - Enhanced Plans Only: Limited to 1 time per consecutive 60 months.	N
D6095	Repair implant abutment, by report	0 - 99	Buy-Up Only - Enhanced Plans Only: Limited to repairs or adjustments performed more than 12 months after initial insertion. Limited to 1 per consecutive 6 months.	Y
D6096	Remove broken implant retaining screw	0 - 99	Buy-Up Only - Enhanced Plans Only: Limited to repairs or adjustments performed more than 12 months after initial insertion. Limited to 1 per consecutive 6 months.	Y
D6118	Implant/abutment supported interim fixed denture for edentulous arch – mandibular	0 - 99	Buy-Up Only - Enhanced Plans Only: Limited to 1 time per consecutive 60 months.	Y
D6119	Implant/abutment supported interim fixed denture for edentulous arch – maxillary	0 - 99	Buy-Up Only - Enhanced Plans Only: Limited to 1 time per consecutive 60 months.	Y
D6100	Implant removal, by report	0 - 99	Buy-Up Only - Enhanced Plans Only: Limited to 1 time per consecutive 60 months.	Y
D6101	Debridement of a periimplant defect and surface cleaning of exposed implant surfaces, including flap entry and closure	0 - 99	Buy-Up Only - Enhanced Plans Only: Limited to 1 time per consecutive 60 months.	Y
D6102	Debridement of osseous contouring of a periimplant defect; includes surface cleaning of exposed implant surfaces and flap entry and closure	0 - 99	Buy-Up Only - Enhanced Plans Only: Limited to 1 time per consecutive 60 months.	Y
D6103	Bone graft for repair of periimplant defect – not including flap entry and closure or, when indicated, placement of a barrier membrane or biologic materials to aid in osseous regeneration	0 - 99	Buy-Up Only - Enhanced Plans Only: Limited to 1 time per consecutive 60 months.	Y
D6104	Bone graft at time of implant placement	0 - 99	Buy-Up Only - Enhanced Plans Only: Limited to 1 time per consecutive 60 months.	Y

Code	Description	Age	Frequencies and limitations	Clinical review req
IMPLANTS				
Implant Supported Prosthetics: Implant/Abutment Supported Removable Dentures				
D6110	Implant /abutment supported removable denture for edentulous arch – maxillary	0 - 99	Buy-Up Only - Enhanced Plans Only: Limited to 1 time per consecutive 60 months.	Y
D6111	Implant /abutment supported removable denture for edentulous arch – mandibular	0 - 99	Buy-Up Only - Enhanced Plans Only: Limited to 1 time per consecutive 60 months.	Y
D6112	Implant /abutment supported removable denture for partially edentulous arch – maxillary	0 - 99	Buy-Up Only - Enhanced Plans Only: Limited to 1 time per consecutive 60 months.	Y
D6113	Implant /abutment supported removable denture for partially edentulous arch – mandibular	0 - 99	Buy-Up Only - Enhanced Plans Only: Limited to 1 time per consecutive 60 months.	Y
Implant Supported Prosthetics: Implant/Abutment Supported Fixed Dentures (Hybrid Prosthesis)				
D6114	Implant /abutment supported fixed denture for edentulous arch – maxillary	0 - 99	Buy-Up Only - Enhanced Plans Only: Limited to 1 time per consecutive 60 months.	Y
D6115	Implant /abutment supported fixed denture for edentulous arch – mandibular	0 - 99	Buy-Up Only - Enhanced Plans Only: Limited to 1 time per consecutive 60 months.	Y
D6116	Implant /abutment supported fixed denture for partially edentulous arch – maxillary	0 - 99	Buy-Up Only - Enhanced Plans Only: Limited to 1 time per consecutive 60 months.	Y
D6117	Implant /abutment supported fixed denture for partially edentulous arch – mandibular	0 - 99	Buy-Up Only - Enhanced Plans Only: Limited to 1 time per consecutive 60 months.	Y
Pre - Surgical Services				
D6190	Radiographic/surgical implant index, by report	0 - 99	Buy-Up Only - Enhanced Plans Only: Limited to 1 time per consecutive 60 months.	N

Code	Description	Age	Frequencies and limitations	Clinical review req
FIXED PROSTHODONTICS				
Fixed Partial Denture Pontics				
D6205	Pontic – indirect resin based composite	0 - 99	Limited to 1 time per tooth per consecutive 60 months.	Y
D6210	Pontic – cast high noble metal	0 - 99	Limited to 1 time per tooth per consecutive 60 months.	Y
D6211	Pontic – cast predominantly base metal	0 - 99	Limited to 1 time per tooth per consecutive 60 months..	Y
D6212	Pontic – cast noble metal	0 - 99	Limited to 1 time per tooth per consecutive 60 months.	Y
D6214	Pontic – titanium	0 - 99	Limited to 1 time per tooth per consecutive 60 months.	Y
D6240	Pontic – porcelain fused to high noble metal	0 - 99	Limited to 1 time per tooth per consecutive 60 months.	Y
D6241	Pontic – porcelain fused to predominantly base metal	0 - 99	Limited to 1 time per tooth per consecutive 60 months.	Y
D6242	Pontic – porcelain fused to noble metal	0 - 99	Limited to 1 time per tooth per consecutive 60 months.	Y
D6245	Pontic – porcelain/ceramic	0 - 99	Limited to 1 time per tooth per consecutive 60 months.	Y
D6250	Pontic – resin with high noble metal	0 - 99	Limited to 1 time per tooth per consecutive 60 months.	Y
D6251	Pontic – resin with predominantly base metal	0 - 99	Limited to 1 time per tooth per consecutive 60 months.	Y
D6252	Pontic – resin with noble metal	0 - 99	Limited to 1 time per tooth per consecutive 60 months.	Y
D6253	Provisional pontic – further treatment of completion of diagnosis necessary prior to final impression	0 - 99	Limited to 1 time per tooth per consecutive 60 months.	Y
D6545	Retainer – cast metal for resin bonded fixed prosthesis	0 - 99	Limited to 1 time per tooth per consecutive 60 months.	Y
D6548	Retainer – porcelain/ceramic for resin bonded fixed prosthesis	0 - 99	Limited to 1 time per tooth per consecutive 60 months.	Y
D6549	Resin retainer – for resin bonded fixed prosthesis	0 - 99	Limited to 1 time per tooth per consecutive 60 months.	Y

Code	Description	Age	Frequencies and limitations	Clinical review req
FIXED PROSTHODONTICS				
D6600	Inlay – porcelain/ceramic, two surfaces	0 - 99	Limited to 1 time per tooth per consecutive 60 months. Not covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.	Y
D6601	Inlay – porcelain/ceramic, three or more surfaces	0 - 99	Limited to 1 time per tooth per consecutive 60 months. Not covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.	Y
D6602	Inlay – cast high noble metal, two surfaces	0 - 99	Limited to 1 time per tooth per consecutive 60 months. Not covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.	Y
D6603	Inlay – cast high noble metal, three or more surfaces	0 - 99	Limited to 1 time per tooth per consecutive 60 months. Not covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.	Y
D6604	inlay – cast predominantly base metal, two surfaces	0 - 99	Limited to 1 time per tooth per consecutive 60 months. Not covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.	Y
D6605	Inlay – cast predominantly base metal, three or more surfaces	0 - 99	Limited to 1 time per tooth per consecutive 60 months. Not covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.	Y
D6606	Inlay – cast noble metal, two surfaces	0 - 99	Limited to 1 time per tooth per consecutive 60 months. Not covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.	Y
D6607	Inlay – cast noble metal, three or more surfaces	0 - 99	Limited to 1 time per tooth per consecutive 60 months. Not covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.	Y
D6608	Onlay – porcelain/ceramic, two surfaces	0 - 99	Limited to 1 time per tooth per consecutive 60 months. Not covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.	Y
D6609	Onlay – porcelain/ceramic, three or more surfaces	0 - 99	Limited to 1 time per tooth per consecutive 60 months. Not covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.	Y
D6610	Onlay – cast high noble metal, two surfaces	0 - 99	Limited to 1 time per tooth per consecutive 60 months. Not covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.	Y
D6611	Onlay – cast high noble metal, three or more surfaces	0 - 99	Limited to 1 time per tooth per consecutive 60 months. Not covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.	Y
D6612	Onlay – cast predominantly base metal, two surfaces	0 - 99	Limited to 1 time per tooth per consecutive 60 months. Not covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.	Y
D6613	Onlay – cast predominantly base metal, three or more surfaces	0 - 99	Limited to 1 time per tooth per consecutive 60 months. Not covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.	Y
D6614	Onlay – cast noble metal, two surfaces	0 - 99	Limited to 1 time per tooth per consecutive 60 months. Not covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.	Y
D6615	Onlay – cast noble metal, three or more surfaces	0 - 99	Limited to 1 time per tooth per consecutive 60 months. Not covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.	Y
D6624	Inlay – titanium	0 - 99	Limited to 1 time per tooth per consecutive 60 months. Not covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.	Y
D6634	Onlay – titanium	0 - 99	Limited to 1 time per tooth per consecutive 60 months. Not covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.	Y
Fixed Partial Denture Retainers – Crowns				
D6710	Crown – indirect resin based composite	0 - 99	Limited to 1 time per tooth per consecutive 60 months. Not covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.	Y
D6720	Crown – resin with high noble metal	0 - 99	Limited to 1 time per tooth per consecutive 60 months. Not covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.	Y
D6721	Crown – resin with predominantly base metal	0 - 99	Limited to 1 time per tooth per consecutive 60 months. Not covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.	Y
D6722	Crown – resin with noble metal	0 - 99	Limited to 1 time per tooth per consecutive 60 months. Not covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.	Y
D6740	Crown – porcelain/ceramic	0 - 99	Limited to 1 time per tooth per consecutive 60 months. Not covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.	Y
D6750	Crown – porcelain fused to high noble metal	0 - 99	Limited to 1 time per tooth per consecutive 60 months. Not covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes	Y
D6751	Crown – porcelain fused to predominantly base metal	0 - 99	Limited to 1 time per tooth per consecutive 60 months. Not covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.	Y
D6752	Crown – porcelain fused to noble metal	0 - 99	Limited to 1 time per tooth per consecutive 60 months. Not covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.	Y
D6780	Crown – 3/4 cast high noble metal	0 - 99	Limited to 1 time per tooth per consecutive 60 months. Not covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.	Y
D6781	Crown – 3/4 cast predominantly base metal	0 - 99	Limited to 1 time per tooth per consecutive 60 months. Not covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.	Y

Code	Description	Age	Frequencies and limitations	Clinical review req
FIXED PROSTHODONTICS				
D6782	Crown – 3/4 cast noble metal	0 - 99	Limited to 1 time per tooth per consecutive 60 months. Not covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.	Y
D6783	Crown – 3/4 porcelain/ceramic	0 - 99	Limited to 1 time per tooth per consecutive 60 months. Not covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.	Y
D6790	Crown – full cast high noble metal	0 - 99	Limited to 1 time per tooth per consecutive 60 months. Not covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.	Y
D6791	Crown – full cast predominantly base metal	0 - 99	Limited to 1 time per tooth per consecutive 60 months. Not covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.	Y
D6792	Crown – full cast noble metal	0 - 99	Limited to 1 time per tooth per consecutive 60 months. Not covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.	Y
D6793	Provisional retainer crown – further treatment of completion of diagnosis necessary prior to final impression	0 - 99	Limited to 1 time per tooth per consecutive 60 months. Not covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.	Y
D6794	Crown – titanium	0 - 99	Limited to 1 time per tooth per consecutive 60 months. Not covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.	Y
Other Fixed Partial Denture Services				
D6930	Recement fixed partial denture	0 - 99	Limited to those performed more than 12 months after the initial insertion.	N
D6980	Fixed partial denture repair necessitated by restorative material failure	0 - 99	Limited to repairs or adjustments performed more than 12 months after the initial insertion. Limited to 1 per consecutive 6 months.	Y

4.1.H Oral and maxillofacial surgery services guidelines

For the most recent and up to date clinical policy criteria and documentation requirements please follow **UHCdental.com> RESOURCES> CLINICAL GUIDELINES**, or you may use this **LINK**.

Code	Description	Age	Frequencies and limitations	Clinical review req
ORAL AND MAXILLOFACIAL SURGERY				
Extractions (Includes Local Anesthesia, Suturing If Needed, and Routine Postoperative Care)				
D7111	Extraction, coronal remnants – deciduous tooth	0 - 99	Limited to 1 time per tooth per lifetime.	N
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	0 - 99	Limited to 1 time per tooth per lifetime.	N
D7210	Surgical removal of erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	0 - 99	Limited to 1 time per tooth per lifetime.	N
D7220	Removal of impacted tooth – soft tissue	0 - 99	Limited to 1 time per tooth per lifetime.	Y
D7230	Removal of impacted tooth – partially bony	0 - 99	Limited to 1 time per tooth per lifetime.	Y
D7240	Removal of impacted tooth – completely bony	0 - 99	Limited to 1 time per tooth per lifetime.	Y
D7241	Removal of impacted tooth – completely bony, with unusual surgical complications	0 - 99	Limited to 1 time per tooth per lifetime.	Y
D7250	Rurgical removal of residual tooth roots (cutting procedure)	0 - 99	Limited to 1 time per tooth per lifetime.	N
Other Surgical Procedures				
D7260	Oroantral fistula closure	0 - 99	Limited to 1 per site per lifetime.	N
D7261	Primary closure of a sinus perforation	0 - 99	Limited to 1 per tooth per lifetime.	Y
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	0 - 99	Limited to 1 per site per lifetime.	N
D7272	Tooth transplantation (includes reimplantation from one site to another and splinting and/or stabilization)	0 - 99	Limited to 1 per site per lifetime.	N
D7280	Surgical access of an unerupted tooth	0 - 99	Limited to 1 time per tooth per lifetime.	N
D7282	Mobilization of erupted or malpositioned tooth to aid eruption	0 - 99	Limited to 1 time per tooth per lifetime.	Y
D7283	Placement of device to facilitate eruption of impacted tooth	0 - 99	Limited to 1 time per tooth per lifetime.	N
D7285	Biopsy of oral tissue – hard (bone, tooth)	0 - 99	Limited to 1 biopsy per site per visit.	N
D7286	Biopsy of oral tissue – soft	0 - 99	Limited to 1 biopsy per site per visit.	N
D7287	Exfoliative cytological sample collection	0 - 99	Limited to 1 biopsy per site per visit.	N
D7288	Brush biopsy – transepithelial sample collection	0 - 99	Limited to 1 biopsy per site per visit.	N
D7291	Transseptal fiberotomy/supra crestal fiberotomy, by report	0 - 99	Limited to 1 time per tooth per lifetime.	N
Alveoloplasty – Preparation of Ridge				
D7310	Alveoloplasty in conjunction with extractions – four or more teeth or tooth spaces, per quadrant	0 - 99	Listed in the COC with no limitation.	N
D7311	Alveoloplasty in conjunction with extractions – one to three teeth or tooth spaces, per quadrant	0 - 99	Listed in the COC with no limitation.	N
D7320	Alveoloplasty not in conjunction with extractions – four or more teeth or tooth spaces, per quadrant	0 - 99	Listed in the COC with no limitation.	N
D7321	Alveoloplasty not in conjunction with extractions – one to three teeth or tooth spaces, per quadrant	0 - 99	Listed in the COC with no limitation.	N
Vestibuloplasty				
D7340	Vestibuloplasty – ridge extension (secondary epithelialization)	0 - 99	Limited to 1 time per site per consecutive 60 months.	N
D7350	Vestibuloplasty – ridge extension (including soft tissue grafts, muscle reattachment, revision of soft tissue attachment and management of hypertrophied and hyperplastic tissue)	0 - 99	Limited to 1 time per site per consecutive 60 months.	N
Excision of Soft Tissue Lesions				
D7410	Excision of benign lesion up to 1.25 cm	0 - 99	Limited to 1 per site per visit.	N
D7411	Excision of benign lesion greater than 1.25 cm	0 - 99	Limited to 1 per site per visit.	Y
D7412	Excision of benign lesion, complicated	0 - 99	Limited to 1 per site per visit.	Y

Code	Description	Age	Frequencies and limitations	Clinical review req
ORAL AND MAXILLOFACIAL SURGERY				
Excision of Bone Tissue				
D7472	Removal of torus palatinus	0 - 99	Limited to 1 per site per visit.	N
D7473	Removal of torus mandibularis	0 - 99	Limited to 1 per site per visit.	N
Surgical Incision				
D7510	Incision and drainage of abscess – intraoral soft tissue	0 - 99	Limited to 1 per site per visit.	N
D7511	Incision and drainage of abscess – intraoral soft tissue – complicated (includes drainage of multiple fascial spaces)	0 - 99	Limited to 1 per site per visit.	N
D7520	Incision and drainage of abscess – extraoral soft tissue	0 - 99	Limited to 1 per site per visit.	N
D7521	Incision and drainage of abscess – extraoral soft tissue – complicated (includes drainage of multiple fascial spaces)	0 - 99	Limited to 1 per site per visit.	N
D7530	Removal of foreign body from mucosa, skin, or subcutaneous alveolar tissue	0 - 99	Limited to 1 per site per visit.	N
D7540	Removal of reaction producing foreign bodies, musculoskeletal system	0 - 99	Limited to 1 per site per visit.	N
D7550	Partial ostectomy/sequestrectomy for removal of non-vital bone	0 - 99	Limited to 1 per site per visit.	N
D7560	Maxillary sinusotomy for removal of tooth fragment or foreign body	0 - 99		N
Reduction of Dislocation and Management of Other Temporomandibular Joint Dysfunctions				
D7880	Occlusal orthotic device, by report	0 - 99	TMJ plans only; not generally covered on core standard plans - Limited to 1 time every consecutive 24 months.	Y
D7881	Occlusal orthotic device adjustment	16 - 99	Limited to repairs or adjustments performed more than 12 months after the initial insertion. Limited to 1 per consecutive 6 months.	N
D7899	Unspecified TMD therapy, by report	0 - 99	TMJ plans only; not generally covered on core standard plans - Limited to 1 per visit. Cannot be billed in conjunction with other TMD procedures.	Y
Other Repair Procedures				
D7960	Frenulectomy – also known as frenectomy or frenotomy – separate procedure not incidental to another procedure.	0 - 99	Listed in the COC with no limitation.	N
D7963	Frenuloplasty	0 - 99	Listed in the COC with no limitation.	N
D7970	Excision of hyperplastic tissue – per arch	0 - 99	Limited to 1 per site per consecutive 36 months.	N
D7971	Excision of pericoronal gingiva	0 - 99	Limited to 1 per site per consecutive 36 months.	N
D7972	Surgical reduction of fibrous tuberosity	0 - 99	Limited to 1 per site per consecutive 36 months.	Y
D7997	Appliance removal (not by dentist who placed appliance), includes removal of archbar	0 - 99	Limited to once per appliance per lifetime.	N

4.1.I Orthodontic services guidelines

For the most recent and up to date clinical policy criteria and documentation requirements please follow **UHCdental.com> RESOURCES> CLINICAL GUIDELINES**, or you may use this **LINK**.

Code	Description	Age	Frequencies and limitations	Clinical review req
ORTHODONTICS				
Limited Orthodontic Treatment				
D8010	Limited orthodontic treatment of the primary dentition	0 - 99	Plans with orthodontic benefits	N
D8020	Limited orthodontic treatment of the transitional dentition	0 - 99	Plans with orthodontic benefits	N
D8030	Limited orthodontic treatment of the adolescent dentition	0 - 99	Plans with orthodontic benefits	N
D8040	Limited orthodontic treatment of the adult dentition	0 - 99	Plans with orthodontic benefits	N
Interceptive Orthodontic Treatment				
D8050	Interceptive orthodontic treatment of the primary dentition	0 - 99	Plans with orthodontic benefits	N
D8060	Interceptive orthodontic treatment of the transitional dentition	0 - 99	Plans with orthodontic benefits	N
Comprehensive Orthodontic Treatment				
D8070	Comprehensive orthodontic treatment of the transitional dentition	0 - 99	Plans with orthodontic benefits	N
D8080	Comprehensive orthodontic treatment of the adolescent dentition	0 - 99	Plans with orthodontic benefits	N
D8090	Comprehensive orthodontic treatment of the adult dentition	0 - 99	Plans with orthodontic benefits	N
Minor Treatment to Control Harmful Habits				
D8210	Removable appliance therapy	0 - 99	Plans with orthodontic benefits	N
D8220	Fixed appliance therapy	0 - 99	Plans with orthodontic benefits	N
D8660	Pre-orthodontic treatment visit	0 - 99	Plans with orthodontic benefits	N
D8670	Periodic orthodontic treatment visit (as part of contract)	0 - 99	Plans with orthodontic benefits	N
D8680	Orthodontic retention (removal of appliances, construction and placement of retainer(s))	0 - 99	Plans with orthodontic benefits	N
D8690	Orthodontic treatment (alternative billing to a contract fee)	0 - 99	Plans with orthodontic benefits	N
D8691	Repair of orthodontic appliance	0 - 99	Plans with orthodontic benefits	N
D8693	Rebonding or recementing; and/or repair, as required, of fixed retainers	0 - 99	Plans with orthodontic benefits	N
D8694	Repair of fixed retainers, includes reattachment	0 - 99	Plans with orthodontic benefits	N
D8695	Removal of fixed orthodontic appliances for reasons other than completion of treatment	0 - 99	Plans with orthodontic benefits	N

4.1.J Adjunctive services guidelines

For the most recent and up to date clinical policy criteria and documentation requirements please follow **UHCdental.com> RESOURCES> CLINICAL GUIDELINES**, or you may use this **LINK**.

Code	Description	Age	Frequencies and limitations	Clinical review req
ADJUNCTIVE GENERAL SERVICES				
Unclassified Treatment				
D9110	Palliative (emergency) treatment of dental pain – minor procedure	0 - 99	Covered as a separate benefit only if no other services, other than exam and radiographs, were done on the same tooth during the visit.	N
D9120	Fixed partial denture sectioning	0 - 99	Limited to one time per bridge.	N
Anesthesia				
D9210	Local anesthesia not in conjunction with operative or surgical procedures	0 - 99		N
D9219	Valuation for moderate sedation, deep sedation or general anesthesia	0 - 99	Consultation (diagnostic service provided by dentists or physician other than practitioner providing treatment). Not covered if done with exams or professional visit.	N
D9222	Deep sedation/general anesthesia – first 15 minutes	0 - 99	Covered when Necessary in conjunction with Covered Dental Services. If required for patients under 6 years of age or patients with behavioral problems or physical disabilities or if it is clinically Necessary. Covered for patients over age of 6 if it is clinically necessary.	Y
D9223	Deep sedation/general anesthesia – each subsequent 15 minutes increment	0 - 99	Covered when Necessary in conjunction with Covered Dental Services. If required for patients under 6 years of age or patients with behavioral problems or physical disabilities or if it is clinically Necessary. Covered for patients over age of 6 if it is clinically necessary.	Y
D9230	Inhalation of nitrous oxide/anxiolysis, analgesia	0 - 99	Covered when Necessary in conjunction with Covered Dental Services. If required for patients under 6 years of age or patients with behavioral problems or physical disabilities or if it is clinically Necessary. Covered for patients over age of 6 if it is clinically necessary.	Y
D9239	Intravenous moderate (conscious) sedatioN/ Anesthesia – first 15 minutes	0 - 99	Covered when Necessary in conjunction with Covered Dental Services. If required for patients under 6 years of age or patients with behavioral problems or physical disabilities or if it is clinically Necessary. Covered for patients over age of 6 if it is clinically necessary.	Y
D9243	Intravenous moderate (conscious) sedatioN/ Analgesia – each 15 minute increment	0 - 99	Covered when Necessary in conjunction with Covered Dental Services. If required for patients under 6 years of age or patients with behavioral problems or physical disabilities or if it is clinically Necessary. Covered for patients over age of 6 if it is clinically necessary.	Y
D9248	Non-intravenous conscious sedation	0 - 99	Covered when Necessary in conjunction with Covered Dental Services. If required for patients under 6 years of age or patients with behavioral problems or physical disabilities or if it is clinically Necessary. Covered for patients over age of 6 if it is clinically necessary.	Y
Professional Consultation				
D9310	Consultation – diagnostic service provided by dentist or physician other than requesting dentist or physician	0 - 99	Consultation (diagnostic service provided by dentists or physician other than practitioner providing treatment). Not covered if done with exams or professional visit.	N
Drugs				
D9610	Therapeutic parenteral drug, single administration	0 - 99	Therapeutic Drug Injection, by report/Other Drugs and/or Medicaments, by report - Limited to 1 per visit.	Y
D9612	Therapeutic parenteral drugs, two or more administrations, different medications	0 - 99	Therapeutic Drug Injection, by report/Other Drugs and/or Medicaments, by report - Limited to 1 per visit.	Y
D9630	Other drugs and/or medicaments, by report	0 - 99	Therapeutic Drug Injection, by report/Other Drugs and/or Medicaments, by report - Limited to 1 per visit.	Y
Miscellaneous Services				
D9910	Application of desensitizing medicament	0 - 99	Desensitizing Medicament	N
D9911	Application of desensitizing resin for cervical and/ or root surface, per tooth	0 - 99	Desensitizing Medicament	N
D9942	Repair and/or reline of occlusal guard	0 - 99	Limited to relining and repair performed more than 6 months after the initial insertion. Limited to 1 time per consecutive 12 months.	N
D9943	Occlusal guard adjustment	16 - 99	Limited to repairs or adjustments performed more than 12 months after the initial insertion. Limited to 1 per consecutive 6 months.	N

Code	Description	Age	Frequencies and limitations	Clinical review req
ADJUNCTIVE GENERAL SERVICES				
D9944	Occlusal guard – hard appliance, full arch	0 - 99	Limited to 1 guard every consecutive 36 months and only covered if prescribed to control habitual grinding.	Y
D9945	Occlusal guard – soft appliance, full arch	0 - 99	Limited to 1 guard every consecutive 36 months and only covered if prescribed to control habitual grinding.	Y
D9946	Occlusal guard – hard appliance, partial arch	0 - 99	Limited to 1 guard every consecutive 36 months and only covered if prescribed to control habitual grinding.	Y
D9950	Occlusion analysis – mounted case	0 - 99	Limited to 1 time per consecutive 60 months.	N
D9951	Occlusal adjustment – limited	0 - 99	In COC with no limitation.	N
D9952	Occlusal adjustment – complete	0 - 99	In COC with no limitation.	N
D9995	Teledentistry – synchronous; real-time encounter	0 - 99	Limited to 2 times per consecutive 12 months.	N
D9996	Teledentistry – asynchronous; information stored and forwarded to dentist for subsequent review	0 - 99	Limited to 2 times per consecutive 12 months.	N

4.2 Exclusions & limitations

Exclusions

Except as may be specifically provided in the Schedule of Covered Dental Services or through a Rider to the Policy, the following are not covered:

- Dental Services that are not necessary.
- Hospitalization or other facility charges.
- Any Dental Procedure performed solely for cosmetic/aesthetic reasons. (Cosmetic procedures are those procedures that improve physical appearance.)
- Reconstructive surgery, regardless of whether or not the surgery is incidental to a dental disease, injury or con- genital anomaly, when the primary purpose is to improve physiological functioning of the involved part of the body.
- Any Dental Procedure not directly associated with dental disease.
- Any Dental Procedure not performed in a dental setting.
- Procedures that are considered to be Experimental, Investigational or Unproven. This includes pharmacological regimens not accepted by the American Dental Association (ADA) 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.
- Any implant procedures performed which are not listed as Covered implant procedures in the Schedule of Covered Dental Services on plans that cover implants.
- Any placement of dental implants, implant supported crowns, abutments and prostheses on plans that do not cover implants.
- Drugs/medications, obtainable with or without a prescription.
- Services for injuries or conditions covered by Workers' Compensation or employer liability laws, and services that are provided without cost to the Covered Person by any municipality, county or other political subdivision. This exclusion does not apply to any services covered by Medicaid or Medicare.
- Setting of facial bony fractures and any treatment associated with the dislocation of facial skeletal hard tissue.
- Treatment of benign neoplasms, cysts or other pathology involving benign lesions, except excisional removal. Treatment of malignant neoplasms or Congenital Anomalies of hard or soft tissue, including excision.
- Replacement of complete dentures, and fixed and removable partial dentures or crowns, and implants, implant crowns, implant prosthesis and implant supporting structures (such as connectors), if damage or breakage was directly related to provider error. This type of replacement is the responsibility of the Dentist. If replacement is Necessary because of patient non-compliance, the patient is liable for the cost of replacement.

- Services related to the temporomandibular joint (TMJ), either bilateral or unilateral. Upper and lower jaw bone surgery (including that related to the temporomandibular joint). No Coverage is provided for orthognathic surgery, jaw alignment or treatment for the temporomandibular joint.
- Charges for failure to keep a scheduled appointment without giving the dental office 24 hours notice.
- Expenses for Dental Procedures begun prior to the Covered Person becoming enrolled under the Policy.
- Fixed or removable prosthodontic restoration procedures or implant services for complete oral rehabili- tation or reconstruction. Employer benefit contracts may vary. Please call **1-800-822-5353** or log on to **UHCdental.com** to verify benefits for a specific patient.
- Attachments to conventional removable prostheses or fixed bridgework. This includes semi-precision or precision attachments associated with partial dentures, crown or bridge abutments, full or partial overdentures, any internal attachment associated with an implant prosthesis, and any elective endodontic procedure related to a tooth or root involved in the construction of a prosthesis of this nature.
- Procedures related to the reconstruction of a patient's correct vertical dimension of occlusion (VDO).
- Replacement of crowns, bridges, and fixed or removable prosthetic appliances, and implants, implant crowns, implant prosthesis and implant supporting structures (such as connectors) inserted prior to plan Coverage unless the patient has been Covered under the Policy for 12 continuous months. If loss of a tooth requires the addition of a clasp, pontic, and/or abutment(s) within this 12-month period, the plan is responsible only for the procedures associated with the addition.
- Replacement of missing natural teeth lost prior to the onset of plan Coverage until the patient has been Covered under the Policy for 12 continuous months.
- Occlusal guards used as safety items or to affect performance primarily in sports-related activities.
- Placement of fixed partial dentures solely for the purpose of achieving periodontal stability.
- 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 spouse, brother, sister, parent or child.
- Dental Services otherwise Covered under the Policy, but rendered after the date individual Coverage under the Policy terminates, including Dental Services for dental conditions arising prior to the date individual Coverage under the Policy terminates.
- Acupuncture; acupressure and other forms of alternative treatment, whether or not used as anesthesia.
- Orthodontic coverage does not include the installation of a space maintainer, any treatment related to treatment of the temporomandibular joint, any surgical procedure to correct a malocclusion, replacement of lost or broken retainers and/or habit appliances, and any fixed or removable interceptive orthodontic appliances previously submitted for payment under the plan.
- In the event that a Non-Network Dentist routinely waives Copayments and/or the Deductible for a particular Dental Service, the Dental Service for which the Copayments and/or Deductible are waived is reduced by the amount waived by the Non-Network provider.
- Foreign Services are not Covered unless required as an Emergency.
- Dental Services received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country.
- Any Dental Services or Procedures not listed in the Schedule of Covered Dental Services.

Limitations

- Dental services are covered at the least costly, clinically accepted treatment.
- Oral examinations are covered with a limit of two times per 12 consecutive months.
- Complete series or panoramic radiographs are limited to one time per 36 consecutive months. Exception to the 36-month limit on panoramic radiographs will be made if taken for diagnosis of third molars, cysts or neoplasms.
- Bitewing radiographs are limited to one series of films per plan year.
- Extraoral radiographs are limited to two films per plan year.
- Dental prophylaxes are limited to two times per 12 consecutive months.
- Diagnostic casts are limited to one per 24 consecutive months.

- Fluoride treatment is limited to covered persons under the age of 12 years, and limited to two times per 12 consecutive months. Treatment should be performed in conjunction with dental prophylaxis.
- Sealants are limited to covered persons under the age of 16 years, and once per first or second permanent molar every 36 consecutive months.
- Space maintainers are limited to covered persons under the age of 16 years, once per lifetime. Benefit includes all adjustments within six months of placement.
- Multiple restorations submitted for the same tooth with contiguous surfaces will be treated as a single multi-surface restoration.
- Pin retention is limited to two pins per tooth; not covered in addition to cast restorations.
- Inlays and onlays are limited to one time per 60 consecutive months. Covered only when a filling cannot restore the tooth.
- Crowns are limited to one time per 60 consecutive months. Covered only when a filling cannot restore the tooth.
- Post and cores are covered as a separate benefit only for teeth that have had root canal therapy.
- Sedative fillings are covered as a separate benefit only if no other service, other than X-rays and exam, were performed on the same tooth during the visit.
- Scaling and root planing is limited to one time per quadrant per 24 consecutive months.
- Periodontal maintenance is limited to two times per 12 consecutive months following active and adjunctive periodontal therapy within the prior 24 months, exclusive of gross debridement.
- For full dentures, there are no additional allowances for over-dentures or customized dentures.
- For partial fixed and removable dentures, there are no additional allowances for precision or semi-precision attachments.
- Relining or rebasing dentures is limited to relining performed more than six months after the initial insertion. Limited to one time every 12 consecutive months.
- Repairs and adjustments to full dentures or partial fixed or removable dentures are limited to those performed more than 12 months after the initial insertion. limited to 1 per consecutive 6 months.
- Palliative treatment is covered as a separate benefit only if no other service, other than X-rays and exam, was performed on the same tooth during that visit.
- Occlusal guards are limited to one guard every 36 consecutive months.
- Full-mouth debridement is limited to once every 36 consecutive months.
- General anesthesia is covered only when medically necessary.

4.3 Member appeals and inquiries

Members and providers acting on a member's behalf have the right to appeal how a claim was paid or how a utilization management decision was made.

Appeals regarding a denial of coverage based on dental necessity must be submitted within 60 days of the date of notification of an adverse decision unless otherwise prescribed by state regulations.

Appeals may be filed in writing or by fax and must include:

- Member name
- Claim ID
- Nature of the appeal including identification of the service
- Appropriate supporting documentation (such as X-rays or periodontal charting) and a narrative stating why the service should be covered.

Appeal reviews will be completed within state mandated time frames upon receipt of all necessary information. Providers and/or members will be notified of an appeal determination within the state law statute requirements.

Expedited appeals:

In time-sensitive circumstances in which the time frame for issuing determinations could seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function, an expedited appeal may be requested.

Expedited Appeals may be submitted by the member, the member's representative, or by the practitioner acting on behalf of the member in writing, telephonically, or by fax.

Determinations will be completed within 48 hours of receipt of all required documentation or within the time frame required by state law, statute, or act.

Please refer to the Resources and Services section of this manual for appeal address and fax number information. Our Provider Services line is also available for any questions.

Section 5: Radiographs

5.1 Radiographs

For some procedures, it is required that copies of radiographs are submitted prior to payment. Requirements for radiographs are found at this **LINK**. Providers should refer to the previously noted link for documentation guidelines before performing a procedure.

Guidelines for providing radiographs are as follows:

- Send a duplicate radiograph instead of the original
- Radiograph must be diagnostic for the condition or site and contain all critical anatomical landmarks
- Radiographs should be labeled with the practice name, member 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.

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

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

Section 6: Claim submission procedures

6.1 Claim submission required elements & best practices

Dental claim form

The most current Dental ADA claim form must be submitted for payment of services rendered or to obtain a Pre-Treatment Estimate.*

Claim submission options

Electronic claims

Electronic claims processing requires access to a computer and usually the use of practice management software. Electronically generated claims can be submitted through a clearinghouse or directly to our claims processing system via the Internet. Most systems have the ability to detect missing information on a claim form and notify you when errors need to be corrected. Electronic submission is private as the information being sent is encrypted. Please call **1-877-620-6194** for more information regarding electronic claims submission.

Paper claims

Due to periodic revisions and varying practice management systems, dental insurance claim forms exist in various formats. Use of the most recently revised American Dental Association (ADA), 2019, format is recommended. Claims and pre-treatment estimates can be submitted directly through the portal at **UHCdental.com** where you can also upload x-rays, case notes and periodontal charts. The portal will indicate when required information is missing from the submission.

Dental claim form required information

One claim form should be used for each member and the claim should reflect only one treating dentist for services rendered. The claims must also have all necessary fields populated as outlined below.

Header information

Indicate the type of transaction by checking the appropriate box: Statement of Actual Services or Request for Pre-Treatment Estimate.

Subscriber information

- Name (Last, First, and Middle Initial)
- Address, City, State, ZIP Code
- Date of Birth
- Gender
- Subscriber ID number

Member information

- Name (Last, First, and Middle Initial)
- Address, City, State, ZIP Code
- Date of Birth
- Gender
- Member ID number

*It is recommended that pre-treatment estimates be obtained for high-dollar procedures such as crowns, bridges and dentures.

Primary payer information

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

Other coverage

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

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

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

- Name of subscriber / policy holder (Last, First, and Middle Initial)
- Date of Birth and Gender
- Subscriber Identification number
- Relationship to the Member

Billing dentist or dental entity

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

- Name
- Address, City, State, ZIP Code
- License number
- TIN
- Phone number

Treating dentist and treatment location

List the following information regarding the dentist that provided treatment:

- Certification – Signature of dentist and the date the form was signed
- Name (use name provided on the Practitioner Application)
- License number
- TIN
- Address, city, state, ZIP code
- Phone number

Services provided

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

- Procedure date
- Area of oral cavity
- Tooth number or letter and the tooth surface
- Procedure code
- Description of procedure
- Charges for dentist's fee/charges for the procedure.
- Total sum of all charges

Missing teeth information

When submitting for periodontal or prosthodontic 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.

Subscriber / member authorization

Signature of subscriber or member authorizing payment of dental benefits is required. A claim form that indicates a signature is "on file" for a particular member will be accepted. The dentist must keep a copy of a signed claim in the member record.

Paper claims

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

By report procedures

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

Using current ADA codes

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

Tips on claim submission

The National Association of Dental Plans says dentists will be reimbursed more quickly if they include the information below on their dental claim forms.

- Attending dentist information should include dentist's name, address and tax identification number (TIN). If any of this information has changed from the last submission, or if the payer was not informed of the change, a delay can occur while verification of correct data is made.
- Patient information should include patient's full name, identification or member number and date of birth and relationship to the insured person (self, dependent or spouse).
- Date of service should be the day on which the service was performed.
- CDT codes of services performed – Dental claim logic systems are designed to read approved current CDT codes according to their definition. Internal codes, outdated codes or codes that are considered an integral part of another procedure can delay a claim while research is conducted.
- Tooth number or quadrant along with the surface, if appropriate, is required to identify where procedure was performed.
- Missing teeth information should be reported on claims for periodontal, prosthodontic (fixed and removable), or implant services procedures, if covered.
- Prior placement date for crowns, bridges – As many plans have frequency limitations on crowns and bridges, it is important to indicate whether this is an initial placement in the claim form box provided. If not an initial placement, the prior placement date should be indicated and an explanation included in the narrative. This is a particular problem when older versions of the ADA claim form are utilized.
- Narratives are an essential ingredient to help the treating dentist explain why a certain procedure was recommended. Payers will not try to validate the course of treatment but will assign benefits according to the plan purchased for that particular patient. If it isn't part of their benefit design, then the dentist can charge the member accordingly.
- Coordination of benefits – If the patient is covered by more than one dental carrier, or if the procedure is also covered under the patient's health plan, include any explanation of benefits or remittance notice from the other payer. Payers are required by state law or regulation to coordinate benefits when more than one entity is involved – this is not a payer choice. The objective

is to ensure the dentist is reimbursed appropriately by the proper payer first (primary) with any other payer coordinating the benefit on the balance.

- Remarks – The Remarks section of the claim form should only be used to provide additional explanation of the procedures performed. For most payers, information included in this section will remove a claim from auto-adjudication, thus delaying the processing.

6.1.A Pre-Treatment Estimate (PTE)

A pre-treatment estimate is a summary estimating how planned treatment will be adjudicated according to the member's plan design and enrollment status at the time the PTE is reviewed. These estimates may be submitted on an ADA claim form and are not a guarantee of coverage or how the claim will be ultimately adjudicated.

Pre-treatment estimates are strongly encouraged to ensure that both the practice and the member fully understand how benefits will be applied, particularly for high-dollar procedures. Your office is encouraged to use features found on the UnitedHealthcare website (**UHCdental.com**) to do your own pre-treatment estimates. In addition, many practice management systems will perform this function (consult your office's practice management system support organization to determine the capabilities of your office's systems).

If a pre-treatment is older than 90 days, a new PTE must be attained prior to delivering clinical services.

6.2 Claims processing systems

UnitedHealthcare processes claims using a proprietary claims processing platform. Claims are edited and paid according to ADA Code and Dental Procedures. There are no modifiers associated with this code set.

Claims are edited and paid according to the specific plan design for a member's employer group. Please refer to the Exclusions and Limitations section of this manual for further information or access one of the resources outlined in Section 2.

Any specific plan design questions that would assist you in determining how to administer claims for a particular member can be answered by our Provider Services line.

6.3 Electronic claims submissions

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 Funds Transfer, which is the ability to be paid electronically directly into your bank account).

UnitedHealthcare partners with electronic clearinghouses to support electronic claims submissions. While the payer ID may vary for some plans, the UnitedHealthcare number is 52133. Please refer to the Important Addresses and Phone Numbers section and Distributor Client List for additional information as needed.

If you wish to submit claims electronically, please contact your clearinghouse to initiate this process. If you do not currently work with a clearinghouse, you may either sign up with one to initiate this process or simply register with our preferred vendor. The UnitedHealthcare website (**UHCdental.com**) also offers the feature to directly submit your claims online through the provider portal.

6.4 HIPAA compliant 837D file

The 837D is a HIPAA compliant EDI transaction format for the submission of dental claims. This transaction set can be used to submit health care claim billing information, encounter information, or both, from providers of health care services to payers via established claims clearinghouses.

6.5 HIPAA compliant 835 file

An 835 is an electronic remittance detailing payments and/or adjustments including cancellations, recoveries, reversals, etc., made on claims submitted electronically via an 837D transaction file or via paper.

For general questions, eligibility and/or claim status inquiries, please call **1-877-620-6194**. Additional tools and resources can also be f**ound online at UHCdental.com.**

6.6 Paper claims submission

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

Please refer to section 6.1 for more information on claims submission best practices and required information.

Our Quick Reference Guide will provide you with the appropriate claims address information to ensure your claims are routed to the correct resource for payment.

6.7 Coordination of Benefits (COB)

Coordination of Benefits (COB) is used when a member is covered by more than one dental insurance policy. By coordinating benefit payments, the member receives maximum benefits available under each plan. It is each provider's responsibility to assist in correct coordination of benefits by notifying all payers so that claims may be paid correctly.

If the patient is covered by more than one dental carrier, or if the procedure is also covered under the patient's health plan, include any explanation of benefits or remittance notice from the other payer. Payers are required by state law or regulation to coordinate benefits when more than one entity is involved — this is not a payer choice. The objective is to ensure that the dentist is reimbursed appropriately by the proper payer first (primary) with any other payer coordinating the benefit on the balance.

When a claim is being submitted to us as the secondary payer for Coordination of Benefits (COB), a fully completed claim form must be submitted along with the primary payer's Explanation of Benefits (EOB) showing the amount paid by the primary payer.

6.8 Dental claim filing limits and adjustments

All Dental Claims should be submitted within ninety (90) days from the date of service (30 days is preferred). Payment may be considered after the date of service for up to three hundred and sixty-five (365) days. This may vary for some plans.

All adjustments or requests for reprocessing must be made within sixty (60) days from receipt of payment. An adjustment can be requested telephonically by calling our Provider Servicing team at **1-800-822-5353**.

6.9 Claim adjudication and periodic overview

In accordance with UnitedHealthcare's standard practice, clean claims will be adjudicated and paid within five to ten days of receipt (this may vary by state and claim submission and/or payment method).

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 in general, on a daily basis, various samples of claims are selected for quality assurance reviews. QA samples include center-specific claims, adjustments, claims adjudicated

by newly hired claims processors and high-dollar claims. In addition, management selects other areas for review, including customer-specific and processor-specific audits. Management reviews the summarized results and correction is implemented, if necessary.

Invalid or incomplete claims:

- If claims are submitted with missing information or incomplete claim forms, the claim will be returned or rejected with a request for the missing required information to be sent.
- If the claim is missing a tooth number or surface, a letter will be generated to the provider requesting this information.
- If the procedure code is invalid or expired, a letter will be sent to the provider requesting the appropriate code.
- If there are inadequate provider details to process under the submitting provider, the claim will be returned with a letter requesting appropriate provider information.
- If the member is not found or ineligible, the claim will be returned.

6.10 Explanation of provider remittance advice

The Provider Remittance Advice is a claim detail of each member and each procedure considered for payment. Please use these as a guide to reconcile member payments. As a best practice it is recommended that Remittance Advices be kept for future reference and reconciliation.

Below is a list and description of each field:

PROVIDER OR MBR NAME AND ID NO
Treating dentist's name, NPI submitted with claim, Member's name and Subscriber's ID number. To conform to HIPAA regulations, the subscriber's alternate ID number is shown in place of the Social Security number.

GROUP NO
Group ID number assigned to the member's plan

CLAIM NO
Number assigned to the claim

ADA CODE
Procedure code submitted pertaining to the service

DESCRIPTION
Description of the procedure code

DATE OF SERVICE
Date when services were rendered

TOOTH NO
Tooth number or the quadrant pertaining to the procedure

AMOUNT CLAIMED
Amount submitted by provider

AMOUNT ALLOWED
Provider's contracted fee amount

DEDUCT APPLIED
Applicable plan deductible

OTHER INS
Member's primary insurance if applicable

MEMBER RESP
Member's copayment that pertains to the procedure

AMOUNT PAID
Claim paid amount

EOB CODE
Refers to the explanations provided within the EOB that explain how the procedure adjudicated

6.11 Provider claim appeal and inquiry process

Appeal rights vary by business and/or state. Refer to the appeals language on the back of the EOB for guidance with the appeals processes that are appropriate for each particular claim.

There are two types of provider appeals:
Utilization Management (UM) Appeal: Any appeal that is based on dental necessity and/or would require review by a dental clinician. UM appeals must include a narrative and any supporting documentation including X-rays.

Administrative Appeal: Appeals that are not based on dental necessity. This type of appeal would include but is not limited to appeals for timely filing of claims, member's eligibility, over/underpayment adjustment requests, etc. Administrative appeals must include a narrative.

Refer to the Quick Reference Guide section for appeal submission addresses.

Section 7: Quality management

7.1 Quality Improvement Program (QIP) description

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

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

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

- 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.
- When indicated, implement improvement plans and document actions taken to increase performance.
- To evaluate the effectiveness of implemented changes to the QIP.
- To reduce or minimize opportunity for adverse impact to members.
- To improve efficiency, 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 ensure quality of care, dentists are vetted through a credentialing and recredentialing process.
- To comply with pertinent legal, professional and regulatory standards.
- To foster the provision of appropriate dental care according to professionally recognized standards.
- To ensure that written policies and procedures are established and maintained by the Plan to ensure that quality dental care is provided to the members.
- To communicate results of performance measurement to the committees and Board of Directors.

A complete copy of our QIP policy and procedure is available upon request by contacting our Provider Services line at **1-800-822-5353**.

7.2 Credentialing

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

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

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

Dental Benefit Providers Credentialing Committee reviews the information submitted in detail based on approved credentialing criteria. Dental Benefit Providers will request a resolution of any discrepancy in credentialing forms submitted. Providers have

the right to review and correct erroneous information and to be informed of the status of their application. Credentialing criteria is reviewed/ approved by the Credentialing Committee, which include input from practicing network providers to make sure that criteria are within generally accepted guidelines.

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.

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

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

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

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

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

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

Initial credentialing

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

Recredentialing

- Completed Recredentialing application
- Signed and dated Attestation
- Current copy of their state license
- Current copy of their Drug Enforcement Agency (DEA) certificate

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

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

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

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

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

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

7.2.A Confidentiality

Our staff treats information obtained in the credentialing process as confidential. We and our delegates maintain mechanisms to properly limit review of confidential credentialing information. Our contracts require Delegated Entities to maintain the confidentiality of credentialing information.

Credentialing staff or representatives will not disclose confidential care provider credentialing information to any persons or entity except with the express written permission of the care provider or as otherwise permitted or required by law.

7.2.B Site visits

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

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

7.3 Grievances

The member grievance process encompasses investigation, review and resolution of member issues related to the plan and/or contracted providers.

Issues are accepted via telephone, fax, email, letter, written grievance form, or through our Web portal. Grievance forms may be requested from our Customer Service Department, website or from a contracted dental provider office. UnitedHealthcare does not delegate grievance processing and resolution to any provider group.

All member benefit and quality of care grievances are received and reviewed in accordance with state and federal regulatory and client-specific requirements both in terms of the notifications sent and the time frames allowed.

Your office is required to cooperate with UnitedHealthcare's Policies and Procedures, Member Rights and Responsibilities (including grievances) and Dental Records.

UnitedHealthcare shall have access to office records for that purpose and such information obtained from the records shall be kept confidential. Your office is required to comply with UnitedHealthcare's request for patient records and films, etc., within five business days of receiving the request.

Failure to comply will result in the grievance resolution in favor of the member. Additionally, your right to appeal the decision will be considered waived.

UnitedHealthcare recognizes the importance of thoroughly reviewing all appropriate documentation to determine if there are any potentially systemic problems.

Periodic reports on member grievance activities are made to all appropriate committees and the Board of Directors.

UnitedHealthcare's Grievance policies are filed with the necessary regulatory agencies when required.

New Mexico Commercial Networks: Provider grievance process

In accordance with New Mexico law, providers have the right to file a grievance about termination from the Network, credentialing and timely claims payment.

The online Grievance form is available through our provider portal. Access the form after you register and log in to **UHCdental.com**.

7.4 Preventive health guideline

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

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

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

Caries management – Begins with a complete evaluation including an assessment for risk.

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

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

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

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

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

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

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

7.5 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. Then click "Drug Lists and Pharmacy". Click Resource Library to find a list of tools and education.

Prevention

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

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

7.6 COVID-19 information and resources

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

7.7 Consumer account cards and qualified medical expenses

You may only charge our HRA or FSA consumer account cards for qualified medical expenses incurred by the cardholder, or the cardholder's spouse or dependent. "Qualified medical expenses" are expenses for medical care that provide diagnosis, cure, mitigation, treatment or prevention of any disease, or for affecting any structure or function of the body.

Examples of non-qualifying expenses include:

- Cosmetic surgery/procedures (i.e., procedures directed at improving a person's appearance that do not meaningfully promote the proper function of the body or prevent or treat illness or disease), such as:
- Teeth whitening and similar cosmetic dental procedures
- Advance expenses for future medical care
- Illegal operations or procedures
- An expense defined as a qualified medical expense but might not be covered under a member's benefit plan

For updated information regarding qualified medical expenses, go to: irs.gov or call the IRS at 1-800-TAX-FORM (1-800-829-3676).

Section 8: Utilization Management program

8.1 Utilization Management

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

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

8.2 Community practice patterns

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

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

8.3 Evaluation of Utilization Management data

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

8.4 Utilization Management analysis results

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

Feedback and recommended follow-up may also be communicated to the provider network as a whole. This is done by using a variety of currently available communication tools including: (bullet) Provider Manual/Standards of Care

- Provider Training
- Continuing Education
- Provider News Bulletins

8.5 Fraud and abuse

Every Network Provider and third party contractor of UnitedHealthcare is responsible for conducting business in an honest and ethical way. This entails fostering a climate of ethical behavior that does not tolerate fraud or abuse, remaining alert to instances of possible fraud and/or abuse and reporting such situations to the appropriate person(s).

We conduct programs and activities to deter, detect and address fraud and abuse in all aspects of our operations. We utilize a variety of resources to carry out these activities, including anti-fraud services from other affiliated entities, as well as outside consultants and experts when necessary.

If adverse practice patterns are found, interventions will be implemented on a variety of levels. The first is with the individual practitioners. The emphasis is heavily weighted toward education and corrective action. In some instances, corrective action, ranging from reimbursement of over payments to additional consideration by UnitedHealthcare's Peer Review Committee – or further action, including potential termination – may be imposed.

If mandated by the state in question, the appropriate state dental board will be notified. If the account is Medicaid or Medicare, the Office of the Inspector General or the State Attorney General's office will also be notified.

8.6 Utilization review

UnitedHealthcare shall perform utilization review on all submitted claims. Utilization review (UR) is a clinical analysis performed to confirm that the services in question are or were necessary dental services as defined in the

member's certificate of coverage. UR may occur after the dental services have been rendered and a claim has been submitted (retrospective review).

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

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

Utilization review is completed based on the following:

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

(See Section 4 for treatment codes that require clinical review and documentation requirements)

Section 9: Evidence-Based Dentistry & the Clinical Policy & Technology Committee

9.1 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, 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 UnitedHealthcare is as follows:

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

Evidence is found in a variety of sources including:

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

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

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

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

Section 10: Practice capacity & appointment scheduling standards

UnitedHealthcare is committed to ensuring that its providers are accessible and available to their members for the full range of services specified in the UnitedHealthcare Provider Agreement and Provider Manual.

Participating providers must comply with any state-mandated appointment scheduling requirements for emergency care as well as elective or routine care appointments.

In states where there are specified access and availability standards, UnitedHealthcare will monitor the access and availability of our participating providers through a variety of methods, including member feed- back/surveys, a review of appointment books, spot checks of waiting room activity, investigation of member complaints and random calls to provider offices. Any noted concerns are discussed with the participating provider(s), and corrective action may be taken.

Walk-in appointment standards

Dental offices that operate by "walk-in" or "first come, first served" appointments are monitored for access and waiting times, where applicable.

Missed appointments

Offices should inform patients of office policies relating to missed appointments and any fees that will be incurred.

1. Appointment scheduling guidelines may vary by state. It is recommended that you confirm whether or not the state in which you're providing services has any state-specific mandates.
2. Emergency Care appointments would be needed if a patient is experiencing excessive bleeding, pain or trauma.
3. Providers are encouraged to schedule member appointments appropriately to avoid inconveniencing the members with long wait times in excess of thirty (30) minutes. Members should be notified of anticipated wait times and given the option to reschedule their appointment.

10.1.A Appointment availability requirements for Connecticut

Effective immediately all PPO Providers in Connecticut are required to follow the required appointment availability standards:

- Urgent appointment wait times within 48 hours.
- Non-urgent appointments for primary care (general dentist) within 10 business days.
- Non-urgent appointments for specialist care within 15 business days.

All Connecticut providers are required to employ an answering service or a telephone answering machine during nonbusiness hours, which provides instructions on how plan enrollees may obtain urgent or emergency care when applicable, how to contact another provider who has agreed to be on call to triage or screen by phone, or if needed deliver urgent or emergency care. We will be conducting a random survey requesting the actual measures.

10.1.B Appointment availability requirements for Maryland

Effective immediately all PPO Providers in Maryland are required to follow the required appointment availability standards:

- Urgent appointment wait times within 3 calendar days..
- Non-urgent appointments for primary care (general dentist) within 45 calendar days.
- Non-urgent appointments for specialist care within 60 calendar days.

All Maryland providers are required to employ an answering service or a telephone answering machine during nonbusiness hours, which provides instructions on how plan enrollees may obtain urgent or emergency care when applicable, how to contact another provider who has agreed to be on call to triage or screen by phone, or if needed deliver urgent or emergency care. We will be conducting a random survey requesting the actual measures

10.2 Emergency coverage

All network dental providers must be available to members during normal business hours. Providers will provide members access to emergency care 24 hours a day, seven 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.

Member Services, Provider Services and Quality Management staff monitor and document all instances of provider unavailability to ensure continuity of care. UnitedHealthcare conducts periodic surveys to ensure that access and availability standards for members are in compliance with state requirements and UnitedHealthcare standards.

Network dentists are required to participate in all activities related to these surveys. Offices out of compliance will be required to submit a corrective action plan to UnitedHealthcare.

10.3 New associates

As your practice expands and changes, and as new associates are added, please contact us to request an application so that they may be credentialed and listed as participating providers.

It is important to remember that an associate may not see members as a participating provider until he/she has been credentialed by our organization.

If you have any questions, please contact our Provider Services line at **1-800-822-5353**. If you need to receive a copy of our provider application packet, please visit **UHCdental.com** > Join Our Network page and request a provider packet.

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

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

A Participating Provider or an entity delegated to conduct credentialing activities on behalf of UnitedHealthcare is expected to review, update provider records and attest to the information available to UnitedHealthcare members, including the information listed below, on no less than a quarterly basis. You are responsible for notifying UnitedHealthcare of these changes for all of the participating providers. Requests may need to be made in writing with corresponding and/or backup documentation. For your convenience, we have included a Demographics Change Form in the Appendix section of this manual to assist in providing the required information. Examples of changes requiring notification within 30 days of the change to UnitedHealthcare:

- The status as to whether the participating provider is accepting new patients or not.
- The address(es) of the office locations where the participating provider currently practices.
- The phone number(s) of the office locations where the participating provider currently practices.
- The email address of the participating provider.
- If the participating provider is still affiliated with the listed provider groups.
- The specialty of the participating provider.
- The license(s) of the participating provider.
- The tax identification number used by the participant provider.
- The NPI(s) of the participating provider.
- The languages spoken/written by the participating provider of the staff.
- The ages/genders served by the participating provider.
- Office hours (7 days a week)

Changes should be submitted to:

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

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

Credentialing updates should be sent to:

UnitedHealthcare Credentialing
2300 Clayton Road, Suite 1000
Concord, CA 94520

Requests must be made in writing with corresponding and/or backup documentation. For example, a tax identification number (TIN) change would require submission of a copy of the new W9, versus an office closing notice where we'd need the notice submitted in writing on office letterhead. Changes may also be submitted through the provider self-service portal at **UHCdental.com**.

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

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

If you have any questions, don't hesitate to contact Provider Services at **1-800-822-5353** for guidance.

10.5 Office conditions

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

You must submit to us an attestation from each dental office location, that the physical office meets ADA standards or describes how accommodation for ADA standards are made, and that medical record-keeping practices conform with our standards.

10.6 Sterilization and asepsis control

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

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

While standard practice is for sterilization costs to be included within office procedure charges, should your office charge this fee separately, these fees must be made known to patients in advance. This may not be a covered code on our fee schedules.

10.7 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, e-mails and advance appointment scheduling.

10.8 Transfer of dental records

Your office shall copy all requested member dental files to another participating dentist as designated by UnitedHealthcare or as requested by the member. The member cannot be held liable for the cost of copying the patient dental files if the member

is transferring to another provider. If your office terminates from UnitedHealthcare, dismisses the member from your practice or is terminated by UnitedHealthcare, the cost of copying files shall be borne by your office. Your office shall cooperate with UnitedHealthcare in maintaining the confidentiality of such member dental records at all times, in accordance with state and federal law.

10.9 Nondiscrimination

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

10.10 Cultural competency

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

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

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

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

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

10.11 Provider directory requirements for California

Notification of Acceptance/Non-Acceptance of New Patients. Participating Dentists shall provide the following information to ensure compliance with the requirements of Section (j) (1) of CA Insurance Code § 10133.15:

Participating Dentist shall inform DBP within **five business days** when either of the following occurs:

1. Participating Dentist is not accepting new patients.
2. If Participating Dentist had previously not accepted new patients, the Participating Dentist is currently accepting new patients.

Section 11: Plan specific information

11.1 Texas Dental Health Maintenance Organization (DHMO)

National Pacific Dental, Inc. (NPD) is the legal entity of UnitedHealthcare's DHMO product located in Texas.

All providers applying to become part of the NPD TX DHMO in-network plan must initially be credentialed then recredentialed every three years. Applications are to be sent to UnitedHealthcare's credentialing office in Concord, CA. All new locations must successfully pass a Facility Site Review prior to activation.

Members must select a Primary Care Provider (PCP) and be assigned to that provider's practice before treatment is rendered. It is important that the provider verify a member's eligibility and assignment prior to providing dental services.

In-network PCPs are reimbursed at a pre-determined fixed rate. The fixed rate, known as capitation, is paid on a per member per month (PMPM) basis, and is based on member eligibility and provider selection. A monthly roster and corresponding capitation check is mailed the first week of each month to participating providers listing membership assigned to their office. Capitation is pre-paid for the month and represents NPD's payment in full.

All in-network providers also receive copayments from members at the time of service. Copayments are payments for covered procedures based on the member's contracted Schedule of Benefits.

NPD has a specialty referral process in place for treatment beyond the scope of the PCP. It is mandatory that all Specialty Referral requests be initiated by the PCP and treatment is authorized by NPD to a contracted DHMO specialist, this does not include pediatric dentist specialty referrals are no longer needed for children up to age 8 to see a pediatric dentist. Children under age 8 who need services of a specialist beyond a pediatric dentist must still obtain a specialty referral. In order to locate an in-network pediatric dentist please instruct the member to contact customer services.

Any unapproved referrals or unauthorized treatment will not be reimbursed by NPD and may become the specialist's financial responsibility. The member is not to be charged for the PCP or specialist's failure to follow the Specialty Referral process.

Plan exclusions and limitations apply. For more information on the National Pacific Dental Texas DHMO, please contact Customer Service at **1-800-232-0990**.

Section 12: Medicare Advantage Regulatory Requirements Addendum Dental Benefit Providers, Inc., Provider (if applicable)

Medicare Advantage regulatory requirements

This Medicare Advantage Regulatory Requirements Addendum (this "Addendum") supplements and is made part of the provider agreement (the "Agreement") between Dental Benefit Providers, Inc. it subsidiaries, and its affiliated companies (collectively, "DBP") and the provider named in the Agreement ("Provider").

12.1 Applicability

This Addendum applies to the Covered Services that Provider provides to Medicare Advantage Customers. In the event of a conflict between this Addendum and other appendices or any provision of the Agreement, the provisions of this Addendum shall control except: (1) with regard to Benefit Plans outside the scope of this Addendum; or (2) as required by applicable law.

12.2 Definitions

For purposes of this Addendum, the following terms shall have the meanings set forth below.

Benefit Plan: A certificate of coverage, summary plan description, or other document or agreement, whether delivered in paper, electronic, or other format, under which a Payer is obligated to provide coverage of Covered Services for a Customer.

CMS Contract: A contract between the Centers for Medicare & Medicaid Services ("CMS") and a Medicare Advantage Organization for the provision of Medicare benefits pursuant to the Medicare Advantage Program under Title XVIII, Part C of the Social Security Act.

Cost Sharing: Those costs, if any, under a Benefit Plan that are the responsibility of the Customer, including deductibles, coinsurance, and copayments.

Covered Service: A health care service or product for which a Customer is entitled to receive coverage from a Payer, pursuant to the terms of the Customer's Benefit Plan with that Payer.

Customer: A person eligible and enrolled to receive coverage from a Payer for Covered Services.

Dual Eligible Customer: A Medicare Advantage Customer who is: (a) eligible for Medicaid; and (b) for whom the state is responsible for paying Medicare Part A and B Cost Sharing.

Medicare Advantage Benefit Plans: Benefit Plans sponsored, issued or administered by a Medicare Advantage Organization as part of the Medicare Advantage program or as part of the Medicare Advantage program together with the Prescription Drug program under Title XVIII, Part C and Part D, respectively, of the Social Security Act (as those program names may change from time to time).

Medicare Advantage Customer or MA Customer: A Customer eligible for and enrolled in a Medicare Advantage Benefit Plan in which Provider participates pursuant to the Agreement.

Medicare Advantage Organization or MA Organization: For purposes of this Addendum, MA Organization is an appropriately licensed entity that has entered into: (a) a CMS Contract; and (b) a contract with DBP, either directly or indirectly, under which DBP provides certain administrative services for Benefit Plans sponsored, issued, or administered by MA Organization.

Payer: An entity obligated to a Customer to provide reimbursement for Covered Services under the Customer's Benefit Plan, and authorized to access Provider's services under the Agreement.

12.3 Provider requirements

12.3.a Data

Provider shall submit to DBP or MA Organization, as applicable, all risk adjustment data as defined in 42 CFR 422.310(a), and other Medicare Advantage program-related information as may be requested by MA Organization, within the timeframes specified and in a form that meets Medicare Advantage program requirements. By submitting data to DBP or MA Organization, Provider represents to MA Organization, and upon MA Organization's request Provider shall certify in writing, that the data is accurate, complete, and truthful, based on Provider's best knowledge, information and belief.

12.3.b Policies

Provider shall cooperate and comply with MA Organization's policies and procedures.

12.3.c Customer protection

Provider agrees that in no event, including but not limited to, non-payment by DBP, MA Organization or an intermediary, insolvency of, MA Organization or an intermediary, or breach by DBP of the Agreement, shall Provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against any MA Customer or person (other than MA Organization or an intermediary) acting on behalf of the MA Customer for Covered Services provided pursuant to the Agreement or for any other fees that are the legal obligation of MA Organization under the CMS Contract. This provision does not prohibit Provider from collecting from MA Customers allowable Cost Sharing. This provision also does not prohibit Provider and an MA Customer from agreeing to the provision of services solely at the expense of the MA Customer, as long as Provider has clearly informed the MA Customer, in accordance with applicable law, that the MA Customer's Benefit Plan may not cover or continue to cover a specific service or services.

In the event of MA Organization's, DBP's or an intermediary's insolvency or other cessation of operations or termination of MA Organization's contract with CMS, Provider shall continue to provide Covered Services to an MA Customer through the later of the period for which premium has been paid to MA Organization on behalf of the MA Customer, or, in the case of MA Customers who are hospitalized as of such period or date, the MA Customer's discharge.

This provision shall be construed in favor of the MA Customer, shall survive the termination of the Agreement regardless of the reason for termination, including DBP's or MA Organization's insolvency, and shall supersede any contrary agreement, oral or written, between Provider and an MA Customer or the representative of an MA Customer if the contrary agreement is inconsistent with this provision.

For the purpose of this provision, an "intermediary" is a person or entity authorized to negotiate and execute the Agreement on behalf of Provider or on behalf of a network through which Provider elects to participate.

12.3.d Dual eligible customers

Provider agrees that in no event, including but not limited to, non-payment by a State Medicaid Agency or other applicable regulatory authority, other state source, or breach by DBP of the Agreement, shall Provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against any Dual Eligible Customer, person acting on behalf of the Dual Eligible Customer, DBP or MA Organization (unless notified otherwise) for Medicare Part A and B Cost Sharing. Instead, Provider will either: (a) accept payment made by or on behalf of MA Organization as payment in full; or (b) bill the appropriate state source for such Cost Sharing amount. If Provider imposes an excess charge on a Dual Eligible Customer, Provider is subject to any lawful sanction that may be imposed under Medicare or Medicaid. This provision does not prohibit Provider and a Dual Eligible Customer from agreeing to the provision of services solely at the expense of the Dual Eligible Customer, as long as Provider has clearly informed the Dual Eligible Customer, in accordance with applicable law, that the Dual Eligible Customer's Benefit Plan may not cover or continue to cover a specific service or services.

12.3.e Eligibility

Provider agrees to immediately notify DBP and MA Organization in the event Provider is or becomes excluded from participation in any federal or state health care program under Section 1128 or 1128A of the Social Security Act. Provider also

shall not employ or contract for the provision of health care services, utilization review, medical social work or administrative services, with or without compensation, with any individual or entity that has been excluded from participation in any federal or state health care program under Section 1128 or 1128A of the Social Security Act.

12.3.f Laws

Provider shall comply with all applicable federal and Medicare laws, regulations, and CMS instructions, including but not limited to: (a) federal laws and regulations designed to prevent or ameliorate fraud, waste, and abuse, including but not limited to, applicable provisions of federal criminal law, the False Claims Act (31 U.S.C. §3729 et seq.), and the anti-kickback statute (§1128B of the Social Security Act); and (b) HIPAA administrative simplification rules at 45 CFR Parts 160, 162, and 164.

12.3.g Federal funds

Provider acknowledges and agrees that MA Organization receives federal payments under the CMS Contract and that payments Provider receives from or on behalf of MA Organization are, in whole or in part, from federal funds. Provider is therefore subject to certain laws that are applicable to individuals and entities receiving federal funds.

12.3.h CMS contract

Provider shall perform the services set forth in the Agreement in a manner consistent with and in compliance with MA Organization's contractual obligations under the CMS Contract.

12.3.i Records

- **Maintenance; Privacy and Confidentiality; Customer Access.** Provider shall maintain records and information related to the services provided under the Agreement, including but not limited to MA Customer medical records and other health and enrollment information, in an accurate and timely manner. Provider shall maintain such records for at least ten (10) years or such longer period as required by law. Provider shall safeguard MA Customer privacy and confidentiality, including but not limited to the privacy and confidentiality of any information that identifies a particular MA Customer, and shall comply with all federal and state laws regarding confidentiality and disclosure of medical records or other health and enrollment information. Provider shall ensure that MA Customers have timely access to medical records and information that pertain to them, in accordance with applicable law.
- **Government Access to Records.** Provider acknowledges and agrees that the Secretary of Health and Human Services, the Comptroller General, or their designees shall have the right to audit, evaluate and inspect any pertinent books, contracts, medical records, patient care documentation and other records and information belonging to Provider that involve transactions related to the CMS Contract. This right shall extend through ten (10) years from the later of the final date of the CMS Contract period in effect at the time the records were created or the date of completion of any audit, or longer in certain instances described in the applicable Medicare Advantage regulations. For the purpose of conducting the above activities, Provider shall make available its premises, physical facilities and equipment, records relating to MA Customers, and any additional relevant information CMS may require.
- **MA Organization Access to Records.** Provider shall grant MA Organization or its designees such audit, evaluation, and inspection rights identified in subsection 3.9(b) as are necessary for MA Organization to comply with its obligations under the CMS Contract. Whenever possible, MA Organization will give Provider reasonable notice of the need for such audit, evaluation or inspection, and will conduct such audit, evaluation or inspection at a reasonable time and place. Provider shall submit medical records of MA Customers to the MA Organization as may be requested, within the timeframes specified, for the purpose of (i) CMS audits of risk adjustment data and (ii) for other purposes medical records from providers are used by MA Organization, as specified by CMS. Provision of medical records must be in the manner consistent with HIPAA privacy statute and regulations.

12.3.j MA organization accountability; delegated activities

Provider acknowledges and agrees that MA Organization oversees and is accountable to CMS for any functions and responsibilities described in the CMS Contract and applicable Medicare Advantage regulations, including those that DBP may

sub-delegate to Provider. If DBP has sub-delegated any of MA Organization's functions and responsibilities under the CMS Contract to Provider pursuant to the Agreement, the following shall apply in addition to the other provisions of this Addendum:

- Provider shall perform those delegated activities specified in the Agreement, if any, and shall comply with any reporting responsibilities as set forth in the Agreement.
- If DBP has delegated to Provider any activities related to the credentialing of health care providers, Provider must comply with all applicable CMS requirements for credentialing, including but not limited to the requirement that the credentials of medical professionals must either be reviewed by MA Organization or its designee, or the credentialing process must be reviewed, pre-approved and audited on an ongoing basis by MA Organization or its designee.
- If DBP has delegated to Provider the selection of health care providers to be participating providers in the MA Organization's Medicare Advantage network, MA Organization retains the right to approve, suspend or terminate the participation status of such health care providers.
- Provider acknowledges that MA Organization or its designee shall monitor Provider's performance of any delegated activities on an ongoing basis. If MA Organization or CMS determines that Provider has not performed satisfactorily, MA Organization may revoke any or all delegated activities and reporting requirements. Provider shall cooperate with MA Organization and DBP regarding the transition of any delegated activities or reporting requirements that have been revoked by MA Organization.

12.3.k Subcontracts

If Provider has any arrangements, in accordance with the terms of the Agreement, with affiliates, subsidiaries, or any other subcontractors, directly or through another person or entity, to perform any of the services Provider is obligated to perform under the Agreement that are the subject of this Addendum, Provider shall ensure that all such arrangements are in writing, duly executed, and include all the terms contained in this Addendum. Provider shall provide proof of such to DBP or MA Organization upon request. Provider further agrees to promptly amend its agreements with subcontractors, in the manner requested by MA Organization or DBP, to meet any additional CMS requirements that may apply to the services.

12.3.l Offshoring

Unless previously authorized by MA Organization in writing, all services provided pursuant to the Agreement that are subject to this Addendum must be performed within the United States, the District of Columbia, or the United States territories.

12.4 Other

12.4.a Payment

MA Organization or its designee shall promptly process and pay or deny Provider's claim no later than sixty (60) days after MA Organization or its designee receives all appropriate information as described in MA Organization's administrative procedures. If Provider is responsible for making payment to subcontracted providers for services provided to MA Customers, Provider shall pay them no later than sixty (60) days after Provider receives request for payment for those services from subcontracted providers.

12.4.b Regulatory amendment

Upon the request of MA Organization, DBP may unilaterally amend this Addendum to comply with applicable laws and regulations and the requirements of applicable regulatory authorities, including but not limited to CMS. DBP or MA Organization shall provide written or electronic notice to Provider of such amendment and its effective date. Unless such laws, regulations or regulatory authority(ies) direct otherwise, the signature of Provider will not be required in order for the amendment to take effect.

Appendix — Provider information

A.1 Definitions

A.1.a Preferred Provider Organizations (PPO)

In PPO plans, practitioners treat members at an agreed-upon rate for each procedure. There is an annual maximum of benefit paid out by the plan that varies by employer group. Typically, fees are paid partially by the member and partially by the insurance company.

Distinctions among the different types of plans are as follows:

Traditional PPO Plans – Members can seek care and still receive benefits if they go out of network. However, members' out-of-pocket expenses are less if they seek care from a participating dentist who charges contracted rates.

Incentive PPO Plans – Members have a richer benefit level (percentage covered) if they seek care at a participating dental office.

Passive PPO Plans – Members have the same benefit level (percentage covered) whether or not they use a partici- pating office. However, if the member seeks care from a participating dentist, his/her out-of-pocket costs are lower.

In-Network Only (INO) Plans – Members only receive benefits if a participating dentist provides care. The plan benefits are the same as for the PPO network, with deductibles, maximums and coinsurance payments. Members must be referred to participating specialists (excluding orthodontists) under this plan to receive benefits.

Participating practitioners in these and other plans offered receive free advertising through online and print directory publications, and gain access to hundreds of employees within the local community.

A.1.b Dental Health Maintenance Organization (DHMO) networks

DHMO plans offer a method of provider reimbursement wherein the insurance carrier or HMO pays the practitioner a fixed rate per month for assigned eligible members regardless of the utilization of dental services. In these plans, members select a designated primary care dentist that they access for all preventive, diagnostic and restorative care.

Practitioners who participate with these plans receive a single monthly payment (capitation amount) along with a roster of assigned members. This is paid whether the member accesses care or not.

Covered services are provided by the practitioner at no additional charge to the member unless otherwise stated on the plan fee schedule. In some instances, there are member and/or plan copayments to offset the cost of a procedure.

In a DHMO plan, the members must only visit dentists that are part of their DHMO network. Members must be assigned to a practice before treatment is rendered.

For certain procedures, referrals to a specialist may be needed. Our provider website and Provider Services line can help in locating specialists available within the member's plan.

A.1.c Discount plans

Discount Plans differ from traditional plans in that there are no claims to file or submit, and they are not insurance plans. The payment comes directly and solely from the member at the time of service. The member (or spouse/dependent) is entitled to a discount in accordance with the terms of your contract with UnitedHealthcare. The fee schedule is exactly the same as the UnitedHealthcare PPO fee schedule.

Members are educated to understand that the discount plans are not insurance and they are expected to pay in full upon delivery of service.

A.1.d Private label clients

UnitedHealthcare partners with other insurance carriers and entities to assist in providing access to dental care through our network. In addition, they leverage our dental claims adjudication capabilities. In some instances, these carriers or entities retain their own company and/or product brand and the UnitedHealthcare relationship is invisible to their members. When other insurance carriers or entities use our network in this manner, it is referred to as a Private Label Arrangement.

As a participating practitioner with the National PPO Plan, you will have access to private label members using the same contracted fee schedule that is outlined in your agreement. Private label members seeking treatment may show a membership identification card that is different from the typical UnitedHealthcare identification card. However, our name and information will appear on the back of the ID card so that you know which network the member is covered through.

A copy of the Private label portfolio reference guide can be found on the provider portal at **UHCdental.com** under Resources > Resource Library.

A.1.e Distributor clients

Distributor clients are clients who have contracted with UnitedHealthcare to utilize our network of dental practitioners, in much the same way as any other PPO client contracts with us to use our dental network. The distinction is that the claims are processed by the Distributor Client. The allowed amounts paid are in accordance with the terms of your agreement with UnitedHealthcare. The fee schedule is the exact same as the UnitedHealthcare PPO fee schedule.

Attachments

A.2 Demographic Change Form

Provider Information Demographic Change Submission Form

United Healthcare | Dental Benefit Providers

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

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

Please check **ALL** the demographic items that **need** to be updated and complete all sections as appropriate. Please submit completed form using one of the methods to the right:
Request Number (if given by Customer Service):_____

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

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

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

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

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

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

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

PRACTICE LOCATION		**REMITTANCE ADDRESS**	
Previous/Current Office Name:		**New Office Name:**	
Previous/Current Address:		**Previous/Current Address:**	
(Street #)	(Suite #)	(Street #)	(Suite #)
(City)	(State) (Zip)	(City)	(State) (Zip)
New Address:		**New Address:**	
(Street #)	(Suite #)	(Street #)	(Suite #)
(City)	(State) (Zip)	(City)	(State) (Zip)

Languages Spoken Other Than English: ☐ Please check box if remittance is same as office location.

Phone Number: **Fax Number:** **Email Address:**

New Office Hours:	Mon	Tue	Wed	Thu	Fri	Sat	Sun

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

Providers associated with the requested change: _____

PROVIDER SIGNATURE: **DATE:**

WPN: Prov W9 Rev May 2023

Attachments

A.3 Provider EOB sample

20190313-003794 UHC01R 201903135030237500 31366643 03/13/19-FL-N-P--N-N

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

EXPLANATION OF DENTAL PLAN REIMBURSEMENT THIS IS NOT A BILL

Sheet: Page 3 of 4
Date: 03/13/2019
Check No: 0011111111
Check Amt: $51.10

JOHN DOE DDS
1234 ANY AVE
CITY FL 00000-0000

PROVIDER OR MBR NAME AND ID NO; PROVIDER NETWORK STATUS; GROUP NO; CLAIM NO ADA CODE DESCRIPTION	DATE OF SERVICE	TOOTH NO	AMOUNT CLAIMED	AMOUNT ALLOWED	DEDUCT APPLIED	OTHER INS	PATIENT RESP	AMOUNT PAID	EOB CODE
JOHN DOE NPI Submitted: 0000000000 MEMBER, JANE 12345670000; Out of Network; 11111100; 190000000000									
ADA CODE D2393 resin-based composite - three surfaces, posterior	03/11/19	12	350.00	77.00	50.00	0.00	336.50	13.50	K69
ADA CODE D1110 prophylaxis - adult	03/11/19	01 32	120.00	47.00	0.00	0.00	82.40	37.60	PSC
SUB-TOTAL			470.00	124.00	50.00	0.00	418.90	51.10	

Notes:

PSC The charge exceeds the allowable amount for this procedure.

K69 Patient responsible for difference in cost between service rendered and the fee for the service on which the plan benefit is based.

Plan underwritten by UnitedHealthcare Insurance Company

	AMOUNT CLAIMED	AMOUNT ALLOWED	DEDUCT APPLIED	OTHER INS	PATIENT RESP	AMOUNT PAID
TOTAL	470.00	124.00	50.00	0.00	418.90	51.10

DEN-PEOB1

Attachments

A.3 Provider EOB sample — continued

For Claim Submissions and ReSubmissions:

To ensure that that your claims are processed in a timely manner, please mail your claims to the following address:

P.O. Box 30567

Salt Lake City, UT 84130-0567

If your claim has been denied and additional documentation was requested, please mail the additional documentation, with the original ADA claim form, to the same address as the initial claim, (listed above).

Sending correspondence to the appropriate addresses will ensure that your claim or resubmission is reviewed as quickly as possible.

For Appeals:

If you are dissatisfied with the Plan's payment of the claims listed herein, you have the right to file a complaint with the Plan. Written complaints should be mailed to:

Dental Appeals/Complaints

P.O. Box 30569

Salt Lake City, UT 84130

(PRC001)

Attachments

A.3 Provider EOB sample — continued

20190313-003794 UHC01R 20190313503023750 0 31366643 03/13/19-FL-N-P--N-N

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

EXPLANATION OF DENTAL PLAN REIMBURSEMENT
THIS IS NOT A BILL

Sheet: Page 1 of 4
Date: 03/13/2019
Check No: 0011111111
Check Amt: $51.10

DPS$$$PKG
JOHN DOE DDS
1234 ANY AVE
CITY GA 00000-0000

DEN-PEOB1

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

Citibank, N.A.
One Penns Way
New Castle, DE 19720

62-20/311 0011111111

Date 03/13/19
PAY: **********$51.10
Void If Not Cashed Within 90 Days

<< NOT NEGOTIABLE >>

Pay Fifty One Dollars and Ten Cents**********

TO THE ORDER OF
JOHN DOE DDS
1234 ANY AVE
CITY GA 00000

Authorized Signature Required

A.4 Fraud, waste and abuse provider training

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

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

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

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

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

A.5 Determination of "necessary" services

A review of an issue for appropriateness of dental services is a prospective or retrospective review performed by licensed dentists who examine the proposed service or submitted claim to determine if the services performed will be/were necessary.

Medical necessity is completed based on the following:

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

A.6 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 infor- mation 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.

NY 137 Rule

If you are a provider in NY who is new to the area or is joining a participating group with the plan, you have a right to provisional credentialing if the process takes more than 90 days.

All written/telephonic inquiries about credentialing or recredentialing must be sent to the following addresses or phone numbers:

Credentialing Department
2300 Clayton Road
Suite 1000
Concord, CA 94520
Phone: 1-855-918-2265
Fax: 1-855-363-9691

CMS preclusion list

The Centers for Medicare and Medicaid Services (CMS) has a Preclusion List effective for claims with dates of service on or after January 1, 2019. The Preclusion List applies to both Medicare Advantage (MA) plans as well as Part D plans.

The Preclusion is comprised of a list of prescribers and individuals or entities who:

- Are revoked from Medicare, are under an active reenrollment bar, and CMS has determined that the underlying conduct that led to the revocation is detrimental to the best interests of the Medicare program; or
- Have engaged in behavior for which CMS could have revoked the prescriber, individual or entity to the extent possible if they had been enrolled in Medicare and that the underlying conduct that would have led to the revocation is detrimental to the best interests of the Medicare program.

Providers receive notification from CMS of their placement on the Preclusion List, via letter, and will have the opportunity to appeal with CMS before the preclusion is effective. There is no opportunity to appeal with UnitedHealthcare. If you are listed on the Preclusion list you cannot participate with any UnitedHealthcare plan.

Through the Preclusion List, which CMS updates monthly, CMS advises MA and Part D plans of the date upon which providers' claims must be rejected or denied due to precluded status ("claim-rejection date"). As of the claim-rejection date, a precluded provider's claims will no longer be paid, pharmacy claims will be rejected, and the provider will be terminated from the United Healthcare network; additionally, the precluded provider must hold Medicare beneficiaries harmless from financial liability for services or items provided on or after the claim-rejection date.

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