# Dental Provider Manual

## UnitedHealthcare Community Plan of Nebraska

**Provider Services: 1-866-519-5961**

January 1, 2025

Revised 5/20/2025

United Healthcare® | Dental Benefit Providers®

# Contents

# Section 1: Introduction — who we are

## Welcome to UnitedHealthcare Community Plan

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

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

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

Dental Benefit Providers, Inc is the legal entity and the material subcontractor partner for the UnitedHealthcare Community Plan of Nebraska to administer dental benefits for Medicaid members.

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

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

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

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

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

## Provider Online Academy

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

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

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

# Section 2: Patient eligibility verification procedures

## 2.1 Member eligibility

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

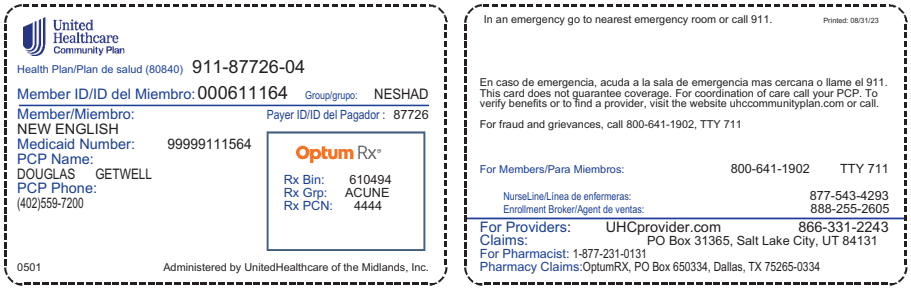
We receive daily updates on member eligibility and can provide the most up-to-date information available.

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

## 2.2 Identification card

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

A member ID card is not a guarantee of payment. It is the responsibility of the provider to verify eligibility at the time of service. To verify a member's dental coverage, go to **UHCdental.com/medicaid** or contact the dental Provider Services line at the telephone number listed on the cover of this document. Please see an image of the member ID card below. Please note: The address for submitting dental claims is UHC NE Claims P.O. Box 2176 Milwaukee, WI 53201.




## 2.3 Eligibility verification

Get member eligibility information by calling Provider Services at **1-866-519-5961**, or contact the Nebraska Medicaid Eligibility System (NMES) at 1-800-642-6092.

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

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

UnitedHealthcare Community Plan also offers an Interactive Voice Response (IVR) system for eligibility verification.

## 2.4 Quick reference guide

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

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

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

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

## 2.5 Provider Portal / Dental Hub

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

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

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

## 2.6 Integrated Voice Response (IVR) system

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

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

# Section 3: Office administration

## 3.1 Office site quality

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

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

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

## 3.2 Office conditions

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

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

## 3.3 Sterilization and infection control fees

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

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

## 3.4 Recall system

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

## 3.5 Transfer of dental records

Your office shall copy all requested member dental records to another participating dentist as designated by UnitedHealthcare Community Plan or as requested by the member. There will be no charge for the copying of charts and/or radiographs subject to Nebraska state requirements. If your office terminates from UnitedHealthcare Community Plan, dismisses the member from your practice or is terminated by UnitedHealthcare Community Plan, the cost of copying records shall be borne by your office. Your office shall cooperate with UnitedHealthcare Community Plan in maintaining the confidentiality of such member dental records at all times, in accordance with state and federal law.

## 3.6 Office hours

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

## 3.7 Protect confidentiality of member data

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

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

## 3.8 Provide access to your records

You shall provide access to any medical, financial or administrative records related to services you provide to UnitedHealthcare Community Plan members within 14 calendar days of our request. The member is entitled to a copy of their medical record at no cost. We may request you respond sooner for cases involving alleged fraud and abuse, a member grievance/appeal, or a regulatory or accreditation agency requirement. Maintain these records for 10 years or longer if required by applicable statutes or regulations.

## 3.9 Inform members of advance directives

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

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

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

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

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

## 3.10 Serious reportable events and reportable incidents

Consistent with the Affordable Care Act administered through the CMS, UnitedHealthcare Community Plan will implement the Provider Preventable Conditions initiative requirements, which include:

1. Reimbursement adjustment for healthcare acquired conditions (HCAC)
2. Present on admission (POA) indicator requirement.
3. No reimbursement for "Never events"
4. Other provider preventable conditions (OPPC) as defined by any additional state regulations that expand or further define the CMS regulations.

## 3.11 Participate in quality initiatives

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

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

## 3.12 New associates

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

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

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

## 3.13 Change of address, phone number, email address, fax or tax identification number

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

Changes should be submitted to:

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

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

Credentialing updates should be sent to:

2300 Clayton Road
Suite 1000
Concord, CA 94520

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

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

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

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

# Section 4: Patient access

## 4.1 Dental Home

UnitedHealthcare Community Plan defines a Primary Care Dentist as the provider of Dental Home services. A dental screening examination should begin at 6 months of age or eruption of the first tooth, whichever is earlier, and can be performed by the member's Primary Care medical provider or the Primary Care dental provider. A Dental Home should be established at or near the first birthday, by which time the first dental visit should be completed.

Nebraska defines the Dental Home in accordance with the American Academy of Pediatric Dentistry (AAPD) as an ongoing relationship between the dentist and the patient, inclusive of all aspects of oral health care delivered in a comprehensive, continuously accessible, coordinated, and family-centered way.

Principles for Dental Homes include:

- Care that is comprehensive and includes acute, corrective, and preventative services.
- Care that is individualized to each member based upon a dental exam for tooth decay and gum problems.
- Care that is preventative and includes information about proper care for the member's teeth and gums, and correct diet.
- For children, care that prepares parents and guardians with guidance about what to expect for their child's age for the growth of teeth and the jaw.
- For children, care that is educational and helps parents and guardians learn about their child's dental health now and as their child grows.
- Care that is provided in a culturally competent manner.

Within a Dental Home, dental care experts work together as a team with the member and/or the member's family to ensure that the member receives the care he or she needs. Primary Care Dentists (PCDs) include general or pediatric dentists that practice in solo or group practices, and the following facilities: Federally Qualified Health Centers, Rural Health Clinics, or Indian Health Service facilities. PCDs provide preventive care and therapeutic care to members.

Members are encouraged to select their own primary care dentist (PCD) to serve as their Dental Home. They may change their PCD any time by contacting UnitedHealthcare's toll-free Member Hotline. When a member does not select a Primary Care Dentist, DentalTrac™ will auto-assign to a Primary Care Dentist based on the following considerations:

1. Providers who are not in good standing are not considered during the auto-assignment methodology.
2. UnitedHealthcare Community Plan strives to keep families together. If a member of a family is assigned to a PCD, other members of the same family will be assigned to the same PCD. However, if the PCD has age restrictions that would prevent a family member from being assigned, we will assign that family member to another PCD in the same office that meets the age restrictions if possible.
3. If there is historical claims data available that identifies a dentist that performed dental services on the member, we will assign the member to such dentist, as long as the dentist is a participating PCD that meets the age restrictions and travel distance requirement for the member.

4. For each member that needs to be auto-assigned to a PCD, we will generate a pool of participating PCDs that meet the age restrictions of the member who are located near the member's residence address. The search radius will be increased until a PCD is located for assignment within the time and distance requirements of the plan. Once a pool of providers is generated, members living within that radius needing auto-assignment will be assigned to PCDs from this pool in a random sequence in order to equalize the patient load amongst providers within such radius.

Participating providers reserve the right to request their office limit enrollment by being placed on closed status, meaning no new patients are allowed to select the office as their dental home. The request must be submitted in writing to the attention of the Provider Relations Department. The change in status becomes effective after thirty (30) days. Dental Benefit Providers reserves the right to place Provider's office on closed status for non-compliance of any of the requirements of the Nebraska Department of Health and Human Services, DHHS.

Participating providers must offer the same services and respect to a Medicaid member as those offered to a non-Medicaid patient provided these services are reimbursable by the Medicaid program. In addition, participating providers have the responsibility to develop a provider-member relationship based on trust and cooperation. Coordination of care strengthens the positive relationship between the member and provider and is a critical tool for achieving positive oral health outcomes.

Dental Home providers are required to educate members about the importance of good oral hygiene and timely preventive care such as sealants, cleanings, and fluoride applications. For members ages 6-35 months of age the education efforts are focused around providing anticipatory guidance to the parents or guardians in order to establish a lifetime of healthy dental habits.

All PCDs are required to educate members about what to do in a dental emergency. The PCD is responsible for coordination with other involved health care providers in the case of acute dental trauma or in situations involving members with cleft or craniofacial anomalies.

Within the Dental Home, dental care experts work together as a team with a member's family to ensure that the child receives the services he or she needs. Dental Home providers must assess the dental needs of members for referral to specialty care providers and provide referrals as needed. The PCD must ensure that an appropriate referral is made as expediently as the patient's clinical condition requires. The PCD/ Dental Home must coordinate the member's care with specialty care providers after a referral takes place and ensure that all appropriate treatment was received.

## 4.2 Appointment scheduling standards

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

- **Urgent care appointments** Within 24 hours
- **Routine care appointments** Offered within 30 calendar days of the request

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

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

Wait times for scheduled appointments should not routinely exceed forty-five (45) minutes, including time spent in the waiting room and the examining room, unless the provider is unavailable or delayed because of an emergency. If a provider is delayed, the member should be notified immediately. If a wait of more than ninety (90) minutes is anticipated, the member should be offered a new appointment.

## 4.3 Emergency coverage

All network dental providers must be available to members during normal business hours.

Emergency services must be available immediately upon presentation at the service delivery site, twenty-four (24) hours a day, seven (7) days a week. Members with emergent behavioral health needs must be referred to services within one (1) hour generally and within two (2) hours in designated rural areas.

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

## 4.4 Specialist referral process

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

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

## 4.5 Missed appointments

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

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

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

Contacting the Member by phone or postcard prior to the appointment to remind the individual of the time and place of the appointment may help to decrease the number of missed appointments. If a member needs transportation services, please have them contact Modivcare at 1-866-394-3984 at least 3 business days in advance to schedule a pick up time.

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

## 4.6 Nondiscrimination

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

### Mainstreaming of members

To help ensure mainstreaming of Nebraska Medicaid members, UnitedHealthcare Community Plan will take affirmative action to provide covered services to members without regard to payer source, race, color, creed, gender, religion, age, national origin (to include those with limited English proficiency), ancestry, marital status, sexual orientation, genetic information, or physical, or will take reasonable steps to help ensure subcontractors do the same. Prohibited practices include, but are not limited to the following, in accordance with 42 CFR 438.6(f):

- Denying or not providing a member a covered service or access to an available facility.
- Providing a member a medically necessary covered service that is different, or is provided in a different manner or time from that provided to other members, other patients or the public at large, except where medically necessary.
- Subjecting a member to segregation or separate treatment related to the receipt of a covered service, or restricting a enjoyment of an advantage or privilege enjoyed by others receiving a covered service.
- Assigning times or places for the provision of services on the basis of race, color, creed, religion, age, gender, national origin, ancestry, marital status, sexual orientation, income status, Medicaid membership, or physical or mental health of the participants to be served.

# Section 5: Utilization Management program

## 5.1 Utilization Management

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

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

## 5.2 Community practice patterns

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

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

## 5.3 Evaluation of utilization management data

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

## 5.4 Utilization Management analysis results

Utilization analysis findings may be shared with individual providers in order to present feedback about their performance relative to their peers. Communications must comply with all applicable federal and state requirements regarding privacy and security, as well as those related to efficiency, economy, and quality of care.

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

- Provider Manual/Standards of Care

- Provider Training
- Continuing Education
- Provider News Bulletins

## 5.5 Utilization review

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

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

Retrospective reviews and prior authorization reviews are performed by a licensed dentist or specialist.

Utilization review is completed based on the following:

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

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

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

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

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

- Systematic review and meta-analysis
- Randomized controlled trials (RCT)

- Retrospective studies
- Case series
- Case studies

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

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

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

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

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

# Section 6: Quality management

## 6.1 Quality Improvement Program (QIP) description

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

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

The QIP description is reviewed and updated annually:

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

Participating practitioners must respond to any requests from the QIP or any of its committee members as outlined in the request.

## 6.2 Credentialing

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

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

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

UnitedHealthcare contracts with the Nebraska Heritage Health Program contracted Credentialing Verification Organization (CVO), as part of its credentialing and recredentialing process. The CVO is responsible for receiving completed applications, attestations and primary source verification documents. 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.

The Dental Director and the Credentialing Committee review information from the Nebraska Heritage Health Program CVO in detail based on approved credentialing criteria. UnitedHealthcare will request a resolution of any discrepancy in credentialing forms submitted. Practitioners have the right to review and correct erroneous information and to be informed of the status of their application. Credentialing criteria are reviewed by advisory committees, which include input from practicing network providers to make sure that criteria are within generally accepted guidelines. You have the right to appeal any decision regarding your participation made by UnitedHealthcare based on information received during the credentialing or recredentialing process. To initiate an appeal of a credentialing or recredentialing decision, follow the instructions provided in the determination letter received from the Credentialing Department. Appeals will be accepted and reviewed for states with appeal rights.

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

## Initial credentialing

- Completed application
- Signed and dated Attestation
- Current copy of W-9
- Current copy of their state license
- Current copy of their Drug Enforcement Agency (DEA) certificate
- General Anesthesia training certificate/diploma, 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)

## 6.3 Recredentialing

To remain a participating provider, all practitioners must go through periodic recredentialing review and be approved (typically every 3 years unless otherwise mandated by the state in which you practice) . Any failure to respond or comply with the recredentialing process constitutes termination for cause under your provider agreement .

In addition to the items in the recredentialing packet, Dental Benefit Providers may also 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

A list of the documents required for a complete Recredentialing packet is as follows (unless otherwise specified by state law):

- Completed Recredentialing application
- Signed and dated Attestation
- Current copy of their state license
- Current copy of their Drug Enforcement Agency (DEA) certificate
- Current copy of their Controlled Dangerous Substance (CDS) certificate, if applicable
- Current copy of their Sedation and/or General Anesthesia certificates, if applicable
- Copy of their Sedation and/or General Anesthesia training certificate/diploma, if applicable
- Signed and dated Sedation and/or General Anesthesia Attestation, if applicable
- Malpractice face sheet which shows their name on the certificate, expiration dates and limits – limits $1/3m
- Explanation of any adverse information, if applicable
- Current Medicaid ID (as required by state)

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

## 6.4 Site visits

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

The site visit focuses primarily on: dental record keeping, patient accessibility, infection control, and emergency preparedness and radiation safety. Results of site reviews will be shared with the dental office. Any significant failures may result in a review by the Peer Review Committee, leading to a corrective

action plan or possible termination. If terminated, the dentist can reapply for network participation once a second review has been completed and a passing score has been achieved.

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

## 6.5 Preventive health guideline

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

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

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

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

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

- A periodontal evaluation should be conducted at the initial examination and periodically thereafter, as appropriate, based on American Academy of Periodontology guidelines.

- Periodontal evaluation and measures to maintain periodontal health after active periodontal treatment should be performed as appropriate.
- Special consideration should be given to those patients with periodontal disease, a previous history of periodontal disease and/or those at risk for future periodontal disease if they concurrently have systemic conditions reported to be linked to periodontal disease such as diabetes, cardiovascular disease and/or pregnancy complications.

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

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

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

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

## 6.6 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:** Improve access and reduce barriers to evidence-based and integrated treatment.

**Recovery:** Improve support care management and referral to person-centered recovery resources.

**Harm Reduction:** Improve access to Naloxone and facilitate 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 support moms in recovery.

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

### Increasing education & awareness of opioid use

UnitedHealthcare Community Plan provides Opioid Use Disorders (OUD) related trainings and resources on our provider portal to help ensure you have the information you need, when you need it. For example, state-specific Behavioral Health Toolkits are developed to provide access to clinical practice guidelines, free substance use disorders/OUD assessments and screening resources, and other important state-specific resources. Additionally, Pain Management Toolkits are available and provide resources to help you identify our members who present with chronic physical pain and may also be in need of behavioral health services to address the psychological aspects of pain. Continuing education is available and includes webinars such as, "The Role of the Health Care Team in Solving the Opioid Epidemic," and "The Fight Against the Prescription Opioid Abuse Epidemic." While resources are available, we also work to help ensure you have the educational resources you need. For example, our Drug Utilization Review Provider Newsletter includes opioid trends, prescribing, and key resources.

Access these resources at **UHCprovider.com** > Tools and resources > Resource library > Pharmacy resources > Drug lists and pharmacy > Opioid Programs and Resources - Community Plan (Medicaid).
The Nebraska Prescription Drug Monitoring Program (PDMP) is a unique statewide tool that collects dispensed prescription medication information and is housed on the Health Information Exchange (HIE) platform. The Nebraska PDMP is a public health model focusing on patient safety. Access the Nebraska PDMP at this link, **https://dhhs.ne.gov/Pages/Drug-Overdose-Prevention.aspx**.

### 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, clinically appropriate healthcare 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 align with the CDC's recommendations for the treatment of chronic non-cancer pain. Prior authorization applies to all long-acting opioids. The CDC guidelines for opioid prevention and overdose can be found at **Preventing Opioid Overdose | Overdose Prevention | CDC**.

# Section 7: Fraud, waste, and abuse training

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

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

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

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

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

# Section 8: Governance

## 8.1 Provider rights bulletin

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

### To review your information

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

### To correct erroneous information

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

### To be informed of status of your application

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

### To appeal adverse committee decisions

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

**UnitedHealthcare Dental**
Credentialing Department
2300 Clayton Road
Suite 1000
Concord, CA 94520

Phone: **1-855-918-2265**
Fax: **1-844-881-4963**

### To file a grievance

A grievance is a written or verbal expression of dissatisfaction about any matter other than an adverse benefit determination. You may file a grievance on your own behalf.

You may file a grievance about:

- Benefit and limitations
- Eligibility and enrollment of a member or care provider
- Member issues or UnitedHealthcare Community Plan issues

- Availability of health services from UnitedHealthcare Community Plan to a member
- The delivery of health services
- The quality of service
- Aspects of interpersonal relationships such as rudeness of a provider or employee

You may only file a grievance on a behalf with the written consent of the member. See Member Appeals and Grievances Definitions and Procedures.

**Phone:** Call Provider Services at 1-866-519-5961 or TTY 711

**Electronically:** You can submit a grievance on your own behalf on **UHCdental.com/medicaid**. Navigate to Prior Authorizations to submit a grievance.

**Mail:** Send care provider name, contact information and your grievance to:

UnitedHealthcare Community Plan
Attn: Appeals and Grievances Unit
P.O. Box 31364
Salt Lake City, UT 84131-0364

**In Person:** You have the right to file a grievance in person 8 a.m.-5 p.m. CT, Monday-Friday, at:

UnitedHealthcare Community Plan
2717 N. 118th St.
Suite #300
Omaha, NE 68164

## 8.2 Quality of care issues

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

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

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

- Advocated on behalf of an enrollee
- Filed a complaint against the MCO
- Appealed a decision of the MCO
- Provided information or filed a report pursuant to PHL4406-c regarding prohibition of plans
- Requested a hearing or review

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

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

## 8.3 Appeals process

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

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

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

## 8.4 Cultural competency

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

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

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

# Section 9: Claim submission procedures

## 9.1 Claim submission options

### 9.1.a Paper claims

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

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

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

### 9.1.b Electronic claims

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

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

### 9.1.c Electronic payments

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

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

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

**ePayment Center allows you to:**

- Improve cash flow with faster primary payments and speed up secondary filing/patient collections
- Access your electronic remittance advice (ERA) remotely and securely 24/7

- Streamline reconciliation with automated payment posting capabilities
- Download remittances in various formats (835, CSV, XLS, PDF)
- Search payments history up to 7 years

**To register:**

1. Visit **UHCdental.epayment.center/register**
2. Follow the instructions to obtain a registration code
3. Your registration will be reviewed by a customer service representative and a link will be sent to your email once confirmed
4. Follow the link to complete your registration and setup your account
5. Log into **UHCdental.epayment.center**
6. Enter your bank account information
7. Select remittance data delivery options
8. Review and accept ACH Agreement
9. Click "Submit"
10. Upon completion of the registration process, your bank account will undergo a prenotification process to validate the account prior to commencing the electronic fund transfer delivery. This process may take up to 6 business days to complete

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

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

**The Zelis Payments advantage:**

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

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

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

## 9.2 Claim submission requirements and best practices

### 9.2.a Dental claim form required information

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

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

**Header information**

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

**Subscriber information**

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

**Patient information**

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

**Primary payer information**

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

**Other coverage**

If the patient has other insurance coverage, completing the "Other Coverage" section of the form with the name, address, city, state and ZIP code of the carrier is required. You 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 patient has other coverage, provide the following information:

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

**Billing dentist or dental entity**

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

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

### Treating dentist and treatment location

List the following information regarding the dentist that provided treatment:

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

### Record of services provided

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

### Missing teeth information

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

### Remarks section

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

## ICD-10 instructions

**RECORD OF SERVICES PROVIDED**

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

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

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

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

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

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

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

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

### By Report procedures

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

### Using current ADA codes

It is expected that providers use Current Dental Terminology (CDT). For the latest dental procedure codes and descriptions, you may order a current CDT book by calling the ADA or visiting the ADA store at **engage.ada.org**. Additional information or training on ADA guidelines can be found on the ADA website at **https://www.ada.org/resources/ada-library/oral-health-topics/medical-emergencies-in-the-dental-office**.

### Supernumerary teeth

UnitedHealthcare recognizes tooth letters "A" through "T" for primary teeth and tooth numbers "1" to "32" for permanent teeth. Supernumerary teeth should be designated by using codes AS through TS or 51 through 82. Designation of the tooth can be determined by using the nearest erupted tooth. If the tooth closest to the supernumerary tooth is # 1 then the supernumerary tooth should be charted as #51,

likewise if the nearest tooth is A the supernumerary tooth should be charted as. These procedure codes must be referenced in the patient's file for record retention and review. Patient records must be kept for a minimum of 10 years.

**Insurance fraud**

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

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

**Invalid or incomplete claims:**

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

## 9.2.b Coordination of Benefits (COB)

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

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

## 9.2.c Timely submission (Timely filing)

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

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

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

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

For claims submitted for members who are enrolled with retroactive enrollment dates, timely filing will be waived if the provider submitted the claim within MLTC's established timely filing limit from the date of member's MCO selection.

## 9.3 Timely payment

Payment will be made in compliance with the State of Nebraska regulations and timely payment terms in your provider agreement.

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

## 9.4 Provider remittance advice

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

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

Below is a list and description of each field:

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

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

**AMOUNT BILLED** - Amount submitted by provider

**AMOUNT PAYABLE** - Amount payable after benefits have been applied

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

**OTHER INSURANCE** - Amount payable by another carrier

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

**NET AMOUNT (Summary Page)** - Total amount paid

**PATIENT NAME**

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

**DOB** (Date of Birth) - Patient date of birth

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

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

**ENCOUNTER NUMBER** - Claim reference number

**BENEFIT LEVEL** - In or out-of-network coverage

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

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

**CODE** - Procedure code of service performed

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

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

**POS** (Place of Service) - Treating location (office, hospital, other)

**QTY OR NO. OF UNITS**

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

**PAYABLE AMOUNT** - Contracted amount

**COPAY AMOUNT** - Member responsibility

**COINSURANCE AMOUNT** - Member responsibility of total payment amount

**DEDUCTIBLE AMOUNT** - Member responsibility before benefits begin

**PATIENT PAY** - Amount to be paid by the member

**OTHER INSURANCE AMOUNT** - Amount paid by other carriers

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

**EXCEPTION CODES** - Codes that explain how the claim was adjudicated

# 9.4.b Provider Remittance Advice sample (page 1)

***UnitedHealthcare NE Medicaid***

Payee ID: 55555 Payee Name: Dental Office Name Remittance Date: 11/09/2023

UnitedHealthcare Community Plan

**Please address questions to:**

UnitedHealthcare NE Medicaid
PO BOX 2176
Milwaukee, WI 53201

Contact: UnitedHealthcare Community Plan-Nebraska
Phone: (866)519-5961
Fax:

Dental Office Name
Street Address
City, State ZIP

**Current Period:** **MM/DD/YYYY**
Payee ID:
Phone:
Fax:
Tax ID:

## Remittance Summary

| | |
|---|---|
| **Fee For Service:** | **$46.70** |
| **Budget Allocation:** | **$0.00** |
| **Capitation:** | **$0.00** |
| **Case Fees:** | **$0.00** |
| **Additional Compensation:** | **$0.00** |
| **Prior Period Recovery and other Payee Adjustments:** | **$0.00** |
| **Total:** | **$46.70** |

PROVIDER APPEALS
Determination of Claims payments are based on the terms and conditions of the member's benefit plan. All original claims must be received within 180 days from the date of service unless otherwise agreed. Corrected claims must be received withing 365 days of the date of service. Appeals of denied or disputed claims must be received within 60 days of receipt of the remittance advice. If the provider fails to request a review within this timeframe, the right to review is forfeited.
All appeals must be received in writing to the address below:
UnitedHealthcare Dental
ATTN: Provider Appeals
PO Box 361
Milwaukee, WI 53201
Your written request for review must include:
- The member's name, identification number, and group policy number
- The actual service for which a no benefit coverage decision was made
- The reasons why you feel benefit coverage should be provided
- Any available medical information to support your reasons for reversing the benefit decision

Balance Billing – Billing or balance billing UnitedHealthcare Community Plan Medicaid members is prohibited and may violate federal and state medical assistance rules and regulations.

By receiving this remit, the provider agrees to the following statement: I understand that Payment and satisfaction of this claim will be from federal and state funds, and that any false claims, statements, documents, or concealment of material fact, may be prosecuted under applicable federal and/or state laws.
COB Primary Carrier Information: When UnitedHealthcare is the secondary payer, additional COB information can be obtained by accessing member detail within UHCprovider.com or calling The Provider Call Center at 1-866-519-8961.
IMPORTANT NOTICE: To maintain HIPAA compliance, effective with claims received October 1, 2015, only ADA 2012 or later Dental Claim forms will be accepted when submitting claims and pre-authorizations. All other forms, including ADA forms dated prior to 2012, will not be accepted and will result in a rejection of the claim or pre-authorization request.
Additionally, when making a correction to a previously submitted claim, please send it clearly marked Corrected Claims on an ADA 2012 or later form to the Corrected Claims mailbox. Please contact the customer service toll free number if you have questions. If you are in need of the new Dental Claim forms, please visit the ADA website at www.ada.org for ordering information.
To report potential billing irregularities, please call our Anonymous Fraud Hotline at 888-233-4877.

Ref #: 55555 / 1 Page 1

# 9.4.c Provider Remittance Advice sample (page 2)

***UnitedHealthcare NE Medicaid***

Payee ID: 55555 Payee Name: Dental Office Name Remittance Date: 11/09/2023

## Fee For Service Summary

Dental Office Name
Street Address
City, State ZIP

| Provider / ID | Location / ID | Amount Billed | Amount Payable | Patient Pay | Other Insurance | Prior Mo. Adj | Net Amount |
|---|---|---|---|---|---|---|---|
| Provider Name / 44444 | Dental Office Name / 55555 | $300.00 | $46.70 | $0.00 | $0.00 | $0.00 | $46.70 |
| | **Totals:** | **$300.00** | **$46.70** | **$0.00** | **$0.00** | **$0.00** | **$46.70** |

Ref #: 55555 / 2 Page 2

# 9.4.d Provider Remittance Advice sample (page 3)

***UnitedHealthcare NE Medicaid***

Payee ID: 55555 Payee Name: Dental Office Name Remittance Date: 11/09/2023

## Services Detail

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

Patient Name: Last, First
Subscriber/Member: 555555555 / 01
DOB: MM/DD/YYYY
Office Reference No:

Provider Name: First Last
Provider NPI: 5555555555
Plan: UnitedHealthcare Nebraska
Product: UHC NE Medicaid

Encounter #: **55555555555555**
Referral #:
Referral Date:
Benefit Level: In Network

| ITM | DOS | CODE | POS | BILLED QTY | BILLED AMOUNT | ALLOWED QTY | ALLOWED AMOUNT | PAY % | PAYABLE AMOUNT | COPAY AMOUNT | COINS AMOUNT | DEDUCT AMOUNT | PATIENT PAY | OTHER INSUR | NET AMOUNT | PAY CODE |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1 | 11/05/23 | D0150 00 | 11 | 1 | $300.00 | 1 | $46.70 | 100.00% | $46.70 | $0.00 | $0.00 | $0.00 | $0.00 | $0.00 | $46.70 | FFS |
| | | | | | **$300.00** | | **$46.70** | | **$46.70** | **$0.00** | **$0.00** | **$0.00** | **$0.00** | **$0.00** | **$46.70** | |

Ref #: 55555 / 3 Page 3

## 9.5 Overpayment

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

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

If you prefer to mail a refund, send an Overpayment Return Check with the following information:

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

Submit to:

Overpayment
P.O. Box 481
Milwaukee, WI 53201

## 9.6 Tips for successful claims resolution

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

## 9.7 Payment for non-covered services

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

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

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

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

## 9.8 Radiology requirements

Guidelines for providing radiographs are as follows:

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

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

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

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

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

## 9.9 Corrected claim submission guidelines

### When should I submit a corrected claim?

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

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

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

### What scenarios are subject to the corrected claim process?

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

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

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

## How do I submit a corrected claim?

- Electronically – Clearing House
- Electronically – Dental Hub
- Provider Web Portal (PWP)
- Paper

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

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

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

## What scenarios ARE NOT subject to the corrected claim process?

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

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

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

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

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

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

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

Submit to:

Corrected Claims
PO Box 481
Milwaukee, WI 53201

# Appendices for the State of Nebraska

# Appendix A: Resources and services — how we help you

## Addresses and phone numbers

| Need: | Address: | Phone Number: | Payer I.D.: | Submission Guidelines: | Form(s) Required: |
|---|---|---|---|---|---|
| Claim Submission (initial) | UHC NE Claims:<br>P.O. Box 2176<br>Milwaukee, WI 53201 | **1-866-519-5961** | GP133 | Within 180 calendar days from the date of service For secondary claims, within 180 calendar days from the primary payer determination | ADA* Claim Form, 2019 version or later |
| Corrected Claims | UHC NE Claims Reprocessing and Over Payments:<br>P.O. Box 481<br>Milwaukee, WI 53201 | **1-866-519-5961** | N/A | Within 365 days from date of service. | ADA Claim Form Reason for requesting adjustment or resubmission |
| Claim Appeals (Appeal of a denied or reduced payment) | UHC NE Appeals:<br>P.O. Box 361<br>Milwaukee, WI 53201 | **1-866-519-5961** | N/A | Within 60 days after the claim determination | Supporting documentation, including claim number is required for processing. |
| Prior Authorization Requests | UHC NE Authorizations:<br>P.O. Box 2053<br>Milwaukee, WI 53201 | **1-866-519-5961** | GP133 | N/A | ADA Claim Form – check the box titled: Request for Predetermination / Preauthorization section of the ADA Dental Claim Form |
| Member Benefit Appeal for Service Authorization (Appeal of a denied or reduced service) | UnitedHealthcare Community<br>Attn: Appeals and Grievances Unit<br>P.O. Box 31364<br>Salt Lake City, UT 84131-0364 | **1-866-293-1796** | N/A | Within 60 calendar days from the date of the adverse benefit determination | N/A |

# Appendix B: Member benefits/exclusions and limitations

For the most updated member benefits, exclusions, and limitations please visit our website at **UHCdental.com/medicaid**. We align benefit design to meet all regulatory requirements by your state's Medicaid and legislature included in your state's Medicaid Provider Billing Manual.

### Medical necessity

Health care services and supplies that are medically appropriate and:

1. Necessary to meet the basic health needs of the member;
2. Rendered in the most cost-efficient manner and type of setting appropriate for the delivery of the covered service;
3. Consistent in type, frequency, and duration of treatment with scientifically-based guidelines of national medical, research, or health care coverage organizations or governmental agencies;
4. Consistent with the diagnosis of the condition;
5. Required for means other than convenience of the client or his/her physician;
6. No more intrusive or restrictive than necessary to provide a proper balance of safety, effectiveness, and efficiency;
7. Of demonstrated value; and
8. No more intensive level of service than can be safely provided.

## B.1 Member benefits

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

### B.1.a Benefit grid

| Code | Description | Age limit | Limits | Prior auth required | Required documentation |
|---|---|---|---|---|---|
| D0120 | PERIODIC ORAL EXAMINATION | 0 - 999 | 1 per 180 days | N | |
| D0140 | LIMITED ORAL EVALUATION - PROBLEM FOCUSED | 0 - 999 | 2 per 12 months | N | |
| D0145 | ORAL EVALUATION FOR A PATIENT UNDER THREE YEARS OF AGE AND COUNSELING WITH PRIMARY CAREGIVER | 0 - 3 | 1 per 175 days | N | |
| D0150 | COMPREHENSIVE ORAL EVALUATION - NEW OR ESTABLISHED PATIENT | 0 - 999 | 1 per 3 years | N | |

| Code | Description | Age limit | Limits | Prior auth required | Required documentation |
|---|---|---|---|---|---|
| D0160 | DETAILED AND EXTENSIVE ORAL EVALUATION - PROBLEM FOCUSED, BY REPORT | 0 - 999 | 1 per 3 years | N | |
| D0170 | RE-EVALUATION-LIMITED, PROBLEM FOCUSED (ESTAB. PATIENT; NOT POST-OP. VISIT) | 0 - 999 | 1 per 12 months | N | |
| D0171 | RE-EVALUATION - POST OPERATIVE OFFICE VISIT | 0-999 | 1 per year | N | |
| D0180 | COMPREHENSIVE PERIODONTAL EVALUATION - NEW OR ESTABLISHED PATIENT | 0 - 999 | 1 per 3 years | N | |
| D0190 | SCREENING OF A PATIENT | 0 - 999 | 1 per 6 months | N | |
| D0191 | ASSESSMENT OF A PATIENT | 0 - 999 | 1 per 6 months | N | |
| D0210 | INTRAORAL-COMPLETE SERIES (INCLUDING BITEWINGS) | 0 - 999 | 1 per code every 3 years | N | |
| D0220 | INTRAORAL - PERIAPICAL-FIRST FILM | 0 - 999 | 1 per 1 day | N | |
| D0230 | INTRAORAL - PERIAPICAL EACH ADDITIONAL FILM | 0 - 999 | no limit but must recode to full mouth as needed per 1 day | N | |
| D0240 | INTRAORAL-OCCLUSAL FILM | 0 - 999 | 2 per code per patient per every 6 months | N | |
| D0270 | BITEWING-EACH FILM | 0 - 999 | 4 per 1 day | N | |
| D0272 | BITEWING-TWO FILMS | 0 - 999 | 2 per 1 day | N | |
| D0273 | BITEWINGS - THREE FILMS | 0 - 999 | 2 per 1 day | N | |
| D0274 | BITEWING-FOUR FILMS | 0 - 999 | 1 per 1 day | N | |
| D0330 | PANORAMIC FILM | 0 - 999 | 1 per 3 years | N | |
| D0340 | CEPHALOMETRIC FILM | 0 - 20 | 1 per 1 lifetime | N | |
| D0470 | DIAGNOSTIC CASTS | 1 - 20 | 1 per 1 lifetime | N | |
| D1110 | PROPHYLAXIS-ADULT (AGE 14 AND OLDER) | 14 - 999 | 1 per 180 days | N | |
| D1120 | PROPHYLAXIS-CHILD (AGE 13 AND YOUNGER) | 0 - 13 | 1 per 180 days | N | |

| Code | Description | Age limit | Limits | Prior auth required | Required documentation |
|---|---|---|---|---|---|
| D1206 | TOPICAL FLUORIDE VARNISH; THERAPEUTIC APPLICATION FOR MODERATE TO HIGH CARIES RISK PATIENTS | 0 - 999 | 4 per 1 year | N | |
| D1208 | TOPICAL APPLICATION OF FLUORIDE-EXCLUDING VARNISH | 0 - 999 | 4 per 1 year | N | |
| D1351 | SEALANT - PER TOOTH | 0 - 20 | 1 per 24 months; per tooth | N | |
| D1354 | INTERIM CARIES ARRESTING MEDICAMENT APPLICATION PER TOOTH | 0 - 999 | 3 per 1 year; per tooth | Y | Narrative of medical necessity; prior authorization required after third application |
| D1355 | CARIES PREVENTITIVE MEDICAMENT APPLICATION PER TOOTH | 0 - 999 | 3 per 1 year; per tooth | Y | Narrative of medical necessity; prior authorization required after third application |
| D1510 | SPACE MAINTAINER - FIXED UNILATERAL | 0 - 20 | 1 per 1 year | N | |
| D1516 | SPACE MAINTAINER FIXED BILATERAL MAXILLARY | 0 - 20 | 1 per tooth or range per 1 year | N | |
| D1517 | SPACE MAINTAINER FIXED BILATERAL MANDIBULAR | 0 - 20 | 1 per tooth or range per 1 year | N | |
| D1551 | RE-CEMENT OR RE-BOND BILATERAL SPACE MAINTAINER-MAXILLARY | 0 - 20 | 1 per 1 year | N | |
| D1552 | RE-CEMENT OR RE-BOND BILATERAL SPACE MAINTAINER-MANDIBULAR | 0 - 20 | 1 per 1 year | N | |
| D1553 | RE-CEMENT OR RE-BOND UNILATERAL SPACE MAINTAINER-PER QUADRANT | 0 - 20 | 1 per 1 year | N | |
| D1556 | REMOVAL OF FIXED UNILATERAL SPACE MAINTAINER-PER QUADRANT | 0 - 20 | 1 per 1 year | N | |
| D1557 | REMOVAL OF FIXED BILATERAL SPACE MAINTAINER-MAXILLARY | 0 - 20 | 1 per 1 year | N | |

| Code | Description | Age limit | Limits | Prior auth required | Required documentation |
|---|---|---|---|---|---|
| D1558 | REMOVAL OF FIXED BILATERAL SPACE MAINTAINER-MANDIBULAR | 0 - 20 | 1 per 1 year | N | |
| D1575 | DISTAL SHOE SPACE MAINTAINER - FIXED - UNILATERAL | 0 - 20 | 1 per 1 year | N | |
| D2140 | AMALGAM - ONE SURFACE, PRIMARY OR PERMANENT | 0 - 999 | 1 per 1 year | N | All restorative services are subject to medical necessity review. Payment is made for restorative services based on the number of surfaces restored, not on the number of restorations per surface, or per tooth, per day. A restoration is considered a two-or-more surface restoration only when two (2) or more actual tooth surfaces are involved, whether they are connected or not. |
| D2150 | AMALGAM - TWO SURFACES, PRIMARY OR PERMANENT | 0 - 999 | 1 per 1 year | N | All restorative services are subject to medical necessity review. Payment is made for restorative services based on the number of surfaces restored, not on the number of restorations per surface, or per tooth, per day. A restoration is considered a two-or-more surface restoration only when two (2) or more actual tooth surfaces are involved, whether they are connected or not. |
| D2160 | AMALGAM - THREE SURFACES, PRIMARY OR PERMANENT | 0 - 999 | 1 per 1 year | N | All restorative services are subject to medical necessity review. Payment is made for restorative services based on the number of surfaces restored, not on the number of restorations per surface, or per tooth, per day. A restoration is considered a two-or-more surface restoration only when two (2) or more actual tooth surfaces are involved, whether they are connected or not. |
| D2161 | AMALGAM - FOUR OR MORE SURFACES, PRIMARY OR PERMANENT | 0 - 999 | 1 per 1 year | N | All restorative services are subject to medical necessity review. Payment is made for restorative services based on the number of surfaces restored, not on the number of restorations per surface, or per tooth, per day. A restoration is considered a two-or-more surface restoration only when two (2) or more actual tooth surfaces are involved, whether they are connected or not. |
| D2330 | RESIN-BASED COMPOSITE - ONE SURFACE, ANTERIOR | 0 - 999 | 1 per 1 year | N | All restorative services are subject to medical necessity review. Payment is made for restorative services based on the number of surfaces restored, not on the number of restorations per surface, or per tooth, per day. A restoration is considered a two-or-more surface restoration only when two (2) or more actual tooth surfaces are involved, whether they are connected or not. |
| D2331 | RESIN-BASED COMPOSITE - TWO SURFACES, ANTERIOR | 0 - 999 | 1 per 1 year | N | All restorative services are subject to medical necessity review. Payment is made for restorative services based on the number of surfaces restored, not on the number of restorations per surface, or per tooth, per day. A restoration is considered a two-or-more surface restoration only when two (2) or more actual tooth surfaces are involved, whether they are connected or not. |
| D2332 | RESIN-BASED COMPOSITE - THREE SURFACES, ANTERIOR | 0 - 999 | 1 per 1 year | N | All restorative services are subject to medical necessity review. Payment is made for restorative services based on the number of surfaces restored, not on the number of restorations per surface, or per tooth, per day. A restoration is considered a two-or-more surface restoration only when two (2) or more actual tooth surfaces are involved, whether they are connected or not. |

| Code | Description | Age limit | Limits | Prior auth required | Required documentation |
|---|---|---|---|---|---|
| D2335 | RESIN-BASED COMPOSITE - FOUR OR MORE SURFACES OR INVOLVING INCISAL ANGLE (ANTERIOR) | 0 - 999 | 1 per 1 year | N | All restorative services are subject to medical necessity review. Payment is made for restorative services based on the number of surfaces restored, not on the number of restorations per surface, or per tooth, per day. A restoration is considered a two-or-more surface restoration only when two (2) or more actual tooth surfaces are involved, whether they are connected or not. |
| D2390 | RESIN-BASED COMPOSITE CROWN, ANTERIOR | 0 - 999 | 1 per 1 year | N | All restorative services are subject to medical necessity review. Payment is made for restorative services based on the number of surfaces restored, not on the number of restorations per surface, or per tooth, per day. A restoration is considered a two-or-more surface restoration only when two (2) or more actual tooth surfaces are involved, whether they are connected or not. |
| D2391 | RESIN-BASED COMPOSITE - ONE SURFACE, POSTERIOR | 0 - 999 | 1 per 1 year | N | All restorative services are subject to medical necessity review. Payment is made for restorative services based on the number of surfaces restored, not on the number of restorations per surface, or per tooth, per day. A restoration is considered a two-or-more surface restoration only when two (2) or more actual tooth surfaces are involved, whether they are connected or not. |
| D2392 | RESIN-BASED COMPOSITE - TWO SURFACES, POSTERIOR | 0 - 999 | 1 per 1 year | N | All restorative services are subject to medical necessity review. Payment is made for restorative services based on the number of surfaces restored, not on the number of restorations per surface, or per tooth, per day. A restoration is considered a two-or-more surface restoration only when two (2) or more actual tooth surfaces are involved, whether they are connected or not. |
| D2393 | RESIN-BASED COMPOSITE - THREE SURFACES, POSTERIOR | 0 - 999 | 1 per 1 year | N | All restorative services are subject to medical necessity review. Payment is made for restorative services based on the number of surfaces restored, not on the number of restorations per surface, or per tooth, per day. A restoration is considered a two-or-more surface restoration only when two (2) or more actual tooth surfaces are involved, whether they are connected or not. |
| D2394 | RESIN-BASED COMPOSITE - FOUR OR MORE SURFACES, POSTERIOR | 0 - 999 | 1 per 1 year | N | All restorative services are subject to medical necessity review. Payment is made for restorative services based on the number of surfaces restored, not on the number of restorations per surface, or per tooth, per day. A restoration is considered a two-or-more surface restoration only when two (2) or more actual tooth surfaces are involved, whether they are connected or not. |
| D2710 | CROWN - RESIN BASED COMPOSITE (INDIRECT) | 0 - 999 | 1 per 5 years | Y | Crown services require radiographic images that depict the pre-condition. The documentation supporting the need for crown services must be available for review by UnitedHealthcare upon request. |
| D2720 | CROWN-RESIN WITH HIGH NOBLE METAL | 0 - 999 | 1 per 5 years | Y | Crown services require radiographic images that depict the pre-condition. The documentation supporting the need for crown services must be available for review by UnitedHealthcare upon request. |
| D2721 | CROWN-RESIN WITH PREDOMINANTLY BASE METAL | 0 - 999 | 1 per 5 years | Y | Crown services require radiographic images that depict the pre-condition. The documentation supporting the need for crown services must be available for review by UnitedHealthcare upon request. |
| D2722 | CROWN-RESIN WITH NOBLE METAL | 0 - 999 | 1 per 5 years | Y | Crown services require radiographic images that depict the pre-condition. The documentation supporting the need for crown services must be available for review by UnitedHealthcare upon request. |
| D2740 | CROWN-PORCELAIN/ CERAMIC SUBSTRATE | 0 - 999 | 1 per 5 years | Y | Crown services require radiographic images that depict the pre-condition. The documentation supporting the need for crown services must be available for review by UnitedHealthcare upon request. |

| Code | Description | Age limit | Limits | Prior auth required | Required documentation |
|---|---|---|---|---|---|
| D2750 | CROWN-PORCELAIN FUSED TO HIGH NOBLE METAL | 0 - 999 | 1 per 5 years | Y | Crown services require radiographic images that depict the pre-condition. The documentation supporting the need for crown services must be available for review by UnitedHealthcare upon request. |
| D2751 | CROWN - PORCELAIN FUSED TO PREDOMINANTLY BASE METAL | 0 - 999 | 1 per 5 years | Y | Crown services require radiographic images that depict the pre-condition. The documentation supporting the need for crown services must be available for review by UnitedHealthcare upon request. |
| D2752 | CROWN-PORCELAIN FUSED TO NOBLE METAL | 0 - 999 | 1 per 5 years | Y | Crown services require radiographic images that depict the pre-condition. The documentation supporting the need for crown services must be available for review by UnitedHealthcare upon request. |
| D2790 | CROWN-FULL CAST HIGH NOBLE METAL | 0 - 999 | 1 per 5 years | Y | Crown services require radiographic images that depict the pre-condition. The documentation supporting the need for crown services must be available for review by UnitedHealthcare upon request. |
| D2791 | CROWN-FULL CAST PREDOMINANTLY BASE METAL | 0 - 999 | 1 per 5 years | Y | Crown services require radiographic images that depict the pre-condition. The documentation supporting the need for crown services must be available for review by UnitedHealthcare upon request. |
| D2792 | CROWN-FULL CAST NOBLE METAL | 0 - 999 | 1 per 5 years | Y | Crown services require radiographic images that depict the pre-condition. The documentation supporting the need for crown services must be available for review by UnitedHealthcare upon request. |
| D2910 | RE-CEMENT OR RE-BOND INLAY, ONLAY, VENEER OR PARTIAL COVERAGE RESTORATION | 0 - 999 | 1 per 6 months | N | |
| D2915 | RE-CEMENT OR RE-BOND INDIRECTLY FABRICATED OR PREFABRICATED POST AND CORE | 0 - 999 | 1 per 6 months | N | |
| D2920 | RE-CEMENT OR RE-BOND CROWN | 0 - 999 | 1 per 6 months | N | |
| D2929 | PRE FABRICATED PORCELAIN/CERAMIC CROWN PRIMARY TOOTH | 0 - 999 | 1 per code per tooth every 2 years | N | |
| D2930 | PREFABRICATED STAINLESS STEEL CROWN - PRIMARY TOOTH | 0 - 999 | 1 per code per tooth every 2 years | N | |
| D2931 | PREFABRICATED STAINLESS STEEL CROWN - PERMANENT TOOTH | 0 - 999 | 1 per code per tooth every 2 years | N | |
| D2932 | PREFABRICATED RESIN CROWN | 0 - 999 | 1 per code per tooth every 2 years | N | |
| D2933 | PREF. STAINLESS STEEL CROWN WITH RESIN WINDOW. | 0 - 999 | 1 per code per tooth every 2 years | N | |

| Code | Description | Age limit | Limits | Prior auth required | Required documentation |
|---|---|---|---|---|---|
| D2934 | PREFABRICATED ESTHETIC COATED STAINLESS STEEL CROWN - PRIMARY TOOTH | 0 - 999 | 1 per code per tooth every 2 years | N | |
| D2940 | PROTECTIVE RESTORATION | 0 - 999 | 1 per 365 days | N | |
| D2950 | CORE BUILDUP, INCLUDING ANY PINS | 0 - 999 | 1 per code per tooth per 5 years | N | |
| D2951 | PIN RETENTION - PER TOOTH, IN ADDITION TO RESTORATION | 0 - 999 | 1 per code per tooth per year | N | |
| D2954 | PREFABRICATED POST AND CORE IN ADDITION TO CROWN | 0 - 999 | 1 per code per tooth per 5 years | N | |
| D2980 | CROWN REPAIR- BY REPORT | 0 - 999 | 1 per 1 lifetime | N | |
| D2999 | UNSPECIFIED RESTORATIVE PROCEDURE, BY REPORT | 0-999 | None | N | |
| D3220 | THERAPEUTIC PULPOTOMY (EXCLUDING FINAL RESTORATION)(PRIMARY TEETH ONLY) | 0 - 999 | 1 per 1 lifetime | N | |
| D3230 | PULPAL THERAPY (RESORBABLE FILLING) - ANTERIOR, PRIMARY TOOTH (EXCLUDING FINAL RESTORATION) | 0 - 999 | 1 per 1 lifetime | N | |
| D3240 | PULPAL THERAPY (RESORBABLE FILLING) - POSTERIOR, PRIMARY TOOTH (EXCLUDING FINAL RESTORATION) | 0 - 999 | 1 per 1 lifetime | N | |
| D3310 | ANTERIOR (EXCLUDING FINAL RESTORATION) | 0 - 999 | 1 per 1 lifetime | N | |
| D3320 | ENDODONTIC THERAPY, BICUSPID TOOTH (EXCLUDING FINAL RESTORATION) | 0 - 999 | 1 per 1 lifetime | N | |
| D3330 | ENDODONTIC THERAPY, MOLAR (EXCLUDING FINAL RESTORATION) | 0 - 999 | 1 per 1 lifetime | N | |
| D3346 | RETREATMENT OF PREVIOUS ROOT CANAL THERAPY - ANTERIOR | 0 - 999 | 1 per code per tooth for lifetime | N | Minimum 365 days post D3310 |

| Code | Description | Age limit | Limits | Prior auth required | Required documentation |
|---|---|---|---|---|---|
| D3347 | RETREATMENT OF PREVIOUS ROOT CANAL THERAPY - BICUSPID | 0 - 999 | 1 per code per tooth for lifetime | N | Minimum 365 days post D3320 |
| D3348 | RETREATMENT OF PREVIOUS ROOT CANAL THERAPY - MOLAR | 0 - 999 | 1 per code per tooth for lifetime | N | Minimum 365 days post D3330 |
| D3351 | APEXIFICATION/ RECALCIFICATION-INITIAL VISIT (APICAL CLOSURE/ CALCIFIC REPAIR OF PERFORATIONS,ROOT RESORPTION, ETC.) | 0 - 999 | 1 per 1 lifetime | N | |
| D3410 | APICOECTOMY/ PERIRADICULAR SURGERY-ANTERIOR | 0 - 999 | 1 per 1 lifetime | N | |
| D3999 | EMERGENCY TREATMENT TO RELIEVE ENDODONTIC PAIN | 0 - 999 | 2 per code per tooth every 12 months | N | No other definitive treatment on same tooth on for same DOS |
| D4210 | GINGIVECTOMY OR GINGIVOPLASTY, 4 OR MORE CONTIGUOUS TEETH OR TOOTH BONDED SPACES PER QUADRANT | 0 - 999 | 1 per code per quadrant per year | N | |
| D4211 | GINGIVECTOMY OR GINGIVOPLASTY, 1 TO 3 CONTIGUOUS TEETH OR TOOTH BONDED SPACES PER QUADRANT | 0 - 999 | 1 per code per quadrant per year | N | |
| D4323 | SPLINT EXTRA-CORONAL NATURAL TEETH OT PROSTHETIC CROWNS | 0 - 999 | 1 per code per arch for lifetime | N | |
| D4341 | PERIODONTAL SCALING AND ROOT PLANING - FOUR OR MORE TEETH PER QUADRANT | 0 - 999 | 1 per code per quadrant every 12 months; max 2 quads per day unless reported in hospital | Y | A minimum of four (4) affected teeth in the quadrant. Periapical x-rays must show subgingival calculus and/or loss of crestal bone. When requiring local anesthesia only one (1) half of the mouth per day is a benefit unless completed as a hospital case. D4341 will be denied if provided within 21 days of D4355. Denied when submitted for the same date of service as other D4000 series codes. When an exam is performed on the same date of service as this procedure, the exam must be performed after completion. Requires pre-authorization with x-rays, periodontal charting including current probing, rationale, a treatment plan that demonstrates that curettage, scaling, or root planing is required in addition to a routine prophylaxis and indication of quadrant (10,20,30,40) |
| D4342 | PERIODONTAL SCALING AND ROOT PLANING - ONE TO THREE TEETH, PER QUADRANT | 0 - 999 | 1 per 12 months | Y | |

| Code | Description | Age limit | Limits | Prior auth required | Required documentation |
|---|---|---|---|---|---|
| D4355 | FULL MOUTH DEBRIDEMENT TO ENABLE COMPREHENSIVE EVALUATION AND DIAGNOSIS | 0 - 999 | 1 per 12 months | N | |
| D4910 | PERIODONTAL MAINTENANCE PROCEDURES (FOLLOWING SCALING & ROOT PLANING) | 0 - 999 | 1 per 90 days | Y | Include date of previous periodontal surgical or SRP Perio charting for authorization. |
| D5110 | COMPLETE DENTURE - MAXILLARY | 0 - 999 | 1 per 5 years | Y | The time period for eligibility for a new prosthesis for the same arch begins on the delivery date of original prosthesis. The provider must inform the member that no reline is covered within six (6) months of the delivery date of the denture or partial denture. A complete prosthetic appliance case includes all materials, fittings and placement of the prosthesis, and all necessary adjustments for a period of 180 days following placement of the prosthesis. Prosthetic appliances are covered once every five (5) years when:<br>• The member's dental history does not show that previous prosthetic appliances have been unsatisfactory to the member.<br>• The member does not have a history of lost prosthetic appliances.<br>• A repair, reline or rebase will not make the existing prosthetic functional.<br>Materials used for codes D5110, D5120, D5130, D5140, D5211, D5212, D5213, D5214, D5820 and D5821 must be of a quality that with normal wear the prosthetic appliance will last a minimum of five (5) years. Medicaid covers a one-time replacement within the five-year coverage limit for broken/lost/stolen appliances. This one time replacement is available once within each member's lifetime, and a prior authorization request must be submitted and marked as a one-time replacement request. |

| Code | Description | Age limit | Limits | Prior auth required | Required documentation |
|---|---|---|---|---|---|
| D5120 | COMPLETE DENTURE - MANDIBLE | 0 - 999 | 1 per 5 years | Y | The time period for eligibility for a new prosthesis for the same arch begins on the delivery date of original prosthesis. The provider must inform the member that no reline is covered within six (6) months of the delivery date of the denture or partial denture. A complete prosthetic appliance case includes all materials, fittings and placement of the prosthesis, and all necessary adjustments for a period of 180 days following placement of the prosthesis. Prosthetic appliances are covered once every five (5) years when:<br>• The member's dental history does not show that previous prosthetic appliances have been unsatisfactory to the member.<br>• The member does not have a history of lost prosthetic appliances.<br>• A repair, reline or rebase will not make the existing prosthetic functional.<br>Materials used for codes D5110, D5120, D5130, D5140, D5211, D5212, D5213, D5214, D5820 and D5821 must be of a quality that with normal wear the prosthetic appliance will last a minimum of five (5) years. Medicaid covers a one-time replacement within the five-year coverage limit for broken/lost/stolen appliances. This one time replacement is available once within each member's lifetime, and a prior authorization request must be submitted and marked as a one-time replacement request. |
| D5130 | IMMEDIATE DENTURE - MAXILLARY | 0 - 999 | 1 per 5 years | Y | The time period for eligibility for a new prosthesis for the same arch begins on the delivery date of original prosthesis. The provider must inform the member that no reline is covered within six (6) months of the delivery date of the denture or partial denture.<br>A complete prosthetic appliance case includes all materials, fittings and placement of the prosthesis, and all necessary adjustments for a period of 180 days following placement of the prosthesis.<br>Prosthetic appliances are covered once every five (5) years when:<br>• The member's dental history does not show that previous prosthetic appliances have been unsatisfactory to the member.<br>• The member does not have a history of lost prosthetic appliances.<br>• A repair, reline or rebase will not make the existing prosthetic functional.<br>Materials used for codes D5110, D5120, D5130, D5140, D5211, D5212, D5213, D5214, D5820 and D5821 must be of a quality that with normal wear the prosthetic appliance will last a minimum of five (5) years. Medicaid covers a one-time replacement within the five-year coverage limit for broken/lost/stolen appliances. This one time replacement is available once within each member's lifetime, and a prior authorization request must be submitted and marked as a one-time replacement request. |

| Code | Description | Age limit | Limits | Prior auth required | Required documentation |
|---|---|---|---|---|---|
| D5140 | IMMEDIATE DENTURE - MANDIBULAR | 0 - 999 | 1 per 5 years | Y | The time period for eligibility for a new prosthesis for the same arch begins on the delivery date of original prosthesis. The provider must inform the member that no reline is covered within six (6) months of the delivery date of the denture or partial denture. A complete prosthetic appliance case includes all materials, fittings and placement of the prosthesis, and all necessary adjustments for a period of 180 days following placement of the prosthesis. Prosthetic appliances are covered once every five (5) years when:<br>• The member's dental history does not show that previous prosthetic appliances have been unsatisfactory to the member.<br>• The member does not have a history of lost prosthetic appliances.<br>• A repair, reline or rebase will not make the existing prosthetic functional.<br>Materials used for codes D5110, D5120, D5130, D5140, D5211, D5212, D5213, D5214, D5820 and D5821 must be of a quality that with normal wear the prosthetic appliance will last a minimum of five (5) years. Medicaid covers a one-time replacement within the five-year coverage limit for broken/lost/stolen appliances. This one time replacement is available once within each member's lifetime, and a prior authorization request must be submitted and marked as a one-time replacement request. |
| D5211 | UPPER PARTIAL DENTURE-RESIN BASE (INC. ANY CONVENTIONAL CLASPS, RESTS AND TEETH) | 0 - 999 | 1 per 5 years | Y | The following codes require pre-authorization, x-rays, and rationale. Medicaid may provide a partial denture (D5211, D5212, D5213, or D5214) in cases where the recipient has matured beyond the mixed dentition stage in the following cases:<br>• Missing three (3) or more maxillary anterior teeth, or<br>• Missing two (2) or more mandibular anterior teeth, or<br>• Missing at least three (3) adjacent posterior permanent teeth in a single quadrant when the prosthesis would restore masticatory function (third molars not considered for replacement), or<br>• Missing at least two (2) adjacent posterior permanent teeth in both quadrants of the same arch when the prosthesis would restore masticatory function in at least one (1) quadrant (third molars not considered for replacement) or,<br>• Missing a combination of two (2) or more anterior and at least one (1) posterior tooth (excluding wisdom teeth and the second molar) in the same arch.<br>Replacement prosthetic appliances are covered when:<br>• The member's dental history does not show that previous prosthetic appliances have been unsatisfactory to the member; and<br>• The member does not have a history of lost prosthetic appliances; and<br>• A repair will not make the existing denture or partial wearable; or<br>• A reline will not make the existing denture or partial wearable; or<br>• A rebase will not make the existing denture or partial wearable<br>Medicaid covers a one-time replacement within the five-year coverage limit for broken/lost/stolen appliances.<br>This one time replacement is available once within each member's lifetime, and a prior authorization request must be submitted and marked as a one-time replacement request.. |

| Code | Description | Age limit | Limits | Prior auth required | Required documentation |
|---|---|---|---|---|---|
| D5212 | LOWER PARTIAL DENTURE-RESIN BASE(INC. ANY CONVENTIONAL CLASPS, RESTS AND TEETH) | 0 - 999 | 1 per 5 years | Y | The following codes require pre-authorization, x-rays, and rationale. Medicaid may provide a partial denture (D5211, D5212, D5213, or D5214) in cases where the recipient has matured beyond the mixed dentition stage in the following cases:<br>• Missing three (3) or more maxillary anterior teeth, or<br>• Missing two (2) or more mandibular anterior teeth, or<br>• Missing at least three (3) adjacent posterior permanent teeth in a single quadrant when the prosthesis would restore masticatory function (third molars not considered for replacement), or<br>• Missing at least two (2) adjacent posterior permanent teeth in both quadrants of the same arch when the prosthesis would restore masticatory function in at least one (1) quadrant (third molars not considered for replacement) or,<br>• Missing a combination of two (2) or more anterior and at least one (1) posterior tooth (excluding wisdom teeth and the second molar) in the same arch.<br>Replacement prosthetic appliances are covered when:<br>• The member's dental history does not show that previous prosthetic appliances have been unsatisfactory to the member; and<br>• The member does not have a history of lost prosthetic appliances; and<br>• A repair will not make the existing denture or partial wearable; or<br>• A reline will not make the existing denture or partial wearable; or<br>• A rebase will not make the existing denture or partial wearable<br>Medicaid covers a one-time replacement within the five-year coverage limit for broken/lost/stolen appliances.<br>This one time replacement is available once within each member's lifetime, and a prior authorization request must be submitted and marked as a one-time replacement request.. |

| Code | Description | Age limit | Limits | Prior auth required | Required documentation |
|---|---|---|---|---|---|
| D5213 | MAXILLARY PARTIAL DENTURE-CAST METAL FRAMEWORK WITH RESIN DENTURE BASES (INCLUDING ANY CONVENTIONAL CLASPS, RESTS AND TEETH) | 0 - 999 | 1 per 5 years | Y | The following codes require pre-authorization, x-rays, and rationale. Medicaid may provide a partial denture (D5211, D5212, D5213, or D5214) in cases where the recipient has matured beyond the mixed dentition stage in the following cases:<br>• Missing three (3) or more maxillary anterior teeth, or<br>• Missing two (2) or more mandibular anterior teeth, or<br>• Missing at least three (3) adjacent posterior permanent teeth in a single quadrant when the prosthesis would restore masticatory function (third molars not considered for replacement), or<br>• Missing at least two (2) adjacent posterior permanent teeth in both quadrants of the same arch when the prosthesis would restore masticatory function in at least one (1) quadrant (third molars not considered for replacement) or,<br>• Missing a combination of two (2) or more anterior and at least one (1) posterior tooth (excluding wisdom teeth and the second molar) in the same arch.<br>Replacement prosthetic appliances are covered when:<br>• The member's dental history does not show that previous prosthetic appliances have been unsatisfactory to the member; and<br>• The member does not have a history of lost prosthetic appliances; and<br>• A repair will not make the existing denture or partial wearable; or<br>• A reline will not make the existing denture or partial wearable; or<br>• A rebase will not make the existing denture or partial wearable<br>Medicaid covers a one-time replacement within the five-year coverage limit for broken/lost/stolen appliances. This one time replacement is available once within each member's lifetime, and a prior authorization request must be submitted and marked as a one-time replacement request.. |

| Code | Description | Age limit | Limits | Prior auth required | Required documentation |
|---|---|---|---|---|---|
| D5214 | MANDIBULAR PARTIAL DENTURE-CASE METAL FRAMEWORK WITH RESIN DENTUR BASES (INCLUDING ANY CONVENTIONAL CLASPS, REST & TEETH) | 0 - 999 | 1 per 5 years | Y | The following codes require pre-authorization, x-rays, and rationale. Medicaid may provide a partial denture (D5211, D5212, D5213, or D5214) in cases where the recipient has matured beyond the mixed dentition stage in the following cases:<br>• Missing three (3) or more maxillary anterior teeth, or<br>• Missing two (2) or more mandibular anterior teeth, or<br>• Missing at least three (3) adjacent posterior permanent teeth in a single quadrant when the prosthesis would restore masticatory function (third molars not considered for replacement), or<br>• Missing at least two (2) adjacent posterior permanent teeth in both quadrants of the same arch when the prosthesis would restore masticatory function in at least one (1) quadrant (third molars not considered for replacement) or,<br>• Missing a combination of two (2) or more anterior and at least one (1) posterior tooth (excluding wisdom teeth and the second molar) in the same arch.<br>Replacement prosthetic appliances are covered when:<br>• The member's dental history does not show that previous prosthetic appliances have been unsatisfactory to the member; and<br>• The member does not have a history of lost prosthetic appliances; and<br>• A repair will not make the existing denture or partial wearable; or<br>• A reline will not make the existing denture or partial wearable; or<br>• A rebase will not make the existing denture or partial wearable<br>Medicaid covers a one-time replacement within the five-year coverage limit for broken/lost/stolen appliances.<br>This one time replacement is available once within each member's lifetime, and a prior authorization request must be submitted and marked as a one-time replacement request. |
| D5410 | ADJUST COMPLETE DENTURE - MAXILLARY | 0 - 999 | None | N | |
| D5411 | ADJUST COMPLETE DENTURE - MANDIBULAR | 0 - 999 | None | N | |
| D5421 | ADJUST PARTIAL DENTURE - MAXILLARY | 0 - 999 | None | N | |
| D5422 | ADJUST PARTIAL DENTURE - MANDIBULAR | 0 - 999 | None | N | |
| D5511 | REPAIR BROKEN COMPLETE DENTURE BASE, MANDIBULAR | 0 - 999 | 2 per 12 months | N | |
| D5512 | REPAIR BROKEN COMPLETE DENTURE BASE, MAXILLARY | 0 - 999 | 2 per 12 months | N | |
| D5520 | REPLACE MISSING OR BROKEN TEETH - COMPLETE DENTURE (EACH TOOTH) | 0 - 999 | 2 per 12 months | N | |
| D5611 | REPAIR RESIN PARTIAL DENTURE BASE, MANDIBULAR | 0 - 999 | 2 per 12 months | N | |

| Code | Description | Age limit | Limits | Prior auth required | Required documentation |
|---|---|---|---|---|---|
| D5612 | REPAIR RESIN PARTIAL DENTURE BASE, MAXILLARY | 0 - 999 | 2 per 12 months | N | |
| D5621 | REPAIR CAST PARTIAL FRAMEWORK, MANDIBULAR | 0 - 999 | 2 per 12 months | N | |
| D5622 | REPAIR CAST PARTIAL FRAMEWORK, MAXILLARY | 0 - 999 | 2 per 12 months | N | |
| D5630 | REPAIR OR REPLACE BROKEN CLASP - PARTIAL PER TOOTH | 0 - 999 | 2 per 12 months | N | |
| D5640 | REPLACE BROKEN TEETH - PER TOOTH | 0 - 999 | 2 per 12 months | N | |
| D5650 | ADD TOOTH TO EXISTING PARTIAL DENTURE | 0 - 999 | 2 per 12 months | N | |
| D5660 | ADD CLASP TO EXISTING PARTIAL DENTURE PER TOOTH | 0 - 999 | 2 per 12 months | N | |
| D5710 | REBASE COMPLETE MAXILLARY DENTURE | 0 - 999 | 1 per 365 days | N | |
| D5711 | REBASE COMPLETE MANDIBULAR DENTURE | 0 - 999 | 1 per 365 days | N | |
| D5720 | REBASE MAXILLARY PARTIAL DENTURE | 0 - 999 | 1 per 365 days | N | |
| D5721 | REBASE MANDIBULAR PARTIAL DENTURE | 0 - 999 | 1 per 365 days | N | |
| D5730 | RELINE COMPLETE MAXILLARY DENTURE (CHAIRSIDE) | 0 - 999 | 1 per 12 months | N | |
| D5731 | RELINE COMPLETE MANDIBULAR DENTURE (CHAIRSIDE) | 0 - 999 | 1 per 12 months | N | |
| D5740 | RELINE MAXILLARY PARTIAL DENTURE (CHAIRSIDE) | 0 - 999 | 1 per 12 months | N | |
| D5741 | RELINE MANDIBULAR PARTIAL DENTURE (CHAIRSIDE) | 0 - 999 | 1 per 12 months | N | |
| D5750 | RELINE COMPLETE MAXILLARY DENTURE (LABORATORY) | 0 - 999 | 1 per 12 months | N | |
| D5751 | RELINE COMPLETE MANDIBULAR DENTURE (LABORATORY) | 0 - 999 | 1 per 12 months | N | |

| Code | Description | Age limit | Limits | Prior auth required | Required documentation |
|---|---|---|---|---|---|
| D5760 | RELINE MAXILLARY PARTIAL DENTURE (LABORATORY) | 0 - 999 | 1 per 12 months | N | |
| D5761 | RELINE MANDIBULAR PARTIAL DENTURE (LABORATORY) | 0 - 999 | 1 per 12 months | N | |
| D5765 | SOFT LINER FOR COMPLETE OR REMOVABLE DENTURE | 0 - 999 | 1 per 365 days | N | |
| D5810 | INTERIM COMPLETE DENTURE (MAXILLARY) | 0 - 999 | 1 per 5 years | Y | Requires pre-authorization, date and list of teeth to be extracted, narrative of medical necessity, and x-rays. D5810 and D5811, interim complete dentures, can be replaced with a complete denture six (6) months after placement of the interim denture. One (1) to three (3) missing anterior teeth should be replaced with a flipper partial (D5820 and D5821), which is considered a permanent replacement. Flipper partials are not covered for temporary replacement of missing teeth. Relines, rebases and adjustments are not billable for 180 days after placement of the prosthesis. Interim complete and flipper partial dentures require pre-authorization, x-rays, and rationale. |
| D5811 | INTERIM COMPLETE DENTURE (MANDIBULAR) | 0 - 999 | 1 per 5 years | Y | Requires pre-authorization, date and list of teeth to be extracted, narrative of medical necessity, and x-rays. D5810 and D5811, interim complete dentures, can be replaced with a complete denture six (6) months after placement of the interim denture. One (1) to three (3) missing anterior teeth should be replaced with a flipper partial (D5820 and D5821), which is considered a permanent replacement. Flipper partials are not covered for temporary replacement of missing teeth. Relines, rebases and adjustments are not billable for 180 days after placement of the prosthesis. Interim complete and flipper partial dentures require pre-authorization, x-rays, and rationale. |
| D5820 | FLIPPER PARTIAL DENTURE (MAXILLARY) | 0 - 999 | 1 per 5 years | Y | Requires pre-authorization, date and list of teeth to be extracted, narrative of medical necessity, and x-rays. D5810 and D5811, interim complete dentures, can be replaced with a complete denture six (6) months after placement of the interim denture. One (1) to three (3) missing anterior teeth should be replaced with a flipper partial (D5820 and D5821), which is considered a permanent replacement. Flipper partials are not covered for temporary replacement of missing teeth. Relines, rebases and adjustments are not billable for 180 days after placement of the prosthesis. Interim complete and flipper partial dentures require pre-authorization, x-rays, and rationale. |
| D5821 | FLIPPER PARTIAL DENTURE (MANDIBULAR) | 0 - 999 | 1 per 5 years | Y | Requires pre-authorization, date and list of teeth to be extracted, narrative of medical necessity, and x-rays. D5810 and D5811, interim complete dentures, can be replaced with a complete denture six (6) months after placement of the interim denture. One (1) to three (3) missing anterior teeth should be replaced with a flipper partial (D5820 and D5821), which is considered a permanent replacement. Flipper partials are not covered for temporary replacement of missing teeth. Relines, rebases and adjustments are not billable for 180 days after placement of the prosthesis. Interim complete and flipper partial dentures require pre-authorization, x-rays, and rationale. |
| D5850 | TISSUE CONDITIONING, MAXILLARY | 0 - 999 | 2 per 12 months | N | |

| Code | Description | Age limit | Limits | Prior auth required | Required documentation |
|---|---|---|---|---|---|
| D5851 | TISSUE CONDITIONING, MANDIBULAR | 0 - 999 | 2 per 12 months | N | |
| D5899 | UNSPECIFIED REMOVABLE PROSTHODONTIC PROCEDURE, BY REPORT | 0 - 999 | 1 per 5 years | Y | Requires pre-authorization, narrative, and operative notes. Documentation must clearly indicate that denture treatment was interrupted and unable to be completed. the stage(s) of treatment completed must be identified. Coverage is allowed under the following circumstances: • Treatment was interrupted after final impressions were taken but before initial jaw relation • Treatment was interrupted after initial jaw relation but before processing. |
| D6930 | RE-CEMENT OR RE-BOND FIXED PARTIAL DENTURE OR FIXED BRIDGE | 0 - 999 | 2 per 12 months | N | |
| D7111 | CORONAL REMNANTS - DECIDUOUS TOOTH | 0 - 999 | 1 per code per tooth per 1 lifetime | N | |
| D7140 | EXTRACTION, ERUPTED TOOTH OR EXPOSED ROOT (ELEVATION AND/ OR FORCEPS REMOVAL) | 0 - 999 | 1 per code per tooth per 1 lifetime | N | |
| D7210 | SURGICAL REMOVAL OF ERUPTED TOOTH REQUIRING ELEVATION OF MUCOPERIOSTEAL FLAP AND REMOVAL OF BONE AND/OR SECTION OF TOOTH | 0 - 999 | 1 per code per tooth per 1 lifetime | N | |
| D7220 | REMOVAL OF IMPACTED TOOTH--SOFT TISSUE | 0 - 999 | 1 per code per tooth per 1 lifetime | N | |
| D7230 | REMOVAL OF IMPACTED TOOTH - PARTICALLY BONY | 0 - 999 | 1 per code per tooth per 1 lifetime | N | |
| D7240 | REMOVAL OF IMPACTED TOOTH - COMPLETELY BONY | 0 - 999 | 1 per code per tooth per 1 lifetime | N | |
| D7241 | REMOVAL OF IMPACTED TOOTH-COMPLETELY BONY, WITH UNUSUAL SURGICAL COMPLICATIONS | 0 - 999 | 1 per code per tooth per 1 lifetime | N | |
| D7250 | SURGICAL REMOVAL OF RESIDUAL TOOTH ROOTS (CUTTING PROCEDURE) | 0 - 999 | 1 per code per tooth per 1 lifetime | N | Involves tissue incision and removal of bone to remove a permanent or primary tooth root left in the bone from a previous extraction, caries, or trauma. Usually some degree of soft or hard tissue healing has occurred. requires x-rays and rationale for all teeth: 1-32, A-T, 51-82, and AS-TS. Includes removal of the roots of a previously erupted tooth missing its clinical crown. If the member's treatment record does not clearly demonstrate the need for the cutting of gingiva and removal of bone and/or sectioning of tooth structure, all records may be reviewed and recoupment of payment for services will be initiated. |

| Code | Description | Age limit | Limits | Prior auth required | Required documentation |
|---|---|---|---|---|---|
| D7270 | TOOTH REIMPLANTATION AND/ OR STABILIZATION OF ACCIDENTLY EVULSED OR DISPLACED TOOTH AND/OR ALVEOLUS | 0 - 999 | 1 per code per tooth per 1 lifetime | N | |
| D7280 | SURGICAL ACCESS OF AN UNERUPTED TOOTH | 0 - 999 | 1 per code per tooth per 1 lifetime | N | |
| D7282 | MOBILIZATION OF ERUPTED OR MALPOSITIONED TOOTH TO AID ERUPTION | 0 - 999 | 1 per code per tooth per 1 lifetime | N | |
| D7283 | PLACEMENT OF DEVICE TO FACILITATE ERUPTION OF IMPACTED TOOTH | 0 - 20 | 1 per code per tooth per 1 lifetime | N | |
| D7285 | INCISIONAL BIOPSY OF ORAL TISSUE - HARD (BONE, TOOTH) | 0 - 999 | 1 per day per patient | N | |
| D7286 | INCISIONAL BIOPSY OF ORAL TISSUE - SOFT | 0 - 999 | 1 per day per patient | N | |
| D7310 | ALVEOLOPLASTY IN CONJUNCTION WITH EXTRACTIONS - FOUR OR MORE TEETH OR TOOTH SPACES PER QUADRANT | 0 - 999 | 1 per code per quadrant per 1 lifetime | N | |
| D7311 | ALVEOLOPLASTY IN CONJUNCTION WITH EXTRACTIONS - ONE TO THREE TEETH OR TOOTH SPACES, PER QUADRANT | 0 - 999 | 1 per code per quadrant per 1 lifetime | N | |
| D7320 | ALVEOLOPLASTY NOT IN CONJUNCTION WITH EXTRACTIONS - FOUR OR MORE TEETH OR TOOTH SPACES PER QUADRANT | 0 - 999 | 1 per code per quadrant per 1 lifetime | N | |
| D7321 | ALVEOLOPLASTY NOT IN CONJUCTION WITH EXTRACTIONS - ONE TO THREE TEETH OR TOOTH SPACES, PER QUADRANT | 0 - 999 | 1 per code per quadrant per 1 lifetime | N | |
| D7410 | EXCISION OF BENIGN LESION UP TO 1.25 CM (1-3-03) | 0-999 | None | N | |
| D7411 | Excision of benign lesion greater than 1.25 cm | 0-999 | None | N | |
| D7412 | Excision of benign lesion, complicated | 0-999 | None | N | |

| Code | Description | Age limit | Limits | Prior auth required | Required documentation |
|---|---|---|---|---|---|
| D7413 | Excision of malignant lesion up to 1.25 cm | 0-999 | None | N | |
| D7414 | Excision of malignant lesion greater than 1.25 cm | 0-999 | None | N | |
| D7415 | Excision of malignant lesion, complicated | 0-999 | None | N | |
| D7440 | Excision of malignant tumor - lesion diameter up to 1.25 cm | 0-999 | None | N | |
| D7441 | Excision of malignant tumor - lesion diameter greater than 1.25 cm | 0-999 | None | N | |
| D7450 | Removal of benign or odontogenic cyst or tumor-lesion diameter up to 1.25 cm (1-3-03) | 0-999 | None | N | |
| D7451 | Removal of benign odontogenic cyst or tumor-lesion diameter greater than 1.25 cm (1-3-03) | 0-999 | None | N | |
| D7460 | Removal of benign nonodontogenic cyst or tumor - lesion diameter greater than 1.25 cm (1-3-03) | 0-999 | None | N | |
| D7461 | Removal of benign nonodontogenic cyst or tumor-lesion diameter greater than 1.25 cm (1-3-03) | 0-999 | None | N | |
| D7465 | Destruction of lesion(s) by physical or chemical method, by report | 0-999 | None | N | |
| D7471 | Removal of lateral exostosis (maxilla or mandible) | 0-999 | None | N | |
| D7510 | INCISION & DRAINAGE OF ABSCESS, INTRAORAL SOFT TISSUE | 0 - 999 | 1 per patient per day | N | |
| D7880 | OCCLUSAL ORTHOTIC DEVICE, BY REPORT | 0 - 999 | 1 per code every 3 years | N | |
| D7961 | BUCCAL LABIAL FRENECTOMY (FRENULECTOMY) | 0 - 999 | 1 per 1 lifetime | N | |
| D7962 | LINGUAL FRENECTOMY (FRENULECTOMY) | 0 - 999 | 1 per 1 lifetime | N | |

| Code | Description | Age limit | Limits | Prior auth required | Required documentation |
|---|---|---|---|---|---|
| D8020 | LIMITED ORTHODONTIC TREATMENT/TRANS. DENTITION | 0 - 20 | 1 per 1 lifetime | Y | Requires pre-authorization and will be limited to 12 months. Must include panoramic radiographs of the teeth being moved or the space that is being maintained. Complete HDL form and rationale/treatment plan. Requires Color photos |
| D8080 | COMPREHENSIVE ORTHODONTIC TREATMENT OF THE ADOLESCENT DENTITION | 0-20 | 1 per lifetime | Y | Requires pre-authorization, rationale/treatment plan, a completed HDL form, complete set of diagnostic color photos (or OrthoCad equivalent), and panoramic x-ray. Cephalometric radiograph is required. Periapical radiographs are optional. When the individual has had a surgical correction (cleft lip or palate, or orthognathic correction), the monthly adjustment procedure is reimbursed at a higher fee. Following completed surgery, a surgical letter of documentation is required accompanying an additional prior authorization request for the added surgical fee. Most cases will be limited to twenty-four months of adjustments. Procedures covered under code D8090: Constructing and placing fixed maxillary appliance, active treatment $422.68 Constructing and placing fixed mandibular appliance, active treatment $422.68 Each one- month period of active treatment - maxillary arch $41.67 Each one-month period of active treatment - maxillary arch, unusual service (surgical correction case) $60.72 Each one-month period of active treatment - mandibular arch $41.67 Each one month period of active treatment - mandibular arch, unusual service (surgical correction case) $60.72 Retainer or retention appliance $113.12 Each one-month period of retention appliance adjustments, maxillary arch. Not to exceed four (4). $22.61 Each one-month period of retention appliance adjustments, mandibular arch. Not to exceed four (4). $22.61 Rapid palatal expander (RPE) or crossbite correcting (fixed) appliance $214.31 Herbst appliance $321.48 Protraction facemask $192.88 Slow expansion appliance $210.75 Headgear $192.88 Inclined plane (Hawley) appliance, bite plane, with clasps $185.76 Orthodontic appliance not listed Manually Priced Orthodontic procedure not listed Manually Priced Space maintainer - fixed - unilateral, part of comprehensive orthodontic treatment plan $130.96 Space maintainer - fixed - bilateral, part of comprehensive $226.22 |

| Code | Description | Age limit | Limits | Prior auth required | Required documentation |
|---|---|---|---|---|---|
| D8090 | COMPREHENSIVE ORTHODONTIC TREATMENT OF THE ADULT DENTITION | 0 - 20 | 1 per 1 lifetime | Y | Requires pre-authorization, rationale/treatment plan, a completed HDL form, complete set of diagnostic color photos (or OrthoCad equivalent), and panoramic x-ray. Cephalometric radiograph is required. Periapical radiographs are optional. When the individual has had a surgical correction (cleft lip or palate, or orthognathic correction), the monthly adjustment procedure is reimbursed at a higher fee. Following completed surgery, a surgical letter of documentation is required accompanying an additional prior authorization request for the added surgical fee. Most cases will be limited to twenty-four months of adjustments. Procedures covered under code D8090: Constructing and placing fixed maxillary appliance, active treatment $422.68 Constructing and placing fixed mandibular appliance, active treatment $422.68 Each one-month period of active treatment - maxillary arch $41.67 Each one-month period of active treatment - maxillary arch, unusual service (surgical correction case) $60.72 Each one-month period of active treatment - mandibular arch $41.67 Each one month period of active treatment - mandibular arch, unusual service (surgical correction case) $60.72 Retainer or retention appliance $113.12 Each one-month period of retention appliance adjustments, maxillary arch. Not to exceed four (4). $22.61 Each one-month period of retention appliance adjustments, mandibular arch. Not to exceed four (4). $22.61 Rapid palatal expander (RPE) or crossbite correcting (fixed) appliance $214.31 Herbst appliance $321.48 Protraction facemask $192.88 Slow expansion appliance $210.75 Headgear $192.88 Inclined plane (Hawley) appliance, bite plane, with clasps $185.76 Orthodontic appliance not listed Manually Priced Orthodontic procedure not listed Manually Priced Space maintainer - fixed - unilateral, part of comprehensive orthodontic treatment plan $130.96 Space maintainer - fixed - bilateral, part of comprehensive $226.22 |
| D8210 | REMOVABLE APPLIANCE THERAPY (THUMB-SUCKING & TONGUE THRUST) | 0 - 20 | 1 per 1 lifetime | N | |
| D8220 | FIXED APPLIANCE THERAPY (THUMB-SUCKING AND TONGUE THRUST) | 0 - 20 | 1 per 1 lifetime | N | |
| D8696 | REPAIR OF ORTHODONTIC APPLIANCE MAXILLARY | 0 - 20 | 5 per 1 lifetime | N | |
| D8697 | REPAIR OF ORTHODONTIC APPLIANCE-MANDIBULAR | 0 - 20 | 5 per 1 lifetime | N | |
| D8698 | RE-CEMENT OF RE-BOND FIXED RETAINER-MAXILLARY | 0 - 20 | 5 per 1 lifetime | N | |
| D8699 | RE-CEMENT OR RE-BOND FIXED RETAINER-MANDIBULAR | 0 - 20 | 5 per 1 lifetime | N | |

| Code | Description | Age limit | Limits | Prior auth required | Required documentation |
|---|---|---|---|---|---|
| D8703 | REPLACEMENT OF OF LOST OR BROKEN RETAINER-MAXILLARY | 0 - 20 | 1 per 1 lifetime | N | |
| D8704 | REPLACEMENT OF LOST OR BROKEN RETAINER-MANDIBULAR | 0 - 20 | 1 per 1 lifetime | N | |
| D8999 | UNSPECIFIED ORTHODONTIC PROCEDURE, BY REPORT. | 0 - 20 | None | Y | Used for transfer cases; additional surgical fees when surgery has been completed; additional requests for appliances for noncompliant patients; and other unspecified orthodontic procedures, by report. Requires pre authorization and narrative of medical necessity |
| D9110 | PALLIATIVE (EMERGENCY) TREATMENT OF DENTAL PAIN-MINOR PROCEDURE (1-3-03) | 0 - 999 | 1 per code per day | N | Not covered if definitive treatment the same day of same tooth. |
| D9219 | EVALUATION FOR MODERATE SEDATION, DEEP SEDATION, OR GENERAL ANESTHESIA | 0-999 | 1 per 12 months | N | |
| D9222 | DEEP SEDATION/ GENERAL ANESTHESIA - FIRST 15 MIN | 0 - 999 | 1 per code per 1 day | N | |
| D9223 | DEEP SEDATION/ GENERAL ANESTHESIA -EACH 15 MIN. INCREMENT | 0 - 999 | 7 per code per 1 day | N | |
| D9230 | INHALATION OF NITROUS OXIDE/ ANXIOLYSIS, ANALGESIA | 0 - 999 | 1 per code per 1 day | N | |
| D9239 | INTRAVENOUS MODERATE ( CONSIOUS ) SEDATION/ANALGESIA-FIRST 15 MIN | 0 - 999 | 1 per code per 1 day | N | |
| D9243 | INTRAVENOUS MODERATE ( CONSCIOUS ) SEDATION/ ANALGESIA - EACH 15 MIN INCREMENT | 0 - 999 | 3 per code per 1 day | N | |
| D9248 | NON-INTRAVENOUS MODERATE (CONSCIOUS) SEDATION | 0 - 999 | 2 per 12 months | N | |
| D9410 | HOUSE CALL- NURSING FAC. OR PERSON'S HOME (1 PER DAY PER FAC. REGARDLESSNUMBER OF PERSON'S SEEN | 0 - 999 | 1 per day per facility | N | |
| D9420 | HOSPITAL CALL | 0 - 999 | 1 per day per facility | N | |
| D9440 | OFFICE VISIT-AFTER REGULAR HOURS | 0 - 999 | 1 per code per 1 day | N | Requires rationale including time of patient arrival |

| Code | Description | Age limit | Limits | Prior auth required | Required documentation |
|---|---|---|---|---|---|
| D9944 | OCCLUSAL GUARD HARD APPLIANCE FULL ARCH REMOVABLE DENTAL APPLIANCE | 0 - 999 | 1 per code every 3 years | N | |
| D9945 | OCCLUSAL GUARD SOFT APPLIANCE FULL ARCH REMOVABLE DENTAL APPLIANCE | 0 - 999 | 1 per code every 3 years | N | |
| D9946 | OCCLUSAL GUARD HARD APPLIANCE PARTIAL ARCH REMOVABLE DENTAL APPLIANCE | 0 - 999 | 1 per code every 3 years | N | |
| D9997 | DENTAL CASE MANAGEMENT - PATIENTS WITH SPECIAL HEALTH CARE NEEDS | 0-999 | | N | A narrative indicating the member's special healthcare need(s) |
| T1013 | SIGN LANGUAGE OR ORAL INTERPRETIVE SERVICES | 0-999 | 8 per code per day (15 mins per code) | N | |

## B.1.b Benefit grid - special healthcare need(s)

| Code | Description | Age limit | Limits | Prior auth required | Required documentation |
|---|---|---|---|---|---|
| D0120 | PERIODIC ORAL EXAMINATION | 0-999 | 1 per 90 days | N | |
| D1110 | PROPHYLAXIS - ADULT | 14-999 | 1 per 90 days | N | |
| D1120 | PROPHYLAXIS - CHILD | 0-13 | 1 per 90 days | N | |
| D9997 | DENTAL CASE MANAGEMENT | | | | No reimbursement for this code. Used to identify a member with special healthcare need(s). A narrative indicting the member's special healthcare need(s) should be included when this code is submitted on a claim. |

## B.2 Exclusions & limitations

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

Any service not listed as a covered service in the benefit grids (Appendix B.1) is excluded.

Please call Provider Services if you have any questions regarding frequency limitations.

### General exclusions

1. Dental services that do not meet medical necessity.
2. Dental services that are (A) cosmetic; (B) more costly than another, equally effective available service; (C) not within the coverage criteria of these regulations
3. Reconstructive surgery, regardless of whether or not the surgery is incidental to a dental disease, injury, or congenital anomaly when the primary purpose is to improve physiological functioning of the involved part of the body.
4. Any non-preventive dental procedure not directly associated with dental disease.

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

**Note:** For Orthodontia, the case rate is paid in full. If the child ages out during treatment, the treatment is expected to continue.

## B.3 Orthodontic forms

### Handicapping Labiolingual Deviation (HLD) Index - NE (Mod):

The submitting dentist shall complete and submit the Handicapping Labiolingual Deviation (HLD) Index score sheet when submitting an orthodontic pre-treatment request. The attached score sheet may be photo copied by the dental office for completion and submission.

If the diagnosed condition does not qualify in 1 through 6 listed on the Handicapping Labiolingual Deviation (HLD) Index the dental provider must complete items 7 through 14. The total score on 7 through 14 of the Handicapping Labiolingual Deviation (HLD)Index must be 28 or greater to qualify for Medicaid coverage of orthodontic treatment.

### Nebraska Orthodontic Pre-Treatment Request Form(s):

Orthodontic (interceptive and comprehensive) pre-treatment request details must be submitted using the description of the treatment to be completed. The pretreatment request can be submitted on the Nebraska Interceptive Orthodontic Pre-Treatment Request form, the Comprehensive Orthodontic Pre-Treatment Request form, or listed on an American Dental Association (ADA) claim.

### Orthodontic Case Tool:

The submitting dentist should complete and submit the orthodontic case tool when submitting an orthodontic pre-treatment request. The tool can be found on **UHCdental.com/medicaid** under Provider resources.

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## NEBRASKA MEDICAID HANDICAPPING LABIO-LINGUAL DEVIATIONS FORM (HLD INDEX)

THIS FORM IS A QUANTITATIVE, OBJECTIVE METHOD FOR MEASURING MALOCCLUSION. THE HLD PROVIDES A SINGLE SCORE, BASED ON A SERIES OF MEASUREMENTS THAT REPRESENT THE DEGREE TO WHICH A CASE DEVIATES FROM NORMAL ALIGNMENT AND OCCLUSION.

PATIENT INFO

CLIENT NAME: _____CLIENT MEDICAID NUMBER_____

CLIENT ADDRESS:_____CLIENT DATE OF BIRTH ___/____/_____

PROVIDER INFO (must be 20 years old or under)

PROVIDER NAME:_____PROVIDER ID NUMBER:_____

### CONDITIONS OBSERVED

PROCEDURE: SCORING STEPS 1 THROUGH 6. IF ONE OF THESE CONDITIONS EXIST, INDICATE WITH AN "X" AND SCORE NO FURTHER.

1. DEEP IMPINGING OVERBITE. SCORE "X"_____
2. CROSSBITE OF THREE OR MORE PERMANENT AND/OR DECIDUOUS POSTERIOR TEETH OR ANTERIOR CROSSBITE OF ONE TO TWO TEETH. SCORE "X"_____
3. CONGENITAL BIRTH DEFECT THAT AFFECTS SKELETAL RELATIONSHIP AND/OR DENTITION. SCORE "X"_____
4. IMPACTED CUSPIDS WITH MOST OF THE PERMANENT DENTITION PRESENT. SCORE "X"_____
5. OVERJET GREATER THAN 9 MM OR ANTERIOR CROSSBITE. SCORE "X"_____
6. MALOCCLUSION WITH OPEN BITE FROM CANINE TO CANINE. SCORE "X"_____

IF YOU HAVE MARKED AN "X" IN ANY OF THE ABOVE; **STOP**; AND PROCEED TO PRIOR AUTHORIZATION STEP 16.

---

PROCEDURE: COMPLETE 7 through 14 IF CASE DOES NOT QUALIFY IN 1 through 6 ABOVE. THE TOTAL SCORE WILL DETERMINE IF THE CASE QUALIFIES FOR ORTHODONTIC TREATMENT. COMPLETE INSTRUCTIONS ARE ON THE SECOND PAGE; "SCORING INSTRUCTIONS FOR HANIDAPPING MALOCCLUSION."

- POSITION THE PATIENT'S TEETH IN CENTRIC OCCLUSION. RECORD MEASUREMENTS N THE ORDER GIVEN AND ROUND TO THE NEAREST MILLIMETER (MM).
- ENTER SCORE "0" IF CONDITION IS ABSENT.
- NOTE: WHEN COMPLETEING 11 AND 12, IF BOTH ANTERIOR CROWDING AND ECTOPIC ERUPTION ARE PRESENT IN THE ANTERIOR PORTION OF THE MOUTH, SCORE ONLY THE MOST SEVER CONDITION. DO NOT SCORE BOTH CONDITIONS.

7. OVERJET IN MM. ( 1 - 8 MM ) _____
8. OVERBITE IN MM. ( ANTERIOR CROSSBITE ) _____
9. MANDIBULAR IN PROTRUSION, IN MM. X5_____
10. OPEN BITE, IN MM. X4 _____
11. ECTOPIC ERUPTION: COUNT EACH TOOTH EXCLUDING 3RD MOLARS.
    LIST TEETH_____ # OF TEETH X3_____
12. ANTERIOR CROWDING OR SPACING: SCORE ONE POINT FOR MAXILLA, AND/OR ONE POINT FOR MANDIBLE; TWO POINT MAXIMUM. SCORE THE ONE OR TWO X5. # X5 _____
13. LABIOLINGUAL SPREAD IN MM. _____
14. POSTERIOR UNILATERAL CROSSBITE. ( MUST INVOLVE TWO OR MORE ADJACENT TEETH, ONE OF WHICH MUST BE A MOLAR ) IF PRESENT SCORE 4 _____

**A TOTAL SCORE OF 28 OR GREATER CONSTITUTES A HANDICAPPING MALOCCLUSION: TOTAL OF 7 through 14** _____

IF 7 – 14 ABOVE SCORED 28 OR GREATER, PROCEED TO PRIOR AUTHORIZATION STEP 16.

15. IF TOTAL SCORE IS 27 OR UNDER**, STOP**, DO NOT PROCEED TO PRIOR AUTHORIZTION STEP 16. A SCORE OF 27 OR UNDER WILL NOT BE REVIEWED, CONSIDER THIS SCORE SHEET AS PROOF OF DENIAL FOR CONSIDERATION. DO NOT PROCEED TO COMPLETE AND BILL FOR CEPH FILM AND DIAGNOSTIC CASTS, THEY MAY NOT BE PAID WITHOUT AN ORTHODONTIC TREATMENT APPROVAL.
16. IF THE ABOVE CONDITIONS QUALIFY FOR A REVIEW (YOU MUST HAVE AN "X" AND/OR A SCORE OF 28 OR ABOVE ) YOU MAY PROCEED TO SUBMIT FOR PRIOR AUTHORIZATION WITH REQUIRED DOCUMENTATION CHECKED OFF BELOW. IN ORDER FOR MEDICAID PATIENTS TO RECEIVE TIMELY TREATMENT, PLEASE CONSIDER YOUR REQUEST FOR APPROVAL AS YOUR ACCEPTANCE OF THE MEDICAID FEE AND A COMMITMENT TO COMPLETE CARE. ADA FORM ____ CEPH FILM ____ X-RAYS _____ PHOTOS _____ NARRATIVE _____

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**Handicapping Labiolingual Index (HLD) - (NE-Mod)**
**Scoring Instructions for Severe Malocclusions**

The intent of the HLD Index is to measure the presence or absence, and the degree, of the handicap caused by the components of the index, and not to diagnose "malocclusion." All measurements are made with a Boley Gauge (or disposable ruler) scaled in millimeters. Absence of any condition must be recorded by entering "0" on 7 - 14. Measurements are rounded to the nearest millimeter.

1 – 6. Indicate an "X" on the score-sheet. These conditions are automatically considered a handicapping malocclusion and no further scoring is necessary.

7. Overjet in Millimeters: This is recorded with the patient's teeth in centric occlusion and measured from the labial portion of the lower incisors to the labial of the upper incisors. The measurement may apply to a protruding single tooth as well as to the whole arch. Enter the number of millimeters as the HLD score.

8. Overbite in Millimeters: A pencil mark on the tooth indicating the extent of overlap facilitates this measurement. Anterior crossbite may exist in certain conditions and should be measured and recorded. Enter the number of millimeters as the HLD score. (Vertical measurement.)

9. Mandibular Protrusion in Millimeters: Score exactly as measured from the labial of the lower incisor to the labial of the upper incisor. A anterior crossbite, if present, should be shown under "overbite". The measurement in millimeters is entered on the score-sheet and multiplied by five (5). Enter the multiplied total as the HLD score. (Horizontal measurement.)

10. Open Bite in Millimeters: This condition is defined as the absence of occlusal contact in the anterior region. It is measured from edge to edge, in millimeters. In cases of pronounced protrusion associated with open bite, measurement of the open bite should be estimated. The measurement is entered on the score-sheet and multiplied by four (4). Enter the multiplied total as the HLD score.

11. Ectopic Eruption: Count each tooth. Teeth deemed to be ectopic must be more than 50% blocked out and clearly out of the dental arch. Mutually blocked teeth are counted one time and third molars are excluded. If condition #12, anterior crowding is also present with an ectopic eruption in the anterior portion of the mouth, score only the most severe condition. DO NOT SCORE BOTH CONDITIONS. Enter the number of teeth on the score-sheet and multiply by three (3). Enter the multiplied total as the HLD score.

12. Anterior Crowding or spacing: Arch length insufficiency or excess must exceed 3.5 mm. Mild rotations that may react favorably to stripping or mild expansion procedures are not to be scored as crowded. If condition #11, ectopic eruption, is also present in the anterior portion of the mouth, score the most severe condition. DO NOT SCORE BOTH CONDITIONS. Two point maximum multiplied by five (5) for a maximum score of 10. Enter the multiplied total as the HLD score.

13. Labiolingual Spread: A Boley Gauge (or a disposable ruler) is used to determine the extent of deviation from a normal arch line. Otherwise, the total distance between the most protruded tooth and the lingually displaced anterior tooth is measured. The labiolingual spread probably comes close to a measurement of overall deviation from what would have been a normal arch. If multiple anterior crowding of teeth is present only the most severe individual millimeter measurement should be entered on the index. Enter the number of millimeters as the HLD score.

14. Posterior Unilateral Crossbite: This condition involves two or more adjacent teeth, one of which must be a molar. The crossbite must be one in which the maxillary posterior teeth involved may be both palatal or both completely buccal in relation to the mandibular posterior teeth. If posterior unilateral crossbite is present enter four (4) as the HLD score.

## Nebraska Medicaid Interceptive Orthodontic Pre-Treatment Request Form

Patient Name: Patient's Medicaid #:

Birthdate: Date of Request:

Provider Name: Provider Medicaid #:

Provider Address: (Street, City, State, Zip) Phone Number:

| Treatment Request: | Maxillary Arch | Mandibular Arch | Fee | Administrative Use Only |
|---|---|---|---|---|
| Inclined plane (Hawley) appliance, bite plane, with clasps | | | | |
| Cross-bite appliance, anterior, acrylic | | | | |
| Cross-bite appliance, posterior, two bands plus attachments | | | | |
| Adjustments of appliance (# each arch) | | | | |
| Space maintainer – fixed – unilateral | | | | |
| Space maintainer – fixed – bilateral | | | | |
| Description appliance not listed: | | | | |
| | | | | |
| | | | | |

| | Number Requested | | |
|---|---|---|---|
| Chrome steel wire clasps – each .036 or minimum .030 | | | |
| Attachment springs for appliance, each | | | |

**Diagnostic Narrative:**

Nebraska Medicaid Interceptive Orthodontic Pre-Treatment Request Form

Patient Name: Enter the full name (first, middle initial, and last name) of the client.

Patient's Medicaid #: Enter the client's eleven-digit Medicaid identification number.

Birthdate: Enter the client's month, day and year of birth.

Date of Request: Enter the submission date for the request.

Provider Name: Enter the dentist name.

Provider Medicaid #: Enter the eleven-digit Medicaid provider number.

Provider Address: Enter the dentist office address (Street, City, State, and Zip).

Provider Phone Number: Enter the dentist office phone number.

Treatment Request:

- Appliances: Under the Maxillary Arch and Mandibular Arch column check the type of appliances being requested.
- Adjustments of pedodontic and interceptive appliances: Enter the number of adjustments for the Maxillary arch and Mandibular Arch in the appropriate column.
- Chrome steel wire clasps - enter the number of clasps requested.
- Attachment springs for appliance - enter the number of springs requested.
- Enter the dentist usual and customary fee for each treatment being requested.

Diagnostic Narrative: Provide information regarding the diagnosis and treatment requested.

## Nebraska Medicaid Comprehensive Orthodontic Pre-Treatment Request Form

Patients Name: Patient's Medicaid #:

Birthdate: Date of Request: Surgical Correction: Yes No Surgical Diagnosis:

Provider Name: Provider Medicaid #:

Provider Address: (Street, City, State, Zip) Phone Number:

| Treatment Request | Maxillary Arch | Mandibular Arch | Fee | Administrative Use Only |
|---|---|---|---|---|
| Construct & place fixed appliance, active trt. | | | | |
| Number of monthly adjustments per arch | | | | |
| Retainer or retention appliance | | | | |
| Number of monthly retention visits, per arch | | | | |
| **Other Appliances:** | | | | |
| Rapid palatal expander (RPE) | | | | |
| Crossbite correcting (fixed appliance) | | | | |
| Herbst appliance | | | | |
| Protraction facemask | | | | |
| Slow expansion appliance | | | | |
| Headgear | | | | |
| Space maintainer – fixed - unilateral | | | | |
| Space Maintainer – fixed – bilateral | | | | |
| **Description orthodontic appliance not listed:** | | | | |
| | | | | |
| | | | | |

**Diagnostic Narrative:**

Nebraska Medicaid Comprehensive Orthodontic Pre-Treatment Request Form

Client Name: Enter the full name (first, middle initial, and last name) of the client.

Client's Medicaid: Enter the client's eleven-digit Medicaid identification number.

Birthdate: Enter the client's month, day and year of birth.

Date of Request: Enter the date the submission date for the request.

Provider Name: Enter the dentist name.

Provider Medicaid #: Enter the eleven-digit Medicaid provider number.

Provider Address: Enter the dentist office address (Street, City, State, and Zip).

Provider Phone Number: Enter the dentist office phone number.

Treatment Request:

- In the Maxillary Arch and Mandibular Arch column check the column for the treatment or type of appliance being requested for each arch.
- Number of months of arch adjustments – Enter the number of months of monthly adjustments being requested for each arch.
- Number of months of retention appliance treatment – Enter the number of months of retention visits.
- Fee Column: Enter the dentist usual and customary fee for the treatment requested.

Diagnostic Narrative: Provide information regarding the diagnosis and treatment requested.

**Nebraska Ortho Case Tool** Choose either one bundled treatment plan OR use the itemized plan calculator to request specific services. Indicate plan In Notes of authorization.

**Member Name** Tess Tester **Member ID** 12345678 **Plan** C4 *Use T99 for itemized treatment plan*

### D8020 Limited Ortho Bundled Plans

Includes 12 monthly adjustments, retainer and 2 post-retainer visits

| REGULAR | | SURGICAL | | Arches Treated | Rapid P E or x-bite | Herbst Appliance | Incline / Hawley |
|---|---|---|---|---|---|---|---|
| plan | fee | plan | fee | | | | |
| *L1* | 678.13 | *SL1* | 913.57 | one | | | |
| *L2* | 869.46 | *SL2* | 1104.90 | one | | | x |
| *L3* | 1009.25 | *SL3* | 1244.69 | one | | x | |
| *L4* | 1200.58 | *SL4* | 1436.02 | one | | x | x |
| *L5* | 898.87 | *SL5* | 1134.31 | one | x | | |
| *L6* | 1090.20 | *SL6* | 1325.64 | one | x | | x |
| *L7* | 1229.99 | *SL7* | 1465.43 | one | x | x | |
| *L8* | 1421.32 | *SL8* | 1656.76 | one | x | x | x |
| *L9* | 1239.75 | *SL9* | 1710.63 | both | | | |
| *L10* | 1431.08 | *SL10* | 1901.96 | both | | | x |
| *L11* | 1570.87 | *SL11* | 2041.75 | both | | x | |
| *L12* | 1762.20 | *SL12* | 2233.08 | both | | x | x |
| *L13* | 1460.49 | *SL13* | 1931.37 | both | x | | |
| *L14* | 1651.82 | *SL14* | 2122.70 | both | x | | x |
| *L15* | 1791.61 | *SL15* | 2262.49 | both | x | x | |
| *L16* | 1982.94 | *SL16* | 2453.82 | both | x | x | x |

### D8090 Comprehensive Ortho Bundled Plans

Includes both-arch banding, 24 monthly adj, retainer and 4 post-retainer visits

| REGULAR | | SURGICAL | | Rpd Pal Exp or crossbite | Unilaterl Space Mnt | Bilateral Space Mnt |
|---|---|---|---|---|---|---|
| plan | fee | plan | fee | | | |
| *C1* | 3233.71 | *SC1* | 4175.47 | | | |
| *C2* | 3368.60 | *SC2* | 4310.36 | | x | |
| *C3* | 3466.72 | *SC3* | 4408.48 | | | x |
| *C4* | 3454.45 | *SC4* | 4396.21 | x | | |
| *C5* | 3589.34 | *SC5* | 4531.10 | x | x | |
| *C6* | 3687.46 | *SC6* | 4629.22 | x | | x |

### Itemized Treatment Plans for D8020 or D8090

**Use only if treatment plan does not match any pre- bundled plan**

| Rate | Qty | Fee Total | Service |
|---|---|---|---|
| 435.36 | | 0.00 | Appliance - Maxillary |
| 435.36 | | 0.00 | Appliance - Mandibular |
| 42.92 | | 0.00 | Monthly Adj - Regular - Maxillary |
| 42.92 | | 0.00 | Monthly Adj - Regular - Mandibular |
| 62.54 | | 0.00 | Monthly Adj - Surgical - Maxillary |
| 62.54 | | 0.00 | Monthly Adj - Surgical - Mandibular |
| 116.51 | | 0.00 | Retainer |
| 23.29 | | 0.00 | Retention Appliance Adj - Maxillary |
| 23.29 | | 0.00 | Retention Appliance Adj - Mandibular |
| 220.74 | | 0.00 | Rapid Palatal Expander or Cross Bite |
| 217.07 | | 0.00 | Slow Expansion Appliance |
| 331.12 | | 0.00 | Herbst Appliance |
| 198.67 | | 0.00 | Headgear |
| 198.67 | | 0.00 | Protration Face Mask |
| 134.89 | | 0.00 | Space Maintainer - Unilateral |
| 233.01 | | 0.00 | Space Maintainer- Bilateral |
| 191.33 | | 0.00 | Inclined Plane / Hawley Device |
| 0.00 | | 0.00 | Other |

| plan | fee |
|---|---|
| *T99* | 0.00 |

*total for all itemized services selected*

## B.4. FQHC/HIS – Heritage Health Multi-visit Procedure PPS Encounter Billing

- All dental services rendered are billed with the appropriate CDT codes and T1015 when a Medicaid covered procedure code is included with the claim.
- Place of Service (POS) must reflect PPS-reimbursed clinic location. Dental services that require prior authorization (PA) must be itemized on the authorization submission on the ADA claim form on lines 1-10. The PA is applied to the CDT code not the T1015*
- Requests to exceed stated limits must be submitted in advance of service(s) and are subject to medical necessity review.
- Multi-visit benefits will be reimbursed as follows:
  - **Restorative (permanent crowns)** – up to two (2) visits*, use of same restorative code included below on both visits

| | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| D2710 | D2720 | D2721 | D2722 | D2740 | D2750 | D2751 | D2752 | D2790 | D2791 | D2792 |

  - **Endodontics (root canals)** – up to two (2) visits*, use of same endodontic code included below on both visits

| | | | | | |
|---|---|---|---|---|---|
| D3310 | D3320 | D3330 | D3346 | D3347 | D3348 |

  - **Prosthodontics, removable (denture)** – up to five (5) visits*, use of same prosthodontic code included below in five visits

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| D5110 | D5120 | D5130 | D5140 | D5211 | D5212 | D5213 | D5214 | D5810 | D5811 | D5820 | D5821 |

  - **Occlusal Guards** – up to two (2) visits*, use of same CDT code included below on both visits

| | | |
|---|---|---|
| D9944 | D9945 | D9946 |

- Reimbursement will be based on provider's encounter rate, regardless of dollar amount submitted.
- Encounter payment is made on T1015 only; individual services pay at zero.
- Please ensure any non-billable services documented in the chart are in alignment with existing guidance.
- Please ensure that the CDT and T1015 code is billed on the ADA claim form on the billing lines 1-10 (box 24-31).

## B.5 Coverage of translation and interpretation services

Reimbursement for interpretation services to support effective communication during covered dental healthcare visits. Interpretation services eligible for reimbursement include:

- Sign language interpretation
- Oral interpretation
- Translation services

### Billing guidance

- Use HCPCS Code T1013 for all eligible interpretation services.
- Reimbursement is calculated at 1 unit per 15 minutes, with a maximum of 8 units (2 hours) per day.
- Interpretation services must be billed on the same claim as the associated dental healthcare service.
- Services cannot be billed as standalone services; they must align with a Medicaid-covered dental benefit.

## Documentation requirements

Providers must maintain documentation that includes:

1. The date and time with interpretation service was provided
2. The name of the interpreter or agency providing the service
3. The language or type of interpretation provided (e.g. ASL, Spanish)
4. The purpose of the interpretation service, connecting it to the dental visit

# Appendix C: Authorization for treatment

## C.1 Dental treatment requiring authorization

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

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

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

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

## C.2 Authorization timelines

The following timelines will apply to requests for authorization:

- We will make a determination on standard authorizations within 2 days of receipt of the request. Written notification of denied determinations will be sent within 7 calendar days of receipt of the request.
- We will make a determination on expedited authorizations within 24 hours of receipt of the request. Written notification denied determinations will be sent within 2 business days of receipt of the request.
- Authorization approvals will expire 180 days from the date of determination.

## C.3 Appealing a denied authorization

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

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

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

Member Denied Authorization Appeal Mailing Address:

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

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

The member has the right to:

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

## C.4 Appeal determination timeframe:

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

## C.5 State Fair Hearing

A state fair hearing is a request by a member or a provider to appeal a decision made by the health plan, addressed to the state.

Members have 120 calendar days from the date on UnitedHealthcare Community Plan's adverse appeal determination letter in which to file a request for State Fair Hearing.

The UnitedHealthcare Community Plan member or the member's representative (if any) may ask for a state fair hearing by writing a letter to:

**Hearings Coordinator**
Nebraska Department of Health & Human Services
Division of Legal and Regulatory Services
Legal Services – Hearing Section
PO Box 98914
Lincoln, Nebraska 68509-8914

**Fax:** 1-402-742-2376
**Web:** www.dhhs.ne.gov

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

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

### Processes related to reversal of our initial decision

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

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

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

## C.6 Filing Grievances

### To file a grievance

A grievance is a written or verbal expression of dissatisfaction about any matter other than an adverse benefit determination. You may file a grievance on your own behalf.

You may file a grievance about:

- Benefit and limitations
- Eligibility and enrollment of a member or care provider
- Member issues or UnitedHealthcare Community Plan issues
- Availability of health services from UnitedHealthcare Community Plan to a member
- The delivery of health services
- The quality of service
- Aspects of interpersonal relationships such as rudeness of a provider or employee

You may only file a grievance on a behalf with the written consent of the member. See Member Appeals and Grievances Definitions and Procedures.

**Phone:** Call Provider Services at **1-866-519-5961** or **TTY 711**

**Electronically:** You can submit a grievance on your own behalf on uhcproviders.com. Navigate to Prior Authorizations to submit a grievance.

**Mail:** Send care provider name, contact information and your grievance to:
UnitedHealthcare Community Plan
Attn: Appeals and Grievances Unit
P.O. Box 31364
Salt Lake City, UT 84131-0364

**In person:** You have the right to file a grievance in person 8 a.m. – 5 p.m. CT, Monday–Friday, at:
UnitedHealthcare Community Plan
2717 N. 118th St.
Suite #300
Omaha, NE 68164

# Appendix D: Member rights and responsibilities

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

## D.1 Member rights

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

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

## D.2 Member responsibilities

Members of UnitedHealthcare Community Plan of Nebraska agree to:

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


Dental Benefit Providers®