



Dental Provider Manual

**UnitedHealthcare Community Plan
NJ FamilyCare**

Provider Services: 1-800-508-4881

Contents

Introduction	1	Section 8: Claim reconsiderations and appeals	27
Section 1: Resources	2	8.1 Administrative denials	27
1.1 Resource reference table	2	8.2 Claim reconsideration	27
1.2 Online provider resources	3	8.3 Formal claim appeal	28
1.3 Provider directories	3	8.4 Tips for successful claims resolution	28
1.4 Helpful links	3	8.5 Program for Independent Claim Payment Arbitration (PICPA)	29
1.5 Assessment tools	3	Section 9: Orthodontic services	30
1.6 Clinical Criteria Grid	3	9.1 Eligibility	30
1.7 Claims process reference table	4	9.2 Treatment planning & consent	30
1.8 Utilization management reference table	5	9.3 NJ Orthodontic assessment tool (HLD NJ-Mod3)	30
Section 2: Member eligibility	7	9.4 Prior authorization guidelines	30
2.1 Eligibility requirements	7	9.5 Special cases	31
2.2 Eligibility verification	7	9.6 Treatment completion	31
2.3 Member rights and responsibilities	8	9.7 Patient compliance	31
Section 3: Benefits	10	9.8 Discontinuation of treatment	32
3.1 Covered benefits	10	Section 10: Professional guidelines and standards of care	33
3.2 Special provisions	10	10.1 Benefits of preventive dental care	33
3.3 Exclusions & limitations	10	10.2 Clinical guidelines	34
3.4 Non-covered services	10	10.3 Preventive oral health guidelines	34
3.5 Medical-Dental overlap	11	10.4 Expanded preventive care focus	34
3.6 Emergency dental services	11	10.5 Clinical focus areas	35
3.7 After-hours care	11	10.6 Cultural competency	35
3.8 EPSDT (Early and Periodic Screening, Diagnostic, and Treatment)	11	Section 11: Governing policies	36
3.9 NJ Smiles Program	12	11.1 Site visits & quality oversight	36
Section 4: Referrals & specialty providers	13	11.2 Dental records	36
4.1 General referral guidelines	13	11.3 Second opinions	37
4.2 Specialty care access	13	11.4 Appointment scheduling standards	37
4.3 EPSDT & IDD referrals	13	11.5 After-hours & emergency coverage	38
Section 5: Utilization management	14	11.6 Missed appointments	38
5.1 Authorization process	14	11.7 Recall system	38
5.2 Special Cases	14	11.8 Office standards	38
5.3 Radiology requirements	15	11.9 Nondiscrimination policy	39
Section 6: Utilization management appeals and grievance process	16	11.10 Outreach for preventive care	39
6.1 UM appeal process	16	Section 12: Provider enrollment & credentialing	40
6.2 Frequently asked questions (FAQs)	18	12.1 Credentialing and recredentialing overview	40
6.3 Grievances	18	12.2 Credentialing process	40
Section 7: Claims and payments	20	12.3 Facility site visits	40
7.1 Submission options	20	12.4 Mobile dental practices	40
7.2 Claim form instructions	20	12.5 Practitioner rights	41
7.3 Claim submission best practices	23	12.6 New associates	41
7.4 Fraud, waste, and abuse	23	12.7 Demographic changes	41
7.5 Payments	25	12.8 Specialist requirements	42
		Definitions	43

Introduction

Welcome to the UnitedHealthcare® Dental Network

UnitedHealthcare is pleased to welcome you as a participating or prospective dental provider. We appreciate your commitment to delivering high-quality, accessible, and cost-effective dental care to our members. We recognize that strong partnerships with our providers are essential to achieving our shared goals. Your role is vital to the success of our dental program, and we value your participation and dedication. If you have any questions or need assistance regarding the contents of this Provider Manual, please contact our Provider Services team at **1-800-508-4881**. Unless otherwise noted, this Manual is effective **January 1, 2025**, for current participating providers, and **immediately** for newly contracted providers.

Definitions for Clarity:

- **“Member”** refers to an individual who is eligible and enrolled to receive covered services under your agreement with UnitedHealthcare.
- **“Manual”** refers to this Provider Manual.
- **“You” or “Your”** refers to any provider subject to this Manual.
- **“We,” “Us,” or “Our”** refers to UnitedHealthcare and its affiliates, as applicable to the products and services governed by this Manual.

Please note that the codes and code ranges included in this Manual were accurate at the time of publication. As coding standards may change, we recommend consulting the appropriate coding guides for the most current information.

Thank you for your continued partnership in serving the Medicaid/NJ FamilyCare community. Your dedication helps ensure our members receive the quality dental care they deserve.

Sincerely, UnitedHealthcare

Section 1: Resources

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

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

Note: To ensure that your information is displayed accurately, and claims are processed efficiently, please submit all demographic changes 30 days in advance.

1.1 Resource reference table

Below 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 phone: 1-800-508-4881		Online information can be found at UHCdental.com/medicaid
	Live agent 9 a.m.-6 p.m. (ET) Monday - Friday	Interactive voice response system 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	✓	✓	✓
Join our Network	✓		✓
Request a copy of your contract	✓		
Request a Fee Schedule	✓		✓
Request a PRA	✓		✓
Request an office visit (e.g., staff training)	✓		
Request benefit information	✓		✓
Request participation status change	✓		

1.2 Online provider resources

To use the website, please go to UHCdental.com/medicaid and register as a participating user. For assistance, please call **1-800-508-4881**. 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.

For specific information for your practice, log on to the [Dental Hub](#).

User specific resources can be found at [Dental Hub Webinars](#).

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 [UHC Dental Online Academy](#).

1.3 Provider directories

NJ Directory of Dentists Seeing Children under Six [NJ-Smiles-Directory.pdf](#)

NJ Directory of Dentists seeing members with Intellectual and Developmental Disabilities [NJ-Dental-IDD-Children-Directory](#) and [NJ-Dental-IDD-Adult-Directory](#).

Additional NJ FamilyCare Lookup Tools can be found at [New Jersey NJ FamilyCare Find a provider or pharmacy | UnitedHealthcare Community Plan](#).

1.4 Helpful links

To obtain additional Plan information please visit UnitedHealthcare Community Plan at [UnitedHealthcare Community Plan of New Jersey Homepage | UHCprovider.com](#)

For the current [New Jersey Periodicity table](#) go to [healthy smiles](#).

To submit a formal claim appeal use [NJ DOBI Health Care Provider Application to Appeal a Claims Determination](#)

1.5 Assessment tools

- [The American Academy of Pediatrics Risk Assessment Tool for PCPs](#)
- [The American Dental Association Risk Assessment Tool\(for Ages 0-6 and Age 6 and older\) for PCDs](#)
- An editable [HLD NJ\(Mod-3\) Orthodontic Assessment Tool](#) and [Tool Instructions](#)

1.6 Clinical Criteria Grid

For current Benefit Coverage and Authorization Requirements go to [Clinical Criteria Grid with Authorization Requirements](#) under New Jersey

1.7 Claims process reference table

There are several ways to work with us to resolve claims issues or disputes. We base these processes on state and federal regulatory requirements and your provider contract. Non-network care providers should refer to applicable appeals and grievances laws, regulations, and state Medicaid contract requirements.

Claim step/ stage	Definition	Submission address	Online form for mail	Contact phone number	Online submission	Filing timeframe	Determination Ttimeframe
Initial claim submission using payor ID GP133	ADA Claim Form, 2019 version or later	UnitedHealthcare P.O. Box 2180 Milwaukee, WI 53201	N/A	1-800-508-4881	UHCdental.com/medicaid	Within 180 calendar days from the date of service for Medicaid and FamilyCare claims Coordination of benefits (COB) must be submitted within 60 days from the date of Primary insurer's Explanation of Benefits (EOB).	Within 30 calendar days
Corrected claim	A replacement of a previously submitted claim such as changes or corrections to charges, clinical or procedure codes, dates of service, member information	UnitedHealthcare Attn: Corrected Claims P.O. Box 481 Milwaukee, WI 53201	N/A	1-800-508-4881	UHCdental.com/medicaid Only available for online submitted claims. Only one online corrected claim is allowed.	Within 365 days	Within 30 calendar days
Claim reconsideration	A request for a one-time case review of an administrative denial you don't agree with. If you submit the Health Care Provider Application to Appeal a Claims Determination (HCAPPA) form, it will be handled as a Formal Claim Appeal.	UnitedHealthcare Attn: Reconsiderations PO Box 1266 Milwaukee, WI 53201	N/A	1-800-508-4881	UHCdental.com/medicaid	Accepted within 90-calendar days from the PRA, EOB, or letter date	Within 30 calendar days

Claim step/ stage	Definition	Submission address	Online form for mail	Contact phone number	Online submission	Filing timeframe	Determination Ttimeframe
Formal claim appeal	An appeal request for review of an administrative denial you don't agree with. Submit it on the Health Care Provider Application to Appeal a Claims Determination (HCAPPA) form . Requests from network providers who do not include the HCAPPA form will be routed for Reconsideration if eligible.	UnitedHealthcare Attn: Provider Appeals PO Box 1266 Milwaukee, WI 53201	N/A	1-800-508-4881	UHCdental.com/medicaid	Medicaid: Accepted within 90-calendar days from the PRA, EOB, or letter date).	Within 30 calendar days
Program for independent claims payment arbitration (PICPA)	Request for an arbitration for a formal appeal determination you don't agree with.	Attn: NJPICPA MAXIMUS 3750 Monroe Avenue Suite 705 Pittsford, NY 14534	Application is accessible online at dispute.maximus.com/nj/indexNJ	1-585-348-3116	dispute.maximus.com/nj/indexNJ	Within 90 days AFTER receiving a determination on an internal claim payment appeal	Within 30 days following receipt of all required information

1.8 Utilization management reference table

Utilization Management (UM) Appeal Process: Service Denial/Limitation/Reduction/Termination based on Medical Necessity

You, the Provider, and the member should receive a notification letter of any decision to deny, reduce, or terminate a service or benefit. If you or the member disagrees with our decision you (or the member) can challenge our decision by requesting a *Utilization Management Appeal* submitted **with the member's written permission**. See the summary below for the timeframes to request an appeal. If you submit the Health Care Provider Application to Appeal a Claims Determination (HCAPAA) form, it will be handled as a Care Provider Formal Claim Appeal.

UM step/stage	Definition	How to submit	Contact phone number	Filing timeframe	Filing timeframe to request continuation of benefits for existing services	Determination timeframe
Utilization management/ prior authorization request using payor ID GP133	A review of treatment requests for medical necessity. This may be an initial request or the resubmission of a request that was missing information.	UnitedHealthcare Authorization Request P.O. Box 2073 Milwaukee, WI 53201 Or Online: Dental Hub	1-800-508-4881	A minimum of 14 calendar days prior to rendering services.	N/A	Urgent requests: within 72 hours Non-urgent requests: within 14 calendar days

UM step/stage	Definition	How to submit	Contact phone number	Filing timeframe	Filing timeframe to request continuation of benefits for existing services	Determination timeframe
Internal utilization management appeal	The first level of appeal, administered by the health plan. This is a formal, internal review by health care professionals selected by the plan who have expertise appropriate to the case in question, and who were not involved in the original determination. This option is for FamilyCare Plan Type A / ABP, B, C, D.	<p>Medicaid: UnitedHealthcare Community Plan Attn: Clinical Appeals P.O. Box 31364 Salt Lake City, UT 84131-0364</p> <p>Or Fax: 1-801-994-1082</p> <p>HIDE SNP: UnitedHealthcare Attn: Clinical Appeals P.O. Box 6103 MS CA120-0360 Cypress, CA 90630-9998</p>	<p>1-888-362-3368</p> <p>1-800-514-4911</p>	60 days from the date of the denial letter	<p>The Later of:</p> <p>On or before the last day of the current authorization; or Within ten calendar days of the date on the initial denial notification letter</p>	<p>Urgent appeals: within 72 hours</p> <p>Standard appeals: within 30 business days</p>
External/IURO appeal	The External/IURO appeal is an external appeal conducted by an Independent Utilization Review Organization (IURO). This option is for FamilyCare Plan Type A /ABP, B, C, D.	<p>Maximus Federal - NJ IHCAP 3750 Monroe Avenue, Suite 705 Pittsford, New York 14534</p> <p>Fax: 1-585-425-5296</p> <p>Online: https://njihcap.maximus.com</p>	1-888-866-6205	60 calendar days from date on Internal Appeal notification letter	<p>The Later of:</p> <p>On or before the last day of the current authorization; or Within ten calendar days of the date on the Internal Appeal notification letter</p>	45 calendar days or less from IURO's decision to review the case
Medicaid fair hearing	You can appeal to the IURO before you request a Medicaid Fair Hearing and wait for the IURO's decision, or you can appeal to the IURO at the same time that you request a Medicaid Fair Hearing. This option is for FamilyCare Plan Types A /ABP only.	<p>State of New Jersey Division of Medical Assistance and Health Services Fair Hearing Unit P.O. Box 712 Trenton, NJ 08625-0712</p> <p>Or Fax: 1-609-588-2435</p>	n/a	120 calendar days from date on Internal Appeal notification letter	<p>The Later of:</p> <p>On or before the last day of the current authorization; or Within ten calendar days of the date on the Internal Appeal notification letter, or Within ten calendar days of the date on the External/ IURO appeal decision notification letter</p>	A final decision will be reached within 90 calendar days of the Fair Hearing request.

Section 2: Member eligibility

NJ FamilyCare provides free or low-cost health coverage for:

- Uninsured children
- Pregnant women
- Parents/caretaker relatives
- Single adults and childless couples

2.1 Eligibility requirements

- Must be a New Jersey resident
- Lawful permanent residents may qualify after 5 years
- Children may qualify regardless of entry date
- Based on **family size and income** only
- Includes populations such as AFDC/TANF, SSI (Aged, Blind, Disabled), DCP&P/DCF, DDD/CCW

For income guidelines, visit: njfamilycare.org > Income Eligibility and Cost

2.2 Eligibility verification

- Eligibility and dental benefits can be verified **online or by phone**
- UnitedHealthcare receives **daily updates** for the most current information
- Members receive a UnitedHealthcare ID card with plan logo and customer service number

UnitedHealthcare Community Plan
Health Plan (80840) 911-86047-08
Member ID: 000300091 Group Number: NJFAMCAR
Member: NEW ENGLISH Payer ID: 86047
PCP Name: DOUGLAS GETWELL
PCP Phone: (201)792-3022
COPAY: No Copays
See reverse for dental/vision benefits: DOI 4501
NJ FamilyCare C Underwritten by AmeriChoice of New Jersey, Inc.

OPTUMRx®
Rx Bin: 610494
Rx Grp: AMNJ
Rx PCN: 4343

Member Services/
Dental/Vision: 1-800-941-4647 TDD/TTY 711
In an emergency go to nearest emergency room or call 911.
For Providers: UHCprovider.com 1-888-362-3368
Medical Claims: PO Box 5250, Kingston, NY, 12402-5250
Pharmacy Claims: OptumRx, PO Box 29044, Hot Springs, AR 71903
For Pharmacists: 1-877-305-8952

Important note

- **Eligibility must be verified on the date of service** and does **not guarantee payment**.
- Some **FamilyCare C and D members** may have a **\$5 copay** for non-diagnostic, non-preventive services – this will be indicated on their ID card.
- **Additional plan-specific rules may apply.**

2.3 Member rights and responsibilities

Uphold member “Bill of Rights”

As a UnitedHealthcare member, you have certain rights and responsibilities when you enroll. These rights also apply to minor members with disabilities. It is important that you fully understand both your rights and your responsibilities. The following statement of rights and responsibilities is presented here for your information. The state must ensure that each enrollee is free to exercise his or her rights, and that the exercise of those rights does not adversely affect the way the health plan and its providers or the State agency treat the enrollee.

Members have the right to:

1. Be treated with respect, dignity and privacy by UnitedHealthcare and its providers.
2. Be told about any illness you have.
3. Be told of any care or treatment that your PCP feels should be done before anything is done, even if UnitedHealthcare does not cover it. This includes the right to get accurate, easy-to-understand information to help you make good choices about your treatment.
4. Refuse treatment as far as the law allows and to know what the outcome may be.
5. Expect your doctors to keep your records and anything you say private. No information will be released to anyone without your consent, unless required by law.
6. Request a current directory of providers in the UnitedHealthcare network to choose your own PCP.
7. Get needed medical services within a reasonable length of time.
8. If you have a baby, you have the right to stay in the hospital for at least 48 hours after the delivery if it is a normal vaginal delivery. If you have a Cesarean section, you may stay in the hospital at least 96 hours after your baby is born.
9. File a grievance or an appeal to UnitedHealthcare and to get a reply in a timely manner.
10. To receive information about UnitedHealthcare, its services, its practitioners and providers, member rights and responsibilities, and to be informed of UnitedHealthcare rules and any changes that are made.
11. Make suggestions regarding UnitedHealthcare policies and procedures, including your rights and responsibilities.
12. Talk about your medical records with your PCP and to get a complete copy of those records.
13. Be informed of all FFS benefits you are eligible for and of all medical services available to you by UnitedHealthcare.
14. Have an authorized representative of your choice to make medical determinations for you.
15. Ask for a second opinion about any medical care that your PCP advises you to have.
16. Know how UnitedHealthcare decides whether a service is covered and/or is medically necessary.
17. A translator if you need one when you talk to us or one of our providers.
18. Participate in all decisions about your health care and the development of any plan of care designed for you.
19. Speak to providers in private and to have your medical records kept private.
20. Be free from harm, including unnecessary physical restraints or isolation, excessive medication, physical or mental abuse or neglect.

21. Be free of hazardous procedures.
22. Be free from balance billing.
23. Have services provided that promote a meaningful quality of life and independence for yourself, including living in your own home or another community setting as long as it is medically and socially feasible, and the right to the preservation and assistance of your natural support system.
24. Receive services without regard to race, religion, color, creed, gender, national origin, political beliefs, sexual orientation, gender identity, marital status, or disability.
25. Obtain information about our providers that includes the provider's education, residency completed, board certification and recertification. To get this information, call our Member Services Department at **1-800-941-4647, TTY 711**.

Additional rights for MLTSS members:

1. To request and receive information on choice of services available.
2. Have access to and choice of qualified service providers.
3. Be informed of your rights prior to receiving chosen and approved services.
4. Receive services without regard to race, religion, color, creed, gender, national origin, political beliefs, sexual orientation, marital status, or disability.
5. Have access to appropriate services that support your health and welfare.
6. To assume risk after being fully informed and able to understand the risks and consequences of the decisions made.
7. To make decisions concerning your care needs.
8. Participate in the development of and changes to your Plan of Care.
9. Request changes in services at any time, including add, increase, decrease or discontinue.
10. Request and receive from your Care Manager a list of names and duties of any person(s) assigned to provide services to you under your Plan of Care.
11. Receive support and direction from your Care Manager to resolve concerns about your care needs and/or grievances about services or providers.
12. Be informed of and receive in writing facility specific resident rights upon admission to an institutional or residential setting.
13. Be informed of all the covered/required services you are entitled to, required by and/or offered by the institutional or residential setting, and any charges not covered by the managed care plan while in the facility.
14. Not to be transferred or discharged out of a facility except for medical necessity; to protect your physical welfare and safety or the welfare and safety of other residents; or because of failure, after reasonable and appropriate notice of non-payment to the facility from available income as
15. reported on the statement of available income for FFS payment.
16. Have your health plan protect and promote your ability to exercise all rights identified in this document.
17. Have all rights and responsibilities outlined here forwarded to your authorized representative or court-appointed legal guardian.

Section 3: Benefits

3.1 Covered benefits

NJ FamilyCare offers a full dental benefit package, including:

- Diagnostic & Preventive Care
- Restorative, Endodontic, Periodontic, and Prosthodontic Services
- Oral & Maxillofacial Surgery
- Orthodontics (age-restricted, medically necessary)
- Adjunctive General Services

Services must comply with N.J.A.C. 10:56 and the NJ FamilyCare Clinical Criteria Grid.

For a list of current benefits, refer to the **Clinical Criteria Grid** in **Section 1.6** of this manual.

3.2 Special provisions

- Members with intellectual and developmental disabilities (IDD) may receive certain services every 3 months (with medical necessity documentation).

3.3 Exclusions & limitations

Not covered:

1. Services not listed in the Clinical Criteria Grid
2. Non-medically necessary procedures
3. Hospital/facility charges (*check medical plan*)
4. Reconstructive surgery for functional improvement
5. Services outside a dental setting without prior authorization
6. Experimental or unproven treatments
7. Services covered by workers' comp or public programs
8. Services by providers who live with or are related to the member

Note: Services started during eligibility are covered for **90 days** after eligibility ends. Refer to **Section 9.1** for exclusions.

3.4 Non-covered services

If a non-covered service is requested:

- Provider must obtain signed informed consent confirming:
- The service is not covered
- The member is financially responsible
- Appeal options have been explained



3.5 Medical-Dental overlap

Some services may be billed through either medical or dental plans:

- Cleft palate repair
- Cyst removal
- Fractured jaw
- Oral/maxillofacial surgery
- Anesthesia services

Submit through:

Medical: uhcprovider.com

Dental: UHCdental.com/medicaid

3.6 Emergency dental services

- Covered for all members
- Use in-network providers when possible
- ER visits are appropriate for:
- Facial trauma (e.g., fractures, dislocations)
- Severe swelling, infection, or uncontrolled bleeding

3.7 After-hours care

For care outside 8 AM–6 PM, M–F:

- Confirm eligibility via portal or IVR
- Check benefit guide for coverage and prior auth
- Provide covered services that don't require prior auth
- For urgent needs requiring prior auth:
- Stabilize with palliative care
- Submit request the next business day

Note: Prior auth requirements may still be required depending on services rendered and may be submitted post-treatment if needed.

3.8 EPSDT (Early and Periodic Screening, Diagnostic, and Treatment)

Refer to the NJ FamilyCare Dental Periodicity Schedule in the Resources section.

Note: Services must be based on medical necessity and are not limited by volume, scope, or duration. If a needed service is not listed in the state plan, members or their representatives should contact their health plan using the number on their ID card.

3.9 NJ Smiles Program

Services by Non-Dental Providers

For children through age 5, trained medical staff may provide:

- Caries risk assessment
- Anticipatory guidance
- Fluoride varnish application
- Dental referral

These services:

- Must be linked to well-child visits
- Can be billed up to 4 times per year using a CPT code
- Do not affect dental provider billing frequency

Section 4: Referrals & specialty providers

4.1 General referral guidelines

- A dental referral **by age 1** or after the first tooth erupts is mandatory.
- Children should have at least two dental visits per year **through age 20**, with follow-up during well-child visits.
- No written referral is required for in-network specialty dental care.
- Out-of-network referrals require prior authorization.
- Pedodontists or general dentists may serve as Primary Care Dentists (PCDs).

4.2 Specialty care access

- Any PCP or dentist may recommend a network specialist, or members may self-select one.
- Referrals for members with intellectual and developmental disabilities are allowed when clinically indicated.
- No limit on the number of PCD visits before a referral can be made.

4.3 EPSDT & IDD referrals

- Dental services must go beyond emergency care.
- EPSDT screenings by medical staff must include:
 - Tooth eruption
 - Occlusion
 - Caries or oral infection
- Referrals for patients are allowed as needed.
- Referring dentists are not required to submit diagnostic documentation; the receiving provider is responsible.

Refer to **Provider directories** in **Section 1: Resources**.



Section 5: Utilization management

Utilization review ensures high-quality, cost-effective care. It is required for certain restorative, endodontic, periodontic, prosthodontic, and oral surgery procedures.

Refer to the **Clinical Criteria Grid** in **Section 1.6** for a full list of current benefits and authorization requirements.

5.1 Authorization process

- Submit requests before treatment with supporting clinical documentation.
- Consider the patient's overall health, compliance, oral condition, and full treatment plan.
- Complex cases may be submitted in stages.

Decision timelines

- Non-emergency: Within 14 calendar days
- Valid for: 180 days from approval
- Orthodontic exceptions: Reviewed case-by-case
- Denials: Include reviewer contact info and allow for peer-to-peer discussion within 7 business days

Contact: Dental Reviewers via Provider Services

Out-of-Network referrals

All out-of-network dental referrals require prior authorization.

5.2 Special Cases

Operating room (OR) services

- Required for patients needing **OR or ambulatory surgery** due to medical necessity.
- Submit under **CDT Code D9999** with:
 - Facility name
 - Narrative explaining necessity
- Intended for children, members with IDD, or those unable to tolerate in-office care.
- Use appropriate CPT (facility) and CDT (professional) codes.
- If additional treatment is needed under anesthesia, proceed and submit post-authorization documentation.

Additional dental services for members with IDD Only

- For oral hygiene instruction or specialized hygiene equipment, submit under **Code D1999** with a narrative of medical necessity.
- Reviewed by NJ-licensed dental consultants.
- Care Managers may assist with dental management plans.



5.3 Radiology requirements

- Refer to the Clinical Criteria Grid for procedures requiring radiographs.
- Radiographs must be:
 - Diagnostic and labeled with practice/patient name and exposure date
 - Mounted or accompanied by intraoral photos/narratives if unclear
- Do not send originals; electronic submission is preferred.
- Orthodontic models are not accepted and will be returned.

Section 6: Utilization management appeals and grievance process

UnitedHealthcare is committed to ensuring that members have access to fair, timely, and transparent processes for resolving concerns related to their care. Providers may assist members in understanding and navigating these processes.

We will not take any action with respect to an enrollee or a health care provider that penalizes or discourages the member or you from undertaking an appeal, dispute resolution, or judicial review of an adverse determination. We will not take any punitive action against you for requesting an expedited resolution or supporting a member's appeal.

6.1 UM appeal process

For Denial, Limitation, Reduction, or Termination of Services Based on Medical Necessity

If UnitedHealthcare denies, reduces, or terminates a service or benefit based on medical necessity, both the provider and the member will receive written notification within two business days.

If the decision is disputed, an appeal may be submitted with the member's written consent.

Note: If a provider submits a Health Care Provider Application to Appeal a Claims Determination (HCPAA) form, it will be processed as a Provider Formal Claim Appeal, not a UM appeal.

Internal appeals (Stage 1)

Eligibility

- Must be filed within 60 calendar days of the denial notice
- May be initiated by the member or provider with the member's written consent

How to File

For Medicaid members:

Phone: 1-800-941-4647 (TTY 711)

Mail:

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

Fax: 801-994-1082

For HIDE SNP members:

Phone: 1-800-514-4911 (TTY 711)

Mail:

UnitedHealthcare - Attn: Clinical Appeals
P.O. Box 6103, MS CA120-0360 Cypress, CA 90630-9998



Review process

- Acknowledgment within 10 business days
- Reviewed by a qualified dental or medical professional not involved in the original decision
- Decision issued within 30 business days

External appeals (IURO Review)

If dissatisfied with the internal appeal outcome, members may request an external review by an Independent Utilization Review Organization (IURO).

Eligibility

- Must be filed within 60 calendar days of the internal appeal decision
- Available to FamilyCare Plan Type A/ABP, B, C, D

How to file

Mail:

Maximus Federal – NJ IHCAP 3750 Monroe Avenue, Suite 705
Pittsford, NY 14534

Fax: 1-585-425-5296

Online: <https://njihcap.maximus.com>

Process

- Case reviewed by an independent physician
- Decision issued within 45 calendar days (or sooner if urgent)

State Fair Hearings

If dissatisfied with the internal appeal outcome, members may request a **Medicaid Fair Hearing**.

You can appeal to the IURO before or at the same time as requesting a Medicaid Fair Hearing. **This option is for FamilyCare Plan Types A/ABP only.**

Eligibility

- Must be filed within 120 calendar days of the internal appeal decision
- Available to NJ FamilyCare Plan Types A/ABP

How to file

Mail:

State of New Jersey
Division of Medical Assistance and Health Services Fair Hearing Unit
P.O. Box 712
Trenton, NJ 08625-0712

Fax: 609-588-2435

Process

- Decision issued within **90 calendar days** (or sooner if urgent)

6.2 Frequently asked questions (FAQs)

Q: Can a provider file an appeal on behalf of a member?

A: Yes, but only with the member's written consent.

Q: What if I miss the 60-day deadline to file an appeal?

A: Contact Member Services immediately to discuss your options.

Q: Can I file both an IURO appeal and request a Medicaid Fair Hearing?

A: Yes. You may file them separately or at the same time.

Q: Will filing an appeal or grievance affect my coverage or relationship with my provider?

A: No. UnitedHealthcare and its providers are prohibited from penalizing members or providers for filing appeals or grievances.

Q: How will I know my appeal or grievance was received?

A: You will receive a written acknowledgment within 5-10 business days.

Q: Who reviews my appeal?

A: Dental or medical professionals not involved in the original decision.

Q: What if I need help understanding or completing the appeal process?

A: Call Member Services at **1-800-941-4647** (TTY **711**) or the NJ Division of Medical Assistance and Health Services at **1-800-356-1561**

For additional information refer to the Utilization Management Reference Table in the Resources section

6.3 Grievances

A grievance is a complaint about UnitedHealthcare or an in-network provider that does not involve the denial of services or benefits.

You may not discriminate against a member for filing a grievance.

For Medicaid members:

Phone: 1-800-941-4647 (TTY **711**)

Mail:

Grievances and Appeals
UnitedHealthcare Community Plan
P.O. Box 31364
Salt Lake City, UT 84131

For HIDE SNP members:

Phone: 1-800-514-4911 (TTY 711)

Mail:

UnitedHealthcare Appeals and Grievances Department

P.O. Box 6103, MS CA120-0360

Cypress, CA 90630-0023

Grievance Process

- Acknowledgment within **5 business days**
- Resolution within **30 calendar days**

Section 7: Claims and payments

7.1 Submission options

Electronic Claims

- Submit electronically via:
 - A clearinghouse, or
 - Directly through the Dental Hub
- **Payor ID: GP133**

Benefits of electronic submission:

- Faster processing
- Built-in error detection (via practice management software)
- Secure, encrypted data transmission

For assistance, call Provider Services

7.2 Claim form instructions

Submit the ADA Dental Claim Form (2019 or later) for all services rendered.

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 Fees(s)						
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	34a. Diagnosis Code(s)		A. _____	C. _____	32. Total Fee
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	(Primary diagnosis in *A*)		B. _____	D. _____	
35. Remarks																				

Item 29 – Procedure Details

• 29a. Diagnosis Code Pointer

Enter the letter(s) (A-D) from Item 34 that correspond to the diagnosis code(s) related to the dental procedure. List the **primary diagnosis pointer first**.

• 29b. Quantity

Enter the number of times (01-99) the procedure was performed on the date of service (Item 24).

Default value: “01”



Item 34 – Diagnosis information

- **34. Diagnosis Code List Qualifier**

Enter the appropriate code to indicate the source of the diagnosis codes.

Required when the diagnosis affects claim adjudication, especially for procedures linked to oral-systemic health.

- **34a. Diagnosis Code(s)**

Enter up to **four** diagnosis codes, labeled A–D.

The **primary diagnosis** must be listed next to “A.”

Required when diagnosis impacts claim adjudication.

General guidelines

- Use one claim form per patient.
- Only one treating dentist per claim.
- All required fields must be completed.

Header information

- Indicate transaction type:
 - Statement of Actual Services
 - Request for Pre-Treatment Estimate

Subscriber information

- Full name (Last, First, MI)
- Address (Street, City, State, ZIP)
- Date of birth
- Gender
- Subscriber ID number

Patient information

- Full name (Last, First, MI)
- Address (Street, City, State, ZIP)
- Date of birth
- Gender
- Patient ID number

Primary payer information

- Carrier name and address (Street, City, State, ZIP)

Other coverage (if applicable)

- Provide carrier details (name, address, city, state, ZIP)
- Indicate if this is the **primary insurance**
- Include documentation from the primary carrier if needed

Other insured's information (if applicable)

- Name (Last, First, MI)
- Date of birth and gender
- Subscriber ID number
- Relationship to the member

Billing dentist or entity

- Name
- Address (Street, City, State, ZIP)
- License number
- TIN (or SSN)
- Phone number
- National Provider Identifier (NPI)

Treating dentist and treatment Location

- Name (as on Practitioner Application)
- License number
- TIN (or SSN)
- Address (Street, City, State, ZIP)
- Phone number
- NPI
- **Certification:** Dentist's signature and date

Record of services provided

Each procedure must include:

- Date of service
- Area of oral cavity
- Tooth number/letter and surface
- Procedure code
- Description
- Billed charges (full fee)
- Total sum of all fees

If more than 10 procedures, use an additional claim form.

Missing teeth information

- For periodontal/prosthetic procedures, mark missing teeth with an "X".

Prorated reimbursement

If services are incomplete due to patient death or non-return within 3 months:

- **Cast Restorative/Fixed Prosthodontics:**

- 10% for prep
- 85% for impression
- 95% for completed but not inserted
- **Removable Prosthodontics:**
 - 10% for impression
 - 55% for bite registration
 - 75% for try-in
 - 85% for completed but not inserted
- **Appliances/Retainers:**
 - 10% for impression
 - 85% for completed but not inserted

Remarks section

- Use for required narratives.
- If space is insufficient, attach a narrative on practice letterhead with all relevant member information.

7.3 Claim submission best practices

Paper claims

- Use legible, computer-generated ADA Dental Claim Forms (2019 or later).
- Attach supporting documentation and radiographs when required (e.g., for pre-treatment estimates or complex procedures).
- Refer to the **Exclusions, limitations, and benefits** section of this manual for documentation guidelines.

Timely filing

- Submit all NJ FamilyCare claims **within 180 days** of the date of service.

“By Report” procedures

- Must include a **narrative** explaining the need for the procedure and any relevant clinical details.

Use of current ADA codes

- Always use Current Dental Terminology (CDT) codes.
- To order the latest CDT book, visit the ADA Store or call the ADA.

7.4 Fraud, waste, and abuse

Insurance Fraud Reminder

All claims must be truthful and accurate. Examples of fraud include:

- Falsifying records (e.g., using whiteout, incorrect dates)
- Billing for services not performed or upcoding
- Adding unnecessary services

Important: Submitting false or misleading claims may result in **criminal charges and civil penalties**.

By signing a claim, the provider certifies that:

- Services were **medically necessary**
- Services were **personally provided or supervised**
- Information is **true and accurate**

Provider Responsibilities

All UnitedHealthcare network providers and contractors must:

- **Conduct business ethically and honestly**
- **Remain alert to potential FWA**
- **Report suspected FWA promptly**

UnitedHealthcare monitors FWA using internal teams and external experts. If adverse patterns are identified, actions may include:

- Education and corrective action
- Reimbursement of overpayments
- Peer Review Committee review
- Possible termination

Serious cases may be reported to:

- State dental boards
- Office of Inspector General (OIG)
- State Attorney General (for Medicaid/Medicare cases)

To report FWA, contact the UnitedHealthcare Compliance Helpline.

FWA training requirements

Providers must:

- Maintain written FWA policies for employees, contractors, and agents
- Provide staff training on:
 1. The Federal False Claims Act
 2. Administrative remedies for false claims
 3. State laws on civil/criminal penalties
 4. Internal procedures for detecting and preventing FWA

Training materials available at:

CMS Medicare Learning Network – FWA Training

Topics include:

- FWA in the Medicare Program
- Relevant laws and penalties
- Prevention, reporting, and correction methods

7.5 Payments

Electronic payments (ePayment Center)

The **ePayment Center** is UnitedHealthcare's secure online portal for managing electronic payments and remittance advice (ERA).

Benefits of ePayment Center

- Faster payments via no-fee ACH (direct deposit)
- 24/7 access to ERA and payment history
- Automated posting to streamline reconciliation
- Download remittances in multiple formats (835, CSV, XLS, PDF)
- Search payment history up to 7 years

To enroll or learn more, visit the ePayment Center via the provider portal.

Here's a **user-friendly, step-by-step guide** for registering for electronic payments and understanding your options:

How to Register for ePayments

1. Go to: **Electronic payments and statements**
2. Follow the instructions to **request a registration code**.
3. A customer service representative will review your request and send a confirmation email.
4. Click the link in the email to complete your registration.
5. Log in at **UHCdental.epayment.center**.
6. Enter your bank account information.
7. Choose how you want to receive remittance data.
8. Review and accept the ACH Agreement.
9. Click "Submit."
10. Your bank account will go through a **prenotification process** (up to 6 business days) to verify before payments begin.

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

Other payment options: Zelis payments

Zelis Payments offers additional electronic payment solutions with added features:

Why Choose Zelis?

- Access all payers in the Zelis network through one portal
- **Faster payments** than mailed checks
- Award-winning customer service
- Virtual card and ACH options
- **24/7 fraud monitoring** (OFAC compliant)
- Reduced admin work and improved revenue flow
- **Download remittance files** in PDF, CSV, XLS, or 835 formats

- View up to **10 years** of payment history

Access your account anytime at: provider.zelispayments.com

For support, call **1-855-496-1571**

Section 8: Claim reconsiderations and appeals

8.1 Administrative denials

An **administrative denial** is a refusal to pay a claim or authorize a service based on contract provisions or non-medical reasons.

Examples include:

- The member was not covered on the date of service
- The service is excluded from coverage (e.g., Orthodontic Services)
- Required services were not authorized in advance
- Claim issues such as overpayment, underpayment, denial, or disagreement with original/corrected claim determinations

8.2 Claim reconsideration

What is it?

A claim reconsideration is a one-time request for review of an administrative denial you believe is incorrect. It is the fastest way to address concerns about whether a claim was paid correctly.

Tip: Include any additional supporting documentation with your request.

How to submit

You can submit a reconsideration request:

- Electronically
- By phone
- By mail
- By fax

Valid proof of timely filing

What is it?

Timely filing proof is required when a claim is denied due to late submission, often due to incomplete information at the time of service.

Acceptable documentation includes:

- A denial or rejection letter from another insurance carrier
- An explanation of benefits (EOB) from another carrier
- A letter from another carrier or employer group stating:
 - Coverage ended before the date of service, or
 - The member had no coverage on the date of service

Note: A submission report alone is **not** valid proof for electronic claims. It must be accompanied by an **acceptance report**.



How to submit

Include the following with your reconsideration request:

- **For electronic claims:**
 - EDI acceptance report showing the claim was received
- **For mailed claims:**
 - Screenshot from your accounting system showing:
 - Member name
 - Date of service
 - Claim submission date

Reminder: Timely filing limits vary by state and contract. Refer to your **Provider Agreement** for specific deadlines.

8.3 Formal claim appeal**What is it?**

An **appeal** is a formal request for review of an administrative denial or the outcome of a reconsideration.

Important: Appeals must be submitted using the **Health Care Provider Application to Appeal a Claims Determination (HCAPPA)** form. Refer to **Helpful Links** in the **Resources** section

If a network provider submits an appeal without this form, it may be routed as a reconsideration (if eligible).

When to use

- You disagree with an administrative denial
- You disagree with the outcome of a reconsideration request

How to submit

- Complete the **HCAPPA form** (approved by the NJ Department of Banking and Insurance)
- Include supporting documents such as:
 - Cover letter
 - Supporting documentation
 - Medical records
 - Any additional information not submitted with the reconsideration
- Submit **electronically** or **by mail**

8.4 Tips for successful claims resolution

- Don't let claim issues go unresolved – act promptly
- Call **Provider Services at 1-800-508-4881** if you can't verify a claim is on file
- **UnitedHealthcare Community Plan is the payer of last resort**
 - Bill other insurance first and obtain an EOB before billing UHC
 - Attach the complete EOB to your claim submission

- Refer to your contract for **third-party claim submission deadlines**

For additional information refer to the Claims Process Reference Table in the Resources section

8.5 Program for Independent Claim Payment Arbitration (PICPA)

What is it?

The PICPA is a program established by the Health Claims Authorization, Processing and Payment Act (HCAPPA), P.L. 2005, c. 352, designed to provide health care providers and carriers offering health benefits plans an independent body able to arbitrate claims disputes between a payer and health care provider. The Department of Banking and Insurance (Department) contracts with an independent vendor to perform the arbitration and related administrative functions.

Important: Request must be submitted using the **Health Care Provider Application to Appeal a Claims Determination (HCAPPA)** form.

Additional information can be found at [NJDOBI | Claims Payment: Claims Handling Appeals and the Program for Independent Claims Payment Arbitration \(PICPA\)](#)

When to use

- You disagree with the outcome of a formal claim appeal

How to submit

- Complete the **HCAPPA form** (approved by the NJ Department of Banking and Insurance)
- Include supporting documents such as:
 - Cover letter
 - Medical records
 - Any additional information not submitted with the appeal

Submit **electronically** or **by mail**

Section 9: Orthodontic services

9.1 Eligibility

Orthodontic treatment is covered **only for children** when **medically necessary**, including:

- Developmental or facial deformities
- Functional issues with speech or chewing
- Trauma-related conditions

Services include limited and comprehensive treatment and related procedures.

Loss of eligibility ends all benefits

Refer to **DMAHS Newsletter Vol. 32, No. 02** under “Newsletters and Alerts” at www.njmmis.com for full details.

9.2 Treatment planning & consent

Providers must coordinate with UnitedHealthcare to ensure treatment is completed **before** the patient ages out of eligibility.

Informed Consent **must include:**

- Age limit for coverage
- Expected treatment duration
- Consequences of non-compliance or appliance damage
- Responsibilities if coverage is lost

9.3 NJ Orthodontic assessment tool (HLD NJ-Mod3)

- **Attach attestation** that all preventive/dental treatment is complete
- Sections 1-6A and 15 = automatic qualification
- Sections 6B-14 must total 26+ points or include documentation of medical necessity

Refer to the **Assessment tools** in the **Resources** section for a link to the HDL instructions and fillable form.

9.4 Prior authorization guidelines

General requirements

- Verify eligibility before each visit

Comprehensive treatment

- Includes placement/removal of appliances
- No extra reimbursement for early removal due to non-compliance or loss of eligibility
- A **signed** Release from Treatment letter is required for early termination



Authorization process

When required:

- For treatment in late mixed or permanent dentition
- Three phases:
 1. Start of treatment (up to 12 visits)
 2. Continuation (after 12 visits or mid-point, up to 12 more visits)
 3. Completion and retention

Submission **must** include:

- Treatment plan
- Surgical consult (if applicable)
- Banding date (must occur within 6 months of approval)
- Treatment must be completed within 36 months from date of banding. Services will not be covered if treatment extends past the 36 months.

9.5 Special cases

Orthognathic surgery:

- Submit surgical and orthodontic plans together
- Same documentation as comprehensive treatment

Transfer cases:

- **Prior authorization required** to continue treatment started outside Medicaid/NJ FamilyCare
- **Up to 12 visits per request**
- Cannot be denied if patient is age-eligible

9.6 Treatment completion

Submit:

- Attestation of case completion
- Final diagnostic photos or panoramic X-ray

Failure to submit may result in reimbursement recovery.

9.7 Patient compliance

Patients must:

- Attend appointments
- Maintain oral hygiene
- Care for appliances
- Complete preventive/general dental treatment

If non-compliance occurs, notify the MCO. A case manager will assist the family in supporting or transitioning care.

9.8 Discontinuation of treatment

If treatment ends early:

- A **signed Release from Treatment letter** is required
- Contact Provider Services for additional information
- If removal is done by a different provider, prior authorization may be requested for reimbursement

Section 10: Professional guidelines and standards of care

As dental professionals, we recognize the pivotal role preventive care plays in maintaining oral health and mitigating overall health care costs. By prioritizing prevention, we can help patients avoid more extensive and costly treatments in the future.

10.1 Benefits of preventive dental care

Mitigation of cavities and periodontal disease

- Prophylactic cleanings and fluoride applications help prevent caries and periodontal disease
- Early diagnosis enables timely intervention
- Periodontal maintenance is crucial in preventing the progression of periodontal disease. Nearly half (42%) of adults aged 30 years and older have periodontitis, and severe periodontitis affects about 8% of adults.

Economic advantages

- Cost-effective interventions can significantly reduce the incidence of expensive treatments by addressing issues at an early stage.
- Encouraging patients to invest in preventive measures can result in substantial savings on future dental expenses. Studies highlight that for every dollar spent on preventive dental care, patients can save between \$8 and \$50 in restorative and emergency treatments.
- Enhanced systemic health
- Maintaining optimal oral health is associated with a reduced risk of systemic conditions such as cardiovascular disease, diabetes and respiratory infections. Educating patients on this correlation is imperative.
- Regular dental visits can reveal early signs of systemic health issues, such as oral malignancies or nutritional deficiencies, allowing for prompt medical intervention and improved health outcomes.

Enhanced systemic health

- Maintaining optimal oral health is associated with a reduced risk of systemic conditions such as cardiovascular disease, diabetes and respiratory infections. Educating patients on this correlation is imperative.
- Regular dental visits can reveal early signs of systemic health issues, such as oral malignancies or nutritional deficiencies, allowing for prompt medical intervention and improved health outcomes.

By emphasizing preventive dental care, we can assist our patients in maintaining healthy smiles and avoiding the high costs associated with untreated dental issues. Regular check-ups and cleanings are integral parts of a proactive approach to oral health, ultimately leading to better health outcomes and cost savings.



10.2 Clinical guidelines

- Caries Management: Begins with a comprehensive evaluation and risk assessment
 - May be performed by PCDs using a CDT code
 - Reimbursed equally regardless of risk level
 - Must be done annually with an oral evaluation
 - Second assessments require prior authorization and medical necessity
- X-ray Periodicity: Tailored to individual needs, following accepted guidelines
- Recall Frequency: Based on clinical and risk assessments, with increased frequency for members with intellectual and developmental disabilities
- Preventive Interventions: Customized by age and risk, including prophylaxis, fluoride, sealants, and adjunctive therapies
- Treatment Approach: Favor conservative, nonsurgical or minimally invasive methods for early, non-cavitated lesions

For clinical guidelines of all covered benefits, refer to the **Clinical Criteria Grid** in **Section 9.1** of this manual.

10.3 Preventive oral health guidelines

- NJ Smiles Program: For children up to age 5 at moderate or high risk for caries, trained medical providers may deliver caries risk assessments, anticipatory guidance, dental referrals, and fluoride varnish.
- Periodontal Management:
 - All adults – and adolescents showing signs or history of periodontal disease – should receive screening and, if needed, a full evaluation.
 - Initial and periodic evaluations should follow American Academy of Periodontology guidelines.
 - Ongoing care is essential after active treatment, especially for patients with a history of periodontal disease or systemic conditions like diabetes, cardiovascular disease, or pregnancy complications.
 - Oral Cancer Screening:
 - Recommended for all adults and at-risk adolescents (e.g., tobacco users, family history, or other risk factors).
 - Screenings should occur at the initial visit and every recall, using at minimum a visual/manual exam. Advanced tools (e.g., light contrast, brush biopsy) may be used when appropriate.

10.4 Expanded preventive care focus

UnitedHealthcare supports a broad preventive care strategy that includes:

- Malocclusion & Oral Habits: Evaluation and intervention for bite issues, sports injuries, and harmful habits (e.g., thumb sucking, pacifier use, tongue thrusting, mouth breathing, piercings, tobacco use).
- Pediatric Oral Health: Emphasis on preserving primary teeth, space maintenance, and proper eruption of permanent teeth.

Training & oversight

- Providers must attest that all staff are trained and supervised.
- PCPs and PCDs receive training on:
 - Dental referrals by age 1
 - Prescribing fluoride supplements
 - Counseling on oral health, habits, and dental emergencies

10.5 Clinical focus areas

UnitedHealthcare may conduct studies and interventions in:

- Access to care
- Preventive services (e.g., fluoride, sealants)
- Procedure utilization patterns

Information is shared with providers and members through multiple channels: manuals, websites, newsletters, training, and community outreach.

10.6 Cultural competency

Culturally competent care is essential for reducing disparities and improving outcomes. UnitedHealthcare:

- Recognizes the impact of race, ethnicity, and cultural values on oral health.
- Supports a diverse provider network to deliver respectful, effective care across populations.

Section 11: Governing policies

11.1 Site visits & quality oversight

UnitedHealthcare Community Plan may conduct in-office site visits with prior notice as part of our quality management program. These visits assess:

- Dental recordkeeping
- Patient accessibility
- Infection control
- Emergency preparedness
- Radiation safety

Surveyed offices are expected to deliver quality care and maintain accurate records. Results will be shared with the practice. Significant deficiencies may be referred to the Peer Review Committee and could result in a corrective action plan or termination. Providers may reapply after corrective actions and a successful re-evaluation.

11.2 Dental records

Records review – key areas

During audits, UnitedHealthcare reviews sample dental records using the following criteria:

Recordkeeping & confidentiality

- Use of electronic records (if not, charts must be organized, legible, and securely fastened)
- Separate records for each patient
- Staff trained in confidentiality
- Signed Release of Information forms
- Policy for timely record transfers
- Organized and accessible records for treating providers
- Secure storage with access limited to authorized personnel
- Compliance with federal regulations for record release
- System for tracking missed appointments
- Written confidentiality policy covering staff training, record retention, and access across locations

Dental record review criteria

Administrative elements

- Patient demographic info in chart
- Patient name or ID on all pages
- All entries dated and signed
- Medical history present
- Allergies/adverse reactions clearly noted



- Screening for high-risk behaviors (age 12+)
- Cultural/linguistic needs addressed
- Updated dental history and medication list

Clinical documentation

- Notes include complaint, findings, diagnosis, and treatment plan
- Caries risk assessment (for patients under 21)
- Head, neck, and soft tissue exams documented
- Oral cancer screening noted
- Oral hygiene status and instruction documented
- Treatment plan reflects medical necessity
- Follow-up on prior issues
- Date of service, tooth/quadrant, and procedure details
- Anesthetic and materials used (if applicable)
- Post-op instructions/medications documented
- Chart signed by dentist/hygienist

Record storage & transfer

- Records must be stored securely at the office per state regulations.
- For long-term care facilities, originals stay on-site; duplicates may be kept centrally.
- Upon termination or patient dismissal, your office must transfer records at no cost to the member.
- All transfers must comply with state and federal confidentiality laws.

11.3 Second opinions

Members are entitled to a second opinion if:

- They disagree with a diagnosis or treatment plan
- They believe a condition was not properly diagnosed

Second opinions may be obtained within the UnitedHealthcare network or, if necessary, arranged outside the network at no cost to the member.

11.4 Appointment scheduling standards

Participating providers must meet or exceed the following access standards:

- Emergency Care: Immediate care for serious orofacial conditions (e.g., excessive bleeding, trauma, severe pain).
- Urgent Care: Treatment within 24 hours of member request for conditions causing pain, infection risk, or potential deterioration.
- Routine/Specialist Appointments: Within 28 days of member request.

Monitoring: Compliance is tracked via appointment book reviews, member feedback, spot checks, complaint investigations, and random calls. Non-compliance may result in corrective action.

Wait times: Members should not wait more than 45 minutes. Notify patients of delays and offer rescheduling if needed.

Walk-In Clinics: Must still meet all access and wait time standards.

11.5 After-hours & emergency coverage

Availability requirements

Providers **must ensure 24/7** phone access through:

- Direct contact
- Answering service
- Voicemail with emergency instructions and provider contact info

Response times:

- Emergencies: Within **15 minutes**
- Non-emergent symptoms: Within **30–45 minutes**

Unacceptable practices:

- No answer or persistent busy signal
- Voicemail directing non-emergencies to the ER
- Hold times over 5 minutes
- No callback option for urgent needs

Emergency care access

Providers **must offer 24/7** emergency care directly or via another provider/facility. Voicemail must clearly explain how to access emergency services after hours.

11.6 Missed appointments

Members cannot be charged for missed appointments. However, they may be informed of non-financial consequences (e.g., rescheduling policies). Appropriate and aggressive outreach shall be documented and must include various methods to reach the enrollee, i.e. telephonic, mailers, electronic (confirmed email), face to face, including utilization of Community Based Care Management for members with special needs who may be hard to reach, along with resources such as providers, external agency contacts, etc.

11.7 Recall system

Offices must maintain an active recall system to support preventive care. Acceptable methods include:

- Postcards
- Letters
- Phone calls
- Emails
- Advance scheduling

11.8 Office standards

- Must comply with OSHA and ADA regulations.
- Submit attestation confirming ADA compliance or accommodations.
- Maintain proper medical recordkeeping.

Sterilization & asepsis:

- Follow OSHA protocols
- Use heat sterilization where possible
- Wear gloves, masks, and eye protection as needed
- Use sharps containers and proper medical waste disposal
- Do not bill separately for sterilization fees

11.9 Nondiscrimination policy

Providers must treat all members equally, regardless of:

- Payment source
- Race, ethnicity, religion, national origin
- Disability, medical condition, age, gender, sexual orientation
- Claims history or insurability

11.10 Outreach for preventive care

UnitedHealthcare provides quarterly lists of members who:

- Haven't had a visit by 12 months of age
- Are overdue per NJFC periodicity
- Haven't had a preventive visit in 6+ months

Provider Action: Contact these members to schedule appointments and document outreach efforts.

Section 12: Provider enrollment & 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 every 3 years.

12.1 Credentialing and recredentialing overview

Initial Credentialing

Includes review of:

- State license, DEA/CDS certificates (if applicable)
- Malpractice insurance (minimum limits: \ \$1M/\ \$3M)
- Work history (5 years, no unexplained gaps >6 months)
- Education and Medicaid ID (if required)
- Sedation/Anesthesia credentials (if applicable)
- Disclosure of Ownership form (if applicable)
- Explanation of any adverse findings

Recredentialing

Occurs **every 3 years** (or as required by state law) and includes:

- Updated documentation (same as initial)
- Performance data (utilization, grievances, facility/chart reviews)
- Providers are contacted up to 6 times before termination for non-response

12.2 Credentialing process

- Managed by the Dental Benefit Providers Credentialing Committee
- Credentialing and recredentialing documentation can be submitted through the Dental Hub
- Providers may review and correct errors and are informed of application status

12.3 Facility site visits

- Required for each office location per state guidelines
- Must pass inspection before activation
- Mobile practices must document service locations and ensure accessibility and continuity of care

12.4 Mobile dental practices

- Must provide comprehensive on-site care and referrals per NJ State Board and NJ FamilyCare MCO Contract
- Must demonstrate their ability to render dental treatment services and assist with dental referrals as needed.
- One-time event services (e.g., health fairs, schools) limited to screenings, exams, fluoride, sealants, prophylaxis, and palliative care to treat an acute condition



- MCO assists with referrals and continuity of care
- State Board regulations must still be followed and patient records are to be maintained in accordance with State Board of Dentistry regulations.
- Patient records
 - Must be maintained at the facility for school, long term care or skilled nursing facilities.
- Must submit documentation to the MCO of all locations they visit and serve and include the days and times for each location, except when a visit is to a residence.

12.5 Practitioner rights

Providers have the right to:

- Review credentialing information used in evaluation
- Correct erroneous information (within 15 business days of notice)
- Be informed of application status
- Appeal adverse recredentialing decisions (if allowed by state or due to quality concerns)

Appeals are reviewed by the Peer Review Committee (PRC), which includes a specialist peer. Final decisions are sent within 10 days.

12.6 New associates

New associates must be credentialed before treating members. To request a provider application packet, visit UHCdental.com/medicaid > Join our network or contact Provider Services at **1-800-508-4881**.

12.7 Demographic changes

Notify UnitedHealthcare of any changes to:

- Address, phone, email, fax, or TIN

Submit updates in writing with supporting documentation to:

Demographic changes

UnitedHealthcare – RMO
 ATTN: 400-Provider Services
 P.O. BOX 30567
 Salt Lake City, UT 84130

Fax: 1-855-363-9691

Email: dbpprvfx@uhc.com

Credentialing Updates:

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

Note: To ensure that your information is displayed accurately, and claims are processed efficiently, please submit all changes a minimum of 30 days in advance.

12.8 Specialist requirements

All dental specialists must be NJ Board Eligible or Certified and hold valid specialty permits. Those in Endodontics, Oral Surgery, Periodontics, or Prosthodontics must have (or have applied for) valid DEA and CDS certificates.

Definitions

The Contractor shall use the state-developed definition for the following terms:

Appeal – a request for review of an action.

Dental home – is the 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. The dental home should be established no later than 12 months of age to help children and their families institute a lifetime of good oral health. A dental home addresses anticipatory guidance and preventive, acute, and comprehensive oral health care and includes referral to dental specialists when appropriate. Schools are not considered a dental home.

Dental records – the complete, comprehensive records of dental services, to include date of service/visit, chief complaint, treatment needed, treatment planned and treatment provided during each patient visit. The dental record shall include charting of the existing dentition, hard and soft tissue findings, completed assessment tools and diagnostic images to include radiographs and digital views as well as photographs where medically necessary. Dental records shall also be kept in compliance with all DMAHS and NJ State Board of Dentistry regulations. The dental record is to be accessible at the office/clinic location of Member's participating dentist and also in the records of a residential facility for those Members residing in a facility. Providers who render dental services in other settings such as in an operating room shall also include a record that documents provided treatment in the Member's dental record located in the office/clinic.

Emergency dental condition – an orofacial condition manifesting itself by acute symptoms of sufficient severity which impair oral functions including: severe pain or infection of dental origin resulting in facial swelling and possible airway obstruction, uncontrolled bleeding due to tissue laceration, oral trauma to include fracture of the jaw or other facial bones and/or dislocation of the mandible. These serious conditions as well as other acute symptoms that occur outside of the normal office hours of a dental clinic or office require immediate medical attention to avoid placing the health of the individual in jeopardy.

Emergency medical condition – a medical condition manifesting itself by acute symptoms of sufficient severity, (including severe pain) such that a prudent layperson, who possesses an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; serious impairment to bodily functions; or serious dysfunction of any bodily organ or part. With respect to a pregnant woman who is having contractions, an emergency exists where there is inadequate time to effect a safe transfer to another hospital before delivery or the transfer may pose a threat to the health or safety of the woman or the unborn child.

Emergency services – covered inpatient and outpatient services furnished by any qualified provider that are necessary to evaluate or stabilize an emergency medical condition.



Grievance – means an expression of dissatisfaction about any matter, a complaint, or a protest by an enrollee or provider as to the conduct by the Contractor or any agent of the Contractor, or an act or failure to act by the Contractor or any agent of the Contractor, or any other matter in which an enrollee or provider feels aggrieved by the Contractor, that is communicated to the Contractor either verbally or in writing. Grievances are to be resolved as required by the exigencies of the situation, but no later than 30 days after receipt.

Mobile dental practice (utilizing portable equipment) – is a dental provider traveling to various locations and utilizing portable equipment to provide dental services. See 4.5 Members with Special Needs for additional information.

Mobile dental practice (utilizing a van) – is a dental provider using a vehicle specifically equipped with stationary dental equipment used to provide dental services. See 12.5 Members with Special Needs for additional information.

Primary Care Dentist (PCD) – a licensed dentist who is the health care provider responsible for supervising, coordinating, and providing initial and primary dental care to patients; for initiating referrals for specialty care; and for maintaining the continuity of patient care. A PCD can be assigned by the MCO or selected by the member.

Primary Care Provider (PCP) – a licensed medical doctor (MD) or doctor of osteopathy (DO) or certain other licensed medical practitioner who, within the scope of practice and in accordance with State certification/licensure requirements, standards, and practices, is responsible for providing all required primary care services to enrollees, including periodic examinations, preventive health care and counseling, immunizations, diagnosis and treatment of illness or injury, coordination of overall medical care, record maintenance, and initiation of referrals to specialty providers described in this contract and the Benefits Package, and for maintaining continuity of patient care. A PCP shall include general/family practitioners, pediatricians, internists, and may include specialist physicians, physician assistants, CNMs or CNPs/CNSs, provided that the practitioner is able and willing to carry out all PCP responsibilities in accordance with these contract provisions and licensure requirement.

Provider – means any physician, hospital, facility, health care professional or other provider of enrollee services who is licensed or otherwise authorized to provide services in the state or jurisdiction in which they are furnished.



**Dental Benefit
Providers**

All documents regarding the recruitment and contracting of providers, payment arrangements, and detailed product information are confidential proprietary information that may not be disclosed to any third party without the express written consent of Dental Benefit Providers, Inc.

UnitedHealthcare Dental® coverage provided by or through UnitedHealthcare Insurance Company, located in Hartford, Connecticut, or its affiliates. Administrative services provided by Dental Benefit Providers, Inc., Dental Benefit Administrative Services (CA only), United HealthCare Services, Inc. or their affiliates. Plans sold in Texas use policy form number DPOL.06.TX (11/15/2006) and associated COC form number DCOC.CER.06.

M57031-KK 11/25 ©2025 United HealthCare Services, Inc. All Rights Reserved.