Dental Provider Manual

UnitedHealthcare Community Plan of Arizona

Arizona Health Care Cost Containment System (AHCCCS) Complete Care (ACC)
Arizona Long Term Care Elderly Physically Disabled (ALTCS EPD)
Developmental Disabilities (DD)

Provider Services: 1-855-812-9208

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UnitedHealthcare® | Dental Benefit Providers®

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Section 1: Introduction — who we are

Welcome to UnitedHealthcare Community Plan

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

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

We offer a portfolio of products including, but not limited to: Medicaid, Medicare, and Special Needs plans

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

Our Commercial program plan requirements are contained in a separate Provider Manual. If you support one of our Commercial plans and need that Manual, please contact Provider Services at 1-800-822-5353 (Please note: all other concerns should be directed to **1-855-812-9208**). Additionally, if you support one of our Medicare Advantage Plans you may find the Quick Reference Guide here.

If you have any questions or concerns about the information contained within this Manual, please contact the UnitedHealthcare Community Plan Provider Services team at **1-855-812-9208.**

Unless otherwise specified herein, this Manual is effective on September 1, 2021 for dental providers currently participating in the UnitedHealthcare Community Plan of Arizona network, and effective immediately for newly contracted dental providers.

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

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

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

Provider Online Academy

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

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

To access Provider Online Academy, visit **UHCdental.com/provideracademy**.

Section 2: Patient eligibility verification procedures

2.1 Member eligibility

UnitedHealthcare Community Plan serves members enrolled with Arizona's Medicaid program. AHCCCS determines program eligibility. An individual who becomes eligible for the Arizona program either chooses or is assigned to one of the Arizona-contracted health plans.

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 Eligibility verification

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

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.

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. Please call **1-855-812-9208** from 8:00 AM to 5:00 PM M-F CST for assistance with any technical website issues.

UnitedHealthcare Community Plan also offers an Interactive Voice Response (IVR) system; simply call **1-855-812-9208.** Through our IVR system, you may access real-time information, 24 hours a day, 7 days a week. The UnitedHealthcare Community Plan IVR system enables you to do the following:

- Verify eligibility
- Obtain claim status

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

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

	Resource		
You want to:	Provider Services Line – Dedicated Service Representatives Phone: 1-855-812-9208 Hours: 8 a.m.-5 p.m. (CST) Monday-Friday	Online UHCdental.com/medicaid	Interactive Voice Response (IVR) System Phone: 1-855-934-9818 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	✓		
Request peer to peer discussion regarding authoritarian request	✓		

2.4 Website UHCdental.com/medicaid

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

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

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

2.5 Integrated Voice Response (IVR) system — 1-855-812-9208

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 code and tooth number).

Section 3: Office administration

3.1 Office site quality

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

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

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

3.2 Office conditions

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

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

3.3 Sterilization and infection control fees

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

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

3.4 Recall system

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

3.5 Transfer of dental records

Your office shall copy all requested member dental records to another participating dentist as designated by UnitedHealthcare Community Plan or as requested by the member. The member is responsible for the cost of copying the patient dental records if the member is transferring to another provider. If your

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

3.6 Office hours

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

3.7 Protect confidentiality of member data

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

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

3.8 Provide access to your records

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

3.9 Inform members of advance directives

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

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

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

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

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

3.10 Participate in quality initiatives

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

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

3.11 New associates

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

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

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

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

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.

3.13 Language interpretation line

We provide free translation and interpreter services to help ensure all members and their families understand the member's diagnosis and treatment plan in a culturally sensitive manner. You may use this service free of charge for translation needs. You may also access the Language Interpretation Line:

- Phone interpretation request: 866-874-3972
- Onsite interpretation request: 888-225-6056

Enter client ID 244722 for ACC/DD. Enter client ID 244162 for ALTCS EPD. T1013 (sign language or oral interpretive services, per 15min) will not be separately reimbursed. Interpretation Services are provided by Language Line on behalf of UnitedHealthcare Community Plan.

3.14 Transportation

Transportation is covered for AHCCCS-eligible members. Members should use their own transportation if available. Medical Transportation Management (MTM) provides non-emergency transportation for:

- **AHCCCS Complete Care:** covered services
- **Developmental Disabilities:** MTM is not responsible for transportation services DD covers
- **Arizona Long-Term Care EPD:** all services, including behavioral health transportation

For non-urgent appointments, members must call for transportation at least three days before their appointment.

Bus transportation will also be available if the member:

- Lives less than half a mile from a bus stop
- Has an appointment less than half a mile from the bus stop

Section 4: Patient access

4.1 Appointment scheduling standards

We are committed to assuring 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:

General dental providers

- **Urgent care appointments** ..as quickly as the member's health condition requires, but no later than 3 business days from the request
- **Routine care appointments** offered within 45 calendar days of referral

Specialty dental providers

- **Urgent care appointments** ..as quickly as the member's health condition requires, but no later than 2 business days from the request
- **Routine care appointments** offered within 45 calendar days of referral

We will 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. Any concerns are discussed with the participating provider(s). If necessary, the findings may be presented to UnitedHealthcare Community Plan's Quality Committee for further discussion and development of a corrective action plan.

For the purpose of this section, "urgent" is defined as an appointment for medically necessary services to prevent deterioration of health following an acute onset of an illness, injury, condition or exacerbation of symptoms.

Dental offices that operate by "walk-in" or "first come, first served" appointments must meet the above state mandated or plan requirements, and are monitored for access and waiting times, where applicable.

4.2 Emergency coverage

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

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

4.3 Specialist referral process

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

To obtain a list of participating dental network specialists, go to our website at **UHCdental.com/medicaid** or contact Provider Services at 1-855-812-9208.

4.4 Missed appointments

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

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

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

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

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

4.5 Nondiscrimination

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

Section 5: Utilization management program

5.1 Utilization management

Through utilization management practices, UnitedHealthcare Community Plan aims to provide members cost-effective, quality dental care through participating providers. By integrating data from a variety of sources, including individual financial analysis reporting, utilization review, claims data and individual audit reporting, UnitedHealthcare Community Plan can evaluate group and individual practice patterns and identify those patterns which deviate from the norm.

By identifying and correcting aberrant provider practice patterns, we can not only reduce the overall impact of such behavior on the cost of care, but also 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 percentage of procedures performed in any given category relative to total procedures are compared with benchmarks such as similarly designed UnitedHealthcare Community Plan plans, to determine if utilization for that category is within expected levels. This method, which looks at the mix of procedures and incurred claims, was chosen in part because it is consistent with other forms of reporting at UnitedHealthcare Community Plan.

Aberrations 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 potentially aberrant practice patterns, utilization may be reviewed at the individual claims level. For each specific dentist, an Audit Report may be run that identifies all procedures performed on all patients for a specified time period. For those dentists who practice at multiple sites, these reports are typically done on a site-by-site basis.

Examples of aberrant patterns could include upcoding, unbundling, miscoding, excessive treatments per patient (e.g., doing 15 restorations at one sitting), duplicate billing, or duplicate payments. Once completed, a sample of patients may be identified for chart audit. The number varies depending on the number of patients on the dentist's panel in the time period being studied and the severity of the problems noted.

5.4 Utilization review data results

Review findings are shared with individual practitioners in order to provide feedback relative to their peers as well as recommended follow-up.

Feedback and recommended follow-up may also be communicated to the provider group 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 and Focus Groups
- Provider Newsflash

Finally, internal interventions may be indicated. These can include improvements to existing policies and procedures, specific interventions and creation of feedback mechanisms to make sure that corrections take place.

In all instances, practitioners will be provided with contact information that they can call to review results and ask any questions they may have.

5.5 Fraud and abuse

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

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

If adverse practice patterns are found, interventions will be implemented on a variety of levels.

If the account is Medicaid, the Office of the Inspector General or the State Attorney General's office will also be notified.

All Network Providers and third-party contractors are expected to promptly report any perceived or alleged instances of fraud. Reporting may be made directly to the compliance helpline at 1-888-233-4877.

Section 6: Quality management

6.1 Quality Improvement Program (QIP) description

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

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

The QIP description is reviewed and updated annually:

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

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

6.2 Quality measures

Providers are essential partners in delivering preventive health services to UnitedHealthcare Community Plan members. UnitedHealthcare Community Plan providers are required to provide Dental services for all assigned members from birth through 20 years of age in accordance with the AHCCCS EPSDT and Dental Periodicity schedules (see section 8.5). Providers can also access the schedules and forms online at UnitedHealthcare Community Plan's website. Ad-hoc mailings, faxes and emails are used to inform providers of new information or changes in AHCCCS policies. All providers have access to EPSDT and Dental information through:

- The UnitedHealthcare Community Plan Provider Manual;
- Online through UnitedHealthcare Community Plan's website and provider portal;
- Ad hoc fax notifications/emails

Both medical and dental providers are encouraged to conduct their own outreach with assigned members, informing members of the need to schedule bi-annual dental visits.

UnitedHealthcare Community Plan, in alignment with AHCCCS, utilizes the Core Set of Children's Health Care Quality Measures for Medicaid and CHIP to measure the effectiveness of the dental program. These include Oral Evaluation Dental Services (OEV-CH), Sealant Receipt on Permanent 1st Molars (SFM-CH) At Least One Sealant, Sealant Receipt on Permanent 1st Molars (SFM-CH) All Four Molars Sealed, and Topical Fluoride for Children (TFL-CH).

Oral Evaluation, Dental Services (OEV-CH)**

The percentage of members under 21 years of age who received a comprehensive or periodic oral evaluation with a dental provider during the measurement year.

Topical Fluoride for Children (TFL-CH)**

The percentage of members 1–4 years of age who received at least two fluoride varnish applications during the measurement year.

Sealant Receipt on Permanent 1st Molars (SFM-CH) **

Percentage of enrolled children who have ever received sealants on permanent first molar teeth: (1) at least one sealant and (2) all four molars sealed by the 10th birthdate.

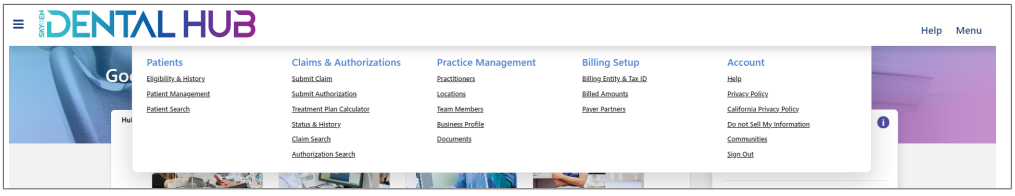
About Primary Care Assignments Report

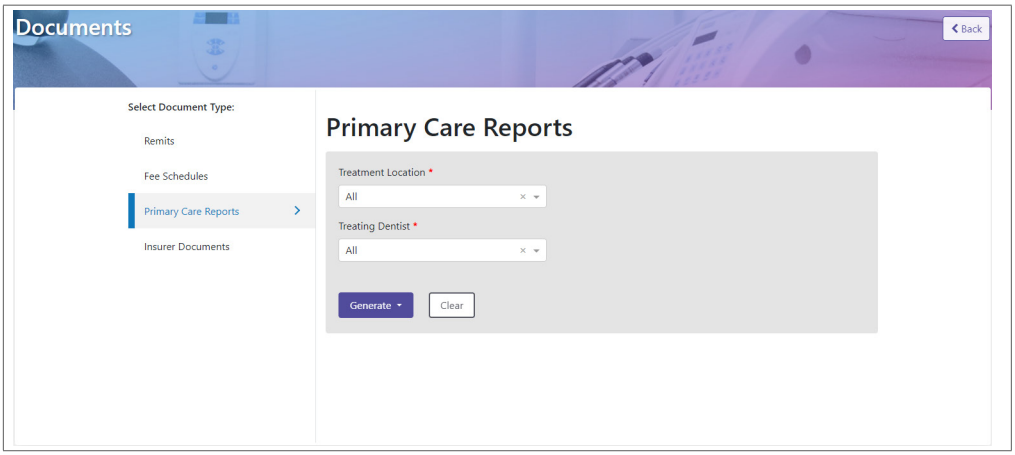
You can access your dental home membership assignment report (aka Primary Care Assignments Report) through the Dental Hub at **UHCdental.com/medicaid**.

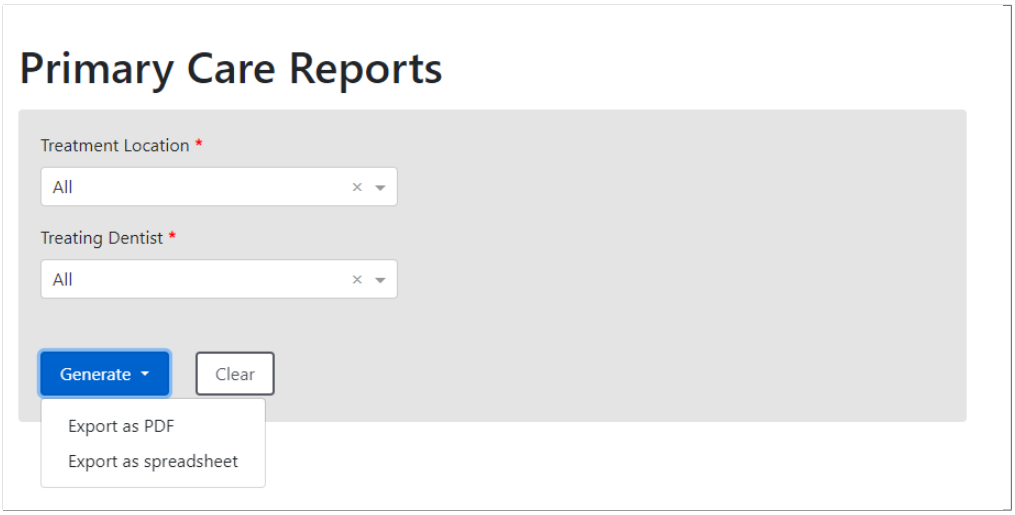
To generate a list of patients who have been assigned a primary care provider and/or location, log into the provider portal (Dental Hub).

Open menu dropdown > Practice Management > Documents > Primary Care Reports > Choose Location, Practitioner, and Export Type page.

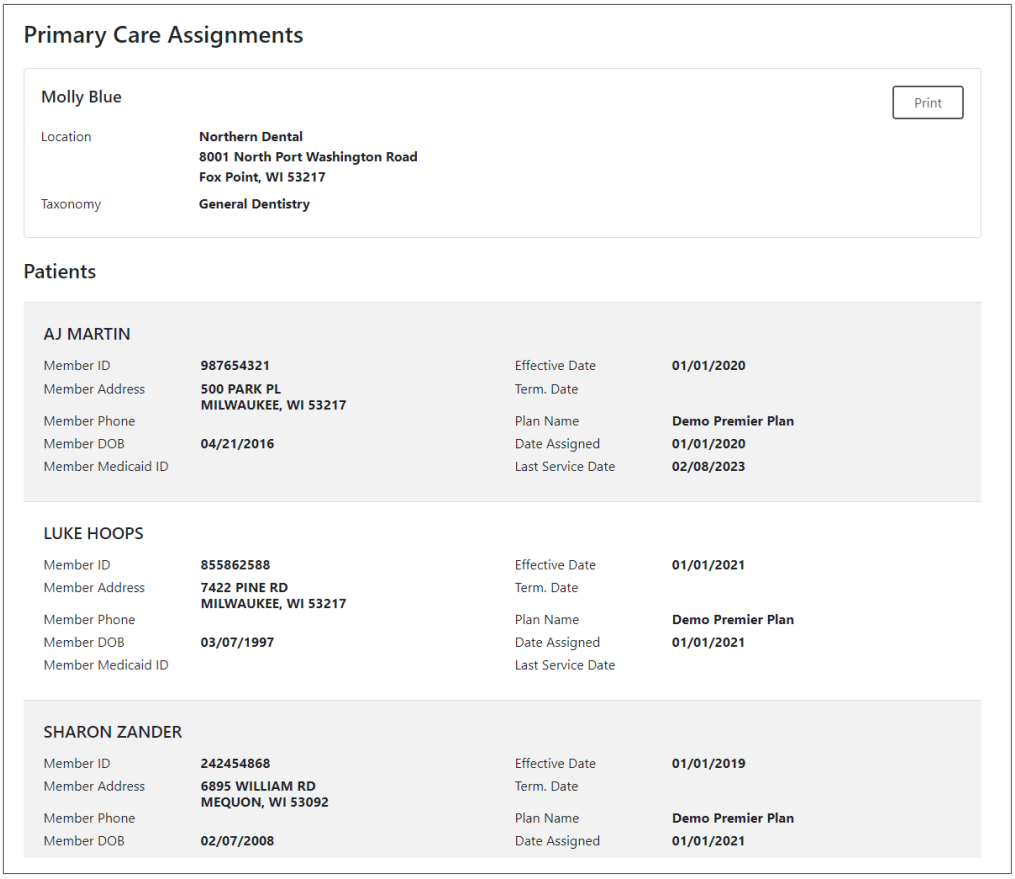
The Primary Care Assignments report includes each patient's name, contact information, ID numbers, birth date, eligibility span, last date of service with their primary care provider, and benefit plan name.







Sample dental home assignment report



Differential Adjusted Payment (DAP) Increase

Maintaining proper oral health matters more than just keeping a sparkling smile – it's also important for good overall health. To help improve the oral health of our AZ Medicaid members, AHCCCS has implemented Differential Adjusted Payment (DAP) rates for dental providers. This will help to ensure that payments for dental services are consistent with efficiency, economy, and quality of care. The goal is to reward Dental providers who meet performance measures.

What is the Differential Adjusted Payment (DAP) increase?

As a component of AHCCCS Value Based Purchasing (VBP) activities, and in alignment with the AHCCCS Quality Strategy, select AHCCCS-registered Arizona Dental providers which meet agency established performance criteria may qualify for annual Differential Adjusted Payment (DAP) rate increases. Each DAP is time-limited for **one-year only (October – September)**, although a similar DAP may be implemented in the subsequent year. Providers must **re-qualify** for a DAP each year even when the DAP criteria remain the same.

Who qualifies for this DAP rate increase?

Each year, select Dental providers see a percentage rate increase to their UnitedHealthcare Community Plan (UHCCP) fee schedules. Qualifying providers' fee schedule adjustments are limited to dates of services within the given contract year. The DAP rates represent a positive adjustment to the UHCCP rates.

The purpose of the DAP is to distinguish providers which have committed to supporting designated actions that improve patients' care experience, improve members' health, and reduce cost of care growth.

The DAP program is established and regulated by AHCCCS. AHCCCS determines which providers qualify and sets the payment adjustment percentages, which are then provided to individual Managed Care Organizations (MCOs), including UnitedHealthcare Community Plan (UHCCP). While each MCO is responsible for applying these state-determined adjustments, the overall structure and eligibility criteria of the DAP program are governed by AHCCCS.

Subsequent re-qualification will be based on new targeted contract years, as determined by AHCCCS.

Additional information, including specifics about current DAP incentives available to dental providers, can be found on the AHCCCS website under Public Notices, Rates and Supplemental Payments, Rates: **https://www.azahcccs.gov/AHCCCS/PublicNotices/**

6.3 Credentialing

Before acceptance into the network, UnitedHealthcare Community Plan conducts a thorough review of each applicant's credentials. We partner with SKYGEN Dental Hub to collect and verify the necessary data for both credentialing and recredentialing. Timely responses to requests from SKYGEN or UnitedHealthcare Community Plan are essential for an efficient process.

The credentialing review includes, but is not limited to:

- State license status
- Sanctions or disciplinary actions
- Malpractice insurance coverage
- Other relevant professional credentials

If any adverse findings are identified, we will request a written explanation detailing the incident, its resolution, and a corrective action plan. For certain plans or markets, state-specific regulations may require an initial facility site visit. Each location must pass this review before activation. Your Professional Networks Representative will inform you if a site visit is necessary.

The Credentialing Committee evaluates all submitted information against established criteria, which are reviewed and approved with input from practicing network providers to ensure alignment with industry standards. If discrepancies are found, UnitedHealthcare Community Plan will request clarification or correction.

Provider Rights During Credentialing

Applicants have the right to:

- Review the information submitted for their application (excluding peer review-protected materials and references).
- Correct erroneous information. If we identify substantial discrepancies, we will notify you in writing, by fax, or email. Corrections must be submitted within 30 days of notification.
- Request the status of your credentialing or recredentialing application by calling 1-855-812-9208.

Credentialing decisions are never based on:

- Race or ethnic/national identity
- Gender
- Age
- Sexual orientation
- Specialties serving high-risk populations or costly conditions

If your state allows credentialing appeals, you may appeal a decision based on information reviewed during the process. Instructions for initiating an appeal will be included in your determination letter.

Recredentialing

Recredentialing is required to maintain participation and is a condition of your provider agreement. Failure to comply may result in termination for cause. Requests are sent several months before the due date, directing you to SKYGEN Dental Hub to begin the process. If SKYGEN cannot obtain a complete packet, UnitedHealthcare Community Plan will make additional outreach attempts. If there is no response, a termination letter will be issued.

In addition to the items verified in the initial credentialing process, UnitedHealthcare Community Plan may also review provider performance measures such as, but not limited to:

- Utilization reports
- Current facility review scores
- Member chart review scores
- Grievance and appeals data

For more details, refer to the **Credentialing Guidelines** at **UHCdental.com/resources**. Questions regarding your credentialing status can be directed to our Provider Services line.

6.4 Site visits

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

The site visit focuses primarily on: dental record keeping, patient accessibility, infectious disease control, and emergency preparedness and radiation safety. Results of site reviews will be shared with the dental office. Any significant failures may result in a review by the 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 consulting the latest literature, including, but not limited to, current ADA Code on Dental Procedures and Nomenclature (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 and AHCCCS periodicity recommendations.

RECOMMENDATIONS FOR PREVENTIVE PEDIATRIC ORAL HEALTH CARE*				
These recommendations are designed for the care of children who have no contributing medical conditions and are developing normally. These recommendations may require modification for children with special health care needs.				
AGE	**12-24 MONTHS***	**2-6 YEARS**	**6-12 YEARS**	**12 YEARS AND OLDER**
CLINICAL ORAL EXAMINATION INCLUDING BUT NOT LIMITED TO THE FOLLOWING:	X	X	X	X
➢ ASSESS ORAL GROWTH AND DEVELOPMENT	X	X	X	X
➢ CARIES-RISK ASSESSMENT	X	X	X	X
➢ ASSESSMENT FOR NEED FOR FLUORIDE SUPPLEMENTATION	X	X	X	X
➢ ANTICIPATORY GUIDANCE/COUNSELING	X	X	X	X
➢ ORAL HYGIENE COUNSELING	X	X	X	X
➢ DIETARY COUNSELING	X	X	X	X
➢ INJURY PREVENTION COUNSELING	X	X	X	X
➢ COUNSELING FOR NONNUTRITIVE HABITS	X	X	X	X
➢ SUBSTANCE USE COUNSELING			X	X
➢ COUNSELING FOR INTRAORAL/PERIORAL PIERCING			X	X
➢ ASSESSMENT FOR PIT AND FISSURE SEALANTS		X	X	X
RADIOGRAPHIC ASSESSMENT	X	X	X	X
PROPHYLAXIS AND TOPICAL FLUORIDE	X	X	X	X

* Those elements of the oral examination deemed appropriate by the provider may be performed as early as six months of age.

NOTE: Health Care Decision Maker (HCDM), Designated Representative (DR) should be included in all consultations and counseling of members regarding preventive oral health care and the clinical findings.

NOTE: As in all medical care, dental care must be based on the individual needs of the member and the professional judgement of the oral health provider.

* Adaptation from the American Academy of Pediatric Dentistry Schedule.

Effective Dates: 10/01/18, 10/01/19, 02/01/21, 10/01/22, 10/01/23, 05/20/24
Approval Dates: 06/07/18, 05/30/19, 11/06/20, 04/21/22, 06/13/23, 04/18/24

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 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, especially 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: Access and reduce barriers to evidence-based and integrated treatment
- Recovery: Support care management and referral to person-centered recovery resources
- Harm Reduction: Access to Naloxone and facilitating safe use, storage, and disposal of opioids
- Strategic community relationships and approaches: Tailor solutions to local needs
- Enhanced solutions for pregnant mom and child: Prevent neonatal abstinence syndrome and supporting moms in recovery
- Enhanced data infrastructure and analytics: Identify needs early and measure progress

Increasing education & awareness of opioids

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

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

Prevention

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

UnitedHealthcare Community Plan has implemented a 90 MED supply limit for the long-acting opioid class. The prior authorization criteria coincide with the CDC’s recommendations for the treatment of chronic non-cancer pain. Prior authorization applies to all long-acting opioids. The CDC guidelines for opioid prevention and overdose can be found at **Preventing Opioid Overdose | Overdose Prevention | CDC**

Section 7: Fraud, waste, and abuse training

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

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

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

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

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

Section 8: Governance

8.1 Provider rights bulletin

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

To review your information

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

To correct erroneous information

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

To be informed of status of your application

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

To appeal adverse committee decisions

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

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

8.2 Quality of care issues

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

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

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

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

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

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

8.3 Appeals process

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

- Providers are notified in writing of their appeal rights within fifteen (15) calendar days of the Committee's determination. The letter will include the reason for denial/termination; notice that the provider has the right to request a hearing or review, at the provider's discretion, before a panel appointed by UnitedHealthcare; notice of a thirty (30)-day time frame for the request; and, a time limit for the hearing date, which must be held within thirty (30) days after the receipt of a request for a hearing.
- The Hearing will be scheduled within thirty (30) days of the request for a hearing.
- The Hearing Committee includes at least three members appointed by UnitedHealthcare, who are not in direct economic competition with the provider, and who have not acted as accuser, investigator, fact-finder, or initial decision-maker in the matter. At least one person on the panel will be the same discipline or same specialty as the person under review. The panel can consist of more than three members, provided the number of clinical peers constitute one-third or more of the total membership.
- The Hearing Committee may uphold, overturn, or modify the original determination. Modifications may include, but are not limited to, placing the provider on probation, requiring completion of specific continuing education courses, requiring site or chart audits, or other corrective actions.
- The decision of the Hearing Committee is sent to the provider by certified letter within thirty (30) calendar days.
- Decisions of terminations shall be effective not less than thirty (30) days after the receipt by the provider of the Hearing Panel's decision.

- In no event shall determination be effective earlier than sixty (60) days from receipt of the notice of termination.

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

8.4 Cultural competency

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

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

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

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

9.1b Electronic claims

Electronic Claims Submission refers to the ability to submit claims electronically versus paper. This expedites the claim

adjudication process and can improve overall claim payment turnaround time (especially when combined with Electronic Payments, which is the ability to be paid electronically directly into your bank account).

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

9.1.c Electronic payments

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

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

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

ePayment Center allows you to:

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

- Download remittances in various formats (835, CSV, XLS, PDF)
- Search payments history up to 7 years

To register:

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

Note: Federally Qualified Health Clinics must follow AHCCCS specific billing guidelines. Please reference **https://azahcccs.gov/PlansProviders/RatesAndBilling/FFS/providermanual.html** for up-to-date AHCCCS provider billing guidelines.

An 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.

- Procedure date
- Area of oral cavity
- Tooth number or letter and the tooth surface
- Procedure code
- Description of procedure
- Billed charges – report the dentist's full fee for the procedure
- Total sum of all fees

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

This section can be used to convey additional information you believe is necessary for us to process the claim (e.g., for a secondary claim, the amount the primary carrier paid).

Federally Qualified Health Clinics and Rural Health Centers should use this section in accordance to the AHCCCS Billing Guidelines Manual, FFS_Chap_10 Addendum FQHC.

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.)

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16

32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17

34. Diagnosis Code List Qualifier ☐☐ (ICD-9 = B; ICD-10 = AB)

34a. Diagnosis Code(s) (Primary diagnosis in "A")

A _____ C _____

B _____ D _____

31a. Other Fee(s)

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**.

9.2.b Claim submission best practices

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.

9.3 Timely submission

All claims should be submitted within 90 days from the date of service or date of eligibility posting.

All adjustments or requests for reprocessing must be made within 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. Refer to the Quick Reference Guide for address and phone number information.

9.4 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, submit the primary payer's Explanation of Benefits or remittance advice with the claim. Secondary claims must be received within six months (180 days) from the date of service, even if the primary carrier has not made payment. If the primary carrier makes payment after this time limit, a reconsideration must be resubmitted with the primary EOB. Claims are processed according to the AHCCCS requirements.

Per R9-22-1002, AHCCCS is not the payer of last resort when the following entities are the third party:

1. The payer is Indian Health Services contract health (IHS/638 tribal plan); or
2. Title IV-E; or
3. Arizona Early Intervention Program (AZEIP); or
4. Local educational agencies providing services under the Individuals with Disabilities Education Act under 34 CFR Part 300;
   or
5. Entities and contractors of entities providing services under grants awarded as part of the HIV Health Care Services Program under 42 USC 300ff et. seq. payer.

Per the AHCCCS FFS Provider Manual, Chapter 9; Community Plan's reimbursement responsibility is limited to no more than the difference between the provider's contracted rate (or the AHCCCS Capped Fee-For-Service rates for non-participating providers) and the amount of the first- or third-party liability.

An AHCCCS registered provider agrees to accept the contracted rate* as payment in full. If the first- or third-party coverage paid more than the provider's contracted amount*, then no further reimbursement is made by Community Plan.

For example, a provider bills $4,500.00 for a surgical procedure:

- The first-party plan allowed $1,388.23, paid $1,110.58 and shows a 20% coinsurance amount of $277.65.
- The provider's contracted rate* allows $753.21 for the surgery.

There will be no Community Plan payment, as the provider has already been paid more than their contracted* amount. The provider must accept the $1,110.58 as payment in full and cannot balance bill the member for any amount.

When the first-party payer is an HMO-type health plan, the same coordination of benefits process would apply.

For example, a contracted HMO provider bills $150.00 for an office visit.

- The HMO plan benefit has a member co-pay of $30.00 and the plan pays the contracted provider $50.00.
- The provider's contracted rate* allows $41.39 for the office visit.

There will be no additional payment from Community Plan, as the provider has already been paid more than their contracted rate*. The provider must accept the $50.00 as payment in full. AHCCCS does not reimburse co-pays, deductibles or coinsurance amounts. If more than one coverage plan makes payment and the total paid by the multiple coverage plans is more than the provider's contracted rate* then there will be no payment. The provider cannot balance bill the member for any amount.

If the first- or third-party payer denies a covered service the provider must follow the payer's appeal process and exhaust all remedies before Community Plan can consider the covered service. The provider must submit a copy of plan's final appeal decision with the claim resubmission or the claim may be denied as incomplete.

* The AHCCCS Capped Fee-For-Service Schedule would be used for non-participating providers that do not have a contracted rate with Community Plan.

Medicare dual cost-sharing

Some UnitedHealthcare Community Plan members are eligible for both Medicaid and Medicare. Claims for dual-eligible members will be paid according to the Medicare Cost Sharing for Members Covered by Medicare and Medicaid policy located in the ACOM policy 201. We are not responsible for cost-sharing should the payment from the primary payer be equal to or greater than what is received under Medicaid. Additional information is available in the Dual Complete Provider Manual.

9.5 Claim adjudication and periodic overview

Claim processing standards:

- 100% of all clean claims will be paid or denied within 30 calendar days of receipt.
- 100% of all unclean claims will be processed within 45 days.

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.

9.6 Explanation of dental plan reimbursement (Remittance Advice)

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

Below is a list and description of each field:

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

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

AMOUNT BILLED - Amount submitted by provider

AMOUNT PAYABLE - Amount payable after benefits have been applied

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

OTHER INSURANCE - Amount payable by another carrier

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

NET AMOUNT (Summary Page) - Total amount paid

PATIENT NAME

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

PATIENT DOB

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

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

ENCOUNTER NUMBER - Claim reference number

BENEFIT LEVEL - In our out-of-network coverage

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

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

CDTCODE - Current Dental Terminology - Procedure code of service performed

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

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

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

QTY OR NO. OF UNITS

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

PAYABLE AMOUNT - Contracted amount

COPAY AMOUNT - Member responsibility

COINSURANCE AMOUNT - Member responsibility of total payment amount

DEDUCTIBLE AMOUNT - Member responsibility before benefits begin

PATIENT PAY - Amount to be paid by the member

OTHER INSURANCE AMOUNT - Amount paid by other carriers

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

EXCEPTION CODES - Codes that explain how the claim was adjudicated

9.7 Provider remittance advice

Explanation of benefits sample (page 1)

UnitedHealthcare Community Plan - AZ LTC

Payee ID: 555555 Payee Name: Dental Office Name Remittance Date: 01/18/2019

UnitedHealthcare®

Please address questions to:

UnitedHealthcare Community Plan - AZ LTC
PO Box 1382

Milwaukee, WI 53201

Contact: UnitedHealthcare Community Plan - AZ
Phone: (855)555-5555
Fax:

Dental Office Name
Street Address
City, State ZIP

Current Period: **01/18/2019**
Payee ID: 555555
Phone:
Fax:
Tax ID: 555555555

Remittance Summary

Fee For Service:	**$163.33**
Budget Allocation:	**$0.00**
Capitation:	**$0.00**
Case Fees:	**$0.00**
Additional Compensation:	**$0.00**
Prior Period Recovery and other Payee Adjustments:	**$0.00**
Total:	**$163.33**

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Explanation of benefits sample (page 2)

UnitedHealthcare Community Plan - AZ LTC

Payee ID: 555555 Payee Name: Dental Office Name Remittance Date: 01/18/2019

Fee For Service Summary

Dental Office Name
Street Address
City, State ZIP

Provider / ID	Location / ID	Amount Billed	Amount Payable	Patient Pay	Other Insurance	Prior Mo. Adj	Net Amount
Provider Name / 55555	Dental Office Name / 55555	$51.00	$24.80	$0.00	$0.00	$0.00	$24.80
Provider Name / 55555	Dental Office Name / 555555	$254.00	$138.53	$0.00	$0.00	$0.00	$138.53
	Totals:	**$305.00**	**$163.33**	**$0.00**	**$0.00**	**$0.00**	**$163.33**

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Explanation of benefits sample (page 3)

UnitedHealthcare Community Plan - AZ LTC

Payee ID: 555555 Payee Name: Dental Office Name Remittance Date: 01/18/2019

Services Detail

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

Patient Name: Last, First Name
Subscriber/Member: 555555555 / 01
DOB: 01/01/2019
Office Reference No:

Provider Name: Last, First Name
Provider NPI: 5555555555
Plan: UnitedHealthcare Community Plan LTC
Product: AZ LTC Medicaid Enhanced

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	01/09/19	D0120 00	11	1	$53.00	1	$27.02	100.00 %	$27.02	$0.00	$0.00	$0.00	$0.00	$0.00	$27.02	FFS
2	01/09/19	D0220 00	11	1	$26.00	1	$13.01	100.00 %	$13.01	$0.00	$0.00	$0.00	$0.00	$0.00	$13.01	FFS
3	01/09/19	D0230 00	11	1	$22.00	1	$10.92	100.00 %	$10.92	$0.00	$0.00	$0.00	$0.00	$0.00	$10.92	FFS
4	01/09/19	D0272 00	11	1	$40.00	1	$20.29	100.00 %	$20.29	$0.00	$0.00	$0.00	$0.00	$0.00	$20.29	FFS
5	01/09/19	D1120 00	11	1	$62.00	1	$42.49	100.00 %	$42.49	$0.00	$0.00	$0.00	$0.00	$0.00	$42.49	FFS
6	01/09/19	D1206 00	11	1	$51.00	1	$24.80	100.00 %	$24.80	$0.00	$0.00	$0.00	$0.00	$0.00	$24.80	FFS
					$254.00		**$138.53**		**$138.53**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$138.53**	

Patient Name: Last, First Name
Subscriber/Member: 555555555 / 01
DOB: 01/01/2019
Office Reference No:

Provider Name: Last, First Name
Provider NPI: 5555555555
Plan: UnitedHealthcare Community Plan LTC
Product: AZ LTC Medicaid Enhanced

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	01/04/19	D1206 00	11	1	$51.00	1	$24.80	100.00 %	$24.80	$0.00	$0.00	$0.00	$0.00	$0.00	$24.80	FFS
					$51.00		**$24.80**		**$24.80**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$24.80**	

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9.8 Disputes, state fair hearings and complaints (grievances)

There are a number of ways to work with us to resolve claims issues or disputes. We base these processes on state and federal regulatory requirements and your provider Agreement.

These definitions and process requirements are subject to modification by state contract or regulations. States may impose more stringent requirements.

UnitedHealthcare Community Plan and its in-network care providers may agree to more stringent requirements within care provider agreements than described in the standard process.

Denial

Your claim may be denied for medical necessity and administrative reasons.

Denial for **medical necessity** means the level of care billed wasn't approved as medically necessary.

Top reasons for administrative denials include:

Duplicate claim. This is one of the most common reasons for denial. It means resubmitting the same claim information. This can reset the clock on the time it takes to pay a claim.

Eligibility expired. Most practices verify coverage beforehand to avoid issues, but sometimes that doesn't happen. One of the most common claim denials involving verification is when a patient's health insurance coverage has expired and the patient and practice were unaware. Also, in some cases, practices may check eligibility when an appointment is made, but between the appointment being made and the actual visit, coverage can be dropped. We recommend an eligibility check again once the patient has arrived.

Claim not covered by UnitedHealthcare Community Plan. Another claim denial you can avoid is when procedures are not covered by Medicaid. You can easily avoid this problem by using real-time verification through the provider portal at **UHCdental.com/medicaid**.

Timely filing. This is when you don't send the claim in time.

If a claim is denied for these reasons, you may be able to request a claim reconsideration or file a dispute.

Claim correction

What is it?

You may need to update information on a claim you've already submitted. A corrected claim replaces a previously processed and paid claim submitted in error.

When to use:

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

Additional Information:

All corrected claims must be submitted on paper to the corrected claims PO Box for proper processing and include the following:

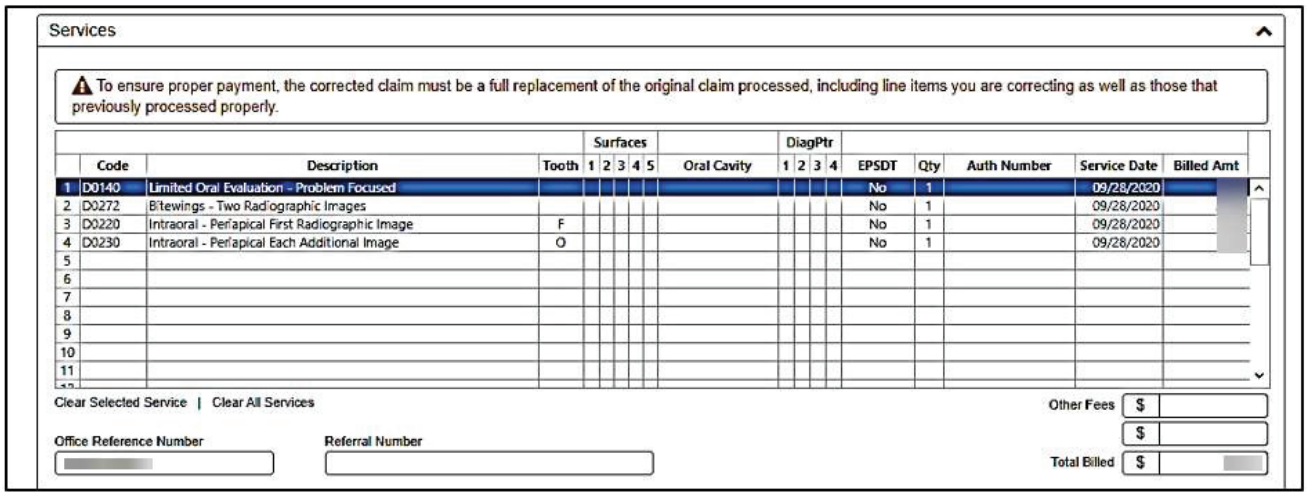
- Current version of the ADA form and all required information.
- The ADA form must be clearly noted “Corrected Claim”
- In the remarks field (Box 35) on the ADA form indicate the original paid encounter number and record all corrections you are requesting to be made.

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

Submitting corrected claims via the Provider Portal

Providers can make corrections on original claims via the Provider Portal. Providers have the ability to:

- Edit or correct ADA dental claim form fields



- Review attachments/documents associated with the original claim to determine if they should remain attached to the corrected claim
- Review attachments/documents that either no longer apply to the corrected claim, or were in error – Note: By default, all original documents will be attached to the new, corrected claim. Providers will have to select the option to remove document(s) as needed.

Corrections will be allowed one time on an original dental claim when submitted via the Dental Hub.

- If additional corrections are required after a corrected after a corrected claim is submitted, the provider will need to submit the correction based on the most recently submitted corrected claim, not the original claim.
- The portal will provide a message stating the claim can no longer be corrected if the provider attempts to correct the original claim more than once.

Submitting corrected claims via EDI

Corrected claims via Clearinghouse file will be accepted when a specific set of criteria is met to ensure the original claim can be identified. In order for a submission to be considered a corrected claim, it must include:

- Claim frequency code of 7 (Replacement) or 8 (Void/Cancel) in CLM05-3 element along with claim or encounter identifier in REF*F8 element
- Original claim in a paid status
- Original claim does not have previously resubmitted services or a corrected claim already processed
- Original claim does not have associated service adjustments or refunds
- Corrected claim must have a data match to original claim on at least 3 of the 4 itemms: Enrollee ID, Provider ID, Location ID, and'or Tax ID

If a corrected claim submitted via Clearinghouse File does not meet these requirements, our system will consider the submission to be a new claim. The provider would then need to send another submission on the file that does meet the above requirements for consideration. If you have questions, please contact customer service for more information.

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 the process for submitting a provider dispute, member appeal, or reprocess request.

Warning! 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.

Mailing address:
UnitedHealthcare Community Plan of Arizona
Att: Corrected Claims
PO Box 481
Milwaukee, WI 53201

Resubmitting a claim

What is it?

When you resubmit a claim, you create a new claim in place of a rejected one. A rejected claim has not been processed due to problems detected before processing.

When to use:

Resubmit the claim if it was rejected. A rejected claim is one that has not been processed due to problems detected before claim processing. Since rejected claims have not been processed yet, there is no dispute. If submitting a corrected claim that is meant to replace a previously received and processed claim, follow the information provided in the Claim Correction section above.

Common Reasons for Rejected Claims:

Some of the common causes of claim rejections happen due to:

- Errors in member demographic data – name, age, date of birth, sex or address
- Errors in care provider data
- Wrong member insurance ID
- No referring care provider ID or NPI number (if applicable)
- Invalid EOBs

How to use:

To resubmit the claim, follow the same submission instructions as a new claim. Mail your resubmission on the most current version of the ADA form and provide all claim information to:

UnitedHealthcare Community Plan of Arizona
PO Box 2185
Milwaukee, WI 53201

Warning! If your claim was denied and you resubmit it, you will receive a duplicate claim denial. A denied claim has been through claim processing. You may submit a corrected claim, claim reconsideration

or dispute a denied claim. See Claim Correction and Reconsideration sections of this chapter for more information.

Claim reconsideration

What is it?

We are committed to improve the experience on all reconsiderations. Claim issues include overpayment, underpayment, denial, or an original or corrected claim determination you do not agree with can be addressed with a claim reconsideration. This request allows a full medical necessity review to be performed if appropriate. A claim reconsideration request is the quickest way to address your concern about whether the claim was paid correctly without the need to file a formal claim dispute.

When to use:

Submit a claim reconsideration within 365 days from date of service or as stated in your Agreement, when you think a claim has not been properly processed.

For administrative denials:

- In your reconsideration request, please submit all relevant supporting information needed for review.

For medical necessity denials:

- In your request, please include any additional clinical information that may not have been reviewed with your original claim.
- Show how specific information in the medical record supports the medical necessity of the level of care performed.

To reach us regarding claims reconsideration please use one of the options below:

- UnitedHealthcare Community Plan of Arizona
  PO Box 2185
  Milwaukee, WI 53201
- Phone: 1-855-812-9208

Include all appropriate documentation to support the services provided when submitting the reconsideration request.

To submit a corrected claim or reconsideration, include:

- The claim
- The Remittance Advice
- Original Claim Number documented in Box 35
- A completed Reconsideration Form with the reason for resubmitting the claim. Note any corrections. Sign and date the cover letter, and provide a contact phone number

Valid proof of timely filing documentation

What is it?

Proof of timely filing occurs when the member gives incorrect insurance information at the time of service. It includes:

- UnitedHealth Group correspondence (data entry send back letter) OR
- A computer-generated activity page/print screen listing the date the claim was submitted to UnitedHealthcare Community Plan. Submission must contain:

  - Member name and Identifying information
  - Date(s) of service
  - Billed amount
  - Date submitted to insurance
- Electronic Claims – Acceptance Report, must include:
  - Universal Electronic Data Interchange (EDI) acceptance code A1:19 coding and an acceptance date within the timely filing period, OR
  - A combination of a version of the words accepted by payer, acknowledged by payer or received by UnitedHealthcare Community Plan
- A billing statement with the date you found out the member had UnitedHealthcare Community Plan
- Other insurance carrier Denial/Rejection EOB or letter (e.g., terminated coverage, not their member)
- Primary carrier EOB showing payment. Secondary claims must be submitted within 180 days from date of service, even if primary carrier has not made payment. Once the primary carrier has paid, you may submit a reconsideration with the primary EOB within 365 days from the date of service.

A submission report is not proof of timely filing for electronic claims. It must be accompanied by an acceptance report. Timely filing denials are often upheld due to incomplete or wrong documentation submitted with a reconsideration request. You may also receive a timely filing denial when you do not submit a claim on time.

How to use:

Submit a reconsideration request with your valid proof of timely filing from the options above.

Additional Information:

Reconsideration guidelines are available in the Reconsideration section provided previously in this chapter.

Overpayment

What is it?

Notify UnitedHealthcare Community Plan of an overpayment on a claim. You may request an adjustment completed or a refund check.

How to use:

If you or UnitedHealthcare Community Plan finds an overpaid claim, 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 we recoup the funds from your next payment, call Provider Services.

If you prefer to mail a refund, send an Overpayment Return Check or the Return Overpayment through the Adjustment Request form.

Also send a letter with the check. Include the following:

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

- Date of payment
- Amount paid
- Amount of overpayment
- Overpayment reason
- Check number

Where to send:

Mail refunds with an Overpayment Return Check or the Overpayment Refund/Notification form to:

UnitedHealthcare Community Plan
P.O. Box 541
Milwaukee, WI 53201

If you do not agree with the overpayment findings, submit a dispute within the required time frame. If you disagree with a claim adjustment or our decision not to make a claim adjustment, you can file a dispute. See Dispute section in this chapter.

We may make claim adjustments without requesting additional information from you. You will see the adjustment on your EOB or Provider Remittance Advice (PRA). When additional information is needed, we will ask you to provide it.

Recovery requests greater than $50,000 or older than one year from payment will be submitted to AHCCCS/DDD for approval and may take more time to complete.

Claims dispute

What is it?

You may file a claim dispute based on a claim denial, dissatisfaction with a claim payment, or recoupment action by UnitedHealthcare Community Plan. In agreement with AHCCCS guidelines, all claim disputes must be filed in writing within the time frame described as follows.

When to use:

If you do not agree with the outcome of the claim reconsideration decision, use the claim dispute process. All claim disputes challenging claim payments, denials or recoupments must be filed in writing with UnitedHealthcare Community Plan no later than 12 months from the date of service, 12 months after the date of eligibility posting or within 60 days after the payment, denial or recoupment of a timely claim submission, whichever is later.

How to use:

The dispute must state that you are filing a "dispute." To help ensure appropriate handling, do not refer to the matter as an appeal. The dispute must include the factual and legal basis for the relief requested, along with all supporting documentation. Please include a cover letter, medical records and any additional information. Send your information electronically or by mail. In your dispute, please include any supporting information not included with your reconsideration request.

UnitedHealthcare Community Plan
Att: Medicaid Claims Disputes
1 East Washington, Suite 900
Phoenix, AZ 85004

You should receive an acknowledgment letter for all claim disputes received within five business days. If you do not, please follow up with the Dispute Department.

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 six months from the date of service, even if the primary carrier has not made payment. If the primary carrier makes payment after this time limit, a corrected claim must be resubmitted with the primary EOB. Claims are processed according to the AHCCCS Contractor Operations Manual (ACOM), Chapter 400, section 434.
- When submitting reconsideration requests, provide the same information required for a clean claim. Explain the discrepancy, what should have been paid and why.
- Refer to your Agreement for submission deadlines concerning third-party claims. Once you have billed the other carrier and received an EOB, submit the claim to UnitedHealthcare Community Plan. Attach a copy of the EOB to the submitted claim. The EOB must be complete to understand the paid amount or the denial reason.
- Claims for dual-eligible members will be paid according to the ACOM Policy 201; Medicare Cost Sharing for Members Covered by Medicare and Medicaid. We are not responsible for cost-sharing should the payment to the primary payer be equal to or greater than what you would have received under Medicaid. Additional information regarding Medicare Cost Sharing is available in the Dual Complete Provider Manual.

Provider grievance

What is it?

Grievances are complaints related to your UnitedHealthcare Community Plan policy, procedures or payments.

When to file:

You may file a grievance about:

- Benefits 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

How to file:

File verbally or in writing.

Phone: Call Provider Services toll free at **1-800-445-1638**

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

UnitedHealthcare Community Plan
Medicaid Grievances
1 East Washington, Suite 900
Phoenix, AZ 85004

You may file a grievance regarding a peer review determination or action to the UnitedHealthcare Community Plan medical director by labeling "ATTN: Medical Director" and mailing it to the aforementioned address.

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

Fraud, waste and abuse

Call the toll-free Fraud, Waste and Abuse Hotline to report questionable incidents involving plan members or care providers. Notify us of suspected fraud or abuse by a care provider or member. Toll-free number is **1-800-455-4521.** You can also call the UnitedHealthcare Special Investigations Unit Fraud Hotline at **1-877-401-9430.**

UnitedHealthcare Community Plan's Anti-Fraud, Waste and Abuse Program focuses on prevention, detection and investigation of false and abusive acts committed by you and plan members. The program also helps identify, investigate and recover money UnitedHealthcare Community Plan paid for such claims. We also refer suspected fraud, waste and abuse cases to law enforcement, regulatory and administrative agencies according to state and federal law. UnitedHealthcare Community Plan seeks to protect the ethical and financial integrity of the company and its employees, members, care providers, government programs and the public. In addition, it aims to protect member health.

UnitedHealthcare Community Plan includes applicable federal and state regulatory requirements in its Anti- Fraud, Waste and Abuse Program. We recognize state and federal health plans are vulnerable to fraud, waste and abuse. As a result, we tailor our efforts to the unique needs of its members and Medicaid, Medicare and other government partners. This means we cooperate with law enforcement and regulatory agencies in the investigation or prevention of fraud, waste and abuse.

An important aspect of the Compliance Program is reviewing our operation's high- risk areas. Then we implement reviews and audits to help ensure compliance with law, regulations and agreements. You are contractually obligated to cooperate with the company and government authorities.

The Deficit Reduction Act (DRA) has provisions reforming Medicare and Medicaid and reducing fraud within the federal health care programs. Every entity that receives at least $5 million in annual Medicaid payments must have written policies for entity employees and contractors. They must provide detailed information about false claims, false statements and whistleblower protections under applicable federal and state fraud and abuse laws. As a participating care provider with UnitedHealthcare Community Plan, you and your staff are subject to these provisions.

This policy details our commitment to compliance with the federal and state false claims acts. It provides a detailed description of these acts and of organizational mechanisms that detect and prevent fraud, waste and abuse. It also details how whistleblowing employees are protected. UnitedHealthcare Community Plan prohibits retaliation if a report is made in good faith.

In addition, in accordance to your Agreement, you must cooperate with the review process to include any requests for medical records. This includes outreach meetings and/ or written correspondence to care providers, record review and/or site audit, individual case peer-to-peer reviews, and referral for further investigation. Once an intervention has occurred, we monitor the practice patterns of an identified care provider to help ensure the potential fraud, waste or abuse practice pattern has been corrected.

As warranted, care providers will be reported to the Arizona Department of Insurance, licensing board(s), and any other regulatory agencies based on the outcome of the investigation and as required by state and federal laws. Throughout this process, we adhere to state law, ERISA guidelines, and confidentiality standards.

Fraud and abuse policies and procedures

You must have established policies and procedures that meet AHCCCS requirements for reporting incidences of health care-acquired conditions, abuse, neglect, exploitation, injuries and unexpected death. The policies and procedures should specify the process of submitting a report of HCACs, abuse, neglect, exploitation, injuries and unexpected death.

Reporting fraud and abuse

If you are aware of any such actions, mail your documentation of the issue to:

UnitedHealthcare Community Plan Compliance Office
1 East Washington, Suite 900
Phoenix, AZ 85004

Reporting physical abuse of a member

If you are aware of any such actions, email **apipa_qualityofcare@uhc.com** with documentation.

Also complete the form on the AHCCCS-OIG website at **azahcccs.gov**.

A form from the AHCCCS website is available on **UHCprovider.com** under the External Guidelines and Resources section. Attach any documentation that would assist AHCCCS in its investigation.

Submit any incidents involving UnitedHealthcare Community Plan members or non-UnitedHealthcare Community Plan members directly to the AHCCCS OIG. Complete and submit the reporting form available on the AHCCCSOIG website. Non- UnitedHealthcare Community Plan members must be reported to the AHCCCS-OIG immediately.

All information provided to UnitedHealthcare Community Plan regarding a potential fraud or abuse occurrence will be kept confidential in accordance with UnitedHealthcare Community Plan's Confidentiality Policy. A copy of this policy is available upon request. Any information developed, obtained or shared among participants in an investigation of a potential fraud and abuse occurrence is maintained specifically for this purpose. Direct any questions to the UnitedHealthcare Community Plan Compliance Officer. HIV-related information should not be disclosed when releasing information related to fraud and abuse.

If you have questions, call the UnitedHealthcare Community Plan Compliance Office or the AHCCCS Administration.

Exclusion checks

First-tier, downstream and related entities (FDRs), must review federal (HHS-OIG and GSA) and state exclusion lists before hiring/contracting employees (including temporary workers and volunteers), the CEO, senior administrators or managers, and sub-delegates. Employees and/or contractors may not be excluded from participating in federal health care programs. FDRs must review the federal and state exclusion lists every month. For more information or access to the publicly accessible, excluded party online databases, please see the following links:

- Health and Human Services – Office of the Inspector General OIG List of Excluded Individuals and Entities (LEIE)

- General Services Administration (GSA) System for Award Management

What you need to do for exclusion checks

Review applicable exclusion lists and maintain a record of exclusion checks for 10 years. UnitedHealthcare Community Plan or CMS may ask for documentation to verify they were completed.

Section 10: Radiology requirements

To learn what Prior Authorization requests would require radiographs, refer to the Dental Benefit Matrix.

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 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 use 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 at **UHCdental.com/medicaid**.

Section 11: Medical records

11.1 Medical record charting standards

UnitedHealthcare Community Plan and AHCCCS Medical Policy Manual, Chapter 900, Policy 940 require you to keep complete and orderly medical records, which fosters efficient and quality member care. You are subject to our periodic quality medical record review. You must also keep medical records in accordance with written protocols related to their care, custody and control as mandated by the state of Arizona AHCCCS program and as prescribed in A.R.S. §12-2297. The review determines compliance to the following requirements:

Topic	Contact
Confidentiality of record	Office policies and procedures exist for: • Privacy of the member medical record. • Initial and periodic training of office staff about medical record privacy. • Release of information. • Record retention. • Availability of medical record if housed in a different office location.

Record organization	• Have a policy that provides medical records upon request. Urgent situations require copies be provided within 48 hours.
	• Maintain medical records in a current, detailed, organized and comprehensive manner. The records should be:
	  – In order.
	  – Fastened, if loose.
	  – Separate for each member.
	  – Filed in a manner for easy retrieval.
	  – Readily available to the treating care provider where the member generally receives care.
	  – Promptly sent to specialists upon request.
	• Medical records are:
	  – Stored in a manner that helps ensure privacy.
	  – Released only to entities as designated consistent with federal requirements.
	  – Kept in a secure area accessible only to authorized personnel.
	  – Backed up with initial and revised information.

Procedural elements	Medical records are readable in blue or black in or typewritten* • Sign and date all entries. • Member name/identification number is on each page of the record. • Corrections made with a line drawn through the incorrect information, a notation, the date the correction was made, and the initials of the person altering the record. Correction fluid or tape is not allowed • If a rubber-stamp signature authenticates the entry, the individual whose signature the stamp represents is accountable for the use of the stamp. • Document language or cultural needs. • Medical records contain demographic data that includes name, identification numbers, date of birth, gender, address, phone number(s), employer, contact information, marital status and an indication whether the member's first language is something other than English. • Procedure for monitoring and handling missed appointments is in place. An advance directive is in a prominent part of the current medical record for adults 18 years and older, emancipated minors and minors with children. Adults 18 years and older, emancipated minors and minors with children are given information about advance directives. • Include a signed and dated acknowledgment of informed consent of proposed treatment from the member or member's legal guardian/custodian. • Include a list of significant illnesses and active medical and behavioral health conditions. • Include a list of prescribed and over-the-counter medications. Review it annually.* • Document the presence or absence of allergies or adverse reactions.* • Obstetric care providers must also complete a risk assessment tool for obstetric patients (i.e., Mutual Insurance Company of Arizona Risk Assessment Tool [MICA] or ACOG). Lab screenings for members requiring obstetric care must also conform to ACOG guidelines. • Documentation that physician or other care provider has notified each member of reproductive age verbally or in writing of the family planning services available. • Documentation of review of the CSPMP database prior to prescribing a controlled substance or another medication that is known to adversely interact with controlled substances. • If assistants are allowed to provide services, the member's record must contain documentation indicating supervision by a licensed professional authorized by the licensing authority to provide the supervision.

History	An initial history (for members seen three or more times) and physical is performed. The initial history for members younger than 21 years should also include prenatal care and birth history. It should include: • Medical, dental, laboratory, behavioral and surgical history* that includes disabilities, immunizations and serious accidents. • A family history that includes relevant medical and behavioral history of parents and/or siblings • A social history that includes information about occupation, living situations, education, smoking, alcohol use, and/or substance abuse use/history beginning at age 11 • Current and history of immunizations of children, adolescents and adults which must be maintained in a separate immunization record. – For all adult members 21 years and older, the record must show the member's immunization status for Td. – For all female members of childbearing age, the record must show blood titer and/or immunization status for rubella. – For members 65 years and older, include immunization status for influenza and pneumococcal. – For at-risk DD/ALTCS EPD members, include immunization status for influenza and pneumococcal. – For all high-risk members 21 years and older, include immunization status for influenza pneumococcal and/or hepatitis B. – For members younger than 21 years, include immunizations given according to CDC recommendations. If no record is available, include documentation about immunization status. For example, state who reported the status and that the copy was requested for the medical records. • Screenings of/for: – Recommended preventive health screenings/tests – Depression – High-risk behaviors such as drug, alcohol and tobacco use; if present, advise to quit – Medicare members for functional status assessment and pain – Adolescents on depression, substance abuse, tobacco use, sexual activity, exercise and nutrition and counseling as appropriate
Problem evaluation and management	Documentation for each visit includes: • Appropriate vital signs (Measurement of height, weight, and BMI annually) – Chief complaint* – Physical assessment* – Diagnosis* – Treatment plan* • Tracking and referral of age and gender appropriate preventive health services consistent with Preventive Health Guidelines. • Documentation of all elements of age appropriate federal Early, Periodic, Screening, Diagnosis and Treatment (EPSDT). • Clinical decisions and safety support tools are in place to ensure evidence based care, such as flow sheets. • Treatment plans are consistent with evidence-based care and with findings/diagnosis: – Timeframe for follow-up visit as appropriate – Appropriate use of referrals/consults, studies, tests • X-rays, labs consultation reports are included in the medical record with evidence of care provider review. • There is evidence of care provider follow-up of abnormal results. • Unresolved issues from a previous visit are followed up on the subsequent visit. • There is evidence of coordination with behavioral health care provider. • Education, including lifestyle counseling, is documented. • Member input and/or understanding of treatment plan and options is documented. • Copies of hospital discharge summaries, home health care reports, emergency room care, practitioner are documented.

*Critical element

11.2 Medical record maintenance

Retain the original or copies of member medical records as follows:

- Adult: for at least six years after the last date the adult member received care services
- Child: either for at least three years after the child's 18th birthday or for at least six years after the last date the adult member received care services, whichever occurs later.

11.3 Sharing medical records and information

You must comply with the following standards:

- Appropriate and confidential exchange of member information among providers, including behavioral health care providers to help ensure:
  - A care provider making a referral transmits necessary information to the care provider receiving the referral.
  - A care provider furnishing a referral service reports appropriate information to the referring care provider.

- You must request information from other treating care providers as necessary to provide appropriate and timely care.
- Medical records and information may be requested by any health plan representative, such as quality management, case management or medical management, at no additional charge.
- When a member chooses a new care provider within the network, the member's records are transferred to the new care provider within 10 working days of the change continuity of care, or if a member subsequently enrolls with a new health plan, sharing of member information is accomplished in a manner to keep it confidential while promoting continuity of care.
- Information form, or copies of records may be released only to, authorized individuals. You must help ensure unauthorized individuals cannot gain access to, or alter, member records.
- Original medical records must be released only in accordance with federal or state laws, AHCCCS policy and contracts, compliance with the Health Insurance Portability and Assurance Act (HIPAA) requirements and 42 CFR 431.300 el seq.
- Confidentiality of member information must be protected by the policy and/or procedures as required by law. There must be documentation that office staff are informed of and agree to confidentiality standards.
- Records for members transitioning to a new contractor must be shared in a way that keeps it confidential while promoting continuity of care.

Appendices for the State of Arizona

Appendix A: Resources and services — how we help you

Addresses and phone numbers

Need:	Resource: Address	Phone number	Payer I.D.	Submission guidelines	Form(s) required
Claim submission (initial)	Claims: UnitedHealthcare Community Plan of Arizona P.O. Box 2185 Milwaukee, WI 53201	1-855-812-9208	GP133	Within 90 calendar days from the date of service, or date of eligibility posting	ADA* Claim Form, 2019 version or later
Prior authorization requests	PTE/Pre-authorizations: UnitedHealthcare Community Plan of Arizona P.O. Box 2020 Milwaukee, WI 53201	1-855-812-9208	GP133	N/A	ADA Claim Form - check the box titled: Request for Predetermination / Preauthorization section of the ADA Dental Claim Form
Provider claims disputes	UnitedHealthcare Community Plan of Arizona Att: Claims Dispute Dept. 1 E. Washington St., Suite 900 Phoenix, AZ 85004	1-800-445-1638 ACC, DD Plans 1-800-293-3740 ALTCS EPD Plans	GP133	No later than 12 months from the date of service, 12 months after the date of eligibility posting or within 60 days after the payment denial or recoupment of a timely claim submission, whichever is later.	Cover sheet requesting a "claims dispute" consideration. Supporting documentation, including claim number is required for processing.
Claims reprocessing & adjustment requests	UnitedHealthcare Community Plan of Arizona Att: Corrected Claims P.O. Box 481 Milwaukee, WI 53201	1-855-812-9208	GP133	Within 365 days from date of service, or date of eligibility posting, only if the initial submission time period has been met.	ADA Claim Form Reason for requesting adjustment or resubmission
Member benefit appeal for service authorization	UnitedHealthcare Community Plan of Arizona Att: Member Appeals 1 E. Washington St., Suite 900 Phoenix, AZ 85004	1-800-587-5187 Expedited Appeals: 1-800-348-4058	N/A	Member appeal must be filed within 60 days from date of the Notice of Adverse Benefit Determination Letter.	N/A

Appendix B: Member benefits/exclusions and limitations

B.1 Member benefits

EPSDT (Early and Periodic Screening, Diagnostic and Treatment) Dental Services (ages 0-20)

Medically necessary emergency, diagnostic, preventative and therapeutic dental services are covered. See the benefit grid (section 4.2) for details.

Adult (ACC, DD and LTC) Dental Services (Ages 21+)

Emergency dental services are covered up to $1,000 per member, per contract year (October 1st to September 30th).

***Dental emergency is defined as an acute disorder of oral health resulting in severe pain and/or infection as a result of pathology or trauma.**

Please see the benefit grid (section 4.2) for details.

Additional emergency services not included in the $1,000 annual benefit limit

Medical and surgical services furnished by dentists which are covered for members 21 years of age and older and are **not subject to the $1000 annual limit,** must be related to the treatment of a medical condition such as

1. acute pain (excluding Temporomandibular Joint Dysfunction (TMJ) pain)
2. infection, or
3. fracture of the jaw

The services qualify if:

1. They may be performed under State law by either a physician or by a dentist, and
2. The services would be considered physician services if furnished by a physician

These covered services include a limited problem focused examination of the oral cavity, required radiographs, complex oral surgical procedures such as treatment of maxillofacial fractures, administration of an appropriate anesthesia and the prescription of pain medication and antibiotics. Members can receive these services even if they have used their $1000 annual benefit. Diagnosis and treatment of TMJ is **not covered** except for reduction of trauma.

Services for transplant, cancer and ventilator cases are not subject to the $1,000 annual benefit limit.

1. Transplant Cases
   Pre-transplant recipients may receive additional dental services in preparation for an organ transplant. All pre-transplant services must be pre-authorized; including initial full exam and x-rays. The member must ask his or her case worker to contact dental department administrative/clinical staff directly to request a pre-authorization for full exam, and x-rays prior to dental visit.

   Covered dental services include the elimination of oral infections and the treatment of oral disease, which include dental cleanings, treatment of periodontal disease, medically necessary extractions, and the provision of simple restorations (silver amalgam and/or composite resin fillings, stainless steel crowns or preformed crowns).

2. Cancer Cases
   Members are eligible for prophylactic extraction of teeth in preparation for radiation treatment of cancer of the jaw, neck, or head.
3. Ventilator Cases
   Members in an inpatient hospital setting who are placed on a ventilator or are physically unable to perform oral hygiene, are eligible for dental cleanings performed by a hygienist working under the supervision of a physician. If services are billed under the physician, then medical codes will be submitted.

Adult ALTCS (DD and LTC) Dental Services (ages 21+)

Medically necessary emergency, diagnostic, preventive and therapeutic dental services are covered up to $1,000 per member, per Contract year (October 1st to September 30th) .

See the benefit grid (section 4 .2) for details .

*ALTCS members are also eligible for services as specified under the Adult Emergency Dental Benefit . (see Adult (ACC, DD and LTC) Dental Services)

Covered Dental Services at IHS/638 Tribal Facilities

Dental services provided to American Indian/Alaska Native members within an IHS/638 tribal facility are not subject to the $1,000 adult emergency or $1,000 ALTCS EPD and DD routine dental benefit limits. Services performed outside of the IHS/638 tribal facilities remain limited to the $1,000 emergency dental benefit for members 21 years of age and over, and the additional $1,000 for dental services for members on ALTCS EPD and DD. Medically necessary services that are eligible for 100 percent Federal reimbursement and that are provided by an IHS or 638 tribal facility to Title XIX members, will be reimbursed by AHCCCS Division of Fee-for Services Management (DFSM).

Intermediate Care Facilities for Individuals with Intellectual Disability/ICF/IID Benefit

For DD members who reside in an ICF/IID, UHCCP will provide all medically necessary dental services including emergency dental services, dental screenings, preventative services, therapeutic services and dental appliances, in accordance with 42 CFR 438.460.

These members are not subject to annual dental benefit limits.

B.2 Benefit grid

Send all dental service billing to UnitedHealthcare Dental using the current ADA claim form. Members cannot be billed for AHCCCS-covered services.

Members may request services from care providers AHCCCS does not cover. Those members must sign a release form stating that they understand the service is not covered under AHCCCS. The form must also state that members are responsible for the bill.

KEY:

ALTCS.....Arizona Long Term Care System
ACC.....AHCCCS Complete Care
APDH.....Affiliated Practice Dental Hygienist
DD.....Developmental Disabilities
LTC.....Long Term Care

C.....Covered service
N.....Non-covered service
C-PA.....Covered only with Prior Authorization (Emergency treatment does not require prior authorization but is subject to retro-review upon claim submission)

CDT Code	Description	Age 0-20	Age 21+		Frequency, Limitations, and Document Requirements***
			ALTCS (DD & LTC) $1000/year	Adult Emergency $1000/year	
D0120	Periodic oral evaluation - established patient	C	C	N	Two per year.
D0140	Limited oral evaluation - problem focused	C	C	C	Not billable within 3 months of original exam date for the same tooth/quadrant. Clinical notes required with claim submission.
D0145	Oral evaluation for patient under 3 years of age, and counseling with primary caregiver	C (Ages 0-2)	N	N	Once per 6 months. Placement required for all patients under age three
D0150	Comprehensive oral evaluation - new or established patient	C	C	N	Once per lifetime per member for each provider group/treating location (unless member has not had a visit in 36 months).
D0160	Detailed and Extensive Oral Evaluation - Problem Focused, By Report	C	C	N	
D0170	Re-Evaluation - Limited, Problem Focused	N	C	N	
D0171	Re-evaluation - Post-operative Office Visit	C	C	N	
D0180	Comprehensive Periodontal Evaluation - New or Established Patient	C-PA	C-PA	N	Once per year. x-rays, periodontal charting, and clinical notes/narrative required.
D0190	Screening of a Patient (APDH only)	C	C	N	One of (D0190, D0191) per 6 months. Not billable within six months of D0120, D0145, D0150.
D0191	Assessment of a Patient (APDH only)	C	C	C	One of (D0190, D0191) per 6 months. Not billable within six months of D0120, D0145, D0150. *Frequency limitation does not apply to emergencies.
D0210	Intraoral-complete series (including bitewings)	C (Ages 6-20)	C	N	One of (D0210, D0330) per 3 years.
D0220	Intraoral- periapical first radiographic image	C	C	C	
D0230	Intraoral- periapical each additional radiographic image	C	C	C	Maximum allowed per day is 5.
D0240	Intraoral- occlusal radiographic image	C	C	N	Maximum allowed per day is 2.
D0250	Extra-oral- 2D projection radiographic image created using a stationary radiation source, and detector	C-PA	C-PA	N	Once per year. Clinical notes or narrative required.
D0251	Extra-oral Posterior Dental Radiographic Image	C	C	N	Once per year.
D0270	Bitewing- single radiographic image	C	C	C	Once per 6 months.
D0272	Bitewings- two radiographic images	C	C	C	Once per 6 months.
D0273	Bitewings- three radiographic images	C	C	C	Once per 6 months.
D0274	Bitewings- four radiographic images	C	C	C	Once per 6 months.
D0277	Vertical Bitewings - 7 to 8 Radiographic Images	C	C	C	Once per 6 months.
D0310	Sialography	C-PA	C-PA	N	Clinical notes or narrative required.
D0320	Temporomandibular Joint Arthrogram, Including Injection	C-PA	C-PA	N	Clinical notes or narrative required.
D0321	Other Temporomandibular Joint Radiographic Images, By Report	C-PA	C-PA	N	Clinical notes or narrative required.

CDT Code	Description	Age 0-20	Age 21+		Frequency, Limitations, and Document Requirements***
			ALTCS (DD & LTC) $1000/year	Adult Emergency $1000/year	
D0330	Panoramic radiographic image	C-PA (Ages 1-5) C (Ages 6-20)	C	C	One of (D0210, D0330) per 3 years. Clinical notes or narrative required for ages 1-5.
D0340	2D Cephalometric Radiographic Image - Acquisition, Measurement and Analysis	C-PA	C-PA	N	Clinical notes or narrative required.
D0350	2D Oral/Facial Photographic Image Obtained Intra-orally or Extra-orally	C-PA	C-PA	N	Once per 6 months. Clinical notes or narrative required.
D0364	Cone Beam - Less Than One Whole Jaw	C-PA	C-PA	C	x-rays and clinical notes/narrative required.
D0372	Intraoral tomosynthesis - comprehensive series of radiographic images	C	C	N	
D0373	Intraoral tomosynthesis - bitewing radiographic image	C	C	C	
D0374	Intraoral tomosynthesis - periapical radiographic image	C	C	C	
D0388	Intraoral tomosynthesis - bitewing radiographic image - image capture only	C	C	C	
D0389	Intraoral tomosynthesis - periapical radiographic image - image capture only	C	C	C	
D0393	Treatment Simulation Using 3D Image Volume	C	C	N	
D0396	3D printing of a 3D dental surface scan	C-PA	C-PA	N	X-rays and clinical notes/narrative required.
D0461	Testing for cracked tooth	C	C	C	Frequency limit is 1 per day per tooth
D0470	Diagnostic Casts	C-PA	C-PA	N	x-rays and clinical notes/narrative required.
D0502	Other Oral Pathology Procedures, By Report	C-PA	C-PA	N	Clinical notes or narrative required.
D0604	Antigen testing for a public health related pathogen, including coronavirus	C	C	C	
D0605	Antibody testing for a public health related pathogen, including coronavirus	C	C	C	
D0701	Panoramic radiographic image - capture only	C-PA (Ages 1-5) C (Ages 6-20)	C	C	Clinical notes or narrative required for ages 1-5.
D0702	2-D cephalometric radiographic image - image capture only	C-PA	C-PA	N	Clinical notes or narrative required.
D0703	2-D oral/facial photographic image obtained intra-orally or extra-orally - image capture only	C-PA	C-PA	N	Once per 6 months. Clinical notes or narrative required.
D0705	Extra oral posterior dental radiographic image - image capture only	C	C	N	Once per 1 year.
D0706	Intraoral-occlusal radiographic image - image capture only	C	C	N	Maximum allowed per day is 2.
D0707	Intraoral-periapical radiographic image - image capture only	C	C	C	Maximum allowed per day is 5.
D0708	Intraoral-bitewing radiographic image - image capture only	C	C	C	Maximum allowed per day is 4.
D0709	Intraoral- complete series of radiographic images - image capture only	C	C	N	Once per 3 years.
D0999	Unspecified Diagnostic Procedure, By Report	C-PA	C-PA	N	Description of procedure, clinical notes and narrative of medical necessity required.

CDT Code	Description	Age 0-20	Age 21+		Frequency, Limitations, and Document Requirements***
			ALTCS (DD & LTC) $1000/year	Adult Emergency $1000/year	
D1110	Prophylaxis- Adult	C	C	N	Once per 6 months.
D1120	Prophylaxis- Child	C	N	N	Once per 6 months.
D1206	Topical application of fluoride varnish/moderate to high caries risk patients	C	C	N	Up to 4 times per year. *application required for all patients aged 3 and under
D1208	Topical application of fluoride	C	C	N	Up to 4 times per year.
D1320	Tobacco counseling for the control and prevention of oral disease	C	C	N	Once per 6 months.
D1321	Counseling for the control and prevention of adverse oral, behavioral, and systemic health effects associated with high-risk substance use.	C	C	N	Once per 6 months.
SEALANTS Replacement/repair of sealant within a 3-year period by the same provider group is not billable					
D1351	Sealant - per tooth	C (Ages 0-15)	N	N	Permanent first and second molars only - teeth #2, 3, 14, 15, 18, 19, 30, 31 Once per 3 years.
D1353	Sealant Repair- per tooth	C (Ages 0-15)	N	N	One of (D1351 or D1353) per provider group, per 3 years.
D1354	Interim Caries Arresting Medicament Application	C	C	N	Application allowed up to 4 times per year. If definitive treatment is completed on tooth within 6 months of SDF, payment for SDF will be netted from restoration/ extraction.
D1355	Caries preventive medicament application – per tooth	C	C	N	Application limited to 5 teeth per day, up to 4 times per year.
D1510	Space maintainer - fixed unilateral - for posterior primary teeth only, which have been lost prematurely	C-PA (Ages 0-14)	N	N	Full arch x-rays and chart notes/narrative required.
D1516	Space maintainer - fixed bilateral, maxillary - for posterior primary teeth only, which have been lost prematurely	C-PA (Ages 0-14)	N	N	Full arch x-rays and chart notes/narrative required.
D1517	Space maintainer - fixed bilateral, mandibular- for posterior primary teeth only, which have been lost prematurely	C-PA (Ages 0-14)	N	N	Full arch x-rays and chart notes/narrative required.
D1520	Space maintainer - removable unilateral - for posterior primary teeth only	C-PA (Ages 0-14)	N	N	Full arch x-rays and chart notes/narrative required.
D1526	Space maintainer - removable bilateral, maxillary - for posterior primary teeth only	C-PA (Ages 0-14)	N	N	Full arch x-rays and chart notes/narrative required.
D1527	Space maintainer - removable bilateral, mandibular - for posterior primary teeth only	C-PA (Ages 0-14)	N	N	Full arch x-rays and chart notes/narrative required.
D1551	Re-cementation of space maintainer - maxillary	C (Ages 0-14)	N	N	Not billable within 6 months of delivery date for the same tooth/quadrant, by the same provider group.
D1552	Re-cementation of space maintainer - mandibular	C (Ages 0-14)	N	N	Not billable within 6 months of delivery date for the same tooth/quadrant, by the same provider group.
D1553	Re-cementation of unilateral space maintainer – per quadrant	C (Ages 0-14)	N	N	Not billable within 6 months of delivery date for the same tooth/quadrant, by the same provider group.
D1556	Removal of fixed unilateral space maintainer – per quadrant	C	C	N	Not billable by the same provider group that originally placed the appliance.
D1557	Removal of fixed bilateral space maintainer – maxillary	C	C	N	Not billable by the same provider group that originally placed the appliance.

CDT Code	Description	Age 0-20	Age 21+		Frequency, Limitations, and Document Requirements***
			ALTCS (DD & LTC) $1000/year	Adult Emergency $1000/year	
D1558	Removal of fixed bilateral space maintainer - mandibular	C	C	N	Not billable by the same provider group that originally placed the appliance.
D1575	Distal shoe space maintainer - fixed unilateral	C-PA (Ages 0-14)	N	N	Full arch x-rays and chart notes/narrative required.
D1999	Unspecified Preventive Procedure, By Report	C-PA	C-PA	N	Description of procedure, clinical notes and narrative of medical necessity required.
RESTORATIVE Multiple surface restorations on a tooth (whether connecting surfaces or not) on the same date of service is reimbursed by the total number of surfaces restored. Replacement of restoration (for the same tooth) within a 2-year period by the same provider group is not billable.					
D2140	Amalgam - one surface, primary or permanent	C	C	N	
D2150	Amalgam - two surfaces, primary or permanent	C	C	N	
D2160	Amalgam - three surfaces, primary or permanent	C	C	N	
D2161	Amalgam - four surfaces, primary or permanent	C	C	N	
D2330	Resin-based composite - one surface, anterior	C	C	C	
D2331	Resin-based composite - two surfaces, anterior	C	C	C	
D2332	Resin-based composite - three surfaces, anterior	C	C	C	
D2335	Resin-based composite - four or more surfaces (anterior)	C	C	C	
D2390	Resin - based composite crown, anterior	C-PA	C-PA	C	Full arch x-rays and chart notes/narrative required.
D2391	Resin - based composite - one surface, posterior	C	C	N	
D2392	Resin - based composite - two surfaces, posterior	C	C	N	
D2393	Resin - based composite - three surfaces, posterior	C	C	N	
D2394	Resin - based composite - four or more surfaces, posterior	C	C	N	
CROWNS Replacement of crowns (for the same tooth) within a 5-year period by the same provider group is not billable.					
D2740	Crown - porcelain/ceramic substrate	C-PA (Ages18-20)	C-PA	C	Ages 18 and over only. Permanent endodontically treated teeth only. Post-op periapical x-ray of completed root canal required.
D2750	Crown - porcelain fused to high noble metal	C-PA (Ages 18-20)	C-PA	C	Ages 18 and over only. Permanent endodontically treated teeth only. Post-op periapical x-ray of completed root canal required.
D2751	Crown - porcelain fused to predominantly base metal	C-PA (Ages 18-20)	C-PA	C	Ages 18 and over only. Permanent endodontically treated teeth only. Post-op periapical x-ray of completed root canal required.
D2752	Crown - porcelain fused to noble metal	C-PA (Ages 18-20)	C-PA	C	Ages 18 and over only. Permanent endodontically treated teeth only. Post-op periapical x-ray of completed root canal required.
D2753	Crown - porcelain fused to titanium and titanium alloys	C-PA (Ages 18-20)	C-PA	C	Ages 18 and over only. Permanent endodontically treated teeth only. Post-op periapical x-ray of completed root canal required.
D2790	Crown - full cast high noble metal	C-PA (Ages18-20)	C-PA	C	Ages 18 and over only. Permanent endodontically treated teeth only. Post-op periapical x-ray of completed root canal required.

CDT Code	Description	Age 0-20	Age 21+		Frequency, Limitations, and Document Requirements***
			ALTCS (DD & LTC) $1000/year	Adult Emergency $1000/year	
D2791	Crown - full cast predominantly base metal	C-PA (Ages18-20)	C-PA	C	Ages 18 and over only. Permanent endodontically treated teeth only. Post-op periapical x-ray of completed root canal required.
D2792	Crown - Full cast noble metal	C-PA (Ages18-20)	C-PA	C	Ages 18 and over only. Permanent endodontically treated teeth only. Post-op periapical x-ray of completed root canal required.
D2794	Crown - titanium	C-PA (Ages18-20)	C-PA	C	Ages 18 and over only. Permanent endodontically treated teeth only. Post-op periapical x-ray of completed root canal required.
D2910	Re-cement inlay, onlay, or partial coverage restoration	C	C	C	x-ray(s) required with claim.
D2915	Re-cement cast or prefabricated post and core	C	C	C	x-ray(s) required with claim.
D2920	Re-cement crown	C	C	C	Not billable within 6 months of delivery date for the same tooth, by the same provider group.
D2921	Reattachment of tooth fragment, incisal edge or cusp	C	C	N	
D2928	Prefabricated porcelain/ceramic crown-permanent tooth	C-PA	C-PA	C	
D2929	Prefabricated Porcelain/Ceramic Crown - Primary Tooth	C-PA	C-PA	N	Primary anterior teeth only. Periapical x-ray showing tooth crown and root structure required.
STAINLESS STEEL CROWNS Replacement of SSCs (for the same tooth) within a 3-year period by the same provider group is not billable.					
D2930	Prefabricated stainless-steel crown - primary tooth	C-PA	C-PA	N	Primary posterior teeth only. Periapical x-ray showing tooth crown and root structure required.
D2931	Prefabricated stainless-steel crown - permanent tooth	C-PA	C-PA	C	Permanent posterior teeth only. Periapical x-ray showing tooth crown and root structure required.
D2932	Prefabricated resin crown	C-PA	C-PA	C	Not covered for anterior primary teeth for patients over age four. Periapical x-ray showing tooth crown and root structure required.
D2933	Prefabricated stainless-steel crown with resin window	C-PA	C-PA	C	Not covered for anterior primary teeth for patients over age four. Periapical x-ray showing tooth crown and root structure required.
D2934	Prefabricated esthetic coated stainless steel crown - primary tooth	C-PA	C-PA	N	Not covered for anterior primary teeth for patients over age four. Periapical x-ray showing tooth crown and root structure required.
D2940	Placement of interim direct restoration	C-PA	C-PA	C	Not covered when done in conjunction with pulpotomies, root canals, and/or permanent restorations. Periapical x-ray and clinical notes/narrative.
D2950	Core build-up, including any pins	C-PA	C-PA	C	Approval of root canal treatment or post-op periapical x-ray of completed root canal therapy required.
D2951	Pin retention - per tooth, in addition to restoration	C-PA	C-PA	N	Post-op periapical x-ray of completed root canal therapy required.
D2952	Post and core in addition to crown	C-PA	C-PA	C	Endodontically treated teeth only. Post-op periapical x-ray of completed root canal therapy required.

CDT Code	Description	Age 0-20	Age 21+		Frequency, Limitations, and Document Requirements***
			ALTCS (DD & LTC) $1000/year	Adult Emergency $1000/year	
ROOT CANALS Retreatment of RCTs (for the same tooth) within one year by the same provider group is not billable.					
D2954	Prefabricated post and core in addition to crown	C-PA	C-PA	C	Endodontically treated teeth only. Post-op periapical x-ray of completed root canal therapy required.
D2976	Band stabilization - per tooth	C-PA (Ages 0-20)	C-PA	N	Once per tooth per year.
D2999	Unspecified Restorative Procedure, By Report	C-PA	C-PA	N	Description of procedure, x-rays, clinical notes and narrative of medical necessity required.
D3110	Pulp cap - direct (excluding final restoration)	C	C	C	Permanent teeth only.
D3120	Pulp cap -indirect (excluding final restoration)	C	C	C	Permanent teeth only.
D3220	Therapeutic pulpotomy (excluding final restoration), primary and permanent teeth (not to be used for apexogenesis)	C-PA	C-PA	C	Not covered for anterior primary teeth for patients over age 4. Periapical x-ray showing tooth coronal and root structure required.
D3221	Pulpal Debridement, Primary and Permanent Tooth	C	C	C	
D3222	Partial pulpotomy for apexogenesis - permanent tooth with incomplete root development	C-PA (Ages 5-20)	C-PA	N	Periapical x-ray of tooth showing coronal and root surfaces, and clinical notes/narrative required.
D3230	Pulpal therapy (resorbable filling)- anterior, primary tooth (excluding restoration)	C-PA (Ages 0-12)	N	N	Not covered for anterior primary teeth for patients over age 4. Periapical x-ray showing tooth coronal and root structure required.
D3240	Pulpal therapy (resorbable filling)- posterior, primary tooth (excluding restoration)	C-PA (Ages 0-14)	N	N	Periapical x-ray showing tooth coronal and root structure required.
D3310	Endodontic therapy, anterior tooth (excluding final restoration)	C-PA	C-PA	C	Permanent teeth only. Periapical x-ray showing tooth coronal and root structure required with authorization request. Periapical of completed root canal required for payment of claim.
D3320	Endodontic therapy, bicuspid tooth (excluding final restoration)	C-PA	C-PA	C	Permanent teeth only. Periapical x-ray showing tooth coronal and root structure required with authorization request. Periapical of completed root canal required for payment of claim.
D3330	Endodontic therapy, molar tooth (excluding final restoration)	C-PA	C-PA	C	Permanent teeth only. Periapical x-ray showing tooth coronal and root structure required with authorization request. Periapical of completed root canal required for payment of claim.
D3331	Treatment of root canal obstruction; non-surgical access	C-PA	C-PA	C	Permanent teeth only. Periapical x-ray showing tooth coronal and root structure required with authorization request. Periapical of completed root canal required for payment of claim.
D3332	Incomplete endodontic therapy; inoperable or fractured	C	C	N	Permanent teeth only. Periapical x-ray showing tooth coronal and root structure, clinical notes/narrative required for payment of claim.

CDT Code	Description	Age 0-20	Age 21+		Frequency, Limitations, and Document Requirements***
			ALTCS (DD & LTC) $1000/year	Adult Emergency $1000/year	
D3333	Internal Root Repair of Perforation Defects	C-PA	C-PA	N	Permanent teeth only. Periapical x-ray showing tooth coronal and root structure required with authorization request. Periapical of completed root canal required for payment of claim.
D3346	Retreatment of previous root canal therapy - anterior	C-PA	C-PA	C	Permanent teeth only. Periapical x-ray showing tooth coronal and root structure required with authorization request. Periapical of completed root canal required for payment of claim.
D3347	Retreatment of previous root canal therapy - bicuspid	C-PA	C-PA	C	Permanent teeth only. Periapical x-ray showing tooth coronal and root structure required with authorization request. Periapical of completed root canal required for payment of claim.
D3348	Retreatment of previous root canal therapy - molar	C-PA	C-PA	C	Permanent teeth only. Periapical x-ray showing tooth coronal and root structure required with authorization request. Periapical of completed root canal required for payment of claim.
D3351	Apexification/recalcification - initial visit (apical closure/calcific repair of perforations root resorption, etc.)	C-PA	C-PA	N	Permanent teeth only. Periapical x-ray showing tooth coronal and root structure, and clinical notes/narrative required.
D3352	Apexification/recalcification - interim medication (apical closure/calcific repair of perforations root resorption, etc.)	C-PA	C-PA	N	Permanent teeth only. Periapical x-ray showing tooth coronal and root structure, and clinical notes/narrative required.
D3353	Apexification/recalcification - final visit (includes completed root canal therapy)	C-PA	C-PA	N	Permanent teeth only. Periapical x-ray showing tooth coronal and root structure, and clinical notes narrative required with authorization request. Periapical of completed root canal required for payment of claim.
D3410	Apicoectomy/periradicular surgery - anterior	C-PA	C-PA	C	Permanent teeth only. Periapical x-ray showing tooth coronal and root structure, and clinical notes/narrative required.
D3421	Apicoectomy/periradicular surgery - bicuspid (first root)	C-PA	C-PA	C	Permanent teeth only. Periapical x-ray showing tooth coronal and root structure, and clinical notes/narrative required.
D3425	Apicoectomy/periradicular surgery molar- (first root)	C-PA	C-PA	C	Permanent teeth only. Periapical x-ray showing tooth coronal and root structure, and clinical notes/narrative required.
D3426	Apicoectomy/ periradicular surgery - each additional root	C-PA	C-PA	C	Permanent teeth only. Periapical x-ray showing tooth coronal and root structure, and clinical notes/narrative required.
D3430	Retrograde filling - per root	C-PA	C-PA	C	Permanent teeth only. Periapical x-ray showing tooth coronal and root structure, and clinical notes/narrative required.
D3450	Root amputation - per root	C-PA	C-PA	N	Permanent teeth only. Periapical x-ray showing tooth coronal and root structure, and clinical notes/narrative required.
D3471	Surgical repair of root resorption - anterior	C-PA	C-PA	C	Permanent teeth only. Periapical x-ray showing tooth coronal and root structure, and clinical notes/narrative required.

CDT Code	Description	Age 0-20	Age 21+		Frequency, Limitations, and Document Requirements***
			ALTCS (DD & LTC) $1000/year	Adult Emergency $1000/year	
D3472	Surgical repair of root resorption - premolar	C-PA	C-PA	C	Permanent teeth only. Periapical x-ray showing tooth coronal and root structure, and clinical notes/narrative required.
D3473	Surgical repair of root resorption - molar	C-PA	C-PA	C	Permanent teeth only. Periapical x-ray showing tooth coronal and root structure, and clinical notes/narrative required.
D3501	Surgical exposure of root surface without apicoectomy or repair of root resorption - anterior	C-PA	C-PA	C	Permanent teeth only. Periapical x-ray showing tooth coronal and root structure, and clinical notes/narrative required.
D3502	Surgical exposure of root surface without apicoectomy or repair of root resorption - premolar	C-PA	C-PA	C	Permanent teeth only. Periapical x-ray showing tooth coronal and root structure, and clinical notes/narrative required.
D3503	Surgical exposure of root surface without apicoectomy or repair of root resorption - molar	C-PA	C-PA	C	Permanent teeth only. Periapical x-ray showing tooth coronal and root structure, and clinical notes/narrative required.
D3920	Hemisection (including any root removal), not including root canal therapy	C-PA	C-PA	N	Permanent teeth only. Periapical x-ray showing tooth coronal and root structure, and clinical notes/narrative required.
D3921	Decoronation or submergence of an erupted tooth	C-PA	C-PA	C	Permanent teeth only. Periapical x-ray showing tooth coronal and root structure, and clinical notes/narrative required.
D3999	Unspecified Endodontic Procedure, By Report	C-PA	C-PA	N	Permanent teeth only. Description of procedure, periapical x-ray showing tooth coronal and root structure, and clinical notes/narrative required.
D4210	Gingivectomy or gingivoplasty - 4 or more contiguous teeth or tooth bounded spaced per quadrant	C-PA	C-PA	N	Full mouth x-rays, and clinical notes/narrative required.
D4211	Gingivectomy or gingivoplasty, one to three teeth, per quadrant	C-PA	C-PA	N	Full mouth x-rays, and clinical notes/narrative required.
D4240	Gingival flap procedure, including root planing, four or more contiguous teeth or bounded spaces per quadrant	C-PA	C-PA	N	Full mouth x-rays, periodontal charting, and clinical notes/narrative required.
D4241	Gingival flap procedure, including root planning, one to three teeth per quadrant	C-PA	C-PA	N	Full mouth x-rays, periodontal charting, and clinical notes/narrative required.
D4249	Clinical crown lengthening - hard tissue	C-PA	C-PA	N	Must be done at least 6 weeks prior to restorative treatment. Full mouth x-rays, and clinical notes/narrative required.
D4260	Osseous surgery (including flap entry and closure), four or more contiguous teeth or bounded teeth spaces per quadrant	C-PA	C-PA	N	Full mouth x-rays, periodontal charting, and clinical notes or narrative required.
D4261	Osseous surgery (including flap entry and closure), one to three teeth, per quadrant	C-PA	C-PA	N	Full mouth x-rays, periodontal charting, and clinical notes/narrative required.
D4263	Bone replacement graft - first site in quadrant	C-PA	C-PA	N	Full mouth x-rays, periodontal charting (when applicable), and clinical notes/narrative required.
D4264	Bone replacement graft - each additional site in quadrant	C-PA	C-PA	N	Full mouth x-rays, periodontal charting (when applicable), and clinical notes/narrative required.
D4265	Biologic materials to aid in soft and osseous tissue regeneration	C-PA	C-PA	N	Full mouth x-rays, periodontal charting (when applicable), and clinical notes/narrative required.
D4266	Guided tissue regeneration - resorbable barrier, per site, per tooth	C-PA	C-PA	N	Full mouth x-rays, periodontal charting (when applicable), and clinical notes/narrative required.

CDT Code	Description	Age 0-20	Age 21+		Frequency, Limitations, and Document Requirements***
			ALTCS (DD & LTC) $1000/year	Adult Emergency $1000/year	
D4267	Guided tissue regeneration - resorbable barrier, per site, per tooth	C-PA	C-PA	N	Full mouth x-rays, periodontal charting (when applicable), and clinical notes/narrative required.
D4270	Pedicle soft tissue graft procedure	C-PA	C-PA	N	Full mouth x-rays, periodontal charting, and clinical notes/narrative required.
D4273	Autogenous connective tissue graft procedure (including donor and recipient surgical sites) first tooth, implant or edentulous tooth position	C-PA	C-PA	N	Full mouth x-rays, periodontal charting (when applicable), and clinical notes/narrative required.
D4274	Distal or proximal wedge procedure (when not performed in conjunction with surgical procedures in the same anatomical area)	C-PA	C-PA	N	Full mouth x-rays and clinical notes/narrative required.
D4275	Non-autogenous connective tissue graft (including recipient site and donor material) first tooth, implant, or edentulous tooth position in graft	C-PA	C-PA	N	Full mouth x-rays and clinical notes/narrative required.
D4276	Combined connective tissue and double pedicle graft, per tooth	C-PA	C-PA	N	Full mouth x-rays and clinical notes/narrative required.
D4286	removal of non-resorbable barrier	C-PA	C-PA	C	Clinical notes or narrative required.
D4322	Splint-intra-coronal; natural teeth or prosthetic crowns	C-PA	C-PA	N	Full mouth x-rays and clinical notes/narrative required.
D4323	Splint-extra-coronal; natural teeth or prosthetic crowns	C-PA	C-PA	N	Full mouth x-rays and clinical notes/narrative required.
D4341	Periodontal scaling and root planning, four or more contiguous teeth or bounded teeth spaces per quadrant	C-PA	C-PA	N	x-rays, periodontal charting, and clinical notes/ narrative required.
D4342	Periodontal scaling and root planning - one to three teeth, per quad	C-PA	C-PA	N	x-rays, periodontal charting, and clinical notes/ narrative required.
D4346	Scaling in presence of generalized moderate or severe gingival inflammation - full mouth, after oral evaluation	C-PA	C-PA	N	Full mouth x-rays, periodontal charting, and clinical notes/narrative required.
D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis	C-PA	C-PA	N	Pre-operative, full mouth x-rays or photos required.
D4910	Periodontal Maintenance	C	C	N	Periodontal diagnosis with history of periodontal scaling required.
D4920	Unscheduled dressing change (by someone other than treating dentist)	C-PA	C-PA	N	Clinical notes or narrative required.
D4999	Unspecified Periodontal Procedure, By Report	C-PA	C-PA	N	Description of procedure, x-rays, periodontal charting, and clinical notes/narrative required.
Prosthodontics (when medically necessary) Allowance for partial and complete dentures include adjustments within six months post-delivery. All partial allowance includes conventional clasps, rests, and teeth. Partial and complete dentures require submission of clinical notes, narrative, and full mouth x-rays to establish medical necessity. Replacement of dentures within three years by the same provider group is not billable.					
D5110	Complete denture - maxillary	C-PA	C-PA	N	Full mouth x-rays and clinical notes/narrative required.
D5120	Complete denture - mandibular	C-PA	C-PA	N	Full mouth x-rays and clinical notes/narrative required.
D5130	Immediate denture - maxillary	C-PA	C-PA	N	Full mouth x-rays and clinical notes/narrative required.
D5140	Immediate denture - mandibular	C-PA	C-PA	N	Full mouth x-rays and clinical notes/narrative required.
D5211	Maxillary partial denture - resin base	C-PA	C-PA	N	Full mouth x-rays and clinical notes/narrative required.

CDT Code	Description	Age 0-20	Age 21+		Frequency, Limitations, and Document Requirements***
			ALTCS (DD & LTC) $1000/year	Adult Emergency $1000/year	
D5212	Mandibular partial denture - resin base	C-PA	C-PA	N	Full mouth x-rays and clinical notes/narrative required.
D5213	Maxillary partial denture-cast metal framework with resin denture bases	C-PA	C-PA	N	Full mouth x-rays and clinical notes/narrative required.
D5214	Mandibular partial denture-cast metal framework with resin denture bases	C-PA	C-PA	N	Full mouth x-rays and clinical notes/narrative required.
D5221	Immediate maxillary partial denture - resin base (including any conventional clasps, rests and teeth)	C-PA	C-PA	N	Full mouth x-rays and clinical notes/narrative required.
D5222	Immediate mandibular partial denture - resin base (including any conventional clasps, rests and teeth)	C-PA	C-PA	N	Full mouth x-rays and clinical notes/narrative required.
D5223	Immediate maxillary partial denture - cast metal framework with resin denture base (including any conventional clasps, rests and teeth)	C-PA	C-PA	N	Full mouth x-rays and clinical notes/narrative required.
D5224	Immediate mandibular partial denture - cast metal framework with resin denture base (including any conventional clasps, rests and teeth)	C-PA	C-PA	N	Full mouth x-rays and clinical notes/narrative required.
D5227	Immediate maxillary partial denture	C-PA	C-PA	N	Full mouth x-rays and clinical notes/narrative required.
D5228	Immediate mandibular partial denture	C-PA	C-PA	N	Full mouth x-rays and clinical notes/narrative required.
D5282	Removable unilateral partial denture - one piece cast metal (including clasps and teeth), maxillary	C-PA	C-PA	N	Full mouth x-rays and clinical notes/narrative required.
D5283	Removable unilateral partial denture - one piece cast metal (including clasps and teeth), mandibular	C-PA	C-PA	N	Full mouth x-rays and clinical notes/narrative required.
D5284	Removable unilateral partial denture – one piece flexible base (including clasps and teeth) – per quadrant	C-PA	C-PA	N	Full mouth x-rays and clinical notes/narrative required.
D5286	Removable unilateral partial denture – one piece resin (including clasps and teeth) – per quadrant	C-PA	C-PA	N	Full mouth x-rays and clinical notes/narrative required.
D5410	Adjust complete denture - maxillary	C	C	N	
D5411	Adjust complete denture - mandibular	C	C	N	
D5421	Adjust partial denture - maxillary	C	C	N	
D5422	Adjust partial denture - mandibular	C	C	N	
D5511	Repair broken complete denture base, mandibular	C	C	N	
D5512	Repair broken complete denture base, maxillary	C	C	N	
D5520	Replace missing or broken teeth - complete denture - per tooth	C	C	N	
D5611	Repair resin partial denture base, mandibular	C	C	N	
D5612	Repair resin partial denture base, maxillary	C	C	N	
D5621	Repair cast partial framework, mandibular	C	C	N	
D5622	Repair cast partial framework, maxillary	C	C	N	
D5630	Repair or replace broken clasp - partial denture	C	C	N	

CDT Code	Description	Age 0-20	Age 21+		Frequency, Limitations, and Document Requirements***
			ALTCS (DD & LTC) $1000/year	Adult Emergency $1000/year	
D5640	Replace missing or broken teeth - partial denture - per tooth	C	C	N	
D5650	Add tooth to existing partial denture - per tooth	C-PA	C-PA	N	Clinical notes or narrative required.
D5660	Add clasp to existing partial denture - per tooth	C-PA	C-PA	N	Clinical notes or narrative required.
D5710	Rebase complete maxillary denture	C-PA	C-PA	N	Clinical notes or narrative required.
D5711	Rebase complete mandibular denture	C-PA	C-PA	N	Clinical notes or narrative required.
D5720	Rebase maxillary partial denture	C-PA	C-PA	N	Clinical notes or narrative required.
D5721	Rebase mandibular partial denture	C-PA	C-PA	N	Clinical notes or narrative required.
D5730	Reline complete maxillary denture (chair side)	C-PA	C-PA	N	Clinical notes or narrative required.
D5731	Reline complete mandibular denture (chair side)	C-PA	C-PA	N	Clinical notes or narrative required.
D5740	Reline maxillary partial denture (chair side)	C-PA	C-PA	N	Clinical notes or narrative required.
D5741	Reline mandibular partial denture (chair side)	C-PA	C-PA	N	Clinical notes or narrative required.
D5750	Reline complete maxillary denture (lab)	C-PA	C-PA	N	Clinical notes or narrative required.
D5751	Reline complete mandibular denture (lab)	C-PA	C-PA	N	Clinical notes or narrative required.
D5760	Reline maxillary partial denture (lab)	C-PA	C-PA	N	Clinical notes or narrative required.
D5761	Reline mandibular partial denture (lab)	C-PA	C-PA	N	Clinical notes or narrative required.
D5765	Soft liner for complete or partial removable denture	C-PA	C-PA	N	Clinical notes or narrative required.
D5820	Interim partial denture (maxillary)	C-PA	C-PA	N	Clinical notes or narrative required.
D5821	Interim partial denture (mandibular)	C-PA	C-PA	N	Clinical notes or narrative required.
D5850	Tissue conditioning (maxillary)	C-PA	C-PA	N	Clinical notes or narrative required.
D5851	Tissue conditioning (mandibular)	C-PA	C-PA	N	Clinical notes or narrative required.
D5876	Add metal substructure to acrylic full denture (per arch)	C-PA	C-PA	N	Clinical notes or narrative required.
D5899	Unspecified removable prosthodontic procedure, by report	C-PA	C-PA	N	Clinical notes or narrative required.
D5909	Maxillary guidance prosthesis with guide flange	C-PA	C-PA	N	Full mouth x-rays and clinical notes/narrative required.
D5911	Facial moulage (sectional)	C-PA	C-PA	N	Clinical notes or narrative required.
D5912	Facial moulage (complete)	C-PA	C-PA	N	Clinical notes or narrative required.
D5913	Nasal prosthesis	C-PA	C-PA	N	Clinical notes or narrative required.
D5914	Auricular prosthesis	C-PA	C-PA	N	Clinical notes or narrative required.
D5915	Orbital prosthesis	C-PA	C-PA	N	Clinical notes or narrative required.
D5916	Ocular prosthesis	C-PA	C-PA	N	Clinical notes or narrative required.
D5919	Facial prosthesis	C-PA	C-PA	N	Clinical notes or narrative required.
D5922	Nasal septal prosthesis	C-PA	C-PA	N	Clinical notes or narrative required.
D5923	Ocular prosthesis, interim	C-PA	C-PA	N	Clinical notes or narrative required.
D5924	Cranial prosthesis	C-PA	C-PA	N	Clinical notes or narrative required.
D5925	Facial augmentation implant prosthesis	C-PA	C-PA	N	Clinical notes or narrative required.
D5926	Nasal prosthesis, replacement	C-PA	C-PA	N	Clinical notes or narrative required.
D5927	Auricular prosthesis, replacement	C-PA	C-PA	N	Clinical notes or narrative required.

CDT Code	Description	Age 0-20	Age 21+		Frequency, Limitations, and Document Requirements***
			ALTCS (DD & LTC) $1000/year	Adult Emergency $1000/year	
D5928	Orbital prosthesis, replacement	C-PA	C-PA	N	Clinical notes or narrative required.
D5929	Facial prosthesis, replacement	C-PA	C-PA	N	Clinical notes or narrative required.
D5929	Facial prosthesis, replacement	C-PA	C-PA	N	Clinical notes or narrative required.
D5930	Maxillary guidance prosthesis without guide flange	C-PA	C-PA	N	Full mouth x-rays and clinical notes/narrative required.
D5932	Obturator prosthesis, definitive	C-PA	C-PA	N	Clinical notes or narrative required.
D5933	Obturator prosthesis, modification	C-PA	C-PA	N	Clinical notes or narrative required.
D5934	Mandibular resection of prosthesis with guided flange	C-PA	C-PA	N	Clinical notes or narrative required.
D5935	Mandibular resection prosthesis without guide flange	C-PA	C-PA	N	Clinical notes or narrative required.
D5936	Obturator prosthesis, interim	C-PA	C-PA	N	Clinical notes or narrative required.
D5937	Trismus appliance (not for TMD treatment)	C-PA	C-PA	N	Clinical notes or narrative required.
D5938	Resection prosthesis, maxillary complete removable	C-PA	C-PA	N	Full mouth x-rays and clinical notes/narrative required.
D5939	Resection prosthesis, mandibular complete removable	C-PA	C-PA	N	Full mouth x-rays and clinical notes/narrative required.
D5940	Resection prosthesis, maxillary partial removable	C-PA	C-PA	N	Full mouth x-rays and clinical notes/narrative required.
D5941	Resection prosthesis, mandibular partial removable	C-PA	C-PA	N	Full mouth x-rays and clinical notes/narrative required.
D5951	Feeding Aid	C-PA (Ages 0-2)	C-PA	N	Clinical notes or narrative required.
D5952	Speech aid prosthesis, pediatric	C-PA (Ages 0-16)	C-PA	N	Clinical notes or narrative required.
D5953	Speech aid prosthesis, adult	C-PA (Ages 16-20)	C-PA	N	Clinical notes or narrative required.
D5954	Palatal augmentation prosthesis	C-PA	C-PA	N	Clinical notes or narrative required.
D5955	Palatal lift prosthesis, definitive	C-PA	C-PA	N	Clinical notes or narrative required.
D5958	Palatal lift prosthesis, interim	C-PA	C-PA	N	Clinical notes or narrative required.
D5959	Palatal lift prosthesis, modification	C-PA	C-PA	N	Clinical notes or narrative required.
D5960	Speech aid prosthesis, modification	C-PA	C-PA	N	Clinical notes or narrative required.
D5982	Surgical stent	C-PA	C-PA	N	Clinical notes or narrative required.
D5983	Radiation Carrier	C-PA	C-PA	N	Clinical notes or narrative required.
D5984	Radiation shield	C-PA	C-PA	N	Clinical notes or narrative required.
D5985	Radiation cone locator	C-PA	C-PA	N	Clinical notes or narrative required.
D5986	Fluoride Gel Carrier	C-PA	C-PA	N	Clinical notes or narrative required.
D5987	Commissure splint	C-PA	C-PA	N	Clinical notes or narrative required.
D5988	Surgical splint	C-PA	C-PA	N	Clinical notes or narrative required.
D5991	Vesiculobullous disease medicament carrier	C-PA	C-PA	N	Once per month. Clinical notes or narrative required.
D5992	Adjust maxillofacial prosthetic appliance, by report	C-PA	C-PA	N	Clinical notes or narrative required.
D5999	Unspecified maxillofacial prosthesis, by report	C-PA	C-PA	N	Clinical notes or narrative required.

CDT Code	Description	Age 0-20	Age 21+		Frequency, Limitations, and Document Requirements***
			ALTCS (DD & LTC) $1000/year	Adult Emergency $1000/year	
D6049	Scaling and debridement of a single implant in the presence of peri-implantitis	C-PA	C-PA	N	This procedure is not performed in conjunction with D1110, D4910 or D4346. x-rays and clinical notes/ narrative required.
D6081	Scaling and debridement of a single implant in the presence of mucositis, including inflammation, bleeding, upon probing, and increased pocket depths; includes cleaning of the implant surfaces, without flap entry and closure	C-PA	C-PA	N	x-rays and clinical notes/narrative required.
D6089	Accessing and retorquing loose implant screw - per screw	C-PA (Ages 0-20)	C-PA	C	Once per tooth per year.
D6105	Removal of implant body not requiring bone removal nor flap elevation	C-PA	C-PA	C	x-rays and clinical notes/narrative required.
D6193	Replacement of an implant screw	C-PA	C-PA	C	Appropriate x-rays and clinical notes/narrative required
D6197	Replacement of restorative material used to close an access opening of a screw-retained implant supported prosthesis, per implant	C-PA	C-PA	C	Clinical notes or narrative required.
D6999	Unspecified fixed prosthodontic procedure, by report	C-PA (Ages18-20)	C-PA	N	Description of procedure, full mouth x-rays, and clinical notes/narrative required.
ORAL AND MAXILLOFACIAL SURGERY (SYMPTOMATIC TEETH ONLY) Extractions of naturally exfoliating teeth are not a covered benefit Extractions will not be billable within 6 months of restorative treatment Extractions performed on an emergency basis will receive retrospective review. Clinical notes, narrative, and x-rays required with claim. Extractions are covered ONLY if: 1. tooth is symptomatic and/or exhibits pathology 2. extraction(s) is NOT for orthodontic purposes					
D7111	Extraction, coronal remnants - primary tooth	C-PA	C-PA	C	Periapical x-ray and clinical notes/narrative required.
D7140	Extraction - single tooth - erupted tooth or exposed root (elevation and/or forceps removal) Includes routine removal of tooth structure, minor smoothing of socket bone, and closure as necessary	C-PA	C-PA	C	Periapical x-ray and clinical notes/narrative required.
D7210	Surgical removal of erupted tooth	C-PA	C-PA	C	Periapical x-ray and clinical notes/narrative required.
D7220	Surgical removal of impacted tooth - soft tissue	C-PA	C-PA	C	Periapical x-ray and clinical notes/narrative required.
D7230	Surgical removal of impacted tooth - partially bony	C-PA	C-PA	C	Periapical x-ray and clinical notes/narrative required.
D7240	Surgical removal of impacted tooth - completely bony	C-PA	C-PA	C	Periapical x-ray and clinical notes/narrative required.
D7241	Removal of impacted tooth completely bony, with unusual surgical complications, by report	C-PA	C-PA	C	Periapical x-ray and clinical notes/narrative required.
D7250	Surgical removal of residual tooth roots (cutting procedure)	C-PA	C-PA	C	Periapical x-ray and clinical notes/narrative required.
D7251	Coronectomy - intentional partial tooth removal	C-PA	C-PA	C	Periapical x-ray and clinical notes/narrative required.
D7259	Nerve dissection	C-PA	C-PA	C	Appropriate x-rays and clinical notes/narrative required
D7260	Oral antral fistula closure	C-PA	C-PA	C	Periapical x-ray and clinical notes/narrative required.
D7261	Primary closure of a sinus perforation	C-PA	C-PA	C	Periapical x-ray and clinical notes/narrative required.
D7270	Tooth re-implantation and/or stabilization of accidentally evulsed or displaced tooth	C	C	C	Periapical x-ray and clinical notes/narrative with claim.

CDT Code	Description	Age 0-20	Age 21+		Frequency, Limitations, and Document Requirements***
			ALTCS (DD & LTC) $1000/year	Adult Emergency $1000/year	
D7280	Exposure of an unerupted tooth	C-PA	C-PA	N	Periapical x-ray and clinical notes/narrative required.
D7282	Mobilization of erupted or malpositioned tooth to aid eruption	C-PA	C-PA	N	Periapical x-ray and clinical notes/narrative required.
D7283	Placement of device to facilitate eruption of impacted tooth	C-PA	C-PA	N	Periapical x-ray and clinical notes/narrative required.
D7284	Excisional biopsy of minor salivary glands	C-PA	C-PA	C	Clinical notes or narrative required.
D7285	Biopsy of oral tissue - hard (bone, teeth)	C-PA	C-PA	C	Periapical x-ray and clinical notes/narrative required.
D7286	Biopsy of oral tissue - soft (all others)	C-PA	C-PA	C	Periapical x-ray and clinical notes/narrative required.
D7292	Surgical placement of temporary anchorage device [screw retained plate] requiring flap; includes device removal	C-PA	C-PA	N	Clinical notes or narrative required.
D7293	Surgical placement of temporary anchorage device requiring flap; includes device removal	C-PA	C-PA	N	x-rays and clinical notes/narrative required.
D7294	Surgical placement of temporary anchorage device without flap; includes device removal	C-PA	C-PA	N	x-ray and clinical notes/narrative required.
D7296	Corticotomy- one to three teeth/tooth spaces, per quadrant	C-PA	C-PA	N	x-rays and clinical notes/narrative required.
D7297	Corticotomy- four or more teeth/tooth spaces, per quadrant	C-PA	C-PA	N	x-rays and clinical notes/narrative required.
D7298	Removal of temporary anchorage device (screw retained plate), requiring flap	C-PA	C-PA	N	Clinical notes or narrative required.
D7299	Removal of temporary anchorage device, requiring flap	C-PA	C-PA	N	Clinical notes or narrative required.
D7300	Removal of temporary anchorage device without flap	C-PA	C-PA	N	Clinical notes or narrative required.
D7310	Alveoloplasty in conjunction with extractions - per quadrant	C-PA	C-PA	C	x-rays and clinical notes/narrative required.
D7311	Alveoloplasty in conjunction with extractions- 1-3 teeth	C-PA	C-PA	C	x-rays and clinical notes/narrative required.
D7320	Alveoloplasty not in conjunction with extractions - per quadrant	C-PA	C-PA	C	x-rays and clinical notes/narrative required.
D7321	Alveoloplasty in conjunction w/o extractions- 1-3 teeth	C-PA	C-PA	C	x-rays and clinical notes/narrative required.
D7410	Excision of benign lesion up to 1.25 cm	C-PA	C-PA	C	x-rays and clinical notes/narrative required.
D7411	Excision of benign lesion greater than 1.25 cm	C-PA	C-PA	C	x-rays and clinical notes/narrative required.
D7412	Excision of benign lesion, complicated	C-PA	C-PA	N	x-rays and clinical notes/narrative required.
D7413	Excision of malignant lesion up to 1.25 cm	C-PA	C-PA	N	x-rays and clinical notes/narrative required.
D7414	Excision of malignant lesion greater than 1.25 cm	C-PA	C-PA	N	x-rays and clinical notes/narrative required.
D7415	Excision of malignant lesion, complicated	C-PA	C-PA	C	x-rays and clinical notes/narrative required.
D7440	Excision of malignant tumor-lesion diameter up to 1.25 cm	C-PA	C-PA	C	x-rays and clinical notes/narrative required.
D7441	Excision of malignant tumor-lesion diameter greater than 1.25 cm	C-PA	C-PA	C	x-rays and clinical notes/narrative required.
D7450	Removal of benign odontogenic cyst or tumor, lesion diameter up to 1.25 cm	C-PA	C-PA	C	x-rays and clinical notes/narrative required.
D7451	Removal of benign odontogenic cyst or tumor, lesion diameter over 1.25 cm	C-PA	C-PA	C	x-rays and clinical notes/narrative required.

CDT Code	Description	Age 0-20	Age 21+		Frequency, Limitations, and Document Requirements***
			ALTCS (DD & LTC) $1000/year	Adult Emergency $1000/year	
D7460	Removal of benign nonodontogenic cyst or tumor, lesion diameter of to 1.25 cm	C-PA	C-PA	C	x-rays and clinical notes/narrative required.
D7461	Removal of benign nonodontogenic cyst or tumor, lesion diameter over 1.25 cm	C-PA	C-PA	C	x-rays and clinical notes/narrative required.
D7465	Destruction of lesion(s) by physical or chemical methods, by report	C-PA	C-PA	C	x-rays and clinical notes/narrative required.
D7471	Removal of lateral exostosis, (maxilla or mandible)	C-PA	C-PA	N	x-rays and clinical notes/narrative required.
D7472	Removal of torus palatinus	C-PA	C-PA	N	x-rays and clinical notes/narrative required.
D7473	Removal of torus mandibularis	C-PA	C-PA	N	x-rays or photos, and clinical notes/narrative required.
D7485	Surgical reduction of osseous tuberosity	C-PA	C-PA	N	x-rays or photos, and clinical notes/narrative required.
D7490	Radical resection of mandible with bone graft	C-PA	C-PA	N	x-rays and clinical notes/narrative required.
D7509	Marsupialization of odontogenic cyst	C-PA	C-PA	C	x-rays and clinical notes/narrative required.
D7510	Incision and drainage of abscess-intraoral soft tissue	C	C	C	x-rays (when applicable) and clinical notes required with claim.
D7511	Incision and drainage of abscess-intraoral soft tissue-complicated	C	C	C	x-rays (when applicable) and clinical notes required with claim.
D7520	Incision and drainage of abscess - extraoral soft tissue	C	C	C	x-rays (when applicable) and clinical notes required with claim.
D7521	Incision and drainage of abscess - extraoral soft tissue-complicated	C	C	C	x-rays (when applicable) and clinical notes required with claim.
D7530	Removal of foreign body from mucosa	C	C	C	x-rays (when applicable) and clinical notes required with claim.
D7540	Removal of reaction producing foreign bodies	C	C	C	x-rays (when applicable) and clinical notes required with claim.
D7550	Partial osteoectomy/sequestrectomy for removal of non-vital bone	C-PA	C-PA	C	Full mouth x-rays and clinical notes/narrative required.
D7560	Maxillary sinusotomy for removal of tooth fragment or foreign body	C-PA	C-PA	C	Full mouth x-rays and clinical notes/narrative required.
D7610	Maxilla-open reduction (teeth immobilized)	C-PA	C-PA	N	Full mouth x-rays and clinical notes/narrative required.
D7620	Maxilla-closed reduction (teeth immobilized)	C-PA	C-PA	N	Full mouth x-rays and clinical notes/narrative required.
D7630	Mandible-open reduction (teeth immobilized)	C-PA	C-PA	N	Full mouth x-rays and clinical notes/narrative required.
D7640	Mandible-closed reduction (teeth immobilized)	C-PA	C-PA	N	Full mouth x-rays and clinical notes/narrative required.
D7650	Malar and/or zygomatic arch open reduction	C-PA	C-PA	N	Full mouth x-rays and clinical notes/narrative required.
D7660	Malar and/or zygomatic arch closed reduction	C-PA	C-PA	N	Full mouth x-rays and clinical notes/narrative required.
D7670	Alveolus-closed reduction	C-PA	C-PA	N	Full mouth x-rays and clinical notes/narrative required.
D7671	Alveolus-open reduction	C-PA	C-PA	N	Full mouth x-rays and clinical notes/narrative required.
D7680	Facial bones-complicated reduction	C-PA	C-PA	N	Full mouth x-rays and clinical notes/narrative required.

CDT Code	Description	Age 0-20	Age 21+		Frequency, Limitations, and Document Requirements***
			ALTCS (DD & LTC) $1000/year	Adult Emergency $1000/year	
D7710	Maxilla-open reduction	C-PA	C-PA	N	Full mouth x-rays and clinical notes/narrative required.
D7720	Maxilla-closed reduction	C-PA	C-PA	N	Full mouth x-rays and clinical notes/narrative required.
D7730	Mandible-open reduction	C-PA	C-PA	N	Full mouth x-rays and clinical notes/narrative required.
D7740	Mandible-closed reduction	C-PA	C-PA	N	Full mouth x-rays and clinical notes/narrative required.
D7750	Malar and/or zygomatic arch-open reduction	C-PA	C-PA	N	Full mouth x-rays and clinical notes/narrative required.
D7760	Malar and/or zygomatic arch-closed reduction	C-PA	C-PA	N	Full mouth x-rays and clinical notes/narrative required.
D7770	Alveolus-open reduction stabilization of teeth	C-PA	C-PA	N	Full mouth x-rays and clinical notes/narrative required.
D7771	Alveolus-closed reduction stabilization of teeth	C-PA	C-PA	N	Full mouth x-rays and clinical notes/narrative required.
D7780	Facial bones-complicated reduction with fixation	C-PA	C-PA	N	Full mouth x-rays and clinical notes/narrative required.
D7810	Open reduction of dislocation	C-PA	C-PA	N	Full mouth x-rays and clinical notes/narrative required.
D7820	Closed reduction of dislocation	C-PA	C-PA	N	Full mouth x-rays and clinical notes/narrative required.
D7830	Manipulation under anesthesia	C-PA	C-PA	N	Full mouth x-rays and clinical notes/narrative required.
D7840	Condylectomy	C-PA	C-PA	N	Full mouth x-rays and clinical notes/narrative required.
D7850	Surgical discectomy; with/without implant	C-PA	C-PA	N	Full mouth x-rays and clinical notes/narrative required.
D7852	Disc repair	C-PA	C-PA	N	Full mouth x-rays and clinical notes/narrative required.
D7854	Synovectomy	C-PA	C-PA	N	Full mouth x-rays and clinical notes/narrative required.
D7856	Myotomy	C-PA	C-PA	N	Appropriate x-rays and clinical notes/narrative required.
D7858	Joint reconstruction	C-PA	C-PA	N	Appropriate x-rays and clinical notes/narrative required.
D7860	Arthrotomy	C-PA	C-PA	N	Appropriate x-rays and clinical notes/narrative required.
D7865	Arthroplasty	C-PA	C-PA	N	Appropriate x-rays and clinical notes/narrative required.
D7870	Arthrocentesis	C-PA	C-PA	N	Appropriate x-rays and clinical notes/narrative required.
D7871	Non-arthroscopic lysis and lavage	C-PA	C-PA	N	Appropriate x-rays and clinical notes/narrative required.
D7872	Arthroscopy-diagnosis, with or without biopsy	C-PA	C-PA	N	Appropriate x-rays and clinical notes/narrative required.
D7873	Arthroscopy-surgical: lavage and lysis of adhesions	C-PA	C-PA	N	Appropriate x-rays and clinical notes/narrative required.
D7874	Arthroscopy-surgical: disc repositioning and stabilization	C-PA	C-PA	N	Appropriate x-rays and clinical notes/narrative required.

CDT Code	Description	Age 0-20	Age 21+		Frequency, Limitations, and Document Requirements***
			ALTCS (DD & LTC) $1000/year	Adult Emergency $1000/year	
D7875	Arthroscopy-surgical: synovectomy	C-PA	C-PA	N	Appropriate x-rays and clinical notes/narrative required.
D7876	Arthroscopy-surgical: discectomy	C-PA	C-PA	N	Appropriate x-rays and clinical notes/narrative required.
D7877	Arthroscopy-surgical: debridement	C-PA	C-PA	N	Appropriate x-rays and clinical notes/narrative required.
D7880	Occlusal orthotic appliance	C-PA	C-PA	N	Appropriate x-rays and clinical notes/narrative required.
D7899	Unspecified TMD therapy, by report	C-PA	C-PA	N	Appropriate x-rays and clinical notes/narrative required.
D7910	Suture of recent small wounds up to 5cm	C-PA	C-PA	N	Appropriate x-rays and clinical notes/narrative required.
D7911	Complicated suture- up to 5 cm	C-PA	C-PA	N	Appropriate x-rays and clinical notes/narrative required.
D7912	Complicated suture-greater than 5 cm	C-PA	C-PA	N	Appropriate x-rays and clinical notes/narrative required.
D7920	Skin graft (identify defect covered, location, and type of graft)	C-PA	C-PA	N	Appropriate x-rays and clinical notes/narrative required.
D7939	Indexing for osteotomy using dynamic robotic assisted or dynamic navigation	C-PA (Ages 0-20)	C-PA	C	Appropriate x-rays and clinical notes/narrative required.
D7940	Osteoplasty - for orthognathic deformities	C-PA	C-PA	N	Appropriate x-rays and clinical notes/narrative required.
D7941	Osteotomy - mandibular rami	C-PA	C-PA	N	Appropriate x-rays and clinical notes/narrative required.
D7943	Osteotomy - mandibular rami with bone graft; includes obtaining the graft	C-PA	C-PA	N	Appropriate x-rays and clinical notes/narrative required.
D7944	Osteotomy - segmented or subapical	C-PA	C-PA	N	Appropriate x-rays and clinical notes/narrative required.
D7945	Osteotomy - body of mandible	C-PA	C-PA	N	Appropriate x-rays and clinical notes/narrative required.
D7946	LeFort I (maxilla - total)	C-PA	C-PA	N	Full mouth x-rays and clinical notes/narrative required.
D7947	LeFort I (maxilla - segmented)	C-PA	C-PA	N	Full mouth x-rays and clinical notes/narrative required.
D7948	Lefort II or Lefort III (osteoplasty of facial bones for midface hypoplasia or retrusion) - without bone graft	C-PA	C-PA	N	Full mouth x-rays and clinical notes/narrative required.
D7949	Lefort II or Lefort III - with bone graft	C-PA	C-PA	N	Full mouth x-rays and clinical notes/narrative required.
D7950	Asseous, osteoperisteal, or cartilage graft of the mandible or maxilla	C-PA	C-PA	N	Full mouth x-rays and clinical notes/narrative required.
D7951	Sinus augmentation with bone or bone substitutes via a lateral open approach	C-PA	C-PA	N	Full mouth x-rays and clinical notes/narrative required.
D7953	Bone replacement graft for ridge preservation- per site	C-PA	C-PA	N	Full mouth x-rays and clinical notes/narrative required.
D7955	Repair of maxillofacial soft and/or hard tissue defect	C-PA	C-PA	N	Full mouth x-rays and clinical notes/narrative required.
D7956	Guided tissue regeneration, edentulous area - resorbable barrier, per site	C-PA	C-PA	C	X-rays and clinical notes/narrative required.

CDT Code	Description	Age 0-20	Age 21+		Frequency, Limitations, and Document Requirements***
			ALTCS (DD & LTC) $1000/year	Adult Emergency $1000/year	
D7957	Guided tissue regeneration, edentulous area - non-resorbable barrier, per site	C-PA	C-PA	C	X-rays and clinical notes/narrative required.
D7961	Buccal/labial frenectomy (frenulectomy)	C-PA	C-PA	N	X-rays and clinical notes/narrative required.
D7962	Lingual frenectomy (frenulectomy)	C-PA	C-PA	N	X-rays and clinical notes/narrative required.
D7963	Frenuloplasty	C-PA	C-PA	N	Full mouth x-rays and clinical notes/narrative required.
D7970	Excision of hyperplastic tissue-per arch	C-PA	C-PA	C	Full mouth x-rays and clinical notes/narrative required.
D7971	Excision of pericoronal gingiva	C-PA	C-PA	C	Full mouth x-rays and clinical notes/narrative required.
D7972	Surgical reduction of fibrous tuberosity	C-PA	C-PA	C	Full mouth x-rays and clinical notes/narrative required.
D7979	Non-surgical Sialolithotomy	C-PA	C-PA	C	Full mouth x-rays and clinical notes/narrative required.
D7980	Sialolithotomy	C-PA	C-PA	C	Full mouth x-rays and clinical notes/narrative required.
D7981	Excision of salivary gland, by report	C-PA	C-PA	C	Clinical notes or narrative required.
D7982	Sialodochoplasty	C-PA	C-PA	C	Full mouth x-rays and clinical notes/narrative required.
D7983	Closure of salivary fistula	C-PA	C-PA	C	Full mouth x-rays and clinical notes/narrative required.
D7990	Emergency tracheotomy	C	C	N	Full mouth x-rays and clinical notes/narrative required.
D7991	Coronoidectomy	C-PA	C-PA	N	Full mouth x-rays and clinical notes/narrative required.
D7995	Synthetic graft-mandible or facial bones, by report	C-PA	C-PA	N	Full mouth x-rays and clinical notes/narrative required.
D7996	Implant-mandible for augmentation purposes, by report	C-PA	C-PA	N	Full mouth x-rays and clinical notes/narrative required.
D7997	Appliance removal (not by dentist who placed appliance)	C-PA	C-PA	N	Full mouth x-rays and clinical notes/narrative required.
D7998	Intraoral placement of a fixation device not in conjunction with a fracture	C-PA	C-PA	N	Full mouth x-rays and clinical notes/narrative required.
D7999	Unspecified oral surgery procedure, by report	C-PA	C-PA	C	Description of procedure, full mouth x-rays, and clinical notes/narrative required.
Orthodontia Braces for cosmetic purposes are not covered. Orthodontic coverage is only allowed when medically necessary and determined to be the primary treatment of choice or an essential part of the overall treatment plan designed by the Primary Care Physician (PCP). The Member's PCP needs to prescribe the braces in conjunction with the help of a dentist for the treatment of a severe condition.					
D8010	Limited orthodontic treatment of the primary dentition	C-PA	C-PA	N	Full mouth x-rays, diagnostic ortho photos, clinical notes/narrative, and letter from PCP required.
D8020	Limited orthodontic treatment of the transitional dentition	C-PA	C-PA	N	Full mouth x-rays, diagnostic ortho photos, clinical notes/narrative, and letter from PCP required.
D8030	Limited orthodontic treatment of the adolescent dentition	C-PA	C-PA	N	Full mouth x-rays, diagnostic ortho photos, clinical notes/narrative, and letter from PCP required.
D8040	Limited orthodontic treatment of the adult dentition	C-PA	C-PA	N	Full mouth x-rays, diagnostic ortho photos, clinical notes/narrative, and letter from PCP required.

CDT Code	Description	Age 0-20	Age 21+		Frequency, Limitations, and Document Requirements***
			ALTCS (DD & LTC) $1000/year	Adult Emergency $1000/year	
D8070	Comprehensive orthodontic treatment of the transitional dentition	C-PA	C-PA	N	Full mouth x-rays, diagnostic ortho photos, clinical notes/narrative, and letter from PCP required.
D8080	Comprehensive orthodontic treatment of the adolescent dentition	C-PA	C-PA	N	Full mouth x-rays, diagnostic ortho photos, clinical notes/narrative, and letter from PCP required.
D8090	Comprehensive orthodontic treatment of the adult dentition	C-PA	C-PA	N	Full mouth x-rays, diagnostic ortho photos, clinical notes/narrative, and letter from PCP required.
D8091	Comprehensive orthodontic treatment with orthognatic surgery	C-PA	C-PA	N	Appropriate x-rays, photos and clinical notes/ narrative required
D8210	Removable appliance therapy	C-PA	C-PA	N	Full mouth x-rays, and clinical notes/narrative required.
D8220	Fixed appliance therapy	C-PA	C-PA	N	Full mouth x-rays, and clinical notes/narrative required.
D8660	Pre-orthodontic treatment visit	C-PA	C-PA	N	Full mouth x-rays, and clinical notes/narrative required.
D8670	Periodic orthodontic treatment visit	C	C	N	Once per 1 month. Clinical notes. History of banding on file required.
D8671	Periodic orthodontic treatment visit associated with orthognatic surgery	C-PA	C-PA	N	Appropriate x-rays, photos and clinical notes/ narrative required
D8680	Orthodontic retention (removal of appliances, construction and placement of retainers(s))	C-PA	C-PA	N	Once per lifetime. Full mouth x-rays and clinical notes/narrative required.
D8695	Removal of fixed orthodontic appliance(s) - for reasons other than completion of treatment	C-PA	C-PA	N	Clinical notes or narrative required.
D8696	Repair of orthodontic appliance - maxillary	C-PA	C-PA	N	Full mouth x-rays and clinical notes/narrative required.
D8697	Repair of orthodontic appliance - mandibular	C-PA	C-PA	N	Full mouth x-rays and clinical notes/narrative required.
D8698	Re-bonding or re-cementing of fixed retainers - maxillary	C-PA	C-PA	N	Full mouth x-rays and clinical notes/narrative required.
D8699	Re-bonding or re-cementing of fixed retainers - mandibular	C-PA	C-PA	N	Full mouth x-rays and clinical notes/narrative required.
D8701	Repair of fixed retainers, includes reattachment - maxillary	C-PA	C-PA	N	Clinical notes or narrative required.
D8702	Repair of fixed retainers, includes reattachment - mandibular	C-PA	C-PA	N	Clinical notes or narrative required.
D8703	Replacement of lost or broken retainer - maxillary	C-PA	C-PA	N	Full mouth x-rays and clinical notes/narrative required.
D8704	Replacement of lost or broken retainer - mandibular	C-PA	C-PA	N	Full mouth x-rays and clinical notes/narrative required.
D8999	Unspecified orthodontic procedure, by report	C-PA	C-PA	N	Description of procedure, full mouth x-rays, clinical notes/narrative, and letter from PCP required.
D9110	Palliative(emergency) treatment of dental pain-minor procedure	C	C	N	x-rays and clinical notes/narrative required. Not a covered procedure if other procedures are reported on same date of service, and same tooth is treated.
D9120	Fixed partial denture sectioning	C-PA	C-PA	N	Full mouth x-rays and clinical notes/narrative required.

CDT Code	Description	Age 0-20	Age 21+		Frequency, Limitations, and Document Requirements***
			ALTCS (DD & LTC) $1000/year	Adult Emergency $1000/year	
ANESTHESIA SERVICES Treating Dentist must indicate on prior authorization if anesthesia services are to be performed by an in-network Anesthesiologist. Prior-authorization request for general anesthesia must include documentation to warrant medical necessity of general anesthesia. Upon approval, the treating dentist will receive an authorization notification. Once treatment has been completed, the Anesthesiologist will submit for the GA performed, including a narrative and anesthesia log for retrospective review of claim. If treatment changes are identified during service delivery, you may submit the services for retrospective review through the standard claims process. Claims must be submitted to the standard claims address, along with supporting documentation.					
D9210	Local anesthesia not in conjunction with operative or surgical procedures	C-PA	C-PA	N	x-rays and clinical notes/narrative required. Not a covered procedure if other procedures are reported on same date of service, and same area is treated.
D9222	Deep sedation/general anesthesia - first 15 minutes	C-PA	C-PA	C	Clinical notes/narrative and medical history must be included with authorization request. Anesthesia logs must be included with claim. Maximum units allowed per day is 1.
D9223	Deep sedation/general anesthesia - each subsequent 15-minute increment	C-PA	C-PA	C	Clinical notes/narrative and medical history must be included with authorization request. Anesthesia logs must be included with claim. Maximum units allowed per day is 11.
D9224	Administration of general anesthesia with advanced airway - first 15 minute increment (or portion thereof) during a dental procedure	C-PA	C-PA	C	Clinical notes/narrative and medical history must be included with authorization request. Anesthesia logs must be included with claim. Maximum units allowed per day is 1.
D9225	Administration of general anesthesia with advanced airway - each subsequent 15 minute increment	C-PA	C-PA	C	Clinical notes/narrative and medical history must be included with authorization request. Anesthesia logs must be included with claim. Maximum units allowed per day is 12.
D9230	Inhalation of nitrous oxide/analgesia, anxiolysis	C (Ages 0-10) C-PA (Ages 11-20)	C-PA	C	Clinical notes/narrative & medical history must be included with authorization request.
D9239	Intravenous moderate (conscious) sedation/ analgesia - first 15 minutes	C-PA	C-PA	C	Clinical notes/narrative and medical history must be included with authorization request. Anesthesia logs must be included with claim. Maximum units allowed per day is 1.
D9243	Intravenous moderate (conscious) sedation/ analgesia - each subsequent 15-minute increment	C-PA	C-PA	C	Clinical notes/narrative and medical history must be included with authorization request. Anesthesia logs must be included with claim. Maximum units allowed per day is 11.
D9244	In-office administration of minimal sedation - single drug - enteral	C-PA	C-PA	C	Clinical notes/narrative & medical history must be included with authorization request.
D9245	Administration of moderate sedation - enteral	C-PA	C-PA	C	Clinical notes/narrative & medical history must be included with authorization request.
D9246	Administration of moderate sedation - non-intravenous parenteral - first 15 minute	C-PA	C-PA	C	Clinical notes/narrative & medical history must be included with authorization request.
D9247	Administration of moderate sedation - non-intravenous parenteral - each subsequent 15 minute, or any portion thereof	C-PA	C-PA	C	Clinical notes/narrative & medical history must be included with authorization request.
D9310	Consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician	C	C	N	Clinical notes or narrative required.
D9410	House/extended care facility call	C-PA	C-PA	N	Clinical notes/narrative and medical history required.
D9420	Professional visit, hospital call	C-PA	C-PA	N	Clinical notes/narrative and medical history must be included with authorization request. Anesthesia logs must be included with claim.

CDT Code	Description	Age 0-20	Age 21+		Frequency, Limitations, and Document Requirements***
			ALTCS (DD & LTC) $1000/year	Adult Emergency $1000/year	
D9430	office visit for observation (during regularly scheduled hours) no other services performed	C	C	N	Applicable x-rays and clinical notes/narrative required.
D9440	Office visit - after regularly scheduled hours	C	C	N	Applicable x-rays and clinical notes/narrative required.
D9610	Therapeutic parenteral drug, single administration	C-PA	C-PA	N	Applicable x-rays and clinical notes/narrative required.
D9612	Therapeutic parenteral drugs, two or more administrations, different medications	C-PA	C-PA	N	Applicable x-rays and clinical notes/narrative required.
D9930	Treatment of complications (postsurgical) - unusual circumstances, by report	C	C	N	Applicable x-rays and clinical notes/narrative required.
D9936	Cleaning and inspection of occlusal guard - per appliance	C	C	N	Frequency limit is once every 6 mos
D9938	Fabrication of a custom removable clear plastic temporary aesthetic appliance	C-PA (Ages 0-20)	C-PA	N	Appropriate x-rays and clinical notes/narrative required.
D9944	Occlusal guard - Hard appliance, full arch	C-PA	C-PA	N	Applicable x-rays and clinical notes/narrative required.
D9945	Occlusal guard - Soft appliance, full arch	C-PA	C-PA	N	Applicable x-rays and clinical notes/narrative required.
D9946	Occlusal guard - Hard appliance, partial arch	C-PA	C-PA	N	Applicable x-rays and clinical notes/narrative required.
D9951	Occlusal adjustment-limited	C-PA	C-PA	N	Full mouth x-rays and clinical notes/narrative required. Coverage is limited to adjustment performed in conjunction with treatment of periodontal disease.
D9995	Teledentistry - synchronous; real-time encounter	C	C	C	Indicates the use of teledentistry only. Does not include a reimbursement fee.
D9996	Teledentistry - asynchronous; information stored and forwarded to dentist for subsequent review	C	C	C	Indicates the use of teledentistry only. Does not include a reimbursement fee.
D9999	Unspecified adjunctive procedure, by report	C-PA	C-PA	N	Description of procedure, periapical x-ray and clinical notes/narrative required.

*** For the convenience of our members and to not pose a barrier to care, in the event all required documentation listed cannot be acquired or is not submitted, we will do our best to review for medical necessity of the requested services based on what is received. However, please be aware that this may cause delay in approvals or may result in a denial if adequate review cannot be performed.

B.3 Exclusions & limitations

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

Any service not listed as a covered service in the benefit grids (Section 4.1) is excluded.

Experimental or investigational testing is not covered, according to AHCCCS guidelines.

Please call Provider Services at **1-855-812-9208** if you have any questions regarding frequency limitations.

B.4 Dental Home Program

Effective August 1, 2014, UnitedHealthcare Community Plan of Arizona implemented the Dental Home Program. This program includes all members (ACC, DD and LTC) aged 0 thru 20 years of age. More recently, UHCCP has also assigned DD and LTC members age 21 and older to a Dental Home.

The American Academy of Pediatric Dentistry (AAPD) defines dental home as "inclusive of all aspects of oral health that result from the interaction of the patient, parents, non-dental professionals, and dental professionals." It constitutes the ongoing relationship between the dentist who is the Primary Care Dentist (PCD) and the patient, which includes comprehensive oral health care, beginning no later than age one, pursuant to ADA policy.

The Dental Home visit can be initiated as early as 6 months of age and should include the following:

- Comprehensive oral examination
- Oral hygiene instruction with primary caregiver
- Dental prophylaxis, if appropriate
- Topical fluoride varnish application when teeth are present
- Caries risk assessment
- Dental anticipatory guidance.

Member assignment to dental homes

UnitedHealthcare Community Plan will inform the members of the selected or assigned dental home. The member will receive relevant contact information and recommendation to schedule a dental visit.

Assignment

New members

- An auto-assignment to a dentist will be conducted based on the member's home address on file
- Family units will have the same dental home

Re-assignment

- Member re-assignment can be triggered by a provider termination, suspension, or other network-related reasons
- Member re-assignment can also be triggered if a member requests a re-assignment to another dental provider of their choice

Member notification

- The member will receive a Dental Home Assignment notification letter that contains the demographic information for their dental home assigned dentist
- The member will receive a Dental Home Reminder letter on the month of their birthdate, annually

- The member will receive a re-assignment letter when a re-assignment is triggered/initiated

Member rights

- The member can exercise the right to change dental homes at any time
- Members are allowed to visit a dentist of their choice, at any time, despite the dental home assignment on file

Participating Provider's Support of the Dental Home Program

- Only pediatric and general dentists are included in the Dental Home program. Specialty dental providers other than pediatric dentists will be excluded.
- A membership roster, for each dentist, is available for download through the Dental Hub at **UHCdental.com/medicaid**
  - Assistance available by calling the Dental Hub assistance team at **1-855-464-5633.**

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 at **1-855-934-9818.**

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.

For Dental prior authorizations, you can submit by paper or submit online at **UHCdental.com/medicaid**.

Authorization submission mailing address:

Prior Authorization
PO Box 2020
Milwaukee, WI 53201

Type of request	Decision TAT	Dental provider notification of approval	Written dental provider notification of denial
STANDARD request (i.e., elective/ routine/non-urgent)	A decision and notification is made no later than 7 calendar days following the receipt of the request. This time frame may be extended up to 14 days if the member or care provider requests an extension or if more information is needed and the delay is the member's best interest.	Within 24 hours of the decision	Within two business days of the decision
EXPEDITED request (i.e., Urgent/STAT)	These requests should ONLY be made when the standard time frame could seriously jeopardize the member's life, health, or ability to attain, maintain or regain maximum function. A decision and notification will be made no later than 72 hours following the receipt of the request, with a possible extension up to 14 days if the member or care provider requests an extension or if more information is needed and the delay is in the member's best interest.	Within three days of the request	Within three days of the request
Retrospective review	Within 30 calendar days of receiving all pertinent clinical information	Within 24 hours of determination	Within 24 hours of determination and member notification within two business days

C.2 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.

C.3 Member appeals and grievances definitions and procedures

UnitedHealthcare Community Plan uses the Centers for Medicare and Medicaid Services (CMS) definitions for member appeals and grievances.

Member benefit appeals

What is it?

You may assist members in filing an appeal on their behalf with the member's written permission. The appeal may be filed either verbally and later confirmed in writing and must be received within 60 days from the date of the Notice of Adverse Benefit Determination letter. If you, on behalf of the member, believe the member's health or ability to function will be harmed unless a decision is made in the next 72 hours, the member or you can ask for an expedited appeal.

For expedited appeals, call **1-800-348-4058** (TDD **711**) or **1-800-293-3740** for ALTCS EPD Member Services. Reasons for filing an appeal include:

- The denial or limited authorization of a requested service, including the type or level of service
- The reduction, suspension, or termination of a previous authorization
- The denial, in whole or in part, or payment of a service
- Not providing service in a timely manner
- For residents of a rural area with only one health plan, the denial of the member's request to obtain services outside of the network

You or a member may appeal when the plan:

- Makes a determination with which you or the member disagrees or limits a requested service(s). This includes the type or level of service.
- Lowers, suspends or ends a previously authorized service
- Refuses, in whole or part, payment for services
- Fails to provide services in a timely manner, as defined by the state or CMS
- Does not act within the time frame CMS or AHCCCS requires

When to use:

You may act on the member's behalf with their written consent within 60 days from the date of the Notice of Adverse Benefit Determination (NABD). You may provide medical records and certification of the appeal as appropriate.

Where to send:

Call or mail the information within 60 calendar days from the date of the Notice of Adverse Benefit Determination to:

UnitedHealthcare Community Plan Member Appeals and Grievance
1 East Washington, Suite 900
Phoenix, AZ 85004
Toll free: **1-866-292-0359**

How to use:

Whenever a service is denied, you must provide the member with UnitedHealthcare Community Plan member appeal rights. 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.
- The member or representative may 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 by calling **1-800-348-4058** (TDD 711) or **1-800-293-3740** for ALTCS EPD Member Services, if waiting for this health service could harm the member's health. You have two business days to represent evidence and allegations of fact or law in person and in writing.
- 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.
- We must resolve a standard appeal 30 calendar days from the day we receive it.
- We must resolve an expedited appeal within 72 hours from when we receive it. We may extend the response times up to 14 calendar days if the following conditions apply:

1. Member requests we take longer.
2. We request additional information and explain how the delay is in the member's interest.

If submitting the appeal by mail or fax, you must complete the Authorization of Review (AOR) form-Claim Appeal.

Member grievance

What is it?

The member and family have the right to voice dissatisfaction with the treatment or care the member receives. They must be free from any punishment, restraint or seclusion for decisions pertaining to filing a complaint. Grievances are complaints related to UnitedHealthcare Community Plan policy, procedures or payments.

When to use:

You may file a grievance as the member's representative.

Where to send:

You or the member may file a grievance by calling Member Services or writing UnitedHealthcare Community Plan:

Mailing address:

UnitedHealthcare Community Plan Member Appeals and Grievance
1 East Washington, Suite 900
Phoenix, AZ 85004

We will send an answer within 10 business days but no later than 90 calendar days from when you filed the complaint/ grievance. We will send an answer within 10 business days but no later than 90 calendar days from when you filed the complaint/grievance. Clinically urgent grievances are resolved within five business days, based on Exhibit F.1.14 Contract language from Att F.1.14: The Contractor shall address identified issues as expeditiously as the member's condition requires and must resolve each grievance within 10 business days of receipt, absent extraordinary circumstances. However, no grievances shall exceed 90 days for resolution. Contractor decisions on member grievances cannot be appealed [42 CFR 457.1260, 42 CFR 438.408(a), 42 CFR 438.408(b)(1) and (3)].

State fair hearings

What is it?

If you disagree with your claim dispute decision, you may submit your written request for a State Fair Hearing (SFH). A member or their representative may file a SFH if they disagree with the appeal or Notice of Decision response, according to 42 CFR Part 438.

When to use:

For a claim dispute, a state fair hearing (SFH) must be filed within 30 calendar days from the receipt of the claim dispute Notice of Decision. For a member appeal, you have 120 calendar days from the receipt of the appeal Notice of Decision to file a SFH.

How to use:

Include in your request for a claim dispute hearing the claim dispute number from the Notice of Decision and the member's name. Clearly identify the request as a SFH.

Include in your request for a member appeal hearing the member's name, ID number and written consent. Clearly identify the claim as a SFH. Mail the request to:

UnitedHealthcare Community Plan State Fair Hearing Coordinator
Appeals & Claim Disputes Department
1 East Washington, Suite 900
Phoenix, AZ 85004

If you submit SFH requests for DD members, submit according to the information provided on the Notice of Decision letter. AHCCCS will send the information on how the SFH will be handled, such as meeting date and time. AHCCCS will decide the outcome of the SFH.

Processes related to reversal of our initial decision

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

C.4 Payment for non-covered services

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

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

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

Please note: It is recommended that benefits and eligibility be confirmed by the provider before treatment is rendered.

Members are held harmless and cannot be billed for services that are covered under the plan or for diagnostic services not deemed medically necessary because they are not the standard of care..

C.5 After-hours emergency

When a provider treats a patient for urgent dental needs, outside of the normal business hours of 8 a.m. to 6 p.m., Monday through Friday, providers should:

- Confirm patient eligibility on the date of service through our website, or our Interactive Voice Response system.
- Services that require prior-authorization will be reviewed for medical necessity retrospectively upon claim submission.
- Consult the benefit guide to determine if services are covered under the plan.

C.6 General care provider responsibilities

Non-discrimination

You can't refuse an enrollment/assignment or disenroll a member or discriminate against them solely based on age, sex, race, physical or mental handicap, national origin, religion, type of illness or condition. You may only direct the member to another care provider type if that illness or condition may be better treated by someone else.

Communication between care providers and members

The UnitedHealthcare Community Plan Agreement does not prevent you from advocating on behalf of the members. It does not interfere with UnitedHealthcare Community Plan's ability to administer its quality improvement, utilization management or credentialing programs. Instead, we require communication between PCDs (Primary Care Dentists) and other participating care providers. This helps ensure UnitedHealthcare Community Plan members receive both quality and cost-effective health services.

UnitedHealthcare Community Plan members and/ or their representative(s) may take part in the planning and implementation of their care. To help ensure members and/or their representative(s) have this chance, UnitedHealthcare Community Plan requires you:

1. Educate members, and/or their representative(s) about their oral health needs.
2. Share findings of history and oral exams.
3. Discuss options (without regard to plan coverage), treatment side effects and symptoms management. This includes any self-administered alternative or information that may help them make care decisions.
4. Recognize members (and/or their representatives) have the right to choose the final course of action among treatment options.
5. Collaborate with the plan care manager in developing a specific care plan for members enrolled in High Risk Care Management.
6. Render covered services to members in an appropriate, timely, cost-effective manner and in accordance with their specific Agreement and AHCCCS requirements.

7. Maintain all licenses, certifications, permits or other prerequisites required by law to provide covered services.
8. Render services to members diagnosed with the Human Immunodeficiency Virus (HIV) or having Acquired Immune Deficiency Syndrome (AIDS) in the same manner and to the same extent as other members
9. Use the Arizona State Board of Pharmacy Controlled Substance Prescription Monitoring Program (CSPMP) when prescribing controlled medications.
10. Complete required re-enrollment process in compliance with AHCCCS guidelines as stated in 42 CFR 455, Subpart E.
11. When transitioning a member to a new PCD or other network care provider, transfer the member's records within 10 working days of the change. If a member enrolls with a new health plan, share member information according to confidentiality rules.

Abuse, neglect and exploitation prevention

Based on the Minimum Subcontract Provisions and Executive Order 2019-03, care providers who directly serve children or vulnerable adults, as defined by A.R.S. § 46-451(A)(9), must develop policies, signage and training aimed at preventing abuse, neglect and exploitation as well as reporting incidents. Please implement and monitor policies aimed at preventing abuse, neglect and exploitation and report incidents, conduct investigations and complete routine testing of staff responses to simulated acts of exploitive, abusive and neglectful behavioral in a manner similar to routine fire and other emergency drills. Post signage about how to anonymously report abuse, neglect and exploitation that also explains whistleblower protections.

Provide official notice

Write to us within 10 calendar days if any of the following events happen:

1. Bankruptcy or insolvency.
2. Indictment, arrest, felony conviction or any criminal charge related to your practice or profession.
3. Suspension, exclusion, debarment or other sanction from a state or federally funded health care program.
4. Loss or suspension of your license to practice.
5. Departure from your practice for any reason.
6. Closure of practice.

You may use the Physician/Provider Demographic Update Fax Form for demographic changes or update NPI information for care providers in your office. This form is located at **UHCdental.com/medicaid**.

Arrange substitute coverage

If you cannot provide care and must find a substitute, arrange for care from other UnitedHealthcare Community Plan care providers and care professionals.

Administrative terminations for inactivity

Up-to-date directories are a critical part of providing our members with the information they need to take care of their health. To accurately list care providers who treat UnitedHealthcare Community Plan members, we:

1. End Agreements with care providers who have not submitted claims for UnitedHealthcare Community Plan members for one year and have voluntarily stopped participation in our network.

2. Inactivate any tax identification numbers (TINs) with no claims submitted for one year. This is not a termination of the Provider Agreement. Call UnitedHealthcare Community Plan to reactivate a TIN.

Also notify AHCCCS about these changes. Details and forms are found on azahcccs.gov. Registered AHCCCS care providers may also change their address with AHCCCS using this website.

After-hours care

Life-threatening situations require the immediate services of an emergency department. Urgent care can provide quick afterhours treatment and is appropriate for infections, fever, and symptoms of cold or flu.

If a member calls you after hours asking about urgent care, and you can't treat them, refer them to an urgent care center.

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.

Provide access to your records

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

Performance data

You shall allow the plan to use care provider performance data.

Comply with protocols

You shall comply with UnitedHealthcare Community Plan's and Payer's Protocols, including those contained in this manual.

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.

Follow medical record standards

Please reference Section 11 for Medical Record Standards.

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 Arizona 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 as well as with the ADHS Division of Licensing Services.

Informed consent

Informed consent is an agreement to receive a service or treatment after the member has been told the associated risks and benefits. It must be obtained from a member or legal guardian prior to delivering services.

The AHCCCS guidelines regarding general and informed consent are available in the Medical Policy Manual, Chapter 300, Policy 320-Q.

In all cases where informed consent is required per Policy 320-Q, informed consent must include at a minimum:

- The member's right to participate in decisions regarding their care, including the right to refuse treatment and to express preferences about future treatment options;
- The information about the member's diagnosis and the proposed treatment, including the intended outcome, nature and all available procedures involved in the proposed treatment;
- The risks of the proposed treatment, including side effects and refusing care;
- The alternatives to the proposed treatment, such as those that offer less risk or other adverse effects;
- That any consent given may be withheld or withdrawn in writing or orally at any time. When this occurs, you must document the member's choice in the medical record;
- The risks involved in revoking informed consent to treatment; and
- A description of clinical indications that might require stopping the proposed treatment.

Review details about documenting informed consent in Section 11.

Appendix D: Member rights and responsibilities

Our Member Handbook has a section on member rights and responsibilities. In it, we ask that members treat you with respect and courtesy. If they do not, please call Provider Services and ask to speak with the member's care manager.

D.1 Privacy regulations

HIPAA privacy regulations offer full federal protection to protect member health care information. These regulations control the internal and external uses and disclosures of such data. They also create member rights.

Access to protected health information

Members may access their medical records or billing information either through you or us. If their information is electronic, they may ask that you or we send a copy in an electronic format. They may also ask that a copy of their information be provided to a third party.

Amendment of PHI

Our members have the right to ask that you or we change information they believe to be inaccurate or incomplete. The member request must be in writing and explain why they want the change. You or we must act on the request within 60 days, or may extend another 30 days with written notice. If denying the request, provide certain information to the member explaining the denial reason and actions the member must take.

Disclosure of member information

Information obtained while providing a member with covered health services is confidential. It may only be disclosed according applicable federal and state law. If an unauthorized use/disclosure of unsecured PHI occurs, the covered entity responsible for the breach must notify all affected persons. Medical records must be maintained based on written protocols related to their care, custody, and control as mandated by the AHCCCS program. Before disclosing PHI, consult the specific citation to HIPAA and state law. Also consult with legal counsel. To prevent breaches, maintain a list of every person or organization that inspects a currently or previously enrolled person's records other than the clinical team. Also track how the information is used. The access list must be placed in the member's record and be made available to them, their guardian or designated representative. Retain consent and authorization medical records as noted in A.R.S. §12-2297.

Right to request restrictions

Members have the right to ask you to restrict the use and disclosures of their PHI for treatment, payment and health care operations. For example, members may request to restrict disclosures to family members or to others who are involved in their care or payment. You may deny this request. If you approve restriction, document the request and restriction details. You will be required to abide by the restriction.

Right to request confidential communications

Members have the right to request communications from you or us be sent to a separate location or other means. You must accommodate reasonable requests, especially if the member states disclosure could

endanger them. Requests for confidential communication do not require a member explanation. Keep a written copy of the request.

D.2 Member rights and responsibilities

Native American access to care

Native American members can access care to tribal clinics and Indian hospitals without approval.

Member rights

Based on 42 CFR 438.100 and 42 CFR 457.1220, members have the right to:

- Request information on advance directives.
- Be treated with respect, dignity and privacy.
- Receive courteous and prompt treatment.
- Receive cultural assistance, including having an interpreter during appointments and procedures. This also includes the right to refuse care from specified providers.
- Receive information about us, their rights and responsibilities, their benefit plan and which services are not covered.
- Receive information about how the health plan evaluates new technology for inclusion as a covered benefit.
- Know the qualifications of their health care provider.
- Give their consent for treatment unless unable to do so because life or health is in immediate danger.
- Discuss any and all treatment options with you.
- Refuse treatment directly or through an advance directive. They may also refuse care from a specific care provider.
- Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.
- Receive medically necessary services covered by their benefit plan.
- Receive information about in-network care providers and practitioners, and choose a care provider from our network.
- Tell us if they are not satisfied with their treatment or with us; they can expect a prompt response.
- Tell us their opinions and concerns about services and care received.
- Register grievances or complaints concerning the health plan or the care provided.
- Appeal any payment or benefit decision we make.
- Review or request a copy of their medical records you keep and request changes and/or additions to any area they feel is needed.
- Receive information about their condition, understand treatment options, regardless of cost or whether such services are covered, alternative treatment options, and talk with you when making decisions about their care.
- Be informed of medical alternatives and other types of care and how they access care.
- Get a second opinion with an in-network care provider.
- Expect health care professionals are not kept from advising them about health status, medical care or treatment, regardless of benefit coverage.
- Make suggestions about our member rights and responsibilities policies.

- Get more information upon request, such as on how our health plan works and a care provider's incentive plan, if they apply.
- Know if they need stop-loss insurance for very large claims.
- Know how we compensate you.
- Exercise their rights and that the exercise if those rights shall not adversely affect service delivery to the member.
- Request a summary of the member survey results.

Member responsibilities

Members should:

- Read their Member Handbook so they can understand their benefits and get the most value from them.
- Show you their Medicaid member ID card.
- Prevent others from using their ID card.
- Understand their health problems and give you true and complete information.
- Ask questions about treatment.
- Work with you to set treatment goals.
- Follow the agreed-upon treatment plan.
- Get to know you before they are sick.
- Keep appointments or tell you when they cannot keep them.
- Treat your staff and our staff with respect and courtesy.
- Get any approvals needed before receiving treatment.
- Use the ER only during a serious threat to life or health.
- Notify us of any change in address or family status.
- Make sure you are in-network.
- Follow your advice and understand what may happen if they do not follow it.
- Give you and us information that could help improve their health.
- Give a copy of their living will to their PCP.

Our member rights and responsibilities help uphold the quality of care and services they receive from you. The three primary member responsibilities as required by the National Committee of Quality Assurance (NCQA) are to:

- Supply information (to the extent possible) to AHCCCS, UnitedHealthcare Community Plan and to you that is needed for you to provide care.
- Follow care to which they have agreed.
- Understand their condition and take part in developing mutually agreed-upon treatment goals, to the degree possible.

D.3 Change of contractor

AHCCCS ACOM policy 401 sets guidelines, criteria and time frames for how, when and by whom insurance contractor change requests are processed for AHCCCS members outside of contractor choice offered upon initial enrollment and the Annual Enrollment Choice (AEC) period. This affects:

- The member
- The member's current/relinquishing contractor

- The receiving contractor
- AHCCCS

Criteria for change of contractor outside of initial enrollment or AEC period

Contractor change requests outside these periods are granted if certain conditions are met. These conditions are:

- **Administrative actions that may merit a contractor change**
  - A member was entitled to freedom of choice but was not sent an auto-assignment/freedom of choice notice.
  - A member was entitled to participate in an AEC but:
    - Was not sent an AEC notice, or
    - Was sent an AEC notice but could not take part due to circumstances beyond the member's control.
  - Family members were inadvertently enrolled with different contractors through the auto-assignment process. Upon receipt of AHCCCS notification, the member who was wrongly enrolled will be disenrolled from the contractor of assignment and enrolled in the contractor where the other family members are enrolled. Other family members may not change to the contractor to which the new member was auto-assigned. This process does not apply if a member was afforded an enrollment choice during their AEC period.
  - A member who was enrolled with a contractor, lost eligibility and was disenrolled, then was subsequently redetermined eligible and reenrolled with a different contractor within 90 days from the date of disenrollment. In this case, the member will be reenrolled with the contractor they were enrolled with prior to the loss of eligibility. If this does not occur, AHCCCS, upon notification, will enroll the member with the correct contractor.
  - Newborns will automatically be assigned to the mother's contractor. If the mother is Title XIX or Title XXI-eligible, she will be given 30 days from notification to select another contractor for the newborn. Newborns of Federal Emergency Services (FES) mothers will be auto-assigned, and the mother will be given 30 days to select another contractor.
  - Adoption subsidy children will be auto-assigned, and the guardian will be given 30 days from notification to select another contractor.
  - A Title XIX-eligible member who is entitled to freedom of choice but becomes eligible and is auto-assigned prior to having the full choice period of 30 days will be allowed to request a contractor change following auto-assignment. The member will be given 30 days to request a contractor change. A member who does not make a selection within 30 days will remain with the auto-assigned contractor.
- **Medical continuity of prenatal care**

  A pregnant member enrolled with a contractor through auto- assignment or freedom of choice but who is receiving or has received prenatal care from a provider who is affiliated with another contractor may be granted a medical continuity contractor change if the medical directors of both contractors agree. If other individuals in the pregnant member's family are also AHCCCS-eligible and enrolled, they may remain with the current contractor or transition to the new one if the medical continuity plan change is granted. The member may not return to the original contractor or change to another after the medical continuity contractor change has been granted except during the AEC period.
  - Members who transition to a new contractor or become enrolled during their third trimester must be allowed to complete maternity care with their current AHCCCS-registered care provider, regardless of contractual status, to help ensure continuity of care.

- **Medical continuity of care**

AHCCCS has standards for network composition that result in uniform availability and accessibility of services from all contractors serving a specific geographic area. In unique situations, contractor changes may be approved on a case- by-case basis to help ensure the member has access to care.

A plan change for medical continuity is not an automatic process. The member's PCP, or other care provider, must provide documentation to both the receiving and relinquishing contractors that supports the need for a contractor change. The contractors must be reasonable in the request for documentation.

However, the burden of proof that a contractor change is necessary rests with the member's medical provider. The contractor change must be approved by both contractor medical directors.

When the medical directors of both contractors cannot agree, the relinquishing contractor will submit the request to the AHCCCS chief medical officer (CMO) or designee. The AHCCCS Acute Care Change of Contractor Form (Attachment A) and the supporting documentation must be sent to the AHCCCS DHCM/ Medical Management Manager within 14 business days from the date of the original request.

The results of the review will be shared with both medical directors. The relinquishing contractor must issue a final decision to the member. If the member request is denied, the relinquishing contractor will send the member a Notice of Adverse Benefit Determination.

The member must be transitioned within the requirements and protocols in ACOM Policy 402 and in AMPM Chapter 500.

Contractor responsibilities when a contractor change is not warranted

The current contractor must promptly address the member's concerns regarding availability and accessibility of service and quality of care or delivery issues that may have caused a contractor change request. These issues include but are not limited to:

- Quality of care delivery.
- Care management responsiveness.
- Transportation convenience and service availability.
- Institutional care issues.
- Care provider preference.
- Care provider recommendation.
- Care provider office hours.
- Timing of appointments and services.
- Office waiting time.
- Network limitations and restrictions.

When the member raises quality of care and delivery of service issues that cannot be solved through the normal care management process, call the health plan Member Services number on the member's ID card to report concerns.

The current contractor must also explore all options available to the member, such as transportation problems, care provider availability issues, allowing the member to choose another PCP or care provider, if appropriate.

The delivery of covered services remains the responsibility of the current contractor if a contractor change for medical continuity of prenatal or other medical care is not approved. The current contractor must notify the member, in writing, that a Contractor change is not warranted. If the contractor change request was the result of a member concern, as defined in Section III A (2) or A (3) of this policy, the notice

must include the contractor's resolution. The notice must also advise the member of the AHCCCS and contractor grievance policy and include timeframes for filing a grievance.

Contractors may reach an agreement with an out-ofnetwork provider to care for the member on a temporary basis, for the members' period of illness, and/or pregnancy to provide continuity of care.

Relinquishing contractor, receiving contractor and AHCCCS administration responsibilities when a contractor change is warranted

- **Relinquishing contractor responsibilities**

If a member contacts the current contractor, verbally or in writing, and states the plan change request is due to situations defined in Section A(1) of this policy, the relinquishing contractor will tell the member to call the AHCCCS Verification Unit at 602-417-7000 or 1-800-962-6690 for AHCCCS to process the change.

If the member contacts the relinquishing contractor, verbally or in writing, to request a plan change for medical continuity of care as defined in III A (2) or A (3) of this policy, the following steps must be taken:

- The relinquishing contractor will contact the receiving contractor. If a plan change is needed for medical continuity of care, the AHCCCS Contractor Change Request Form (Attachment A) must be completed. All affected members are added to the form, which the medical directors or physician designees of both contractors sign. The form is then submitted to the AHCCCS CMO.
- To facilitate continuity of prenatal care, contractors will sign off and forward the AHCCCS Contractor Change Request Form to the AHCCCS CMO within two business days of the change request. The timeframe for other continuity of care issues is 10 business days.
- The AHCCCS CMO will review the contractor change documentation and forward to the Communications Center for processing.

- **Receiving contractor responsibilities**

The member must be transitioned within the requirements and protocols in ACOM Policy 402 and in AMPM Chapter 500.

- **Member responsibilities**

The member will request a change of contractor directly from AHCCCS only for situations defined in Section III A (1) of this policy. The member should direct all other contractor change requests to the member's current contractor.

- **AHCCCS responsibilities**

AHCCCS will process change of contractor requests that are listed in Section III A (1) and send notification through the daily recipient roster to the relinquishing and receiving contractors. The contractor must identify members from the daily recipient roster who are leaving the contractor. If AHCCCS denies a Section III A (1) change of contractor request, AHCCCS will send the member a denial letter. The member will be given 60 days to file a grievance.

If AHCCCS receives a letter or verbal request from a member requesting a contractor change, for reasons defined in Section A(1) of this policy, and notes other problems, that information will be sent to the current contractor. If AHCCCS receives a letter or verbal request from a member requesting a contractor change for reasons listed in Section III A (2) or A (3), the information will be forwarded to the current contractor.

The AHCCCS Acute Care Change of Contractor Form is located in the AHCCCS Contractor Operations Manual, Chapter 400.

D.4 DD members

DD members or their responsible person(s) are assisted with their rights and responsibilities through their DES/ DDD support coordinator. Their member rights and responsibilities include:

- Maintaining their ALTCS eligibility redetermination appointments.
- Selecting a PCP within 10 days of notification of plan enrollments.
- Coordinating all necessary covered medical services through their PCP.
- Notifying their DES/DDD Support Coordinator and UnitedHealthcare Community Plan of changes in their address or phone.
- Arriving on time for their appointments or calling ahead if they can't make it.
- Providing all the information to their PCP that is requested by the PCP.
- Providing DES/DDD and UnitedHealthcare Community Plan with all the information, including changes, in private and public insurance, third-party liability, financial assistance, or other benefits received by the DD member.
- Pursuing eligibility with Children's Rehabilitative Services (CRS) when referred by DES/DDD or UnitedHealthcare Community Plan.
- Directing any complaints or problems to DES/DDD, Health Care Services, Member Services, or their UnitedHealthcare Community Plan DD Liaison as soon as possible.
- Participating in family-centered consultations at the request of UnitedHealthcare Community Plan, their support coordinator or other personnel.

D.5 ALTCS EPD (LTC) members

Their member rights and responsibilities include:

Use of services

- Ask questions if they do not understand their rights or plan of treatment.
- Keep their appointments.
- Cancel appointments in advance when they cannot keep them.
- Contact their PCP first for non-emergency medical needs.
- Understand when they should and should not go to an emergency room.
- Know whom to call if they need a ride to the doctor or for other covered services.
- Treat providers and health plan staff with respect and dignity.
- Be in charge of their planning meeting.
- Ask anyone they want to come to their planning meetings.
- Choose their goals to work on and what is on their plan.
- Schedule their person-centered planning meeting at a time and place when the people who they want to attend are available.
- Agree to the services they want from the choice of services they can have.
- Pick an available provider they want to give them their services.
- Know that they may need help from their guardian, family and/or friends to make good choices.

Give information

- Tell their PCP and Case Manager about their health and changes in their health.

- Tell Member Services and/or their Case Manager about changes in their Medicare, Medicare HMO or private insurance. This includes adding or ending other insurance.
- Talk to their providers and their Case Manager about their health care. Ask questions about the ways their health problems can be treated.
- Notify their Case Manager and AHCCCS if their family size changes, if they move or if their income changes.

Appendix E: Attachments

E.1 Medicaid overview

Dental services under Title XIX of the Social Security Act, the Medicaid program, are an optional service for the adult population (individuals age 21 and older). However, dental services are a required service for most Medicaid-eligible individuals under the age of 21, as a required component of the Early and Periodic Screening,Diagnostic and Treatment (EPSDT) benefit.

Individuals under age 21

EPSDT is Medicaid's comprehensive child health program. The programs' focus is on prevention, early diagnosis and treatment of medical conditions. EPSDT is a mandatory service required to be provided under a state's Medicaid program.

Individuals age 21 and older

States may elect to provide dental services to their adult Medicaid-eligible population or elect not to provide dental services at all as part of its Medicaid program. While most states provide at least emergency dental services for adults, less than half of the states provide comprehensive dental care. There are no minimum requirements for adult dental coverage.

E.2 Practitioner rights bulletin

If you elect to participate/continue to participate with UnitedHealthcare Community 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

This is specific to the information the Plan has utilized to evaluate your credentialing application and includes 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, in the event that the credentialing information you provided varies substantially from information obtained from other sources, we will notify you in writing within fifteen (15) business days of receipt of the information. You will have an additional fifteen (15) business days to submit your reply in writing; within two (2) business days we 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

1. Providers applying for initial credentialing do not have appeal rights, unless required by State regulation.
2. Providers rejected for recredentialing based on a history of adverse actions, and who have no active sanctions, have appeal rights only in states that require them or due to Quality of Care concerns

against UnitedHealthcare Community Plan members. An appeal, if allowed, must be submitted within 30 days of the date of the rejection letter. The provider has the right to be represented by an attorney or another person of the provider's choice.

3. Appeals are reviewed by Peer Review Committee (PRC). The PRC panel will include at least 1 member who is of the same specialty as the provider who is submitting the appeal.
4. PRC will consider all information and documentation provided with the appeal and make a determination to uphold or overturn the Credentialing Committee's decision. The PRC may request a corrective action plan, a Site Visit and/or chart review.
5. Within 10 days of making a determination, the PRC will send the provider, by certified mail, written notice of its final decision, including reasons for the decision.

Credentialing Supervisor
Credentialing Department
2300 Clayton Road, Suite 100
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