Dental Provider Manual

UnitedHealthcare | RIte Smiles

Provider Services: 1-877-378-5303

Revised 8/30/2024

United Healthcare® | Dental Benefit Providers®

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Section 1: Introduction — who we are

Welcome to UnitedHealthcare Dental

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

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

We offer a portfolio of products including, but not limited to, Medicaid and Medicare Special Needs plans, as well as Commercial products such as Preferred Provider Organization (PPO) plans.

This Provider Manual (the "Manual") is designed as a comprehensive reference guide for the dental plans in your area. 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 alerts and resources.

Our Commercial program plan requirements are contained in a separate Provider Manual. If you support one of our Commercial plans and need that Manual, please contact Provider Services at **1-800-822-5353** (Please note: all other concerns should be directed to **1-877-378-5303**).

If you have any questions or concerns about the information contained within this Manual, please contact the UnitedHealthcare Dental Provider Services team at **1-877-378-5303**.

Unless otherwise specified herein, this Manual is effective on September 1, 2021 for dental providers currently participating in the UnitedHealthcare Dental 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 Dental 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** and go to Resources > Dental Provider Online Academy.

Required trainings

To remain compliant with the Rhode Island Department of Health requirement, participating providers with the RIte Smiles program are required to complete the Rhode Island Cultural Competency training annually.

To complete the training:

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

Section 2: Patient eligibility verification procedures

2.1 Member eligibility

Each practitioner is responsible for verifying a RIte Smiles member's eligibility prior to providing services. Eligibility should be verified when scheduling an appointment and again at time of service. Member eligibility or dental benefits may be verified online or via phone.

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

2.1.a Rhode Island Anchor medical eligibility verification — 1-855-697-4347

The Rhode Island Department of Human Services (DHS) determines member eligibility for dental benefits. If a member presents a Rhode Island Anchor card, eligibility may be verified through DHS. If the recipient is covered by RIte Smiles, their eligibility with the plan is indicated immediately. Practitioners must participate with the Medical Assistance Program in order to use the DHS eligibility verification system.

2.1.b UnitedHealthcare Dental RIte Smiles eligibility verification — 1-877-378-5303

UnitedHealthcare Dental offers an Interactive Voice Response (IVR) system for efficiency. The IVR system is easy to use and should take under two minutes. Through our IVR system, you may access real time information, seven days a week, twenty-four hours a day. You may also speak directly with a representative to receive an answer or acknowledgment to an inquiry by dialing zero (Monday through Friday, 8 a.m. to 11 p.m., EST)

The UnitedHealthcare Dental IVR system enables you to do the following.

- Verify Eligibility and Benefits
- Obtain Claims Status and Payment Information
- Speak with a service representative regarding general information, utilization management, quality improvement, or UnitedHealthcare dental fraud and abuse

To reach IVR, dial **1-877-378-5303** and have the following information available. Please note that each RIte Smiles member holds an individual policy.

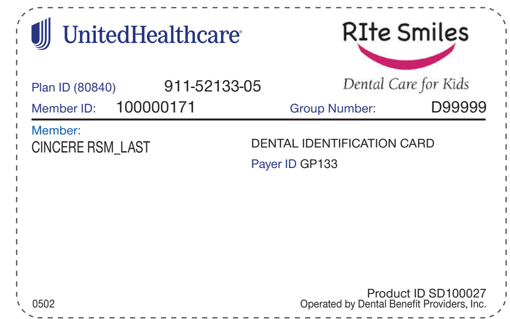
- RIte Smiles member ID number,
  or
- RIte Smiles member last name and date of birth

2.1.c American Indian and Alaskan Native plans

Visit the **Indian Health Service (IHS) Health Center** to search for IHS, Tribal or Urban Indian Health Programs.

2.2 Member identification card

The Rhode Island Department of Human Services (DHS) issues a Medical Anchor ID card to all eligible Medical Assistance recipients, including RIte Smiles members or recipients. RIte Smiles members will have both a medical Anchor ID card and a UnitedHealthcare Dental RIte Smiles Identification Card. You may verify eligibility using **UHCdental.com/medicaid** or from information from either of these cards. However, it is recommended that providers verify through UnitedHealthcare Dental using information from the RIte Smiles Plan identification card (see sample RIte Smiles ID card), as this will inform them of the benefits package information. RIte Smiles members are enrolled on the first day of a month and terminate the last day of a month. A member will no longer be eligible for coverage upon their birth date upon aging out of the State benefit. RIte Smiles members should show both of their ID cards at each appointment. Each RIte Smiles members have a unique individual ID policy number.



2.4 Quick reference guide

UnitedHealthcare Dental 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:

You want to:	Provider Services Line— Dedicated Service Representatives Phone: 1-877-378-5303 Hours: 8 a.m.-6 p.m. (EST) Monday-Friday	Online UHCdental.com/ medicaid	Interactive Voice Response (IVR) System and Voicemail Phone: 1-877-378-5303 Hours: 24 hours a day, 7 days a week
Ask a Benefit/Plan Question (including prior authorization requirements)	✓	✓	
Ask a question about your contract	✓		
Changes to practice information (e.g., associate updates, address changes, adding or deleting addresses, Tax Identification Number change, specialty designation)	✓	✓	
Inquire about a claim	✓	✓	✓
Inquire about eligibility	✓	✓	✓
Inquire about the In-Network Practitioner Listing	✓	✓	✓
Nominate a provider for participation	✓	✓	
Request a copy of your contract	✓		
Request a Fee Schedule	✓	✓	
Request an EOB	✓	✓	
Request an office visit (e.g., staff training)	✓		
Request benefit information	✓	✓	
Request documents	✓	✓	
Request participation status change	✓		

2.5 Provider Portal / Dental Hub

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

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

To register on the site, you will need information on a prior paid claim or a Registration code. To receive your Registration code and for other Dental Hub assistance, call Provider Services at **1-877-378-5303**.

2.6 Integrated Voice Response (IVR) system — 1-877-378-5303

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

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

Section 3: Office administration

3.1 Office site quality

UnitedHealthcare Dental 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 Dental has set Clinical Site Standards for all primary care provider office sites to help ensure facility quality.

UnitedHealthcare Dental 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, American Dental Association (ADA) standards, and should comply with the Americans with Disabilities Act and Section 504 of the Rehabilitation Act of 1973. A portable oxygen unit or ambu bag should be readily available.

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 CDC, OSHA & EPA 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

There should be an active and definable recall system to assure that the practice maintains preventive services, including patient education and appropriate access. The recall system should be individualized to the patient's need and should not be a fixed interval for all patients. The dentist is required to conduct affirmative outreach when a RIte Smiles member misses an appointment and to document this in the medical record. Such an effort shall be deemed to be reasonable if it includes three (3) attempts to contact the member. Such attempts may include, but are not limited to: written attempts, telephone calls and home visits. At least one (1) such attempt must be a follow-up telephone call.

3.5 Transfer of dental records

Your office shall copy all requested member dental records to another participating dentist as designated by UnitedHealthcare Dental or as requested by the member. The member is responsible for the reasonable cost of copying the patient dental records if the member is transferring to another provider. If your office terminates from UnitedHealthcare Dental, dismisses the member from your practice or is terminated by UnitedHealthcare Dental, the cost of copying records shall be borne by your office. Your

office shall cooperate with UnitedHealthcare Dental 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 Dental members as those offered to commercial members.

3.7 Protect confidentiality of member data

UnitedHealthcare Dental 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 Dental uses member information for treatment, operations and payment. UnitedHealthcare Dental 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 UnitedHealthcare Dental staff are trained yearly on HIPAA and confidentiality requirements.

3.8 Provide access to your records

You shall provide access to any medical, dental, financial or administrative records related to services you provide to UnitedHealthcare Dental 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 state/federal 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 Rhode Island 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 and dental records. Or provide a copy to the member's PCP. Do not send a copy of a member's advance directive to UnitedHealthcare Dental.

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

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

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

If you have any questions or need to receive a copy of our provider application packet, please contact Provider Services at **1-877-378-5303**.

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

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

Credentialing updates should be sent to:

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

If you have any questions, don't hesitate to contact Provider Services at **1-877-378-5303** for guidance.

Section 4: Patient access

4.1 Appointment scheduling standards

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

- **Urgent care appointments** Within 48 hours
- **Routine care appointments** Offered within 60 calendar days of the request

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

- A true emergency is defined as services required for treatment of severe pain, swelling, bleeding or immediate diagnosis and treatment of unforeseen dental conditions which if not immediately diagnosed and treated, would lead to disability or death.
- Urgent care appointments would be needed if a patient is experiencing excessive bleeding, pain or trauma.
- Providers are encouraged to schedule members appropriately to avoid inconveniencing the members with long wait times in excess of thirty (30) minutes. Members should be notified of anticipated wait times and given the option to reschedule their appointment.

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 Dental 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**. Click "Find a Dentist" on the top right and then choose "Medicaid Plans" to search by location. You may also contact Provider Services at **1-877-378-5303**.

4.4 Missed appointments

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

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

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

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

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

4.5 Nondiscrimination

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

Section 5: Utilization Management program

5.1 Utilization Management

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

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

5.2 Community practice patterns

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

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

5.3 Evaluation of utilization management data

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

5.4 Utilization Management analysis results

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

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

- Provider Manual/Standards of Care
- Provider Training
- Continuing Education
- Provider News Bulletins

5.5 Utilization review

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

Utilization review may also occur prior to dental services being rendered. This is known as prior authorization, pre-authorization, or a request for a pre-treatment estimate.

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

Utilization review is completed based on the following:

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

(See Appendix B.5 and Appendix C for treatment codes that require clinical review and documentation requirements)

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

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

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

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

- Systematic review and meta-analysis
- Randomized controlled trials (RCT)
- Retrospective studies
- Case series
- Case studies

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

- Electronic database searches such as Medline®, PubMed®, and the Cochrane Library.
- Hand search of the scientific literature
- Recognized dental school textbooks
- Evidence based dentistry can be used clinically to guide treatment decisions, and aid health plans in the development of benefits. At UnitedHealthcare Community Plan, we use evidence as the foundation of our efforts, including:
- Practice guidelines, parameters and algorithms based on evidence and consensus.
- Comparing dentist quality and utilization data
- Conducting audits and site visits
- Development of dental policies and coverage guidelines

The Dental Clinical Policy and Technology Committee (DCPTC) is responsible for developing and evaluating the inclusion of evidence-based practice guidelines, new technology and the new application of existing technology in the UnitedHealthcare Community Plan dental policies, benefits, clinical programs, and business functions; to include, but not limited to dental

procedures, pharmaceuticals as utilized in the practice of dentistry, equipment, and dental services. The DCPTC convenes every other month and no less frequently than four times per year. The DCPTC is comprised of Dental Policy Development and Implementation Staff Members, Non-Voting Members, and Voting Members. Voting Members are UnitedHealth Group Dentists with diverse dental experience and business background including but not limited to members from Utilization Management and Quality Management.

Section 6: Quality management

6.1 Quality Improvement Program (QIP) description

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

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

The QIP description is reviewed and updated annually:

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

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

6.2 Credentialing

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

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

Before an applicant dentist is accepted as a participating provider, the dentist’s credentials are evaluated. Initial facility site visits are required for some plans and/or markets. Please note that a site visit is required for each location. If a new location is added after initial contracting is completed, a site visit would be required for the new location before patients can be seen. Your Professional Networks Representative will inform you of any facility visits needed during the recruiting process. Offices must pass the facility review prior to activation.

The Dental Director and the Credentialing Committee review the information submitted in detail based on approved credentialing criteria. UnitedHealthcare Community Plan will request a resolution of any discrepancy in credentialing forms submitted. Practitioners have the right to review and correct erroneous information and to be informed of the status of their application. Refer to Section 8.1 of this Manual for additional details regarding practitioner rights.

Credentialing criteria are reviewed by advisory committees, which include input from practicing network providers to make sure that criteria are within generally accepted guidelines.

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

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

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

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

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

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

Initial credentialing

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

Recredentialing

- Completed Recredentialing application
- Signed and dated Attestation
- Current copy of their state license
- Current copy of their Drug Enforcement Agency (DEA) certificate
- Current copy of their Controlled Dangerous Substance (CDS) certificate, if applicable

- Current copy of their Sedation and/or General Anesthesia certificates, if applicable
- Copy of their Sedation and/or General Anesthesia training certificate/diploma, if applicable
- Signed and dated Sedation and/or General Anesthesia Attestation, if applicable
- Malpractice face sheet which shows their name on the certificate, expiration dates and limits— limits $1/3m
- Explanation of any adverse information, if applicable
- Current Medicaid ID (as required by state)

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

6.3 Site visits

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

The site visit focuses primarily on: dental record keeping, patient accessibility, 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."

6.4 Preventive health guideline

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

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

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

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

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

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

Additional areas for prevention evaluation and intervention include malocclusion, prevention of sports injuries and harmful habits (including, but not limited to, digit- and pacifier-sucking, tongue thrusting, mouth breathing, intraoral and perioral piercing, and/or similar use of tobacco products). Other preventive concerns may include preservation of primary teeth, space maintenance and eruption of permanent dentition. UnitedHealthcare Dental 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 Dental to educate providers and members on maintaining oral health, specifically in the areas of prevention, caries, periodontal disease and oral cancer screening.

6.5 Addressing the opioid epidemic

Combating the opioid epidemic must include prevention, treatment, recovery and harm reduction. We engage in strategic community relationships and approaches for special populations with unique risks, such as pregnant women and infants. We use our robust data infrastructure to identify needs, drive targeted actions, and measure progress. Finally, we help ensure our approaches are trauma-informed and reduce harm where possible.

Brief summary of framework

Prevention: Prevent Opioid-Use Disorders before they occur through pharmacy management, provider practices, and education.

Treatment: Access and reduce barriers to evidence-based and integrated treatment.

Recovery: Support care management and referral to person-centered recovery resources.

Harm Reduction: Access to Naloxone and facilitating safe use, storage, and disposal of opioids.

Strategic community relationships and approaches: Tailor solutions to local needs.

Enhanced solutions for pregnant mom and child: Prevent neonatal abstinence syndrome and supporting moms in recovery.

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

Increasing education & awareness of opioids

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

6.6 COVID-19 information and resources

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

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 Practitioner rights bulletin

- Providers applying for initial credentialing do not have appeal rights, unless required by State regulation.
- Providers rejected for re-credentialing 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 DBP 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.
- Appeals are reviewed by Peer Review Committee (PRC). The PRC panel will include at least one member who is of the same specialty as the provider who is submitting the appeal.
- 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.
- Within ten 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.

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 or 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 15 business days of receipt of the information. You will have an additional 15 business days to submit your reply in writing; and within two 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 to us in writing (U.S. mail, e-mail, facsimile) 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 calendar days of the date of receipt of the rejection/denial letter. To appeal the decision, submit your request to the following address:

UnitedHealthcare Dental
Government Programs – Provider Operations
Fax: **1-866-829-1841**

8.2 Provider terminations

A Provider has a right to terminate upon request in writing with 90 days notice.

The provider office is required to notify UnitedHealthcare Dental in writing in the event that any dentist terminates his or her contract or employment and will no longer be treating UnitedHealthcare Dental members.

A Provider office is required to give written notice of the provider termination from the RIte Smiles network within fifteen (15) business days after receipt or issuance of the termination notice, to each RIte Smiles member who has received preventive dental care.

Upon notification of termination the Provider shall continue to provide Covered Services to RIte Smiles eligible members for a period not to exceed ninety (90) days during which time payment will be made pursuant to the United Healthcare contracted fee schedule.

Providers who are found to be in breach of their Provider Agreement or have demonstrated quality of care issues are subject to review, corrective action, and/or termination in accordance with approved criteria.

A provider may be found in violation of their Provider Agreement for, but not limited to, the following reasons:

- Failure to comply with DBP UnitedHealthcare's credentialing or recredentialing procedures
- Violations of DBP UnitedHealthcare's Policies and Procedures or the provisions of the Provider Manual
- Insufficient malpractice coverage with refusal to obtain such
- Information supplied (such as licensure, dental school and training) is not supported by primary source verification
- Failure to report prior, present or pending disciplinary action by any government agency
- Any federal or state sanction that precludes participation in Government Programs (such providers will be excluded from participation in our Medicaid panel)
- Failure to report fraud or malpractice claims

8.3 Quality of care issues

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

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

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

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

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

- Cases which meet disciplinary or malpractice criteria are initially reviewed by the Credentialing Committee. Other quality-of-care cases are reviewed by the Peer Review Committee.
- The Committees make very 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.

8.4 Appeals process for determination of participation

- 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.
- Providers must request an appeal in writing within ninety (90) calendar days of the date of notice of termination, and provide any applicable information and documentation to support the appeal.
- The Hearing will be scheduled within thirty (30) days of the request for a hearing.
- The appeal may be heard telephonically, unless the clinician requests an in-person hearing. In such cases, all additional costs relevant to the Hearing are the provider's responsibility.
- 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.

8.5 Cultural competency

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

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

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

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

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

Section 9: Claim submission procedures

9.1 Claim submission options

9.1.a Paper claims

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

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

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

9.1.b Electronic claims

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

If you wish to submit claims electronically, please contact your clearinghouse to initiate this process. If you do not currently work with a clearinghouse, you may 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.

HIPPAA-compliant 837D file

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

9.1.c Electronic payments

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

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

ePayment Center allows you to:

- Improve cash flow with faster primary payments and speed up secondary filing/patient collections
- Access your electronic remittance advice (ERA) remotely and securely 24/7
- Streamline reconciliation with automated payment posting capabilities
- Download remittances in various formats (835, CSV, XLS, PDF)
- Search payments history up to 7 years back

To register:

1. Visit **UHCdental.epayment.center/register**

2. Follow the instructions to obtain a registration code
3. Your registration will be reviewed by a customer service representative and a link will be sent to your email once confirmed
4. Follow the link to complete your registration and setup your account
5. Log into **uhcdental.epayment.center**
6. Enter your bank account information
7. Select remittance data delivery options
8. Review and accept ACH Agreement
9. Click “Submit”
10. Upon completion of the registration process, your bank account will undergo a pre notification 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

One ADA claim form (2019 version or later) 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 or Request for Predetermination/ Prior Authorization.

RIte Smiles member information

- Name (Last, First, and Middle Initial)
- Address, City, State, Zip Code
- Date of Birth
- Gender
- RIte Smiles ID number – located on the RIte Smiles member ID card

Primary payer information/other coverage

UnitedHealthcare Dental RIte Smiles is always considered the payer of last resort. If the member has other insurance coverage, you are required to inform UnitedHealthcare Dental RIte Smiles by completing the “Other Coverage” section of the form with the name, address, city, state, and zip code of the carrier.

You must bill the other insurance carrier first. When billing UnitedHealthcare Dental, you will need to provide documentation from the primary insurance carrier, including amounts paid for specific services.

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

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

- Name of subscriber/policy holder (Last, First, and Middle Initial)
- Date of Birth and Gender
- Subscriber Identification number
- Relationship to the RIte Smiles 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
- Provider ID (UnitedHealthcare Dental assigned)
- License number
- SSN or TIN
- Address, city, state, zip code
- Phone number
- NPI
- Taxonomy

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

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

Missing teeth information

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

Remarks section

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

Member authorization

Signature of member or guardian authorizing payment of dental benefits is required. UnitedHealthcare Dental will accept a claim form that indicates a signature is “on file” for a particular member. The dentist must keep a copy of a signed claim in the patient record.

Paper claims

All dental claims must be legible. Computer-generated forms are recommended. Additional documentation and radiographs

should be attached, when applicable. Such attachments are required for pre-treatment estimates and for the submission of claims for complex clinical procedures. Refer to the Exclusions, Limitations and Benefits section of this Manual to find the recommendations for dental services.

By Report procedures

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

Using current ADA codes

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

Supernumerary teeth

UnitedHealthcare recognizes tooth letters “A” through “T” for primary teeth and tooth numbers “1” to “32” for permanent teeth. Supernumerary teeth should be designated by using codes AS through TS or 51 through 82.Designation of the tooth can be determined by using the nearest erupted tooth. If the tooth closest to the supernumerary tooth is # 1 then the supernumerary tooth should be charted as #51, likewise if the nearest tooth is A the supernumerary tooth should be charted as. These procedure codes must be referenced in the patient’s file for record retention and review. Patient records must be kept for a minimum of 7 years.

Insurance fraud

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

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

Invalid or incomplete claims

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

9.2.b Coordination of medical assistance (Medicaid) benefits

Any Medicaid coverage is the payor of last resort. All other insurance coverage must be exhausted before billing UnitedHealthcare Dental. UnitedHealthcare Dental is responsible only for the unsatisfied portion of the bill, up to the maximum allowable, contracted UnitedHealthcare RIte Smiles Dental fee for the service. RIte Smiles Dental fee schedule as the provider may be participating with other products so you need to be clear on the fee schedule applicable.

It is the provider's responsibility to ask if the member has other coverage.

If other/primary insurance coverage exists, you must bill the primary dental carrier using the standard procedures required by that carrier. You will need a copy of the primary carrier's Explanation of Benefits, along with a completed dental claim form to submit to and receive payment from UnitedHealthcare Dental.

9.2.c Timely submission (Timely filing)

All claims should be submitted within 30 calendar days from the date of service.

All adjustments or requests for reprocessing must be made within 365 days from date of service.

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

9.3 Corrected claim submission guidelines

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

Examples of correction(s) for a prior paid claim are:

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

A corrected claim may be submitted using the methods below:

- Electronically through Clearing House
- Electronically through the Dental Hub if original claim was submitted on the Dental Hub. If original claim was not submitted on the Dental Hub, another method should be utilized.
- Paper to the mailing address below
  UnitedHealthcare Community Plan Corrected Claims
  P.O. Box 481
  Milwaukee, WI 53201

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

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

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

If a claim or service originally DENIED due to incorrect or missing information/authorization, or was not previously processed for payment, DO NOT submit a corrected claim. Denied services have no impact on member tooth history or service accumulators,

and, as such, do not require reprocessing. Submit a new claim with the updated information per your normal claim submission channels. Timely filing limitations apply when a denied claim is being resubmitted with additional information for processing.

If you received a claim or service denial which you do not agree with, including denials for no authorization, please refer to the appeals language on the Provider Remittance Advice for guidance with the appeals process applicable to the state plan.

Appendices for the State of Rhode Island's RIte Smiles

Appendix A: Resources and services — how we help you

A.1 Addresses and phone numbers

Need:	Address:	Phone Number:	Payer I.D.:	Submission Guidelines:	Form(s) Required:
Claim Submission (initial)	Claims: UnitedHealthcare Dental RIte Smiles PO Box 138 Milwaukee, WI 53201	**1-877-378-5303**	GP133	Within 365 calendar days from the date of service For secondary claims, within 30 days from the primary payer determination	ADA* Claim Form, 2019 version or later
Corrected Claims	Corrected Claims: UnitedHealthcare Dental RIte Smiles PO Box 481 Milwaukee, WI 53201	**1-877-378-5303**	N/A	Within 365 days from date of service.	ADA Claim Form Reason for requesting adjustment or resubmission
Claim Appeals (Appeal of a denied or reduced payment)	Claim Appeals: UnitedHealthcare Dental RIte Smiles Appeals/Complaints Department PO Box 170 Milwaukee, WI 53201	**1-877-378-5303**	N/A	Within 60 days after the claim determination	Supporting documentation, including claim number is required for processing.
Prior Authorization Requests	Pre-authorizations: UnitedHealthcare Dental RIte Smiles PO Box 1274 Milwaukee, WI 53201	**1-877-378-5303**	GP133	N/A	ADA Claim Form – check the box titled: Request for Predetermination / Preauthorization section of the ADA Dental Claim Form
Member Benefit Appeal for Service Authorization (Appeal of a denied or reduced service)	UnitedHealthcare Dental – RIte Smiles Attn: Appeals & Greivance Dept. P.O. Box 170 Milwaukee, WI 53201	**1-866-293-1796**	N/A	Within 60 calendar days from the date of the adverse benefit determination	N/A

Appendix B: Member benefits and referral guidelines

B.1 Primary care physician

RIte Smiles members obtain most of their medical health care services either directly from or upon referral by their Primary Care Physician (PCP), except for services available on a self-referral basis. Dental services are considered as a self-referral service.. Therefore, a referral from a RIte Smiles member's PCP is not necessary for the member to seek care from a participating UnitedHealthcare Dental provider.

B.2 Dental referral

Any UnitedHealthcare provider participating in RIte Smiles may refer a member to another participating dentist for specialty care services that are covered by RIte Smiles using the following guidelines.

- The participating dental provider may refer a member to a participating specialist without a written referral.
- Please provide the member with written or verbal dental care recommendations.
- You may choose a specialist that is listed in the UnitedHealthcare RIte Smiles Dental Network Directory on our Web site at **https://prod.member.myuhc.com/content/myuhc/en/public/member-ei-login.html**. If a specialist is not available in the member's area, you may also call the UnitedHealthcare Dental Provider Help line at **1-877-378-5303** for referral assistance.

B.3 Specialty care providers

It is recommended that a RIte Smiles general dentist evaluate a member before scheduling an appointment with a RIte Smiles specialty dental care provider. However, if time does not permit a general dental evaluation, such as in the case of an emergency, the member may seek and receive treatment by a dental specialist. Dental specialty care providers may treat a member without a referral from a general dentist.

B.4 Covered benefits

The UnitedHealthcare – RIte Smiles dental schedule plan is a comprehensive dental plan that covers all Medicaid eligible children in Rhode Island born on or after May 1, 2000. Under the RIte Smiles plan there is no member copay, deductible, or coinsurance. There is no annual maximum benefit. Some services do require prior authorization. Comprehensive dental benefits include coverage in the following categories.

Covered services	Benefit guidelines
Periodic Oral Exam	Twice in calendar year
Prophylaxis	Twice in calendar year
X-Rays	Bitewing- Allowed once per calendar year
Intraoral/complete series	Every 4 years
Panoramic Film	Every 4 years
Interim Caries Arresting Medicament Application – per tooth	PA required only for ages 13-22
Fluoride treatments	Twice in calendar year
Sealants	Covered only for permanent molars; One treatment per tooth every 5 years excluding third molars
Emergency Services	As medically necessary*
Restorative Services	As medically necessary*
Endo/Perio/Extractions	As medically necessary* requires prior approval
Oral Surgery	As medically necessary* requires prior approval

Covered services	Benefit guidelines
Inlays, Onlays, Crowns	As medically necessary* requires prior approval
Root Canals	As medically necessary*
Orthodontics	As medically necessary* The handicapping malocclusion must be supported by either an indication of an automatic qualifier on the HLD Index (Handicapping Labio-lingual Deviation Index), or a minimum score of 26 on the HLD Index (Handicapping Labio-lingual Deviation Index). Requires prior Authorization

The term "medical necessity" or "medically necessary service" means medical, surgical, or other services required for the prevention, diagnosis, cure or treatment of a health-related condition including such services necessary to prevent a detrimental change in either medical or mental health status.

Medically necessary services must be provided in the most cost effective and appropriate setting and shall not be provided solely for the convenience of the member or service provider.

Enrollee hold harmless

RIte Smiles eligible members shall not be liable to Practice for charges for covered Services, except as otherwise permitted by the General Laws of Rhode Island. Unless, specifically permitted by state regulatory agencies through publicly available documentation, providers are not permitted to pass through additional charges related to protective equipment, sanitation procedures, or other equipment or administrative needs to Medicaid members.

Rhode Island Medicaid frenectomy policy related to nutrition & breastfeeding

The Rhode Island Executive Office of Health and Human Services implemented the RI Medicaid Frenectomy Policy Related to Nutrition & Breastfeeding effective May 3, 2021. Frenectomy is an oral procedure releasing tissue that limits movement of the tongue or lip. It is identified as a medical benefit by Managed Care Organization (MCO) when performed for lactation purposes.

Frenectomy may be performed for dental and non-dental purposes, such as those related to tongue-tie and the breastfeeding function. Dentists wanting to perform the procedure must:

- Be trained in a safe and effective manner
- Be enrolled as a provider under the medical managed care in-plan benefit
- Not charge members and/or their parents/guardians out of pocket costs in place of participating in the medical managed care program

Trained dentists can perform the frenectomy procedure if:

- All treatment alternatives were considered
- A referral was made by a pediatrician

Proof of collaboration with the pediatrician must be documented in the patient's medical record, and both the medical MCO and dental MCO must provide a seamless care transition.

B.5 Prior authorization pend process

Effective 9/1/2021, UnitedHealthcare Dental will implement a Prior Authorization Pend process in support of eligible RIte Smiles members and our valued RIte Smiles contracted providers.

This process will inform of a need for missing or additional information required by UnitedHealthcare to make a timely authorization determination.

A request for additional information will be sent via fax and mail to the requesting provider informing of missing or additional information. Information will be required to be submitted within ten (10) calendar days from the issue date of the notification.

- Text (ONLY) information can be sent to fax #: 866-292-3205.
  Images cannot be received via fax.

- Images and text information can be mailed to:
  UnitedHealthcare Dental RIte Smiles
  P.O. Box 683
  Milwaukee, WI 53201

To complete a review for determination within thirty (30) days of the initial request, the decision to approve or deny the requested service(s) will be made by UnitedHealthcare based on the information submitted with the initial request.

If you have questions, please contact Provider Service at **1-877-378-5303.**

B.6 Medical access assistance program

The Medical Access Assistance Program supports RIte Smiles providers when Rhode Island medical facilities have informed providers of limited operating room availability, and a RIte Smiles member is unable to receive necessary dental treatment.

To request scheduling assistance from us for an eligible RIte Smiles patient, you will need to use the **RIte Smiles Medical Access Request and Dental Referral form.** You should use this form if you've made attempts to schedule time with a Rhode Island facility and have been unable to do so.

How to submit the form

Include the following items with the **RIte Smiles Medical Access Request and Dental Referral form.**

- Clinical documentation
- Radiographs (x-rays)
- Medical history

Provider should email the completed form(s) to UnitedHealthcare Dental, Attention: Dental Team Coordinator at **dccri@uhc.com**.

The UnitedHealthcare RIte Smiles Medical Access Request form is available for download post login-in at **UHCdental.com/medicaid** under State specific alerts and resources.

1. Select "Documents" tab on the navigational bar
2. Select "Insurer Documents"
3. Find plan name (UnitedHealthcare Rhode Island)

We are here to help. If you have questions, please contact Provider Services at **1-877-378-5303.**

Appendix C: Authorization for treatment

C.1 Prior authorization guidelines

"Prior Authorization required" means the practitioner must submit those procedures for approval with clinical documentation supporting necessity before performing those procedures. Please refer to the Exclusions, Limitations, and Benefits section for prior authorization requirements.

To request clinical criteria utilized for each prior authorization service, please call UnitedHealthcare Dental's Provider Relations Department at 1-**877-378-5303**.

C.2 Requesting a prior authorization

Complete a standard ADA claim form (2019 or later) and check the box marked "Pre-Treatment ESTIMATE." Mail the form, to the below address, along with any required supplemental information (films, narrative, perio-charting, etc). Your office will then receive an Explanation of Benefits (EOB) outlining the denial or approval of requested treatment and plan payment amounts when applicable.

Mail all Prior Authorization requests, including Orthodontics to:

UnitedHealthcare Dental RIte Smiles
PO Box 1274
Milwaukee, WI 53201

Submit online to:

UHCdental.com/medicaid

If after a course of limited orthodontic treatment is rendered, comprehensive treatment is medically necessary, a new request for comprehensive orthodontia treatment (billable with procedure codes D8070, D8080, D8090) is required. A new prior authorization must be requested and current/updated documentation is required upon submission for review.

The RIte Smiles benefit limit for code D8670 is 23 visits per lifetime when billed for limited orthodontia and when billed in conjunction with approved comprehensive orthodontia.

C.3 Orthodontic prior authorization requests

The following must be included with your orthodontic prior authorization request:

- A completed ADA claim form clearly marked as Pre-Treatment ESTIMATE,
- A completed HLD Index Diagnostic Score Sheet,
- Cephalometric film, lips together, including tracing, and
- A digital panoramic image. Treatment plan, including projected length and cost of treatment.

All radiographs, photographs, and accompanying documentation should be clearly labeled with patient name, date, and provider requesting treatment. The orthodontic records listed above must be submitted on a separate claim form for payment.

Prior Authorizations are subject to the following conditions:

1. Total benefit maximums may not exceed the plan maximums. Actual dates of service may alter benefits payable.
2. Allowances may vary if plan benefits change prior to treatment.
3. The patient must be eligible for benefits when the services are deemed incurred. An expense is incurred when a service is performed.

When submitting for payment, please include the approved EOB, including the actual date(s) of service

C.4 Peer to Peer Request prior to Appeal

The attending dentist may ask to speak on the telephone with a licensed dental consultant regarding an adverse determination, on a peer-to-peer basis. Call Provider Service to request a Peer to Peer discussion 1-877-378-5303.

If additional information can be provided to the dental consultant, a reversal of the adverse determination can be considered.

If a peer-to-peer conversation does not result in redetermination the provider and member have the right to initiate an appeal.

C.5 Timeframes and written notification

Standard decision (prior-authorization non-urgent):

- Decision will occur no later than fourteen (14) business days following the receipt of the request and all necessary information.
- Prior Authorization approvals are valid for 180 days from date of approval.
- Appropriate Denial Notification, with denial reason and appeal rights (including any state specific requirements) is mailed to the member within two (2) days of determination for all medical necessity denials.
- Verbal notification of denial will be given to the provider within one (1) day of determination to deny, and an appropriate Denial Notification letter will be mailed to the dentist within one day of the verbal notification.

Expedited decision (prior-authorization urgent):

- If a dentist indicates or it is determined that following the standard prior authorization time frame could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function, an expedited decision is warranted and written notice will be provided to the member no later than 72 hours following the receipt of the request.
- A verbal determination to deny will be communicated to the provider within 24 hours of the determination, when appropriate, and a Denial Notification Letter, with denial reason and appeal rights is mailed to the provider and member within 72 hours of receipt of the request.

C.6 Palliative treatment without prior authorization

In emergency situations, it is not possible to submit an estimate with appropriate documentation for palliative treatment prior to treatment being rendered. Members are encouraged to seek treatment when in pain. Providers may treat the member's immediate ailment and submit a claim with narrative explaining the decision to treat without first obtaining approval.

Appendix D: Early and Periodic Screening, Diagnosis and Treatment (EPSDT)

The Medicaid program's benefit for children and adolescents is known as Early and Periodic Screening, Diagnostic and Treatment services, or EPSDT. EPSDT provides a complete range of prevention, diagnostic, and treatment services for children in Medicaid programs, including RIte Smiles. The EPSDT benefit is designed to make sure that children receive early examination and care, so that health problems are prevented or diagnosed and treated as early as possible.

Dental services in the EPSDT benefit include:

- Dental care needed for treatment of pain, infection, restoration of teeth (ex. fillings), and upkeep of dental health (provided at as early an age as necessary); and
- Emergency, preventive, and treatment services for dental disease, such as tooth decay, that, if left untreated, may become a more serious dental problem or cause permanent damage to the teeth or supporting structures (such as the gums or jaw bone).

Medicaid's EPSDT and clinical guidelines recommend that a child have a first dental visit when the first tooth erupts or by the child's first birthday.

Dental care that is seen as necessary for an individual child is covered even when the frequency is greater than specified in the periodicity schedule. For example, a child determined by a qualified provider, such as a dentist, to be at moderate or high risk for developing Early Childhood Caries (ECC), (baby bottle tooth decay), could receive dental exams and preventive treatments more frequently than the twice-yearly schedule recommended by the American Academy of Pediatric Dentistry.

Non-covered services include:

- Cosmetic procedures (for example, tooth whitening)
- Dental implants
- Procedures considered experimental or investigational

Providers agree to provide early and periodic dental screening, diagnosis, and treatment services to RIte Smiles eligible children enrolled in the RIte Smiles plan in accordance with the Rhode Island EPSDT Periodicity Schedule.

The full scope of Provider's EPSDT requirements is described below.

D.1 Screening

The RIte Smiles dental plan must conduct EPSDT screenings on RIte Smiles eligible members to identify dental problems in conformance. Additional screenings should be provided as Medically Necessary.

D.2 Diagnosis and treatment

If a suspected problem is detected by a screening examination as described above, the RIte Smiles eligible child shall be evaluated as necessary for further diagnosis. This diagnosis is used to determine treatment needs.

EPSDT requires coverage for all follow-up diagnostic and treatment services deemed Medically Necessary to ameliorate or correct a dental or oral health problem discovered during an EPSDT screening. Such Medically Necessary diagnosis and treatment services must be provided regardless of whether such services are covered by the State Medicaid Plan, as long as they are Medicaid-covered services as defined in the Social Security Act.

Provider shall assure that all Medically Necessary, Medicaid-covered diagnosis and treatment services are provided, either directly or by referral. However, if the services are neither covered by the State Medicaid Plan nor included in the comprehensive dental benefit package, Provider may bill the State fee-for-service for these services if provided by Provider.

D.3 Tracking

Provider shall establish a tracking system that provides up-to-date information on compliance with EPSDT service provision requirements in the following areas:

- Semi-annual preventive dental visits beginning at age 6 months and no later than 1st birthday in accordance with the Rhode Island EPSDT Periodicity Schedule.
- Diagnosis and/or treatment, or other referrals in accordance with EPSDT screen results.

D.4 Follow-up and outreach

Provider shall have an established process for reminders, follow-ups, and outreach to members that includes:

- Telephone protocols to remind Members of upcoming visits and follow-up on missed appointments within a set time period. This process must take into account the multi-lingual, multi-cultural nature of the Medicaid population as well as other unique characteristics of this population such as a greater frequency of changes of address and absence of telephones.

D.5 Transportation services

RIte Smiles members may qualify for transportation services to their dental appointments. Members should be referred to call MTM at **1-855-330-9131** (TTY **711**) to request services.

Rhode Island Public Transit Authority (RIPTA)

RIPTA has fixed-route bus services to most communities in Rhode Island. Routes are available online at **www.ripta.com** or by calling Customer Support at **401-781-9400**. RIPTA also offers flex services and the ADA Disabled Program.

- **Non-Emergency Medical Transportation broker**
  Non-Emergency Medical Transportation is a covered benefit in RI Medicaid. The contracted vendor for these services is MTM, Inc. Members should contact MTM at **1-855-330-9131** (TTY **711**), Monday- Friday, 8 am to 5 pm to arrange for rides to medical, dental or other health-related appointments. Bus tickets for appointments need to be requested seven (7) business days prior to the appointment.
  Van or taxi rides to medical appointments may be available for members who qualify. Please allow 48 hours prior to your appointment. For example:
  - Call Monday for a ride on Wednesday;
  - Call Tuesday for a ride on Thursday;
  - Call Wednesday for a ride on Friday, Saturday or Sunday;
  - Call Thursday for a ride on Monday;
  - Call for Friday for a ride on Tuesday.
- **Mileage reimbursement**
  Members may qualify for fuel reimbursement. If an appointment date or time changes the Member is responsible to inform MTM of the change.

D.6 Interpreter/translation services

Professional in-person interpreter services are available for dental appointments. Members can request an interpreter by calling Member Services at **1-866-375-3257**, TTY **711** at least 72 hours before the scheduled appointment. If a sign language interpreter is needed, a minimum of 2 weeks notice is required before the appointment. If the appointment date or time changes the Member is responsible to contact and inform Member Services.

Dentists (In and our of network) may request an interpreter service on behalf of an eligible RIte Smiles member by calling our Provider Services Line at **1-877-378-5303**.

D.7 Second opinion

A RIte Smiles eligible member is entitled to a second opinion from a qualified health professional within the network or, by a non-participating provider outside the network at no cost to the member.

D.8 Self-referrals

RIte Smiles members may self-refer to dental specialists in or out of the RIte Smiles network.

D.9 Network changes

UnitedHealthcare requires network providers to give written notice of his/her termination from the RIte Smiles network, within fifteen (15) business days after receipt or issuance of the termination notice.

D.10 Service accessibility standards

Providers will assure UnitedHealthcare that it has the capacity to serve the expected enrollment in its service area in accordance with the State's standards set forth as follows:

- **Make services available within 48 hours for treatment of an urgent dental condition**
- **Offer treatment for non-emergent, non-urgent dental conditions within 60 days of the Member's request**
- **Offer preventive dental services within 60 days of the Member's request**
- **Make services available to a new RIte Smiles Members within 60 days of enrollment**

D.11 Missed appointments

RIte Smiles providers cannot bill a RIte Smiles eligibile member for a missed appointment.

Federal regulations dating back to 2004 state that physicians who participate in Medicaid must accept Medicaid reimbursement as "payment in full" (42 C.F.R. §447.15). According to the Center for Medicare and Medicaid Services (CMS) and the Oral Health Technical Advisory Group, a provider cannot bill a Medicaid beneficiary for missed appointments.

Current Medicaid policy does not allow for billing beneficiaries for missed appointments because a service was not provided; therefore, no reimbursement is available. In addition, missed appointments are not a reimbursable Medicaid service, but are considered a part of providers' overall cost of doing business. In no case may providers impose separate charges to beneficiaries.

D.12 Updating member personal information

It is very important that members keep their dempgraphic information updated. Members are required to report demographic changes to Healthsource RI or the RI Department of Human Services (DHS) within 10 days of the change. Members should be referred to contact HealthsourceRI to report changes online at www. healthsourceri. com or call **1-855-840-4774**. Members can also visit the Healthsource RI walk-in center at 401 Wampanoag Trail, East Providence, RI 02915. Business hours are Monday – Friday, 8 am – 6 pm.

Appendix E: Grievance and appeal procedures

Your office is required to cooperate with UnitedHealthcare Dental Policies and Procedures and Member Rights and Responsibilities, including member complaint or grievance processes. UnitedHealthcare Dental RIte Smiles shall have access to office records for these purposes and information obtained from the records shall be kept confidential.

Your office is required to comply with UnitedHealthcare Dental RIte Smile's requests for patient records, films, etc. within five (5) business days of receiving the request. Your office may not charge UnitedHealthcare Dental RIte Smiles or the patient for costs associated with documentation or duplication of materials involved in a grievance investigation. These obligations shall survive the contractual relationship between UnitedHealthcare Dental and your office.

You have the right to appeal any determination by UnitedHealthcare Dental as the result of an investigation. Appeals should be in writing and mailed within thirty (30) days after you receive the determination to:

UnitedHealthcare Dental - RIte Smiles
Attn: Appeals and Grievance Dept.
P.O. Box 170
Milwaukee, WI 53201

E.1 Peer to Peer Request prior to Appeal

The attending dentist may ask to speak on the telephone with a licensed dental consultant regarding an adverse determination, on a peer-to-peer basis. Call Provider Service to request a Peer to Peer discussion 1-877-378-5303.

If additional information can be provided to the dental consultant, a reversal of the adverse determination can be considered.

If a peer-to-peer conversation does not result in redetermination the provider and member have the right to initiate an appeal.

E.2 Internal appeals process

UnitedHealthcare Dental will consider a request for initial internal appeal of a determination not to certify treatment as long as the enrollee or the dental provider of record makes the appeal request within sixty (60) days from the date of the adverse determination.

Capitol Dental providers may direct requests for reconsideration of an adverse decision either orally or in writing to the following address and phone number:

UnitedHealthcare Dental – RIte Smiles
Attn: Appeals Dept.
P.O. Box 170
Milwaukee, WI 53201

Provider Services:
1-877-378-5303

UnitedHealthcare Dental will obtain copies of the enrollee's patient record from the dental provider where appropriate. UnitedHealthcare Dental will provide written notification to the enrollee and dental provider of record of its determination on the appeal as soon as practical. Written or verbal notification must be given within fifteen (15) business days. If the decision notice is verbal, a written notice will follow the verbal notice within six (6) business days. All determinations not to certify treatment that had been ordered by a dental provider shall be made, documented, signed by a dentist and maintained on file. No adverse determination will be made until a qualified and licensed practitioner has spoken to the dental provider.

All initial level appeal decisions are made only after an appropriately qualified and licensed practitioner with the same licensure status as the ordering practitioner has spoken to, or otherwise provided for, an equivalent two-way direct communication with the patient's attending practitioner (or designee) concerning the health care services. The reviewing practitioner documents all such discussion. Such equivalent two-way direct communication shall include: facsimile or electronic transmissions, if mutually agreed upon. UnitedHealthcare Dental shall make no fewer than two documented attempts to communicate, consistent with the

requirements of section 5.2.2. R23-17.12- 1-UR, with the attending provider (or designee), giving the provider sufficient time to respond after each attempt.

E.3 Medicaid RI state fair hearing appeals process

Members who are not satisfied with the outcome of UnitedHealthcare—RIte Smiles decision on an iinitial appeal may request a state Fair Hearing within 120 days of the notice of initial appeal determinaton. Members can request a Fair Hearing with the Executive Office of Health and Human Services (EOHHS). Members have the right to have Medicaid covered services continued while seeking a Fair Hearing.

To request a Medicaid Fair Hearing, members can either:

- Call **401-462-2132 (TDD 401-462-3363)** after finishing UnitedHealthcare RIte Smiles' internal process,
- Fax your request to **401-462-0458**,
- Email the request to **OHHS.AppealsOffice@ohhs.ri.gov**, or
- Mail the request to: **EOHHS Appeals Office**
  Virks Building
  3 West Road
  Cranston, RI 02920

Members can continue to have Medicaid covered services while an appeal is under review. To have these Medicaid covered services continue, a provider or member must call or tell UnitedHealthcare RIte Smiles within 10 calendar days of being notified. If the appeal is denied, the member may be responsible for the cost of any continued benefits received. If the appeal is approved and a request for services to be continued while the appeal was pending, UnitedHealthcare RIte Smiles will authorize or provide services within 72 hours.

E.4 Expedited appeals

An expedited internal review is provided upon request by the Dental Plan for an appeal deemed an emergency (see **Treatment Review Process**). After an emergency appeal is filed, UnitedHealthcare Dental will complete the adjudication within two (2) business days of receiving all pertinent information.

E.5 External appeals process

If an adverse determination is affirmed at the internal appeals process, UnitedHealthcare Dental will inform the patient and/or dental provider of his/her right to an external appeal by an unrelated objective agency designated by the Rhode Island Department of Health. To initiate an external appeal, the member, guardian or dental provider will file written notification of such appeal with UnitedHealthcare Dental within 4 months of receipt of notice that the first level appeal has been denied.

Within five (5) business days of receipt of written notification, the reviewing agent will forward to the external appeals agency the complete file upon which the adverse decision was based, the specific review agency criteria utilized in rendering the adverse determination, and documentation that payment has been authorized for the predetermined administrative cost and one half the predetermined cost of the reviewing dentist. For all nonemergency appeals, the external appeals agency shall complete its review and make a final determination within 45 calendar days. For appeals determined to be an emergency, an expedited external appeal shall be completed and a final determination shall be made within two (2) business days.

E.6 General requirements

The following general requirements will apply to all appeals provided by UnitedHealthcare Dental for adverse determinations that fall within the UR Laws.

1. No reviewer that has been involved in prior reviews of the case under appeal may participate as the sole reviewer in reviewing a case under appeal.
2. No reviewer who has participated in the direct care of the patient (who is the subject of the review), may participate as a reviewer in reviewing the case under appeal.
3. No reviewer may be compensated or paid a bonus or incentive based on upholding an adverse determination.

4. A reviewer is entitled to review only that information that is reasonably relevant to the utilization review process. UnitedHealthcare Dental and/or its review agents shall not engage in direct discussions and/or patient interview to assess the medical and/or mental health status of a patient.
5. All assessments shall be made through chart reviewed discussion with attending provider and/or his/her designee. Individual medical records or any confidential medical information obtained in the performance of utilization review activities will be accorded the protections of the Confidentiality of Health Care Information Act, as Chapter 37.3 of Title 5 of the General Laws of Rhode Island.
6. Clinical reviews and clinical adverse determinations will be done by an appropriately licensed dentist. The type and qualifications of the Utilization Review agents employed by, affiliated with, contracted with or otherwise acting on behalf of UnitedHealthcare include:
   - Clinical Reviewer
   - UR, Director
   - UR, Manager
   - UR, Administrator
   - Licensed DDS or DMD
   - Non-Clinical
7. Within 2 business days of an appeal determination, UnitedHealthcare Dental will forward the written decision to the patient and/or dental provider via the U.S. Postal Service or similar means. Such notice shall include a case reference number, notice that the decision may be appealed to the state designated external appeals agency, and the means by which such an external appeal may be initiated.
8. UnitedHealthcare Dental will comply with requests by the Department of Health, made pursuant to Section 6.9 of the Rules and Regulations governing utilization review, to review any internal appeals processes or determinations.

The following applies to complaints as defined by the Health Care Accessibility and Quality Assurance Act (Chapter 23-17.13 of the General Laws of Rhode Island) and the Rules and Regulations of the Department of Health (R23-17. 13-CHP): contact by a provider to UnitedHealthcare Dental when they are not satisfied with the following as they relate to the plan:

1. A utilization review decision;
2. The quality of health care services delivered;
3. Any activity related to the management of the delivery of health care services.

UnitedHealthcare Dental will inform complainants, either telephonically or in writing of the right to notify the Rhode Island Department of Health if they are not satisfied with the outcome of UnitedHealthcare Dental's internal complaint or appeal process.

The following process applies to adverse determinations that constitute utilization review under the Utilization Review Act (Chapter 17.12 of Title 23 of the General Laws of Rhode Island) and the Rules and Regulations of the Department of Health (R23-17- 12.1-UR) (collectively referred to herein as UR Laws). This process does not apply to:

1. Services that are not covered benefits under an enrollees subscriber agreement
2. The denials of benefits based on a failure to follow the necessary steps to obtain proper authorization or referral for a covered service determinations that are made concerning enrollees care by that enrollees treating dental provider. Any discussion/negotiation with or agreement to accept an alternative treatment will be clearly documented by the Clinical Reviewer. Any such agreement reached does not constitute an adverse determination.
3. Set forth below is the standard appeals process that UnitedHealthcare Dental will use when it performs dental utilization review services for entities in Rhode Island. Clinical review criteria are themselves reviewed annually or amended as required. Five (5) Rhode Island dental providers are included in the review team and their comments and for recommendations to make material changes to review criteria and any actions taken by UnitedHealthcare Dental to incorporate these comments and/or recommendations will be documented and maintained by UnitedHealthcare Dental.

E.7 Treatment review process

For treatment that requires prior review and authorization, UnitedHealthcare Dental will assure that a dentist in the same or similar specialty as typically manages the dental condition, procedure, or treatment under discussion reviews the case. UnitedHealthcare Dental will provide written notification to the patient and dental provider of record of its determination for non-urgent and non-emergency cases as (defined in sections 1.13, 1.14 and 1.34 of R23-17.12-1-UR within seven (7) business days after receiving the required documentation for the review. For urgent or emergency cases notification of a prospective adverse determination by UnitedHealthcare Dental will be mailed or otherwise communicated to the provider of record and to the individual patient within one (1) business day of receipt of all information necessary to complete the review. All determinations not to certify treatment shall be documented and signed by a dentist. No coverage for dental services is retrospectively denied to a covered enrollee when prior approval was obtained unless the approval was based upon inaccurate information material to the review or the services were not consistent with the dental provider's submitted plan of care and/or any restrictions included in the prior approval granted by UnitedHealthcare Dental. All prospective and emergency adverse determinations are made, signed and documented only by a licensed practitioner with the same licensure status as the ordering practitioner.

In emergency cases (defined in Department of Health Rules and Regulations governing Utilization Review as the unexpected onset of symptoms of an injury, condition or illness that, if not treated immediately, could reasonably be expected to result in serious impairment or loss of life), the patient is always given immediate access to care.

Upon the rendering of any emergency services, the provider shall evaluate the need, if any, for post stabilization treatment and disposition of the patient.

Once the need for the post stabilization treatment has been established, the patient's status shall be assessed. Reappointment for necessary follow-up therapy or referral to a specialist for appropriate care must be timely: preferably before that patient is discharged.

Due to the fact that medical benefits cover such events rather than dental benefits, if the condition warrants admission to a medical facility, the patient will be advised to contact his/her medical plan for any authorization that may be required.

Appendix F: Office standards of care

F.1 Quality improvement and utilization program

UnitedHealthcare Dental has established an ongoing program of quality improvement to improve member care and services. Your office is required to cooperate with all of UnitedHealthcare Dental's Quality Management Policies and Procedures and Quality Improvement activities conducted by RIte Smiles.

The policies and procedures include, but are not limited to, Utilization Management, as described in the Prior Authorization Process, Grievance, Internal Peer Review and Credentialing sections of this manual. The policies and procedures may also be requested by contacting UnitedHealthcare Dental at **1-877-378-5303**.

UnitedHealthcare Dental encourages all providers/dentists to practice appropriate utilization. UnitedHealthcare Dental makes utilization review decisions based solely upon the appropriateness of care and services. UnitedHealthcare Dental does not specifically reward providers, dentists or other individuals for issuing denials of coverage any service.

F.2 Accessibility

How to help a member find dental care

The dental plan member ID card lists the name and phone number of the UnitedHealthcare Member Service line. The member can go to **uhc.com/RItesmiles** to locate a dental provider at any time. A member should call member services at **1-800-375-3257** (TTY **711**) to verify their RIte Smiles eligibility, Plan benefits or if they require a new RIte Smiles ID card.

If a RI Medicaid member does not have a dental plan listed or is missing a dental card, the member can call the RI Anchor Eligibility verification line at **1-855-697-4347** (TTY **711**).

Customer service

A segment of our toll-free telephone support is dedicated to providers. Provider-specific assistance is available such as how to reach your assigned provider advocate, claims adjustments or general "where to go" inquiries. Member-specific information for you is also available such as eligibility and benefits, arranging language assistance and transportation as well as referrals to services such as vision and dental.

This service is available Monday – Friday, 8 a.m. –11 p.m. ET, closed New Year's Day, Martin Luther King Jr Day, Memorial Day, Fourth of July, Labor Day, Thanksgiving and the day after, and Christmas Day. You may call the toll-free number at **1-877-378-5303** (TTY **711**).

Provider Services

UnitedHealthcare Dental – RIte Smiles Plan agreement begins in Provider Services. This is your resource for contractual issues and helping ensure that your contact information is correct. Your information should match your claims submission. If you have any changes or updates, please contact Provider Services immediately at **1-877-378-5303** or make directory status changes online at **UHCdental.com**.

Physician and provider advocates

Provider advocates are in the community working with contracted providers. Provider advocates are responsible for supporting contract inquiries, providing guidance for trends and supporting escalations that are not resolved through first contact with Provider Service.

Practice capacity and appointment scheduling

UnitedHealthcare Dental requires your office to appoint Routine Periodic Oral Evaluations for eligible members within sixty (60) days of member's request. This allows members reasonable access to care and timely treatment plan completion.

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

Urgent coverage

Your office is required to provide services to the patients within 48 hours of request for urgent service.

Office wait time

Average office wait time should be no more than 15 minutes or no more than 1 hour when the provider encounters an unanticipated urgent condition or need.

If your office or UnitedHealthcare Dental determines your practice has reached capacity and can no longer schedule appointments within the timeframes outlined above, your office may be placed in an "unpublished" status and your office will not appear in the directory. This will occur within sixty (60) days of the determination. Your office is required to provide covered services to all members who choose your office during the sixty (60) day period. When both your office and UnitedHealthcare Dental agree that your office can again become published, UnitedHealthcare Dental will do so immediately.

F.3 Continuity and coordination of care

UnitedHealthcare Dental should be contacted in situations where continuity and coordination of care may be necessary to complete dental care that is in process at the time the member became eligible with RIte Smiles.

Coordination of care (Orthodontia) :

1. If an eligible RIte Smiles member was banded under another RI Medicaid program and has now enrolled into UnitedHealthcare Dental the provider (or member) must submit for Continuation of Care to the UnitedHealthcare Appeals P.O. Box before submitting claims for code D8670*.

   Cases banded longer than 36 months and/or cases where D8670 has paid to the lifetime maximum of 23 exam visits will not be approved.

   Documentation Submission requirements:

   a. Completed 2019 (or greater) ADA claim form with code D8999.

   b. Copy of original approval from prior Medicaid Vendor.

   c. Copy of EOB/remit showing paid banding (D8080).

2. If an eligible RIte Smiles member has self-pay or covered by commercial insurance, a request for continuation of care will be denied.
3. If an eligible RIte Smiles member was previously self-pay or commercially covered, the new provider should submit all original records (if available) and a submit a PA request for a new D8080. The case will be reviewed (as if the treatment had never been started) to determine if the request documentation meets the state guidelines for approval.

UnitedHealthcare Dental providers, physicians and behavioral health clinicians have the obligation to coordinate care of mutual patients in accordance with state and federal confidentiality laws and regulations. This includes but is not limited to: obtaining appropriate releases to share clinical information; making referrals for social, vocational, education or human services when a need is identified through assessment; notifying each other of prescribed medications; and being available for consultation when necessary. Contact UnitedHealthcare Dental provider services for additional information.

4. A provider and/or member must attempt to obtain prior treatment history/records. If obtaining prior treatment history/records is not possible, a new provider must document attempts to retrieve prior treatment information.

Transition of care (Orthodontia):

1. Situations in which the Orthodontic care of an eligible RIte Smiles member is transferred from one UnitedHealthcare Dental RIte Smiles provider to another UnitedHealthcare Dental RIte Smiles provider (in which there is record of the approval of the original orthodontic treatment), prior authorization issued to a UnitedHealthcare provider for orthodontic services is not transferable to another UnitedHealthcare provider. The new provider must request a new prior authorization to complete the treatment initiated by the original provider. The new provider must obtain his/her own records, which must be submitted with the request for transfer of services. The new provider will only be paid their case fee minus what was paid to the previous provider.

   Documentation submission requirements:

   a. All the documentation that is required for the original request

   b. ADA 2019 or newer claim form with procedure code D8999 and the number of remaining visits (D8670) needing to be rendered. (D8999 is set up as the CDT intent ,“unspecified ortho procedure, with document requirements of: Description of procedure and narrative of medical necessity”).

   c. The reason the member left the previous provider and a Narrative noting the treatment status.

2. If an eligible RIte Smiles member was banded under a Medicaid program (outside of RI or a dental program outside of United States) the new provider must request a new prior authorization to complete the treatment initiated by the original provider. The new provider must obtain his/her own records, which must be submitted with a request for transfer of services.

   Documentation submission requirements:

   a. All the documentation that is required for the original request (if available),

   b. ADA 2019 or newer claim form with procedure code D8999 and the number of remaining visits (D8670) needing to be rendered.

   c. The reason the client left the previous provider and a Narrative noting the treatment status.

   d. A provider and/or member must attempt to obtain prior treatment history/records. If obtaining prior treatment history/records is not possible, a new provider must document attempts to retrieve prior treatment information.

F.4 Members with primary care needs

Should a member present with symptoms that may require evaluation or care by his or her Primary Care Physician (PCP), refer the member to his or her PCP.

F.5 Americans with Disabilities Act — effective communication

Excerpts from Title III – 4.3100 of the Americans with Disabilities Act

A public accommodation (dental provider) is required to provide auxiliary aids and services that are necessary to ensure equal access to the goods, services, facilities, privileges, or accommodations that it offers, unless an undue burden or a fundamental alteration would result.

Excerpts from Title III – 4.3200 of the Americans with Disabilities Act

In order to provide equal access, a public accommodation (i.e. a dental provider) is required to make available appropriate auxiliary aids and services where necessary to ensure effective communication. The type of auxiliary aid or service necessary to ensure effective communication will vary in accordance with the length and complexity of the communication involved.

Public accommodations (dental providers) should consult with individuals with disabilities wherever possible to determine what type of auxiliary aid is needed to ensure effective communication. In many cases, more than one type of auxiliary aid or service may make effective communication possible. While consultation is strongly encouraged, the ultimate decision as to what measures to take to ensure effective communication rests in the hands of the public accommodation, provided that the method chosen results in effective communication.

For more information on the Americans with Disabilities Act please visit **ada.gov**.

F.6 TITLE VI of the Civil Rights Act of 1964

Practitioners are expected to comply with the Civil Rights Act of 1964. Title VI of the Act pertains to discrimination on the basis of national origin or limited English proficiency. Practitioner are obligated to take reasonable steps to provide meaningful access to services for members with limited English proficiency, including provision of translator service as necessary for these members. Practitioner offices are expected to address the need for interpreter services in accordance with the Americans with Disabilities Act (ADA). Each practitioner is expected to arrange and coordinate interpreter services to assist members who are hearing impaired. RIte Smiles will assist practitioners in locating resources upon request. Practitioner offices are required to adhere to the Americans with Disabilities Act guidelines, Section 504, the Rehabilitation Act of 1973 and related federal and state requirements that are enacted from time to time. Practitioners may obtain copies of documents that explain legal requirements for translation services by contacting UnitedHealthcare Dental at **1-877-378-5303**.

F.7 Record keeping

All patient dental records should be legible and contain the following:

1. A complete and current medical history, including medical alerts, known allergies, current medications, pre-medications. Must be signed by patient and dentist.
2. An initial detailed intra/extra-oral exam, documenting condition of teeth and hard and soft tissues of the head and neck, updated at each routine visit.
3. Documentation of periodontal condition and charting for adult patients as needed.
4. A comprehensive, sequential treatment plan, with appropriate approvals by the patient or a parent or legal guardian.
5. Documentation of broken appointments and patient non-compliance.
6. Treatment notes updated at each patient encounter and where applicable:
   - Tooth/surface
   - Amount/type of anesthesia
   - Amount/type of materials used
   - Drugs prescribed or administered
   - Plans for next visit
   - Operator's signature
   - Appropriate radiographs of diagnostic quality, labeled and cataloged
   - Advance Directives, if appropriate

F.8 Confidentiality

Through contractual agreements, all providers participating with UnitedHealthcare Dental agree to abide by all policies and procedures regarding member confidentiality. Providers must protect and keep confidential members' medical and personal information used for any purposes in accordance with the following Laws:

- The Mental Health Procedures Act, 50 P.S. § 7111.
- The Patient Bill of Rights, 28 Pa. Code §115.27 and 71 P.S.§103.21.
- Health Insurance Portability and Accountability Act of 1996, 45 CFR, Parts 160 and 164.

Providers must assure that a member's individually identifiable health information as defined under 45 CFR 160.103, also known as Protected Health Information ("PHI"), necessary for treatment, payment or health care operations ("TPO") is released to UnitedHealthcare Dental, including information used for claims payment, continuity and coordination of care, accreditation surveys, medical record audits, treatment, quality assessment and measurement, quality of care issues and disease management.

Further, providers will assure that PHI will be made available to the Department of Health Services, Department of Health, Department of Insurance, or Business Associates of UnitedHealthcare Dental RIte Smiles for use without member consent. All other requests for release of or access to PHI will be handled in accordance with Federal and State regulations.

F.9 Reporting abuse

All known or suspected, abuse and/or neglect incidents should be reported pursuant to the applicable RI Laws.

RI Department of Elderly Affairs Protective Services: 1-401-462-0555
Developmental Disability Protective Services: 1-401-462-2629
Child Protective Services: 1-800-742-4453
Domestic Violence Prevention Coalition: 1-800-494-8100
911 In the case of emergency

Elder abuse:

RI Law (R.I.G.L. 42.66.10)

- RI Law requires any person who has reasonable cause to believe that and elderly person 60 or older has been abused to report it immediately to EOHHS and DEA. Failure to report abuse of a person over 60 can result in a fine of $1000.
- Cases of self- neglect require reporting to the DEA Protective Services Unit.
- Under RI Law records pertaining to a person reported to be abused, neglected, exploited or abandoned are confidential and are not deemed public records.
- To file an elder abuse case call DEA Protective Services Unit @ 401-462-0555.

Child abuse laws:

Code Section 40-11-1, et seq.

- What Constitutes Abuse Child whose physical or mental health or welfare is harmed or threatened with harm including excessive corporal punishment, sexual abuse/exploitation, neglect, or abandonment
- Mandatory Reporting Required by any person with reasonable cause
- All persons in Rhode Island are required by law (RIGL 40-11-3) to report known or suspected cases of child abuse and/or neglect to the Department within 24 hours of becoming aware of such abuse/neglect.
- Basis of Report of Abuse/neglect Reasonable cause to know or suspect that a child has been abused or neglected or been the victim of sexual abuse
- To Whom Reported Department of Children, Youth and Families (Statewide toll-free 24-hour/7-day-a-week hotline: 1-800-RI-CHILD)
- Penalty for Failure to Report or False Reporting Misdemeanor and up to $500 fine and/or imprisonment for up to 1 year for failure to report; misdemeanor and up to $1000 fine and/or imprisonment for up to 1 year for false report

Developmentally disabled:

RI Law 23-27.8-2

A. Any physician, medical intern, registered nurse, licensed practical nurse, nurse's aide, orderly, certified nursing assistant, medical examiner, dentist, optometrist, optician, chiropractor, podiatrist, coroner, police officer, emergency medical technician, fire-fighter, speech pathologist, audiologist, social worker, pharmacist, physical or occupational therapist, or health officer, or any person, within the scope of their employment at a facility or in their professional capacity, who has knowledge of or reasonable cause to believe that a patient or resident in a facility has been abused, mistreated, or neglected shall make, within twenty-four (24) hours or by the end of the next business day, a telephone report to the director of the department of health or his or her designee for those incidents involving health care facilities, and in addition to the office of the state long-term care ombudsperson for those incidents involving nursing facilities, assisted living residences, home-care and home nursing-care providers, veterans' homes and long-term care units in Eleanor Slater Hospital, or to the director of the department of behavioral healthcare, developmental disabilities and hospitals or his or her designee for those incidents involving community residences for people who are mentally retarded or persons with developmental disabilities. The report shall contain:
Terms Used In Rhode Island General Laws 23-17.8-2
person: extends to and includes co-partnerships and bodies corporate and politic. See Rhode Island General Laws 43-3-6.

1. The name, address, telephone number, occupation, and employer's address and the phone number of the person reporting;
2. The name and address of the patient or resident who is believed to be the victim of the abuse, mistreatment, or neglect;
3. The details, observations, and beliefs concerning the incident(s);
4. Any statements regarding the incident made by the patient or resident and to whom they were made;
5. The date, time, and place of the incident;
6. The name of any individual(s) believed to have knowledge of the incident;
7. The name of any individual(s) believed to have been responsible for the incident.

B. In addition to those persons required to report pursuant to this section, any other person may make a report if that person has reasonable cause to believe that a patient or resident of a facility has been abused, mistreated, or neglected.

C. Any person required to make a report pursuant to this section shall be deemed to have complied with these requirements if a report is made to a high managerial agent of the facility in which the alleged incident occurred. Once notified, the high managerial agent shall be required to meet all reporting requirements of this section within the time frames specified by this chapter.

D. Telephone reports made pursuant to subsection (a) shall be followed-up within three (3) business days with a written report.

Domestic Violence Prevention Act-Chapter 29-12-29-

12-29-2. Definitions.

§ 12-29-1. Legislative purpose.

A. The purpose of this chapter is to recognize the importance of domestic violence as a serious crime against society and to assure victims of domestic violence the maximum protection from abuse which the law and those who enforce the law can provide.

B. "Domestic violence" includes, but is not limited to, any of the following crimes when committed by one family or household member against another:

1. Simple assault (§ 11-5-3);
2. Felony assaults (chapter 5 of title 11);
3. Vandalism (§ 11-44-1);
4. Disorderly conduct (§ 11-45-1);
5. Trespass (§ 11-44-26);
6. Kidnapping (§ 11-26-1);
7. Child-snatching (§ 11-26-1.1);
8. Sexual assault (§§ 11-37-2, 11-37-4);
9. Homicide (§§ 11-23-1 and 11-23-3);
10. Violation of the provisions of a protective order entered pursuant to § 15-5-19, chapter 15 of title 15, or chapter 8.1 of title 8 where the respondent has knowledge of the order and the penalty for its violation, or a violation of a no contact order issued pursuant to § 12-29-4;
11. Stalking (chapter 59 of title 11);
12. Refusal to relinquish or to damage or to obstruct a telephone (§ 11-35-14);
13. Burglary and Unlawful Entry (chapter 8 of title 11);
14. Arson (chapter 4 of title 11);
15. Cyberstalking and cyber harassment (§ 11-52-4.2);
16. Domestic assault by strangulation § 11-5-2.3; and

Electronic tracking of motor vehicles (§ 11-69-1)

Appendix G: Procedural guidelines

G.1 Preventive and diagnostic services

Providers should recall patients every six months for preventive services, unless an alternate interval is clinically warranted. Preventive care, early detection of disease, and proper home care should be discussed with each patient.

A preventive visit should include a prophylaxis, oral hygiene instruction, an examination, and radiographs as indicated. A prophylaxis should include removal of plaque, calculus and stains from tooth structures of the permanent/primary and transitional dentition.

Fluoride status should be reviewed for children starting at the eruption of the first tooth. Fluoride should be provided every six months as indicated and based on caries risk and exposure to other sources of fluoride. Pit and fissure sealants should be considered for all permanent molars (except 3rd molars/wisdom teeth) once these are fully erupted for children over 5 years of age.

G.2 Radiographs

Patients should wear protective lead aprons with thyroid collars during all radiographic procedures. Aprons should be hung after use, not folded. Films and/or digital images should be of diagnostic quality, labeled with date and patient's name, and stored in the patient's chart.

G.3 Clinical oral evaluations

A comprehensive oral evaluation is a thorough evaluation and recording of the extra-oral and intra-oral hard and soft tissues. This evaluation should include the following:

- Comprehensive examination by a dentist
- Tooth charting (existing fillings, missing teeth, etc.)
- Periodontal charting when appropriate
- Recording of a patient's medical and dental history, including known allergies and medications
- Review of x-rays necessary for diagnosis
- Intraoral and extraoral cancer screening
- Complete diagnosis of dental condition with written treatment plan
- A periodic oral evaluation is intended to determine changes in dental/medical health status since a previous evaluation. Periodic evaluation should include the following:
- Examination by a dentist
- Documentation of changes in medical history, including known allergies and medications
- Documentation of changes in oral health
- Diagnosis of dental problems/diseases
- Intraoral and extraoral cancer screening
- Review of x-rays and treatment plan when necessary

G.4 Crowns

Crowns are indicated for teeth that cannot be restored using filling materials. Crowns usually should not begin until the patient has progressed in the treatment plan to a point of adequate dental health, so that immediate needs such as caries control and periodontal stability have been treated. A conservative treatment plan should be followed with alternative methods of treatment discussed with the patient. A sequential treatment plan and alternatives should be documented in the chart. Crowns should not be recommended for teeth that have a poor five-year prognosis (periodontally compromised, unrestoreable, or have chronic infections). Crowns should be placed on decay-free tooth structure and have good marginal integrity.

G.5 Endodontic services

Examination of the endodontic patient should include treatment necessary to relieve discomfort. Endodontic treatment should include a thorough diagnosis of the origin of the pain, pulpal necrosis and/or lesions of endodontic origin, as appropriate.

When root canal treatment is performed, the canals should be filled completely and appropriately sealed.

G.6 Periodontal services

Initial examination should include at a minimum a Periodontal Screening Record (PSR) and a history of relevant medical conditions, such as diabetes. In cases of Periodontal Disease, a baseline periodontal evaluation should be recorded in the patient's chart, including the recording of periodontal pocket depth and presence of inflammation. A recommended treatment plan should be documented in the chart. The patient should be educated in home care and oral hygiene techniques. The dentist should document in the patient's chart whether periodontal treatment needs indicate referral to a specialist and whether the patient consents to proceed with treatment.

G.7 Prosthodontic services

Complete denture restorations are best utilized as the last existing treatment alternative. Complete dentures are indicated if all upper or lower teeth are removed, or the teeth are diseased to a degree that there is no other alternative. Immediate dentures/partials are appropriate when extracted teeth are deemed unsalvageable. Providers should review the proper care of any prosthesis.

Complete denture repairs include repair of major fractures, broken flanges, or replacement of fractured denture teeth. Old dentures with severely worn teeth or fractures should be replaced with patient's approval. Repairs to damaged partial dentures include repair of fractured flanges, repair of major or minor cast connectors, cast clasps, replacing a broken clasp with wrought wire clasps, and selective repair or addition of teeth.

G.8 Oral surgery

All appropriate post-operative care should be performed following oral surgery. If general anesthesia or I.V. sedation is administered, the patient's vital signs should be continuously monitored during administration and recovery. The administering provider must be a current Rhode Island dental board permit holder. Oral Surgeons must follow current rules and regulation guidelines pertaining to administration of minimal, moderate and general sedation.

G.9 Orthodontic services

Orthodontic treatment must be performed by a Board Certified or Eligible orthodontist who has completed an ADA certified, postgraduate orthodontic course.

- Retainers are considered part of comprehensive treatment and may not be billed separately.
- Retainer maintenance visits are part of comprehensive orthodontic care.
- A member must be eligible at the time of delivery for payment to be received.
- If a member becomes ineligible during treatment the provider will receive payment for the final period of eligibility and may there after seek compensation from the member.
- The handicapping malocclusion must be supported by either:
  - an indication of an automatic qualifier on the HLD Index (Handicapping Labio-lingual Deviation Index),
  - or, a minimum score of 26 on the HLD Index (Handicapping Labio-lingual Deviation Index).
- Clinical records submitted by provider must support the score given on the HLD Index. The HLD is reviewed by a Board-qualified orthodontic consultant.
- Limited Ortho prepares for Comprehensive Ortho and typically does not require adjustments.
- Limited ortho codes D8010, D8020, D8030 &D8040 will remain.

- Comprehensive Ortho banding D8080 is billed and subsequently the adjustments D8670 are billed for periodic maintenance/ adjustments. Rite Smiles benefit limit for D8670 is 23 visits lifetime and is currently set up to be billed with either limited or comprehensive ortho.

G.10 Reimbursement

Reimbursement for orthodontic treatment is based on submission of the appropriate procedure code(s).
Prior authorized procedure codes: D8210, D8220, D8050, D8060, D8070, D8080 or D8090

- Will be considered for payment as the initial reimbursement when all bands, brackets and/or appliances have been placed and active treatment has been initiated.
- The diagnostic workup is considered part of this initial reimbursement.

Procedure code D8670: Periodic Orthodontic Treatment Visit

- Limited to one service per month.
- The total number of monthly adjustments allowed will vary by approved level of orthodontic treatment.
- May not be submitted for an observational visit only.

Procedure code D8680: Orthodontic retention - removal of appliances, construction and placement of retainer(s)

- Will be considered for payment as the last payment when orthodontic treatment is complete and has been prior authorized. Denied cases will not be reimbursed.

Completion of all levels of orthodontic treatment

- Prior authorization is required for completion of treatment (last payment) and must be reviewed for proof of completion of case.
- Providers must use procedure code D8680 for the removal of all bands, brackets and appliances.

G.11 Adjunctive general services

Palliative treatment is rendered to a patient for the immediate relief of pain. If the procedure performed has its own ADA code the procedure may not be billed as palliative treatment. Telephoning in a prescription without seeing the patient or beginning a definitive procedure does not qualify for payment under this code.

Local anesthesia is included in the fee for specific procedures.

Appendix H: Definitions

Abuse

Provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes consumer practices that result in unnecessary cost to the Medicaid program.

By Report

A narrative description used to describe a service that does not have a procedure code or is specified in a code as “by report”; may be requested by a third party payer to provide additional information for claims processing.

CAP

Corrective action plan.

Coordination of Benefits

A procedure establishing the order in which health care entities pay their claims. UnitedHealthcare Dental RIte Smiles is always the payer of last resort.

Denial

Any determination made in response to a provider’s request for approval to provide MA covered services of a specific duration and scope which: disapproves the request completely; approves provision of the requested service(s), but for a lesser scope or duration than requested by the provider; or disapproves provision of the requested service(s), but approves provision of an alternative service(s).

Early and Periodic Screening, Diagnosis and Treatment (EPSDT)

Items and services which must be made available to persons under the age of twenty- one (21) upon a determination of medical necessity and required by federal law at 42 U.S.C §1396d(r).

Emergency Medical Condition

A dental condition requiring immediate treatment to control hemorrhage, relieve acute pain, and eliminate acute infection, pulpal death, or loss of teeth. In alignment with 42 C.F.R. § 438.114, an emergency dental condition means a dental condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following:

1. Placing the health of the individual (or, for a pregnant woman, the health of the woman or her unborn child) in serious jeopardy)
2. Serious impairment to bodily functions
3. Serious dysfunction of any bodily organ or part

Experimental Treatment

A course of treatment, procedure, device or other medical intervention that is not yet recognized by the professional medical community as an effective, safe and proven treatment for the condition for which it is being used.

Fraud

Any type of intentional deception or misrepresentation made by an entity or person with the knowledge that the deception could result in some unauthorized benefit to the entity, him/herself, or some other person in a managed care setting. The Fraud

can be committed by many entities, including RIte Smiles, UnitedHealthcare Dental, any subcontractor, a Provider, a State employee, or a Member among others.

Grievance

A request to reconsider a decision solely concerning the medical necessity and appropriateness of a health care service. This applies to a decision to 1) deny, in who or in part, payment for a service or item if based on lack of medical necessity; 2) deny or issue a limited authorization of a requested service or item, including the type or level of service or item; 3) reduce, suspend, or terminate a previously authorized service or item; 4) deny the requested service or item but approve an alternative service or item.

IVR

Interactive Voice Response system allows a participating provider to retrieve information by following telephonic prompts.

Medicaid

Medical assistance provided under a state plan approved under Title XIX of the Social Security Act.

Medically Necessary

A service or benefit is Medically Necessary if it is compensable under the Medical Assistance Program and if it meets any of the following standards:

- The service or benefit will, or is reasonably expected to, prevent the onset of an illness, condition or disability.
- The service or benefit will, or is reasonably expected to, reduce or ameliorate the physical, mental or developmental effects of an illness, condition, injury or disability.
- The service or benefit will assist the member in achieving or maintaining maximum functional capacity in performing daily activities, taking into account both the functional capacity of the member and those functional capacities that are appropriate for a member of the same age.

Determination of Medical Necessity for covered care and services, whether made on a prior authorization, concurrent review, post-utilization, or exception basis, must be documented in writing.

The determination is based on medical information provided by the member, the member's family/caretaker, and the Primary Care Practitioner, as well as any other providers, programs, agencies that have evaluated the member.

Qualified and trained health care providers must make all such determinations. A health care provider who makes such determinations of Medical Necessity is not considered to be providing a health care service.

Primary Care Physician

A specific physician, physician group or a CRNP operating under the scope of his/her licensure, and who is responsible for supervising, prescribing, and providing primary care services; locating, coordinating and monitoring other medical care and rehabilitative services and maintaining continuity of care on behalf of a UnitedHealthcare/RIte Smiles member.

Prior Authorization

A determination made by UnitedHealthcare Dental or RIte Smiles to approve or deny payment for a provider's request to provide a service or course of treatment of a specific duration and scope to a member prior to the provider's initiating provision of the requested service.

Retrospective Review

A review conducted by UnitedHealthcare Dental to determine whether services were delivered as described and consistent with UnitedHealthcare Dental's payment policies and procedures.

Special Needs

The circumstances for which a member will be classified as having a special need will be based on a non-categorical or generic perspective that identifies key attributes of physical, developmental, emotional or behavioral conditions.

Dental Benefit Providers®

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

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

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