# UnitedHealthcare Community Plan of Texas Medicare-Medicaid (MMP), STAR, STAR+PLUS/SNF, STAR+PLUS Waiver Medicaid Dental Quick Reference Guide

Effective: 2024

## UHCdental.com/medicaid

The Dental Hub may be used to check eligibility, submit claims, and access useful information regarding plan coverage.

To register for the Dental Hub, 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.

## Provider services

Phone: **1-877-378-5301**
8 a.m. – 5 p.m. CST Monday–Friday (IVR: 24/7)

Member eligibility, benefits, claims, authorizations, network participation and contract questions

## Prior authorization

UnitedHealthcare Dental Authorizations
P.O. Box 1511
Milwaukee WI 53201

## Appeals for service denials

UnitedHealthcare Community Plan
Attn: Appeals Department
P.O. BOX 1471
Milwaukee, WI 53201

Toll-free: **1-888-887-9003**

## Claims

**UnitedHealthcare Dental Claims**
P.O. BOX 1471
Milwaukee, WI 53201

## EDI Payer ID

GP133

## Claim disputes or adjustments

UnitedHealthcare Dental
Claim Appeals
Provider Disputes:
P.O. Box 1427
Milwaukee, WI 53201

## Corrected claims

UnitedHealthcare Dental
Corrected Claims
P.O. Box 481
Milwaukee, WI 53201

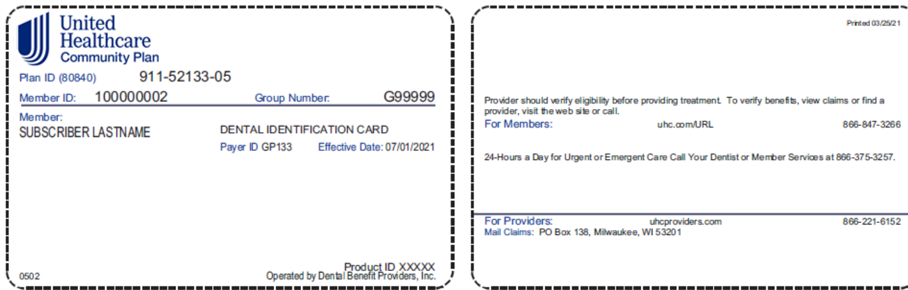
Claims may be submitted electronically via your clearinghouse, online via the provider portal or via the mailing addresses here.

## Important notes

This guide is intended to be used for quick reference and may not contain all of the necessary information; it is subject to change without notice. For current detailed benefit information, please visit the Dental Hub or contact our Provider Services toll free number.

Dental Benefit Providers®

## Sample member ID card




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

# Exclusions & limitations

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

Any service not listed as a covered service in the benefit grids (Appendix B.2) is excluded.

Please call Provider Services at **1-877-378-5301** if you have any questions regarding frequency limitations.

## Exclusions & limitations

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

## Benefit grid

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

## Covered services for UnitedHealthcare Texas Medicaid

### Product overview

For UnitedHealthcare Texas, we offer the following plans:

- UnitedHealthcare of Texas STAR Medicaid Dental Plan
- UnitedHealthcare of Texas STAR+PLUS Medicaid Dental Plan
- UnitedHealthcare Connected™ Medicare-Medicaid Dental Plan

### Benefit Overview: UnitedHealthcare of Texas STAR Medicaid Dental Plan

Value-added adult dental benefit services for members age 21 and over are covered under this plan. It includes preventive and diagnostic services. The plan has a $250 maximum annual benefit. Covered services are paid at 100 percent of the provider fee schedule amount with no deductible or copay amount.

Should you have any questions regarding the benefits, please contact the Dental Provider Services Department at **1-877-378-5301.**

#### UnitedHealthcare of Texas STAR Medicaid Dental Plan

| Code | Description | Frequency limits | Auth required? | Required documents |
|---|---|---|---|---|
| D0120 | Periodic Oral Evaluation - Established Patient | 1 per 6 month period | No | |
| D0140 | Limited Oral Evaluation - Problem Focused | 1 per 6 month period | No | |
| D0150 | Comprehensive Oral Evaluation - New Or Established Patient | 1 per 12 month period | No | |
| D0210 | Intraoral - Complete Series of Radiographic Images | 1 per 3 years | No | |
| D1110 | Prophylaxis - Adult | 1 per 6 month period | No | |

### Benefit Overview: UnitedHealthcare of Texas STAR+PLUS Medicaid Dental Plan

The UnitedHealthcare of Texas STAR+PLUS Medicaid plan has 3 dental products: the Standard dental benefit, the Skilled Nursing Facilities (SNF) dental benefit and the Waiver dental benefit. The products are described below.

#### UnitedHealthcare of Texas STAR+PLUS/SNF Dental Plan

Value-added adult dental benefit services for members age 21 and over are covered under this plan. It includes diagnostic, preventive, minor restorative and oral surgery services. The plan has a $500 maximum annual benefit. Covered services are paid at 100 percent of the provider fee schedule amount with no deductible or copay amount. Should you have any questions regarding the benefits, please contact the Dental Provider Services Department at **1-877-378-5301.**

| Code | Description | Frequency limits | Auth required? | Required documents |
|---|---|---|---|---|
| D0120 | Periodic Oral Evaluation - Established Patient | 1 per 6 month period | | |
| D0140 | Limited Oral Evaluation - Problem Focused | 1 per 6 month period | | |
| D0150 | Comprehensive Oral Evaluation - New Or Established Patient | 1 per 12 month period | | |
| D0210 | Intraoral - Complete Series of Radiographic Images | 1 per 3 years | | |
| D1110 | Prophylaxis - Adult | 1 per 6 month period | | |
| D4341 | Periodontal Scaling And Root Planing - Four Or More Teeth Per Quadrant | 4 quadrant per year, any combination of D4341 or D4342, no more than 2 quadrants payable per visit | Yes | Periodontal charting and pre-op x-rays |
| D4342 | Periodontal Scaling And Root Planing - One To Three Teeth Per Quadrant | 4 quadrant per year, any combination of D4341 or D4342, no more than 2 quadrants payable per visit | Yes | Periodontal charting and pre-op x-rays |

## UnitedHealthcare of Texas STAR+PLUS Waiver Medicaid Dental Plan

STAR+PLUS members who qualify for the 1915(c) STAR+PLUS Waiver services program are eligible for dental services that are not covered under the standard STAR+PLUS benefit.

In order to qualify for the Waiver Services benefit, a member must be an eligible STAR+PLUS Long-Term Care facility member, who is either disabled, chronically ill, or has another qualifying condition as outlined by the Texas Health and Human Services Commission (HHSC).

To confirm member eligibility under STAR+PLUS Waiver plan, call our Provider Service Center at 1-877-378-5301 . Always verify eligibility via our website, or Provider Services Call Center before treating patients.

Dental services must be provided by a participating UnitedHealthcare STAR+PLUS Waiver network dentist, who is enrolled as a Medicaid provider with Texas Medicaid Healthcare Partnership. Allowable Waiver program dental services include:

- Emergency dental treatment procedures necessary to control bleeding, relieve pain and eliminate swelling;
- Acute infection: preventive procedures required to prevent the imminent loss of teeth;
- Treatment of injuries to the teeth or supporting structures;
- Dentures and the cost of fitting and preparing for dentures, including extractions, molds, etc.; and
- Routine and preventive dental treatment.
- Participating Dentist will discount non-covered services by 25 percent off their usual fees. Members can be billed for the balance after the discount for non-covered services.

Cosmetic dental services are not covered under the plan. For more information regarding dental services covered under the Waiver program, call our Provider Service Center at **1-877-378-5301.**

There is a $5,000 Annual Maximum benefit under the Waiver services program.

The $5,000 annual maximum expires 1 year after the member's effective date under the Waiver program.

Example: If a member is effective under the waiver program on Nov. 1, 2020, then the $5,000.00 annual maximum is good through Oct. 31, 2021.

## Benefit Overview: UnitedHealthcare Connected™ Medicare–Medicaid Dental Plan (Texas MMP)

The UnitedHealthcare Connected™ (Medicare-Medicaid plan) has two dental benefit levels, the Standard dental benefit and the Waiver dental benefit. Both are described separately below. Should you have any questions regarding the benefits, contact the Dental Provider Services Department at **1-877-378-5301.**

### Benefit Overview: UnitedHealthcare Connected™ Medicare- Medicaid Dental Plan (Standard Benefit)

Value-added adult dental benefit services for members age 21 and over are covered under this plan. It includes diagnostic, preventive, minor restorative and oral surgery services. The plan has a $1,000 maximum annual benefit. Covered services are paid at 100 percent of the provider fee schedule amount with no deductible or copay amount. Should you have any questions regarding the benefits, contact the Dental Provider Services Department at **1-877-378-5301.**

| Code | Description | Frequency limits | Auth required? | Required documents |
|---|---|---|---|---|
| D0120 | Periodic Oral Evaluation - Established Patient | 1 per 12 month period | No | N/A |
| D0140 | Limited Oral Evaluation - Problem Focused | 2 Per 12 month period | No | N/A |
| D0150 | Comprehensive Oral Evaluation - New or Established Patient | 1 per 12 month period | No | N/A |
| D0160 | Detailed And Extensive Oral Evaluation - Problem Focused, By Report | 1 per 1 plan year per patient | No | N/A |
| D0210 | Intraoral - Complete Series of Radiographic Images | 1 per 3 years | No | N/A |
| D0220 | Intraoral - Periapical First Radiographic Image | 1 per 12 month period | No | N/A |
| D0230 | Intraoral - Periapical Each Additional Radiographic Image | 1 per 12 month period | No | N/A |
| D0270 | Bitewing - Single Radiographic Image | 1 per 12 month period for any combination of D0270, D0272, D0273, or D0274 | No | N/A |
| D0272 | Bitewings - Two Radiographic Images | 1 per 12 month period for any combination of D0270, D0272, D0273, or D0274 | No | N/A |
| D0273 | Bitewings - Three Radiographic Images | 1 per 1 plan year (codeset: D0270, D0272, D0273, D0274, D0277) | No | N/A |

| Code | Description | Frequency limits | Auth required? | Required documents |
|---|---|---|---|---|
| D0274 | Bitewings - Four Radiographic Images | 1 per 12 month period for any combination of D0270, D0272, D0273, or D0274 | No | N/A |
| D0277 | Vertical Bitewings - 7 to 8 Radiographic Images | 1 per 1 plan year (codeset: D0270, D0272, D0273, D0274, D0277) | No | N/A |
| D0330 | Panoramic Radiographic Image | 1 per 3 years | No | N/A |
| D1110 | Prophylaxis Adult | 1 per 12 month period | No | N/A |
| D1206 | Topical Application of Fluoride Varnish | 1 per 12 month period | No | N/A |
| D1208 | Topical Application of Fluoride - Excluding Varnish | 1 per 12 month period | No | N/A |
| D1310 | Nutritional Counseling For Control of Dental Disease | 1 per 1 plan year per patient | No | N/A |
| D1354 | Interim Caries Arresting Medicament Application - Per Tooth | Unlimited | No | N/A |
| D2140 | Amalgam - One Surface, Primary or Permanent | Unlimited | No | N/A |
| D2150 | Amalgam - Two Surfaces, Primary or Permanent | Unlimited | No | N/A |
| D2160 | Amalgam - Three Surfaces, Primary or Permanent | Unlimited | No | N/A |
| D2161 | Amalgam - Four or More Surfaces, Primary or Permanent | Unlimited | No | N/A |
| D2330 | Resin-Based Composite - One Surface, Anterior | Unlimited | No | N/A |
| D2331 | Resin-Based Composite - Two Surfaces, Anterior | Unlimited | No | N/A |
| D2332 | Resin-Based Composite - Three Surfaces, Anterior | Unlimited | No | N/A |
| D2335 | Resin-Based Composite - Four or More Surfaces Involving Incisal Angle (Anterior) | Unlimited | No | N/A |
| D2391 | Resin-Bsed Composite - One Surface Posterior | Unlimited | No | N/A |
| D2392 | Resin-Based Composite - Two Surfaces, Posterior | Unlimited | No | N/A |
| D2393 | Resin-Based Composite - Three Surfaces, Posterior | Unlimited | No | N/A |
| D2394 | Resin-Based Composite - Four or More Surfaces, Posterior | Unlimited | No | N/A |
| D2510 | Inlay - Metallic - One Surface | 1 per 5 floating year per tooth | No | N/A |
| D2520 | Inlay - Metallic - Two Surfaces | 1 per 5 floating year per tooth | No | N/A |
| D2530 | Inlay - Metallic - Three or More Surfaces | 1 per 5 floating year per tooth | No | N/A |
| D2542 | Onlay - Metallic - Two Surfaces | 1 per 5 floating year per tooth | Yes | Current X-rays, narrative of med. necessity and/or treatment plan |
| D2543 | Onlay - Metallic - Three Surfaces | 1 per 5 floating year per tooth | Yes | Current X-rays, narrative of med. necessity and/or treatment plan |
| D2544 | Onlay - Metallic - Four or More Surfaces | 1 per 5 floating year per tooth | Yes | Current X-rays, narrative of med. necessity and/or treatment plan |
| D2610 | Inlay - Porcelain/Ceramic - One Surface | 1 per 5 floating year per tooth | No | N/A |
| D2620 | Inlay - Porcelain/Ceramic - Two Surfaces | 1 per 5 floating year per tooth | No | N/A |
| D2630 | Inlay - Porcelain/Ceramic - Three or More Surfaces | 1 per 5 floating year per tooth | No | N/A |
| D2642 | Onlay - Porcelain/Ceramic - Two Surfaces | 1 per 5 floating year per tooth | Yes | Current X-rays, narrative of med. necessity and/or treatment plan |
| D2643 | Onlay - Porcelain/Ceramic - Three Surfaces | 1 per 5 floating year per tooth | Yes | Current X-rays, narrative of med. necessity and/or treatment plan |
| D2644 | Onlay - Porcelain/Ceramic - Four or More Surfaces | 1 per 5 floating year per tooth | Yes | Current X-rays, narrative of med. necessity and/or treatment plan |
| D4341 | Periodontal Scaling And Root Planing - Four or More Teeth Per Quadrant | 4 Quadrant per year, any combination of D4341 or D4342, no more than 2 quadrants payable per visit | Yes | Periodontal charting and Pre-op X-rays |
| D4342 | Periodontal Scaling And Root Planing - One to Three Teeth Per Quadrant | 4 Quadrant per year, any combination of D4341 or D4342, no more than 2 quadrants payable per visit | Yes | Periodontal charting and Pre-op X-rays |
| D4355 | Full Mouth Debridement to Enable a Comprehensive Evaluation And Diagnosis On a Subsequent Visit | 1 per 3 floating year per patient | No | N/A |

| Code | Description | Frequency limits | Auth required? | Required documents |
|---|---|---|---|---|
| D4381 | Localized Delivery of Antimicrobial Agents Via a Controlled Release Vehicle Into Diseased Crevicular Tissue, Per Tooth | Unlimited | Yes | Periodontal charting and Pre-op X-rays |
| D4910 | Periodontal Maintenance | 3 Per 1 plan year per patient | No | N/A |
| D5110 | Complete Denture - Maxillary | 1 per 5 floating year per patient | Yes | FMX or Panorex X-rays |
| D5120 | Complete Denture - Mandibular | 1 per 5 floating year per patient | Yes | FMX or Panorex X-rays |
| D5130 | Immediate Denture - Maxillary | 1 per 1 lifetime per patient | Yes | FMX or Panorex X-rays |
| D5140 | Immediate Denture - Mandibular | 1 per 1 lifetime per patient | Yes | FMX or Panorex X-rays |
| D5211 | Maxillary Partial Denture - Resin Base (Including Retentive/Clasping Materials, Rests And Teeth) | 1 per 5 floating year (codeset: D5211, D5213, D5225) | Yes | FMX or Panorex X-rays |
| D5212 | Mandibular Partial Denture - Resin Base (Including Retentive/ Clasping Materials, Rests And Teeth) | 1 per 5 floating year (codeset: D5212, D5214, D5226) | Yes | FMX or Panorex X-rays |
| D5213 | Maxillary Partial Denture - Cast Metal Framework With Resin Denture Bases (Including Any Conventional Clasps, Rests And Teeth) | 1 per 5 floating year (codeset: D5211, D5213, D5225) | Yes | FMX or Panorex X-rays |
| D5214 | Mandibular Partial Denture - Cast Metal Framework With Resin Denture Bases (Including Any Conventional Clasps, Rests And Teeth) | 1 per 5 floating year (codeset: D5212, D5214, D5226) | Yes | FMX or Panorex X-rays |
| D5221 | Immediate Maxillary Partial Denture - Resin Base (Including Any Conventional Clasps, Rests And Teeth) | 1 per 5 floating year per patient | No | N/A |
| D5222 | Immediate Mandibular Partial Denture - Resin Base (Including Any Conventional Clasps, Rests And Teeth) | 1 per 5 floating year per patient | No | N/A |
| D5225 | Maxillary Partial Denture - Flexible Base (Including Any Clasps, Rests And Teeth) | 1 per 5 floating year (codeset: D5211, D5213, D5225) | No | N/A |
| D5226 | Mandibular Partial Denture - Flexible Base (Including Any Clasps, Rests And Teeth) | 1 per 5 floating year (codeset: D5212, D5214, D5226) | No | N/A |
| D5410 | Adjust Complete Denture - Maxillary | 2 Per 1 plan year per patient | No | N/A |
| D5411 | Adjust Complete Denture - Mandibular | 2 Per 1 plan year per patient | No | N/A |
| D5421 | Adjust Partial Denture - Maxillary | 2 Per 1 plan year per patient | No | N/A |
| D5422 | Adjust Partial Denture - Mandibular | 2 Per 1 plan year per patient | No | N/A |
| D5511 | Repair Broken Complete Denture Base, Mandibular | 1 per 1 plan year per patient | No | N/A |
| D5512 | Repair Broken Complete Denture Base, Maxillary | 1 per 1 plan year per patient | No | N/A |
| D5520 | Replace Missing or Broken Teeth - Complete Denture (Each Tooth) | 1 per 1 plan year per patient | No | N/A |
| D5611 | Repair Resin Partial Denture Base, Mandibular | 1 per 1 plan year per patient | No | N/A |
| D5612 | Repair Resin Partial Denture Base, Maxillary | 1 per 1 plan year per patient | No | N/A |
| D5621 | Repair Cast Partial Framework, Mandibular | 1 per 1 plan year per patient | No | N/A |
| D5622 | Repair Cast Partial Framework, Maxillary | 1 per 1 plan year per patient | No | N/A |
| D5630 | Repair or Replace Broken Retentive/Clasping Material - Per Tooth | 1 per 1 plan year per patient | No | N/A |
| D5640 | Replace Broken Teeth - Per Tooth | 1 per 1 plan year per patient | No | N/A |
| D5650 | Add Tooth to Existing Partial Denture | 1 per 1 plan year per patient | No | N/A |
| D5660 | Add Clasp to Existing Partial Denture - Per Tooth | 1 per 1 plan year per patient | No | N/A |
| D5730 | Reline Complete Maxillary Denture (Chairside) | 1 per 1 plan year per patient | No | N/A |
| D5731 | Reline Complete Mandibular Denture (Chairside) | 1 per 1 plan year per patient | No | N/A |
| D5740 | Reline Maxillarly Partial Denture (Chairside) | 1 per 1 plan year (codeset: D5740, D5760) | No | N/A |
| D5741 | Reline Mandibular Partial Denture (Chairside) | 1 per 1 plan year (codeset: D5741, D5761) | No | N/A |
| D5750 | Reline Complete Maxillary Denture (Laboratory) | 1 per 1 plan year per patient | No | N/A |
| D5751 | Reline Complete Mandibular Denture (Laboratory) | 1 per 1 plan year per patient | No | N/A |
| D5760 | Reline Maxillary Partial Denture (Laboratory) | 1 per 1 plan year (codeset: D5740, D5760) | No | N/A |
| D5761 | Reline Mandibular Partial Denture (Laboratory) | 1 per 1 plan year (codeset: D5741, D5761) | No | N/A |
| D5850 | Tissue Conditioning, Maxillary | 2 Per 1 plan year per patient | No | N/A |
| D5851 | Tissue Condiditoning, Mandibular | 2 Per 1 plan year per patient | No | N/A |

| Code | Description | Frequency limits | Auth required? | Required documents |
|---|---|---|---|---|
| D6210 | Pontic - Cast High Noble Metal | 1 per 5 plan year (codeset: D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6245) | Yes | Pre-op X-rays |
| D6211 | Pontic - Cast Predominantly Base Metal | 1 per 5 plan year (codeset: D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6245) | Yes | Pre-op X-rays |
| D6212 | Pontic - Cast Noble Metal | 1 per 5 plan year (codeset: D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6245) | Yes | Pre-op X-rays |
| D6214 | Pontic - Titanium | 1 per 5 plan year (codeset: D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6245) | No | N/A |
| D6240 | Pontic - Porcelain Fused to High Noble Metal | 1 per 5 plan year (codeset: D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6245) | Yes | Pre-op X-rays |
| D6241 | Pontic - Porcelain Fused to Predominantly Base Metal | 1 per 5 plan year (codeset: D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6245) | Yes | Pre-op X-rays |
| D6242 | Pontic - Porcelain Fused to Noble Metal | 1 per 5 plan year (codeset: D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6245) | Yes | Pre-op X-rays |
| D6245 | Pontic - Porcelain/Ceramic | 1 per 5 plan year (codeset: D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6245) | Yes | Pre-op X-rays |
| D6740 | Retainer Crown - Porcelain/Ceramic | 1 per 5 plan year (codeset: D6740, D6750, D6751, D6752, D6790, D6791, D6792, D6794, ) | Yes | FMX & charting |
| D6750 | Retainer Crown - Porcelain Fused to High Noble Metal | 1 per 5 plan year (codeset: D6740, D6750, D6751, D6752, D6790, D6791, D6792, D6794, ) | Yes | Pre-op X-rays |
| D6751 | Retainer Crown - Porcelain Fused to Predominantly Base Metal | 1 per 5 plan year (codeset: D6740, D6750, D6751, D6752, D6790, D6791, D6792, D6794, ) | Yes | Pre-op X-rays |
| D6752 | Retainer Crown - Porcelain Fused to Noble Metal | 1 per 5 plan year (codeset: D6740, D6750, D6751, D6752, D6790, D6791, D6792, D6794, ) | Yes | Pre-op X-rays |
| D6790 | Retainer Crown - Full Cast High Noble Metal | 1 per 5 plan year (codeset: D6740, D6750, D6751, D6752, D6790, D6791, D6792, D6794, ) | Yes | Pre-op X-rays |
| D6791 | Retainer Crown - Full Cast Predominantly Base Metal | 1 per 5 plan year (codeset: D6740, D6750, D6751, D6752, D6790, D6791, D6792, D6794, ) | Yes | Pre-op X-rays |
| D6792 | Retainer Crown - Full Cast Noble Metal | 1 per 5 plan year (codeset: D6740, D6750, D6751, D6752, D6790, D6791, D6792, D6794, ) | Yes | Pre-op X-rays |
| D6794 | Retainer Crown - Titanium | 1 per 5 plan year (codeset: D6740, D6750, D6751, D6752, D6790, D6791, D6792, D6794, ) | Yes | FMX or pan w/ perio chart |
| D6930 | Re-Cement or Re-Bond Fixed Partial Denture | Unlimited | No | N/A |
| D7111 | Extraction, Coronal Remnants - Primary Tooth | 1 per 1 lifetime per tooth | No | N/A |
| D7140 | Extraction, Erupted Tooth or Exposed Root (Elevation And/Or Forceps Removal) | 1 per 1 lifetime (codeset: D7140, D7210, D7250) | No | N/A |
| D7210 | Extraction, Erupted Tooth Requiring Removal of Bone And/Or Sectioning of Tooth, And Including Elevation of Mucoperiosteal Flap If Indicated | 1 per 1 lifetime (codeset: D7140, D7210, D7250) | No | N/A |
| D7250 | Removal of Residual Tooth Roots (Cutting Procedure) | 1 per 1 lifetime (codeset: D7140, D7210, D7250) | No | N/A |
| D7310 | Alveoloplasty In Conjunction With Extractions - Four or More Teeth or Tooth Spaces, Per Quadrant | 1 per 1 plan year per quadrant | No | N/A |
| D7311 | Alveoloplasty In Conjunction With Extractions - One to Three Teeth or Tooth Spaces Per Quadrant | 1 per 1 plan year per quadrant | No | N/A |
| D7320 | Alveoloplasty Not In Conjunction With Extractions - Four or More Teeth or Tooth Spaces, Per Quadrant | 1 per 1 plan year per quadrant | No | N/A |
| D7321 | Alveoloplasty Not In Conjunction With Extractions - One to Three Teeth or Tooth Spaces, Per Quadrant | 1 per 1 plan year per quadrant | No | N/A |

| Code | Description | Frequency limits | Auth required? | Required documents |
|---|---|---|---|---|
| D7510 | Incision And Drainage of Abscess - Intraoral Soft Tissue | Unlimited | No | N/A |
| D7511 | Incision And Drainage of Abscess - Intraoral Soft Tissue - Complicated (Includes Drainage of Multiple Fascial Spaces) | Unlimited | No | N/A |
| D7880 | Occlusal Orthotic Device, By Report | 1 per 3 floating year per patient | No | N/A |
| D9110 | Palliative (Emergency) Treatment of Dental Pain - Minor Procedure | Unlimited | No | N/A |
| D9219 | Evaluation For Moderate Sedation, Deep Sedation, or General Anesthesia | Unlimited | No | N/A |
| D9230 | Inhalation of Nitrous Oxide/Analgesia, Anxiolysis | Unlimited | No | N/A |
| D9910 | Application of Desensitizing Medicament | 1 per 1 day per patient | No | N/A |
| D9943 | Occlusal Guard Adjustment | 2 Per 1 plan year per patient | No | N/A |
| D9944 | Occlusal Guard - Hard Appliance, Full Arch | 1 per 3 floating year per patient | No | N/A |
| D9995 | Teledentistry - Synchronous; Real-Time Encounter | 1 per 1 day per patient | No | N/A |
| D9996 | Teledentistry - Asynchronous; Information Stored And Forwarded To Dentist | 1 per 1 day per patient | No | N/A |

## TX Adult Medicaid - Benefit Limit Exception (BLE) Process

### Members Eligible for BLE

Medicaid Members enrolled in Star Plus Waiver and MMP Waiver

### Procedures Eligible for BLE

The BLE process will be required for the following procedures. Example of codes:

| Code | Procedure | Frequency allowed without a BLE |
|---|---|---|
| D5110 | complete denture - maxillary | 1/1 Lifetime |
| D5130 | immediate denture - maxillary | 1/1 Lifetime |
| D5211 | maxillary partial denture - resin base (including retentive/clasping materials, rests, and teeth) | 1/1 Lifetime Regardless of Code* |
| D5213 | maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and | 1/1 Lifetime Regardless of Code* |
| D5120 | complete denture - mandibular | 1/1 Lifetime Regardless of Code* |
| D5140 | immediate denture - mandibular | 1/1 Lifetime Regardless of Code* |
| D5212 | mandibular partial denture - resin base (including retentive/clasping materials, rests, and teeth) | 1/1 Lifetime Regardless of Code* |
| D5214 | mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and | 1/1 Lifetime Regardless of Code* |

### BLE process

- **Authorization:** To access procedures that are eligible for BLE, providers must submit an authorization on the standard ADA form and attach the UnitedHealthcare BLE form. This may be an electronic or a paper authorization. Without an approved authorization, BLE claim will be denied.
  - **Note:** It is not required to have a denied authorization before seeking a BLE service. BLE Services are initiated by the submission of an authorization along with a BLE form.
  - **Diagnosis Code:** To request BLE services, providers must use diagnosis code **Z98.818** in the diagnosis code field on the standard ADA form. This will enable the claim system to allow the additional BLE services. Without this diagnosis code, procedures will be subject to standard limitations.
    - Note: The diagnosis code must be present on both the authorization request and the claim in order to be paid for BLE services.
  - **UnitedHealthcare BLE Form:** Providers must attach the approved UnitedHealthcare BLE form to the authorization request. Providers will use this form to indicate the reason the BLE is necessary according to the state criteria. Providers must check the appropriate box and include a description of the medical needs that require the requested service(s) in the appropriate section. Without a complete UnitedHealthcare BLE form, the request will be denied.
  - A UnitedHealthcare Dental Consultant will review the authorization request along with the attached UnitedHealthcare BLE form and make a determination. The determination will be communicated in writing and on the online provider portal. See “Member and Provider Communication” section.

- **Claim:** If the BLE authorization request was approved, the provider will perform the requested treatment and submit the corresponding claim documentation.
  - **Diagnosis Code:** The same diagnosis code (**Z98.818**) must be documented in the diagnosis code field on the standard ADA claim form. This will enable the claim system to allow the additional BLE services. Without this diagnosis code, procedures will be subject to standard limitations.
    - Note: The diagnosis code must be present on both the authorization request and the claim in order to be paid for BLE services.

### Criteria for approval

Upon receipt of the BLE authorization request, UnitedHealthcare dental consultants will review the documentation submitted to determine if the BLE is approved. UnitedHealthcare dental consultants use the criteria defined by the State of Texas, as reflected on the UnitedHealthcare BLE Form.

The following qualifiers will be evaluated:

- Does the patient have a serious chronic systemic illness or other serious health condition and denial of the exception will jeopardize the life of the recipient?
- Does the patient have a serious chronic systemic illness or other serious health condition and denial of the exception will result in the serious deterioration of the health of the recipient?
- Would granting the exception be a cost-effective alternative for the MA Program?
- Would granting the exception be necessary in order to comply with Federal law?

Along with checking the appropriate boxes, providers must include a description of the medical needs that require the requested services in the appropriate field and should include supplemental information to substantiate the selected qualifier.

### Member and provider communication

UnitedHealthcare will communicate the determination of the BLE request in writing to both the member and the provider. The communication will be mailed to the member, faxed to the provider, and made available online via the provider portal.

## Benefit Overview: UnitedHealthcare Connected™ Medicare- Medicaid Dental Plan (Waiver Benefit)

There is a $5,000 Annual Maximum benefit under the Waiver services program.

The $5,000 annual maximum expires 1 year after the member's effective date under the Waiver program.

Example: If a member is effective under the waiver program on Nov. 1, 2020, then the $5,000.00 annual maximum is good through Oct. 31, 2021.

### Payment for non-covered services

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

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

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

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

### Non covered services disclosure form

This Non covered services disclosure form is intended for use for Medicaid recipients who seek non-covered (and in some instances, non-authorized) services under Medicaid and who are agreeing, prior to any services being rendered, to pay the service provider for such non-covered services, thereby "waiving" the recipients' rights protected generally under the Federal Regulations that prohibit providers from balance billing Medicaid recipients for services rendered.

With this MEDICAID WAIVER, the provider acknowledges that for services that are not authorized or covered by the UnitedHealthcare Dental (including Medicaid sponsored health care programs), the Medicaid Member must be informed of their payment responsibility prior to receiving the service and the Member must consent in writing.

## Member Statement:

I understand that by signing this waiver form I am agreeing to be responsible to pay the provider for the services stated below as they are not covered or deemed medically necessary under my current health insurance.

**That the specific service(s) sought are:**

ADA Code and Description of Service ________________________________________ Fee: $ ______________

That the service(s) sought is not a covered service under Medicaid guidelines;

That the service(s) is determined to be medically unnecessary before rendered;

That the provider does not participate in the Medicaid, either generally or for the services sought;

That I have been informed that one or more of the conditions listed (above) exists and, I voluntarily and knowingly agree to pay the provider for the charge they have indicated to me for these services.

By signing this waiver form, I certify that I am aware of the services covered by my health plan and of my rights under the Medicaid Program.

Member Name ____________________________________________________________

Member Signature ______________________________________________________ Date ______________

Dental Benefit Providers®

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