Dental Benefit Providers (DBP), Inc.

Notice to participating providers that are leased to Dental Benefit Providers (DBP), Inc here is more information on your detailed responsibilities to the health carrier's applicable administrative policies and programs in regard to utilization review, quality assessment and improvement program, and data reporting requirements policies.

Section 6: **Claim Submission Procedures**

6.1 **Claim Submission Required Elements & Best Practices**

Dental Claim Form

The most current Dental ADA claim form must be submitted for payment of services rendered or to obtain a Pre-Treatment Estimate.*

Claim Submission Options

Electronic Claims

Electronic claims processing requires access to a computer and usually the use of practice management software. Electronically generated claims can be submitted through a clearinghouse or directly to our claims processing system via the Internet. Most systems have the ability to detect missing information on a claim form and notify you when errors need to be corrected. Electronic submission is private as the information being sent is encrypted. Please call **1-877-620-6194** for more information regarding electronic claims submission.

Paper Claims

Due to periodic revisions and varying practice management systems, dental insurance claim forms exist in various formats. Use of the most recently revised American Dental Association (ADA), 2012, format is recommended. Claims and pre-treatment estimates can be submitted directly through the portal at www.uhcdental.com where you can also upload x-rays, case notes and periodontal charts. The portal will indicate when required information is missing from the submission.

Dental Claim Form Required Information

One claim form should be used for each member and the claim should reflect only one treating dentist for services rendered. The claims must also have all necessary fields populated as outlined below.

Header Information

Indicate the type of transaction by checking the appropriate box: Statement of Actual Services or Request for Pre-Treatment Estimate.

Subscriber Information

- Name (Last, First, and Middle Initial)
- Address, City, State, ZIP Code
- Date of Birth
- Gender
- Subscriber ID number

Member Information

- Name (Last, First, and Middle Initial)
- Address, City, State, ZIP Code
- Date of Birth
- Gender
- Member ID number

Primary Payer Information

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

Other Coverage

If the member has other insurance coverage, completing the "Other Coverage" section of the form with the name, address, city, state and ZIP code of the carrier is required. You will need to indicate if the "other insurance" is the primary insurance. You may need to provide documentation from the primary insurance carrier, including amounts paid for specific services.

*It is recommended that pre-treatment estimates be obtained for high-dollar procedures such as crowns, bridges and dentures.

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 Member

Billing Dentist or Dental Entity

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

- Name
- Address, City, State, ZIP Code
- License number
- TIN
- Phone number

Treating Dentist and Treatment Location

List the following information regarding the dentist that provided treatment:

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

Services Provided

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
- Charges for dentist's fee/charges for the procedure.
- Total sum of all charges

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 practice letterhead with all pertinent member information, is acceptable.

Subscriber / Member Authorization

Signature of subscriber or member authorizing payment of dental benefits is required. A claim form that indicates a signature is "on file" for a particular member will be accepted. The dentist must keep a copy of a signed claim in the member 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. Please refer to the Exclusions & Limitations 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 Web site at www.adacatalog.org.

Tips on Claim Submission

The National Association of Dental Plans says dentists will be reimbursed more quickly if they include the information below on their dental claim forms.

- Attending dentist information should include dentist's name, address and tax identification number (TIN). If any of this information has changed from the last submission, or if the payer was not informed of the change, a delay can occur while verification of correct data is made.
- Patient information should include patient's full name, identification or member number and date of birth and relationship to the insured person (self, dependent or spouse).
- Date of service should be the day on which the service was performed.
- CDT codes of services performed – Dental claim logic systems are designed to read approved current CDT codes according to their definition. Internal codes, outdated codes or codes that are considered an integral part of another procedure can delay a claim while research is conducted.
- Tooth number or quadrant along with the surface, if appropriate, is required to identify where procedure was performed.
- Missing teeth information should be reported on claims for periodontal, prosthodontic (fixed and removable), or implant services procedures, if covered.
- Prior placement date for crowns, bridges – As many plans have frequency limitations on crowns and bridges, it is important to indicate whether this is an initial placement in the claim form box provided. If not an initial placement, the prior placement date should be indicated and an explanation included in the narrative. This is a particular problem when older versions of the ADA claim form are utilized.
- Narratives are an essential ingredient to help the treating dentist explain why a certain procedure was recommended. Payers will not try to validate the course of treatment but will assign benefits according to the plan purchased for that particular patient. If it isn't part of their benefit design, then the dentist can charge the member accordingly.
- Coordination of benefits – If the patient is covered by more than one dental carrier, or if the procedure is also covered under the patient's health plan, include any explanation of benefits or remittance notice from the other payer. Payers are required by state law or regulation to coordinate benefits when more than one entity is involved – this is not a payer choice. The objective is to ensure the dentist is reimbursed appropriately by the proper payer first (primary) with any other payer coordinating the benefit on the balance.
- Remarks – The Remarks section of the claim form should only be used to provide additional explanation of the procedures performed. For most payers, information included in this section will remove a claim from auto-adjudication, thus delaying the processing.

6.1.A **Pre-Treatment Estimate (PTE)**

A pre-treatment estimate is a summary estimating how planned treatment will be adjudicated according to the member's plan design and enrollment status at the time the PTE is reviewed. These estimates may be submitted on an ADA claim form and are not a guarantee of coverage or how the claim will be ultimately adjudicated.

Pre-treatment estimates are strongly encouraged to ensure that both the practice and the member fully understand how benefits will be applied, particularly for high-dollar procedures. Your office is encouraged to use features found on the UnitedHealthcare Web site (uhcdental.com) to do your own pre-treatment estimates. In addition, many practice management systems will perform this function (consult your office's practice management system support organization to determine the capabilities of your office's systems).

If a pre-treatment is older than 90 days, a new PTE must be attained prior to delivering clinical services.

6.2 Claims Processing Systems

UnitedHealthcare processes claims using a proprietary claims processing platform. Claims are edited and paid according to ADA Code and Dental Procedures. There are no modifiers associated with this code set.

Claims are edited and paid according to the specific plan design for a member's employer group. Please refer to the Exclusions and Limitations section of this manual for further information or access one of the resources outlined in Section 2.

Any specific plan design questions that would assist you in determining how to administer claims for a particular member can be answered by our Provider Services line.

6.3 Electronic Claims Submissions

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 Funds Transfer, which is the ability to be paid electronically directly into your bank account).

UnitedHealthcare partners with electronic clearinghouses to support electronic claims submissions. While the payer ID may vary for some plans, the UnitedHealthcare number is 52133. Please refer to the Important Addresses and Phone Numbers section and Distributor Client List for additional information as needed.

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 or simply register with our preferred vendor.

6.4 HIPAA 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.

6.5 HIPAA Compliant 835 File

An 835 is an electronic remittance detailing payments and/or adjustments including cancellations, recoveries, reversals, etc., made on claims submitted electronically via an 837D transaction file or via paper.

For practitioners participating in Electronic Payments and Statements (EPS), the 835 file can be accessed via EPS. You must be an EPS participant to access this information.

If you're not already participating with EPS and would like to take advantage of this cost-savings opportunity, simply visit uhcdental.com. The Electronic Payments and Statements section in this manual provides a detailed overview of this service and how to enroll.

For general questions, eligibility and/or claim status inquiries, please call **1-877-620-6194**. Additional tools and resources can also be found online at uhcdental.com.

6.6 Paper Claims Submission

To receive payment for services, practices must submit claims via paper or electronically. Network dentists are recommended to submit an American Dental Association (ADA) Dental Claim Form (2012 version or later).

Please refer to section 6.1 for more information on claims submission best practices and required information.

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

6.7 Coordination of Benefits (COB)

Coordination of Benefits (COB) is used when a member is covered by more than one dental insurance policy. By coordinating benefit payments, the member receives maximum benefits available under each plan. It is each provider's responsibility to assist in correct coordination of benefits by notifying all payers so that claims may be paid correctly.

If the patient is covered by more than one dental carrier, or if the procedure is also covered under the patient's health plan, include any explanation of benefits or remittance notice from the other payer. Payers are required by state law or regulation to coordinate benefits when more than one entity is involved — this is not a payer choice. The objective is to ensure that the dentist is reimbursed appropriately by the proper payer first (primary) with any other payer coordinating the benefit on the balance.

When a claim is being submitted to us as the secondary payer for Coordination of Benefits (COB), a fully completed claim form must be submitted along with the primary payer's Explanation of Benefits (EOB) showing the amount paid by the primary payer.

6.8 Dental Claim Filing Limits and Adjustments

All Dental Claims should be submitted within ninety (90) days from the date of service (30 days is preferred). Payment may be considered after the date of service for up to three hundred and sixty-five (365) days. This may vary for some plans.

All adjustments or requests for reprocessing must be made within sixty (60) days from receipt of payment. An adjustment can be requested telephonically by calling our Provider Servicing team at **1-800-822-5353**.

6.9 Claim Adjudication and Periodic Overview

In accordance with UnitedHealthcare's standard practice, clean claims will be adjudicated and paid within five to ten days of receipt (this may vary by state and claim submission and/or payment method).

Quality Assurance (QA) audits are performed to ensure the accuracy and effectiveness of our claim adjudication procedures. Any identified discrepancies are resolved within established timelines. The QA process is based on an established methodology, but in general, on a daily basis, various samples of claims are selected for quality assurance reviews. QA samples include center-specific claims, adjustments, claims adjudicated

by newly hired claims processors and high-dollar claims. In addition, management selects other areas for review, including customer-specific and processor-specific audits. Management reviews the summarized results and correction is implemented, if necessary.

Invalid or incomplete claims:

- If claims are submitted with missing information or incomplete claim forms, the claim will be returned or rejected with a request for the missing required information to be sent.
- If the claim is missing a tooth number or surface, a letter will be generated to the provider requesting this information.
- If the procedure code is invalid or expired, a letter will be sent to the provider requesting the appropriate code.
- If there are inadequate provider details to process under the submitting provider, the claim will be returned with a letter requesting appropriate provider information.
- If the member is not found or ineligible, the claim will be returned.

6.10 Explanation of Provider Remittance Advice

The Provider Remittance Advice is a claim detail of each member and each procedure considered for payment. Please use these as a guide to reconcile member payments. As a best practice it is recommended that Remittance Advices be kept for future reference and reconciliation.

Below is a list and description of each field:

PROVIDER OR MBR NAME AND ID NO
Treating dentist's name, NPI submitted with claim, Member's name and Subscriber's ID number. To conform to HIPAA regulations, the subscriber's alternate ID number is shown in place of the Social Security number.

GROUP NO
Group ID number assigned to the member's plan

CLAIM NO
Number assigned to the claim

ADA CODE
Procedure code submitted pertaining to the service

DESCRIPTION
Description of the procedure code

DATE OF SERVICE
Date when services were rendered

TOOTH NO
Tooth number or the quadrant pertaining to the procedure

AMOUNT CLAIMED
Amount submitted by provider

AMOUNT ALLOWED
Provider's contracted fee amount

DEDUCT APPLIED
Applicable plan deductible

OTHER INS
Member's primary insurance if applicable

MEMBER RESP
Member's copayment that pertains to the procedure

AMOUNT PAID
Claim paid amount

EOB CODE
Refers to the explanations provided within the EOB that explain how the procedure adjudicated

6.11 Provider Claim Appeal and Inquiry Process

Appeal rights vary by business and/or state. Refer to the appeals language on the back of the EOB for guidance with the appeals processes that are appropriate for each particular claim.

There are two types of provider appeals:

Utilization Management (UM) Appeal: Any appeal that is based on dental necessity and/or would require review by a dental clinician. UM appeals must include a narrative and any supporting documentation including X-rays.

Administrative Appeal: Appeals that are not based on dental necessity. This type of appeal would include but is not limited to appeals for timely filing of claims, member's eligibility, over/underpayment adjustment requests, etc. Administrative appeals must include a narrative.

Refer to the Quick Reference Guide section for appeal submission addresses.

Section 7: **Quality Management**

7.1 **Quality Improvement Program (QIP) Description**

UnitedHealthcare has established and maintains 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 ensure that quality of care is being reviewed; that problems are being identified and that follow up is planned where indicated. The program is directed by state, federal and client requirements. The program addresses various service elements including accessibility, availability and continuity of care. It also monitors the provisions and utilization of services to ensure that professionally recognized standards of care are being met. The QIP Description is reviewed annually and updated as needed.

The QIP includes, but is not limited to, the following goals:

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

A complete copy of our QIP policy and procedure is available upon request by contacting our Provider Services line at **1-800-822-5353.**

7.2 **Credentialing**

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

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

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

The Dental Director and the Credentialing Committee review the information submitted in detail based on approved credentialing criteria. UnitedHealthcare will request a resolution of any discrepancy in credentialing forms submitted. Practitioners have the right to review and correct erroneous information and to be informed of the status of their application. Credentialing criteria are reviewed by advisory committees, which include input from practicing network providers to make sure that criteria are within generally accepted guidelines. You have the right to appeal any recredentialing decision regarding your participation made by UnitedHealthcare based on information received during the recredentialing process. Appeals do not

Section 8: **Utilization Management Program**

8.1 **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.

8.2 **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 over-utilization 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.

8.3 **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.

8.4 **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: (bullet) Provider Manual/Standards of Care

- Provider Training
- Continuing Education
- Provider News Bulletins

8.5 **Fraud and Abuse**

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

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

If adverse practice patterns are found, interventions will be implemented on a variety of levels. The first is with the individual practitioners. The emphasis is heavily weighted toward education and corrective action. In some instances, corrective action,

ranging from reimbursement of over payments to additional consideration by UnitedHealthcare's Peer Review Committee – or further action, including potential termination – may be imposed.

If mandated by the state in question, the appropriate state dental board will be notified. If the account is Medicaid or Medicare, the Office of the Inspector General or the State Attorney General's office will also be notified.

8.6 **Utilization Review**

UnitedHealthcare shall perform utilization review on all submitted claims. Utilization review (UR) is a clinical analysis performed to confirm that the services in question are or were necessary dental services as defined in the

member's certificate of coverage. UR may occur after the dental services have been rendered and a claim has been submitted (retrospective review).

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

Retrospective reviews and prior authorization reviews are performed by 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 Clinical Policy and Technology Committee, Clinical Affairs 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 Section 4 for treatment codes that require clinical review and documentation requirements)