Medical Assistance – DE, PA, WV

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United Concordia dental®

Dental Reference Guide

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Quick Reference	
United Concordia Provider Number	
Dental Network Services Representative	
Name	
Phone/Extension	
Email	
www.UnitedConcordia.com Login Information	
User ID:	
Password:	
Websites	
www.UnitedConcordia.com	www.highmarkwholecare.com
www.highmarkhealthoptions.com	www.highmark.com/health-options-wv

Key Contact Information	Phone	Fax	Mailing Address, Email, Website
Applications/Agreements	(800) 307-8514 ext. 2	(844) 235-7261	**Mail:** Dental Network Operations PO Box 69404 Harrisburg, PA 17106-9404 **Email:** ProviderRequests@ucci.com **Website:** https://www.unitedconcordia.com/pifria
Government Business Operations Customer Service/ Interactive Voice Response (IVR) System	(866) 566-5467	(877) 602-3008	United Concordia Companies, Inc. PO Box 69428 Harrisburg, PA 17106-9428
Dental Electronic Services	(800) 633-5430	N/A	United Concordia Companies, Inc. ATTN: Dental Electronic Services PO Box 69408 Harrisburg, PA 17106-9408
Dental Network Services	(800) 307-8514	(866) 335-3969	N/A
Dentist Advisor Unit (Second Review/Appeal Requests)	(800) 772-1133	(866) 335-3971	United Concordia Companies, Inc. Dentist Advisor Unit PO Box 69420 Harrisburg, PA 17106
Maintaining Provider Data	N/A	(844) 235-7261	**Mail:** Dental Network Operations PO Box 69404 Harrisburg, PA 17106-9404 **Email:** ProviderRequests@ucci.com **Website:** https://www.unitedconcordia.com/pifria
NPI Updates	N/A	(844) 235-7261	**Mail:** Dental Network Operations PO Box 69404 Harrisburg, PA 17106-9404 **Email:** ProviderRequests@ucci.com **Website:** https://www.unitedconcordia.com/pifria

Key Contact Information	Phone	Fax	Mailing Address, Email, Website
Provider Dispute Resolution Mechanism	N/A	N/A	United Concordia Companies, Inc. Provide Dispute Resolution PO Box 69414 Harrisburg, PA 17106-9414
Refunds	N/A	N/A	United Concordia Companies, Inc. Cashier PO Box 69402 Harrisburg, PA 17106-9402
Resignation	N/A	(844) 235-7261	**Email:** ProviderRequests@ucci.com **Website:** https://www.unitedconcordia.com/pifria
Routine and Advisor Review Inquiries	N/A	N/A	United Concordia Companies, Inc. ATTN: Claims Appeal PO Box 69420 Harrisburg, PA 17106-9420
Special Investigations Unit (SIU)	(877) 968-7455	N/A	United Concordia Companies, Inc. Special Investigations Unit 1800 Center Street, Suite 2B 220 Camp Hill, PA 17011

Claims and Customer Service Contact Information

United Concordia encourages electronic claims submission to save you time and money. The appropriate Payer IDs to use for electronic claims submission are supplied below ( ). To learn more about United Concordia's free electronic claims submission, please visit www.UnitedConcordia.com, select the Dentists tab, and then click on **Claims and Payments** for additional information.

For Highmark Wholecare, claims and authorization processing is handled by SKYGEN USA. Electronic claim submission is strongly recommended. Electronically submitted claims are processed faster than paper claims and that means faster reimbursement to you. If you choose to submit paper claims, you must use the most current ADA claim form (the 2024 ADA claim form will be required as of 11/1/2025).

Providers can order the most current ADA claims form by calling 1-800-947-4746 or by accessing the website at:
https://catalog.ada.org/catalog

Highmark Health Options

- United Concordia Payer ID CX007 or 89070
- Highmark Health Options Claims
  PO Box 69455
  Harrisburg, PA 17106-9455
- Highmark Health Options Corrected Claims
  PO Box 69456
  Harrisburg, PA 17106-9456
- Highmark Health Options Authorizations
  PO Box 69455
  Harrisburg, PA 17106-9455

Delaware

- (866) 568-5933

West Virginia

- (844) 789-1722

Highmark Wholecare SM

- (866) 568-5467
- SCION Payer ID 96938
- Highmark Wholecare Claims
  PO Box 2190
  Milwaukee, WI 53201
- Highmark Wholecare Corrected Claims
  PO Box 1613
  Milwaukee, WI 53201
- Highmark Wholecare Pre-Authorizations
  PO Box 2170
  Milwaukee, WI 53201

Introduction

Section 1

Valuing Your Participation

Our goal is to help our customers and members lead healthier lives with quality dental insurance plans that fit every lifestyle and budget, and we understand this cannot be achieved without the skilled, dedicated, and caring dentists that comprise our networks. Network dentists assist us in ensuring our members located in all 50 states, the District of Columbia, Guam, Puerto Rico, and the U.S. Virgin Islands receive convenient access to quality dental care. We value your network participation and continually seek new and innovative offerings to better serve you. Our experienced staff is dedicated to ensuring your office has access to on demand support when you need it, providing an optimized, frictionless experience that works in harmony with your practice.

About United Concordia

We are one of the nation's largest and most respected dental insurance companies. Established in 1992 as a wholly owned subsidiary of Highmark, Inc. (a Pennsylvania-based non-profit health service plan), United Concordia is exclusively focused on providing high-quality, cost-effective dental benefits programs to clients ranging from local businesses to global organizations. Our diverse product portfolio includes fee-for-service, dental health maintenance organizations (DHMOs), preferred provider organizations (PPOs), and Medical Assistance as a dental vendor to Managed Care Organizations (MCOs) like Highmark Wholecare, Highmark Health Options Delaware, and Highmark Health Options West Virginia. To support these products, United Concordia maintains some of the largest provider networks in the nation and offers a full array of innovative electronic tools and high-quality customer service.

About the Dental Reference Guide

This Dental Reference Guide is designed to provide you and your office staff with information about United Concordia's policies and procedures used to administer our programs. While it is not intended to be the sole legal basis for contract/benefit interpretation, it will be your reference guide for eligibility, coverage, policies, procedures, procedure codes, claims and payments. Familiarity with the concepts in this guide and United Concordia procedures and policies will ensure proper and efficient administration. If you require additional information or clarification on any of the items addressed within this guide, please contact your Dental Network Service Representative. You can download an electronic copy of this guide from our website at www.unitedconcordia.com.

Dental Network Service Representatives

We have a team of Dental Network Service Representatives located across the country who are exclusively dedicated to assisting providers and their office staff in understanding our dental programs and products. Dental Network Service Representatives are available to answer policy questions, offer professional support, and provide program information. While our network service representatives can typically resolve most questions by telephone or email, they are also available to visit your office to provide in-person support.

Government Business Operations Department

United Concordia's Government Business Operations Department consists of trained Customer Service personnel to assist in responding to inquiries about our dental networks, programs, and products.

To contact Customer Service by email, complete the form accessible by clicking Contact Us at the bottom of the Dentist page of our website, www.unitedconcordia.com. Or you may write to the Government Business Operations Department at:

United Concordia Dental
Government Business Operations
PO Box 69420
Harrisburg, PA 17106-9420

When contacting United Concordia, whether by email, telephone or letter, the following information is needed:

- Member's Name
- Member's Identification Number
- Member's Date of Birth

- Claim or Inquiry Number, if applicable
- Dentist's Identification Number (United Concordia Provider Number and/or National Practitioner Number (NPI)) or Master Provider Identifier (MPI)

Networks, Products, Special Accounts, Partnerships

Section 2

Networks

The success of United Concordia is primarily based on our ability to provide access to care through our various networks of participating dentists. We currently offer the following Medicaid and CHIP networks:

- PA Medicaid
- DE Medicaid
- WV Medicaid
- WV CHIP

Participating dentists are reimbursed directly for rendered services covered within the plan design of the patient receiving care. To confirm your participation status, please utilize ***MyPatients'****Benefits* or Find a Dentist on our website. For PA Medicaid, to confirm your participation status, please use the SkygenUSA.com website or contact customer service. If you still have questions regarding your participation status, our customer service department can assist you.

Network Access Arrangements

Through strategic partnerships, United Concordia handles claim administration and/or customer service for members and/or providers of several of our partners. In addition, through network leasing arrangements, members of our trusted leasing partners have access to United Concordia networks.

As such, in addition to agreeing to accept communications from United Concordia via mail, facsimile or email at the address/numbers shown on Dentists' Credentialing Application and/or at other addresses/numbers Dentist has provided, Dentist agrees to receive such communications directly from the companies in partnership with United Concordia as well as those leasing United Concordia networks.

The following are details on our strategic and network leasing partnerships.

Highmark Wholecare PA Medicaid

United Concordia has collaborated with Highmark Wholecare effective November 2007.

Highmark Wholecare Medicaid is the benefit administrator for the following groups:

- **Highmark Wholecare Medicaid**

Claims

Members of the above groups will have access to our PA Medicaid network. Claims processing is handled by a third-party vendor, Skygen USA.

Paper Claims

Highmark Wholecare Dental Claims
PO Box 2190
Milwaukee, WI 53201

Electronic Claims

Use your Skygen USA Payer ID: 96938

Preauthorization's

All requests for preauthorization on services that require a preauthorization approval prior to rendering can be sent using the below methods:

Paper Preauthorization

Pre-Authorizations
PO Box 2170
Milwaukee, WI 53201

Electronic Preauthorization

Use your Skygen USA Payer ID: 96938

Provider Customer Service

Questions for these members regarding eligibility verification, claims status and submission should be directed to United Concordia Monday – Friday, 8:00 AM to 5:00 PM, EST at (866) 568-5467. Member eligibility can also be verified 24 hours a day, seven days a week, using Highmark Wholecare's Interactive Voice Response System (IVR) at 1-800-642-3515 or 1-800-392-1147 (TTY 711).

ID Cards

The Department of Human Services (DHS) issues a Pennsylvania ACCESS card to all eligible Medical Assistance recipients, including those recipients that choose to join Highmark Wholecare. Members will have both a DHS ACCESS card and a Highmark Wholecare identification card. Members should show their Highmark Wholecare identification card at each appointment.

Eligibility Verification

Because of frequent changes in a member's eligibility, each provider is responsible for verifying the member's eligibility prior to providing services. Eligibility should be verified when scheduling an appointment, and again at the time of service.

DHS determines member eligibility for dental benefits. If a member presents a Pennsylvania ACESS card, eligibility may be verified using the DHS Eligibility Verification System (EVS) by calling 1-800-766-5387. Providers can determine if a member is eligible for services through Highmark Wholecare. Please have your 13-digit Master Provider Index (MPI) Number and the member's recipient number from the member's ACCESS card available.

Reimbursement / Allowances

Reimbursement is based on the Department of Human Services (DHS) Medical Assistance (MA) fee schedule.

Gateway Health Plan, Inc. d/b/a Highmark Wholecare is an independent licensee of the Blue Cross Blue Shield Association.
United Concordia is a separate company that administers dental benefits and provides the dental provider network.

Highmark Health Options DE Medicaid

United Concordia has collaborated with Highmark Health Options DE effective October 1, 2020.

Highmark Health Options DE is the benefit administrator for the following groups:

- **Highmark Health Options DE Adult Medicaid** (age 21 and older)
- **Highmark Health Options DE Children's Medicaid** (age 20 and younger) (effective 01/01/2025)
- **Highmark Health Options Delaware Healthy Children Program (DHCP)** (age 18 and younger) (effective 01/01/2025)

Claims

Members of the above groups will have access to our DE Medicaid network.

Paper Claims

Highmark Health Options: Claims
PO Box 69455
Harrisburg, PA 17106

Electronic Claims

Use your United Concordia Payer ID: CX007 or 89070

Preauthorization's

All requests for preauthorization on services that require a preauthorization approval prior to rendering can be sent using the below methods:

Paper Preauthorization

Pre-Authorizations
PO Box 69455
Harrisburg, PA 17106

Electronic Preauthorization

Use your United Concordia Payer ID: CX007 or 89070

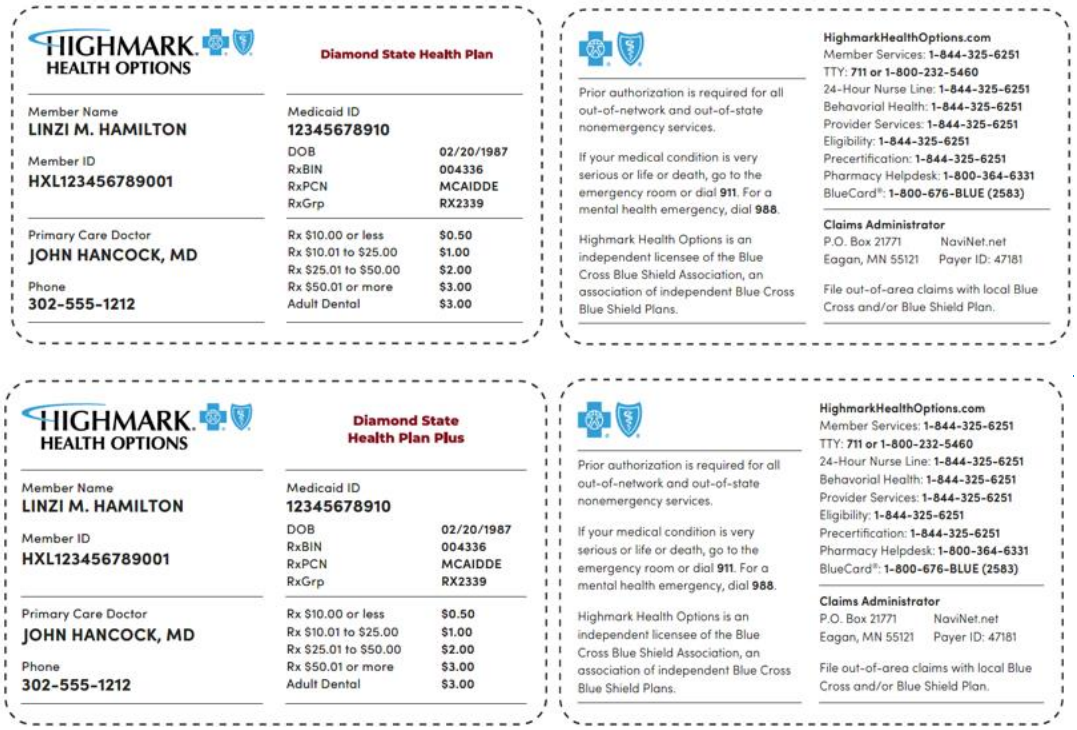
Provider Customer Service

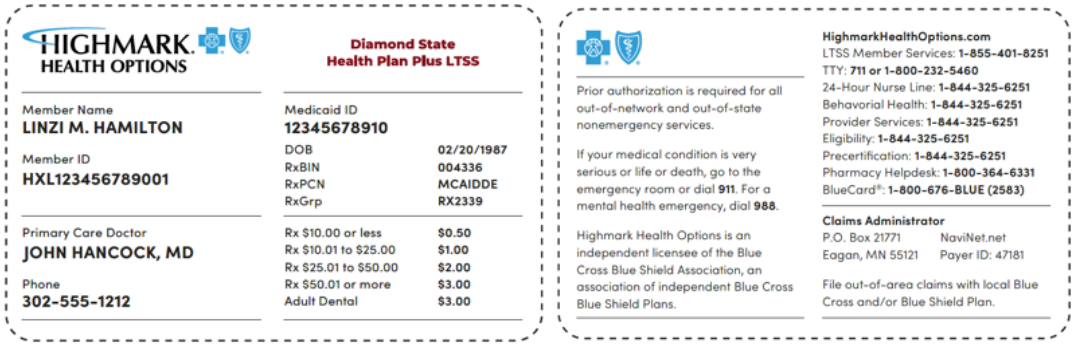
Patient information such as benefits, enrollment, claim status, allowance information, maximums, deductibles, and procedure history for these members is available through MyPatients' Benefits or by calling United Concordia, Monday – Friday 8:00 AM to 8:00 PM at (866) 568-5933.

Member Customer Service

Questions for these members regarding eligibility verification, claims status and submission should be directed to Highmark Health Options, seven days a week, 8:00 AM to 8:00 PM, EST at (844)-325-6251 (TTY: 711 or (800) 232-5460).

ID Cards





Reimbursement / Allowances

Reimbursement is based on the Department of Medicaid and Medical Assistance (DMMA) Medical Assistance (MA) fee schedule.

Highmark BCBSD Health Options Inc. d/b/a Highmark Health Options is an independent licensee of the Blue Cross Blue Shield Association. United Concordia is a separate company that administers dental benefits and provides the dental provider network.

Highmark Health Options WV Medicaid

United Concordia has collaborated with Highmark Health Options WV effective August 1, 2024.

Highmark Health Options WV is the benefit administrator for the following groups:

- **Highmark Health Options Medicaid** (Child Plan under age 21 and Adult Plan age 21 and older)
- **Highmark Health Options WVCHIP** (age 18 and younger)

Claims

Members of the above groups will have access to our WV Medicaid and WV CHIP network.

Paper Claims

Highmark Health Options: Claims
PO Box 69455
Harrisburg, PA 17106

Electronic Claims

Use your United Concordia Payer ID: 96938

Preauthorization's

All requests for preauthorization on services that require a preauthorization approval prior to rendering care are required by the West Virginia Department of Human Services (DoHS) to be submitted electronically. United Concordia will not submit any paper preauthorization requests for West Virginia Medicaid and/of West Virginia CHIP members.

Provider Customer Service

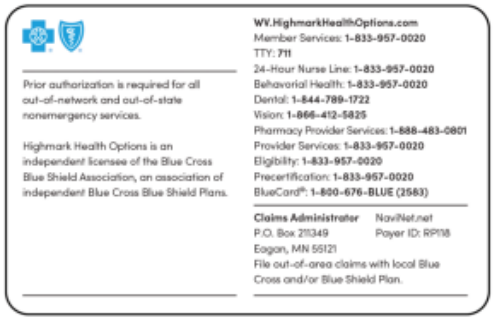
Patient information such as benefits, enrollment, claim status, allowance information, maximums, deductibles, and procedure history for these members is available through MyPatients' Benefits or by calling United Concordia, Monday – Friday 8:00 AM to 8:00 PM at (866) 568-5933.

Member Customer Service

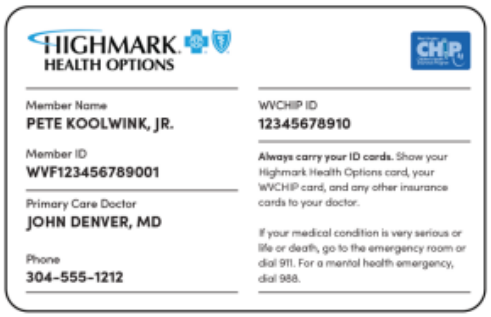
Questions for these members regarding eligibility verification, claims status and submission should be directed to Highmark Health Options, seven days a week, 8:00 AM to 5:00 PM, EST at (833)-957-0020 (TTY: 711 or (833) 957-0020). For eligibility verification, Highmark Health Options Interactive Voice Response System (IVR) is available 24 hours a day, 7 days a week at (833)-957-0020 (TTY: 711)

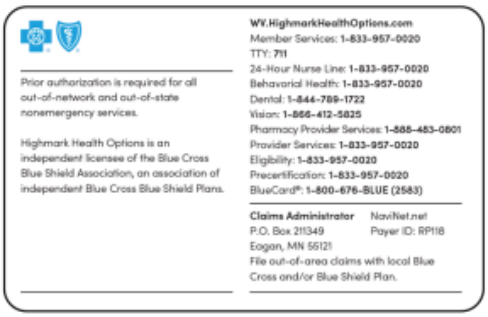
ID Cards

Highmark Health Options WV Medicaid



Highmark Health Options WVCHIP





Reimbursement / Allowances

Reimbursement is based on the West Virginia Bureau for Medical Services (BMS) Medical Assistance (MA) fee schedule.

Highmark Health Options West Virginia Inc. d/b/a Highmark Health Options is an independent licensee of the Blue Cross Blue Shield Association. United Concordia is a separate company that administers dental benefits and provides the dental provider network.

Requests for Network Access Information

In addition to the information contained within this Dental Reference Guide, a complete listing of all current Network Access Arrangements and partnership details is available under the 'Office Resources' section on the Dentist portal of our website at www.unitedconcordia.com or by directly visiting Network Access Arrangements | United Concordia. You may also call our Customer Service Department at (800) 332-0366 to request a current listing of our network access arrangements.

Participating with United Concordia

Section 3

Advantages of Participation

Network dentists are an important part of the United Concordia's success, and our networks include every clinical specialty in all 50 United States, the District of Columbia, Guam, Puerto Rico and the U.S. Virgin Islands. United Concordia is dedicated to fostering a mutually beneficial relationship with participating providers by offering the following business incentives:

- All payments for services are distributed directly to network dentists.
- Names, addresses and phone numbers of network dentists are regularly made available to all members on our website.
- On demand support and self-service tools available 24/7 to get the answers you need, when you want them.
- Dedicated network service representatives to assist with questions, training, support, etc.
- An optimized and frictionless experience to allow you to focus on treating your patients.
- Access to exclusive discounts available only to our network dentists. Visit www.unitedconcordia.com and click on Dentists and then Discounts for Dentists to find out more information.
- Access to free CDEWorld Continuing Education (CE) courses, which include articles and webinars created by experts in the field. All course content is ADA CERP AGD Pace accredited, and double-blind peer reviewed to ensure the highest quality and clinical rigor. The CDEWorld course catalog, available at united-concordia.cdeworld.com, includes the following offerings on pertinent dental health topics.
    - **Opioid Courses**: The "Prescribing Opioids in Dentistry" and "Opioids and Alternatives for Postsurgical Pain Management" courses assist dentists in understanding the alternatives in prescription protocols for treating acute pain, strategies to minimize potential opioid abuse or misuse, and proper opioid disposal techniques.
    - **Cultural Competency Course:** The "Cultural Competency and Oral Healthcare: A Critical Intersection" webinar focuses on the impacts of cultural competence on oral healthcare, including health disparities as they relate to cultural competence and methods to educate, inform, and bridge communication gaps for successful delivery of care.

How to Become a Participating Provider

Selection Criteria

To be eligible to participate in United Concordia's networks a dentist must:

- Hold an active, valid license to practice dentistry in the state(s) in which they practice.
- Complete a United Concordia or state-specific Credentialing Application. If a dentist has a record with CAQH they can provide their CAQH ID for United Concordia to obtain current credentialing information
- Please note that any negative responses to the attestation section of the United Concordia application will be investigated.
- Demonstrate a utilization review pattern acceptable to United Concordia
- Hold current professional liability insurance, except Guam.
- Have no current sanction, termination or other peer review action by a professional review body, state dental board or Health and Human Service (HHS)
- Hold an active unrestricted federal Drug Enforcement Agency (DEA) certificate, if applicable
- Complete and sign a Medicare Advantage Participating Dentist Agreement with United Concordia
- Be enrolled in Medical Assistance and have an active Master Provider Index (MPI) number. This applies to Pennsylvania Medicaid, Delaware Medicaid, West Virginia Medicaid, and West Virginia CHIP.

The following credentialing documents can be requested by contacting Customer Service. Once your submitted paperwork has been received and fully processed, you will be notified in writing of your assigned United Concordia Provider Number and effective date of participation.

Standard Credentialing Application

The Standard Credentialing Application is used to become a participating provider in most states.

Participating Provider Agreement

Our standard agreement is used in most states, although some state mandates require a state-specific agreement be used. The agreement must be completed and signed by each dentist seeking to participate in any of the United Concordia networks.

How to Become a Participating Public Health Dental Hygiene Practitioner (PHDHP)

This is only eligible for PHDHP's that are practicing in Pennsylvania. Highmark Wholecare Medicaid and the Department of Human Services (DHS) allows PHDHP's to render certain services to their Medical Assistance members.

Selection Criteria

To be eligible to participate in United Concordia's networks a PHDHP must:

- Be enrolled in Medical Assistance and have an active Master Provider Index (MPI) number. This applies to Pennsylvania Medicaid.
- Hold an active, valid license to practice dentistry in the state(s) in which they practice.
- Complete a United Concordia or state-specific Credentialing Application. If a dentist has a record with CAQH they can provide their CAQH ID for United Concordia to obtain current credentialing information
- Hold current professional liability insurance.
- Complete and sign a Participating PHDHP Agreement with United Concordia

Debarred, Precluded or Sanctioned

United Concordia reviews the credentials of dentists initially applying for participation in our network(s) as well during ongoing monitoring procedures for existing in-network dentists. This includes a thorough review of the following exclusion lists:

- List of Excluded Individuals and Entities (LEIE), maintained by the Department of Health and Human Services, Office of Inspector General
- System for Award Management (SAM), maintained by the General Services Administration (GSA)
- CMS Preclusion List (only applies to Medicare programs), maintained by the Center for Medicare and
- Medicaid Services (CMS)
- OFAC precluded providers, maintained by Office of Foreign Assets Control
- Medicaid state-specific exclusion lists

If a dentist appears on any of the above-named exclusion lists with sanctions relating to fraud, felony or quality of care, not only will participation in Government funded programs be canceled, they will also be terminated from all of United Concordia's commercial networks. Commercial Claim payments will be paid at an out of network level if the United Concordia member being treated has out of network benefits.

Re-Credentialing

Provider is considered to be re-credentialed unless otherwise notified.

VPoint

United Concordia utilizes the services of VPoint™ (previously known as VerifPoint) to collect necessary documentation for our dental provider network continual credentialing process, which helps ensure compliance with mandated regulations.

These collection activities will further qualify and distinguish the credentialing paperwork requirements for provider offices, as VPoint is a centralized Credentials Verification Organization (CVO) for a number of carriers.

To help facilitate United Concordia's ongoing credentialing process, we ask that you promptly respond to VPoint requests by completing and returning all forms and providing clear copies of necessary documents. Please note that all requested information will remain confidential.

Provider Enrollment Requirements

Highmark Wholecare PA Medicaid

The Department of Human Services (DHS) and the Affordable Care Act (ACA) require all Medicaid providers and Public Health Dental Hygiene Practitioners (PHDHPs) who render services for Medicaid beneficiaries, to enroll with DHS and obtain a valid PROMISe Identification Number (PROMISe ID) for each service location at which a provider operates. DHS uses the National Provider Identification (NPI) number and taxonomy submitted on claims to validate the enrollment of providers in the PROMISe system.

There are many resources available to you as a Medicaid provider. If you need to verify your enrollment in PROMISe at all service locations, you can access the DHS online portal at:
https://promise.dpw.state.pa.us/portal/Default.aspx?alias=promise.dpw.state.pa.us/portal/provider

For a copy of the complete DHS notice regarding the enrollment requirement and process, visit
http://www.dhs.pa.gov/cs/groups/webcontent/documents/bulletin_admin/c_284208.pdf

Public Health Dental Hygiene Practitioners (PHDHPs) are licensed dental hygienists who are certified by the Pennsylvania State Board of Dentistry and may render certain services without the direct supervision of a dentist including cleaning teeth, taking x-rays, polishing

fillings, identifying cavities, making molds for dental prosthetics, evaluating patients and educating patients about oral health. PHDHPs may render those services in schools, correctional facilities, health care facilities, personal care homes, domiciliary care facilities, older adult daily living centers, continuing care provider facilities, health centers and public or private institutions under jurisdiction of a Federal, State or local agency.

The Department will enroll licensed PHDHPs to provide services within their scope of practice under the MA managed care delivery system. PHDHPs will be enrolled as Mid-Level Practitioners with a Public Health Dental Hygienist specialty as follows:

Provider Type	Specialty Code	Specialty Code Description
10	269	Public Health Dental Hygienist

Highmark Health Options DE Medicaid

In compliance with 42 CFR Part 455, subparts B and E and the 21st Century Cures Act, all Delaware Medicaid Managed Care Organization (MCO) network providers must be enrolled in the Delaware Medicaid Assistance Program (DMAP) to provide services to Delaware Medicaid members. This requirement applies to all United Concordia network providers who furnish, order, refer or prescribe items or services to Delaware Medicaid members. **Provider enrollment must be competed to continue to serve Medicaid members.**

Delaware Division of Medicaid and Medical Assistance (DMMA) is working with Gainwell Technologies (Gainwell) to implement the requirements of 42 CFR Part 455, subparts B and E and the 21st Century Cures Act. DMAP will notify each provider to complete a Provider Enrollment Application via the Delaware Medical Assistance Portal for Providers. Providers have 60 calendar days to complete the required Provider Enrollment Application in DMAP. Failure to adhere to this requirement timely will result in termination with the DMMA and UCCI network participation with the Delaware Medicaid Program. Once this date expires, you will no longer be able to participate in Delaware Medicaid until you have successfully enrolled with DMAP.

There are many resources available to you as an MCO provider. Please check out the announcement section of the Delaware Medical Assistance Portal for Providers at https://medicaid.dhss.delaware.gov to locate important information regarding DMAP policies, How-To documents, and additional resources. For questions pertaining to DMAP registration contact Gainwell Provider Services at (800) 999 3371 and select option 0, then option 4.

Highmark Health Options WV Medicaid

In compliance with 42 CFR Part 455, subparts B and E and the 21st Century Cures Act, all West Virigina Medicaid Managed Care Organization (MCO) network providers must be enrolled with the Bureau for Medical Services (BMS) to provide services to West Virigina Medicaid members. This requirement applies to all United Concordia network providers who furnish, order, refer or prescribe items or services to West Virigina Medicaid members. **Provider enrollment must be competed to continue to serve Medicaid members.**

The Bureau for Medical Services is working with Gainwell Technologies (Gainwell) to implement the requirements of 42 CFR Part 455, subparts B and E and the 21st Century Cures Act.

There are many resources available to you as an MCO provider. Please check out the providers section of the West Virginia Department of Human Services Bureau for Medical Services at https://bms.wv.gov/ to locate important information regarding BMS policies, How-To documents, and additional resources. For questions pertaining to DMAP registration contact Gainwell Provider Services at (888) 483 0793 or (304) 348-3360.

How Individual Provider Identification Numbers Are Established

No payment can be made to you or your patient for eligible services until you have secured a United Concordia Provider Number. All providers are assigned this number when the first claim is submitted, and primary source verification is completed on your dental license. Non-participating providers may obtain a United Concordia Provider Number by submitting a claim form and including Treating Provider's name, copy of the provider's W9, physical address, mailing address (if different than physical address), telephone number, NPI and provider license number. United Concordia will mail you a letter with your assigned United Concordia Provider Number.

Group Practice

The purpose of establishing a group practice is to permit two or more providers to submit claims and receive payment using one United Concordia Provider Number. All payments will then be payable to the group practice under the group practice tax identification number.

Group Practice Participation Reminder

United Concordia is committed to easing the administrative burden for both providers and members. When scheduling an appointment for a United Concordia member at your group practice, please remember to share the participation details of the provider rendering service with the member. If services are rendered by a non-participating provider, the member is responsible for the difference between the office's standard fee and United Concordia's allowance. By providing participation details, you will ensure member satisfaction and receive appropriate reimbursement from both United Concordia and the member.

How to Form a Group Practice

Two or more providers practicing under the same tax identification number at the same practice location may establish a group practice to have the group recognized as a single entity for purposes of billing and payment. Examples of typical group practice arrangements are:

- Two or more providers practicing as a partnership.
- A group of providers forms a professional corporation, and the corporation becomes the employer of the providers.
- A provider employs one or more other providers as associates in the provider's practice.

Members of a group practice may be either participating or non-participating with United Concordia. To form a participating group, all required paperwork must be completed and submitted for each individual provider concurrent with forming the group practice.

Changes in Group Practice Membership

You must notify United Concordia in writing of any changes in the group's personnel. When a new provider joins a participating group practice, the provider should complete an application and agreement, if they wish to be a participating provider.

When a provider leaves the group, please notify United Concordia of the provider's new address and current tax identification number (either an Employer Identification Number or Social Security Number, as appropriate), if known. Notifying United Concordia that a provider is no longer associated with the group will minimize inappropriate claims payment under the group's Tax Identification Number.

Maintaining Provider Data

United Concordia maintains a provider database, which contains pertinent information on all individual providers and group accounts who have submitted claims or whose patients have submitted claims to United Concordia. Your record remains active on the provider database as long as you or your patients submit claims to United Concordia or until we receive notification of retirement, death, license suspension/revocation or HHS debarment.

It is important that our database contains accurate information regarding your group practice. United Concordia urges you to keep your provider information current by reporting any changes immediately. Keeping United Concordia informed of these changes will ensure timely delivery of checks and mailings. Please submit updates by using one of the following methods:

Website
https://www.unitedconcordia.com/pifria

Email *
ProviderRequests@ucci.com
** (Please Note: HTML documents and secure messages/weblinks are not accepted at this email address.)*

Fax
(844) 235-7261

Mail
Dental Network Operations
PO Box 69404
Harrisburg, PA 17106-9404

You can verify or make changes to directory related items via our online report a correction process. Simply visit our website at UnitedConcordia.com and click on Find a Dentist or enter the following into your web browser: UnitedConcordia.com/find-a-dentist/. Next, search for your information and select Report a Correction or Verify Information. Your existing network participation will also apply if you move to another address or begin practicing at an additional office within the same state.

How to Resign from Participation

To resign from participation with United Concordia, you must submit a signed, written statement to United Concordia. You may submit this at any time and resignations are normally effective 60 days following the date United Concordia receives your letter but may vary due to state-specific mandates or regulations. United Concordia will send you a letter indicating the effective

date of your resignation. When resigning an entire group, please include a resignation letter or signed document with the signature of each provider associated with the group practice. Please submit request by using one of the following methods:

Website
https://www.unitedconcordia.com/pifria

Email *
ProviderRequests@ucci.com

** (Please Note: HTML documents and secure messages/weblinks are not accepted at this email address.)*

Fax
(844) 235-7261

Mail
Dental Network Operations
PO Box 69404
Harrisburg, PA 17106-9404

Member Notice of Provider Terminations

Several states have enacted laws that require United Concordia to notify a member of the provider's change in network status from participating to non-participating. Although these laws often contain different notification requirements, they generally require notification to members who have been treated on a regular basis by the provider including current patients or members who received services within a certain period prior to the termination.

The following states require notice of termination to members: DE, PA, and WV

Non-Participating Providers

Non-participating providers do not sign an agreement with United Concordia and therefore have no contractual obligation to accept United Concordia's fees as payment-in-full. However, non-participating providers are required to accurately report services performed and fees charged. United Concordia urges providers to keep their information current by reporting any changes in writing. Informing United Concordia of these changes will ensure timely processing of claims and delivery of checks (when payment has been assigned by the member).

Please submit updates by using one of the following methods:
Website
https://www.unitedconcordia.com/pifria

Email *
ProviderRequests@ucci.com
** (Please Note: HTML documents and secure messages/weblinks are not accepted at this email address.)*

Fax
(844) 235-7261

Mail
Dental Network Operations
PO Box 69404
Harrisburg, PA 17106-9404

Assignment of benefits is available on a state-by-state and contract basis.

Specialty Care Providers

It is recommended that a general dentist evaluate a member before scheduling an appointment with a specialty dental care provider. However, if time does not permit a general dentist 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 in the case of an emergency. Please contact Customer Service for a listing of specialty dental care providers.

Coordination of Benefits

Section 4

Coordination of Benefits (COB) applies when a member is covered by two or more group insurance policies. The purpose of COB is to allow members to receive the highest level of benefits they are entitled to, up to 100 percent of the cost of covered services. COB also ensures that no one collects more than the actual cost of his/her dental expenses.

The program that takes precedence in the order of making payment is called the "primary plan." The program that is responsible for paying after the primary program is called the "secondary plan."

Medical Assistance and, therefore, United Concordia is mandated as the payer of last resort. All other insurance coverage must be exhausted before billing United Concordia. United Concordia is responsible only for the unsatisfied portion of the bill, up to the maximum allowable, contracted United Concordia fee for the service. As a participating provider, you may not bill the patient for any difference between the primary dental carrier's payment and the United Concordia payment.

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 carrier using the standard procedures required by that carrier. You will need a copy of the primary carrier's Explanation of Benefits, along with the completed dental claim form to submit to and receive payment from United Concordia. United Concordia is responsible for the unsatisfied deductible or coinsurance amounts if the payment you receive from the other insurance carrier is less than the allowable, contracted United Concordia fee for a service. Providers should bill for ALL services, even if they expect a $0 payment. This is necessary for encounter reporting to appropriate governing bodies.

Determining the Primary Plan

United Concordia follows these general guidelines for determining the primary plan:

- Medicaid is programmed to pay up to the allowance for covered services. Medicaid is always the payer of last resort.
- Medicaid is the "payer of last resort".
  - Any claims will go through the member's Medicare or other dental insurance coverage first.
  - The provider can, then, submit to the Medicaid payer to receive the portion owed based on the member's Medicaid Benefits.
  - If the member has Medicaid and a United Concordia plan, the other plan should be listed first on the claim form and submitted to that coverage. In the other insurance area on the claim form, the office should list the Medicaid plan information and address. The claim will be automatically processed under both coverages with the one claim submission.
- When Medicare is paying for a service, the member does not require an authorization from our plan for covered services.

If you are uncertain which dental plan is the primary plan for the patient, contact the Government Business Operations Department at (866)568-5933.

Pennsylvania Coordination of Benefits (COB) for Highmark Wholecare

Highmark Wholecare Medicaid is always the last insurance to be billed for COB.

- When a member has both PA Medicare and Access, PA Medicare is the primary plan.
- When a member has both PA Medicaid and PA Medicare, PA Medicare is the primary plan.
- Commercial contracts are primary to Medicare and Medicaid.

Medicaid will only pay up to what is listed as the patient's liability on the primary and/or secondary explanation of benefits (EOB) sent with the claim to SKYGEN. If the primary EOB lists the patient liability is $0, Highmark Wholecare will not make a payment as the secondary insurance.

- If a member has both Highmark Wholecare Medicaid and Medicare, the member will have two ID numbers.
- When a member switches from PA Medicaid to Medicare, their benefits will reset, and Medicare will be treated as an entirely new coverage.

If the rendered service is covered by the primary payer and is not from a Federally Qualified Health Center (FQHC), the following rules will apply.

- If Medicaid allowance is equal to or less than the primary paid amount, the payment is $0.
- If the rendered service is not covered by Medicaid (i.e. no allowed amount), the payment is $0.

- If the service is covered by Medicaid and the Medicaid allowed amount is greater than the primary paid amount (not including patient responsibility), Medicaid will pay the lesser of: **Patient responsibility amount as calculated by the primary insurer** or **Medicaid allowed amount minus primary paid amount.**
- For non-participating providers, Highmark Wholecare will pay up to the provider's charge regardless of patient liability unless the other insurance payment exceeds the providers charge.
- If the payee is a FQHC and the claim was covered by the primary payer, the claim payment formula is: FQHC Prospective Payment Schedule (PPS) rate (T1015) – primary payer payment = Medicaid payable amount

Delaware Coordination of Benefits (COB) for Highmark Health Options

In order to receive payment for services provided to members with other insurance coverage, the practitioner must first bill the member's primary insurance carrier. Submit a copy of the primary carrier's EOB with the claim to United Concordia within one hundred twenty (120) days of the date of the primary carrier's EOB. Secondary and tertiary claims can be sent electronically. Providers are required to submit claims on behalf of the member whenever other insurance is present.

Highmark Health Options Medicaid is always the last insurance to be billed for COB.

- When a member has both DE Medicaid and DE Medicare (DSNP), DE Medicare (DSNP) is the primary plan.
- Commercial contracts are primary to both Medicare (DSNP) and Medicaid.

Medicaid will only pay up to what is listed as the patient's liability on the primary and/or secondary explanation of benefits (EOB) sent with the claim to United Concordia. If the primary EOB lists the patient liability is $0, Highmark Health Options will not make a payment as the secondary insurance.

- If the service is covered by Medicaid and the Medicaid allowed amount is greater than the primary paid amount (not including patient responsibility), Medicaid will pay the lesser of:
    - Patient responsibility amount as calculated by the primary insurer
      OR
    - Medicaid allowed amounts minus primary paid amounts.
- For approved non-participating providers, Highmark Health Options will pay up to the provider's charge regardless of patient liability.

Timely filing can only be waived if the primary EOB is received within 120 days of the date the EOB was generated by the primary carrier.

West Virginia Coordination of Benefits (COB) for Highmark Health Options

In order to receive payment for services provided to members with other insurance coverage, the practitioner must first bill the member's primary insurance carrier. Submit a copy of the primary carrier's EOB with the claim to United Concordia within three hundred sixty-five (365) days of the date of the primary carrier's EOB. Secondary and tertiary claims can be sent electronically. Providers are required to submit claims on behalf of the member whenever other insurance is present.

Highmark Health Options WV Medicaid is always the last insurance to be billed for COB.

- When a member has both WV Medicaid and WV Medicare (DSNP), WV Medicare (DSNP) is the primary plan.
- Commercial contracts are primary to both Medicare (DSNP) and Medicaid.

Medicaid will only pay up to what is listed as the patient's liability on the primary and/or secondary explanation of benefits (EOB) sent with the claim to United Concordia. If the primary EOB lists the patient liability is $0, Highmark Health Options will not make a payment as the secondary insurance.

- If the service is covered by Medicaid and the Medicaid allowed amount is greater than the primary paid amount (not including patient responsibility), Medicaid will pay the lesser of:
    - Patient responsibility amount as calculated by the primary insurer
      OR
    - Medicaid allowed amounts minus primary paid amounts.
- For approved non-participating providers, Highmark Health Options will pay up to the provider's charge regardless of patient liability.
- If the payee is an FQHC, we will only pay the patient responsibility, which includes coinsurance and deductibles, and not the full encounter rate.

Timely filing can only be waived if the primary EOB is received within 365 days of the date the EOB was generated by the primary carrier.

Administration

Section 5

Dental Electronic Services

Electronic Claims Submission

United Concordia encourages all providers to submit claims electronically. The benefits of electronic claim submission include:

- **Elimination of paperwork and postage costs:** By submitting claims electronically, you can eliminate the staff time and postage cost required to prepare and mail paper claims.
- **Accuracy:** Because electronic claims are entered directly into United Concordia's automated claims processing system, your claims process more quickly and the chance of processing errors is significantly reduced
- **Flexibility:** You control the frequency and volume of submission
- **Dedicated support personnel:** United Concordia has a department dedicated to supporting electronic claim billers known as Dental Electronic Services (DES), who can provide information about electronic services available with United Concordia, assist throughout the testing process and supply ongoing support during the production phase.
- **Security:** Your computer files remain secure and confidential. The only data we can read are the claims that you send to us. You initiate the request to send us files; we can never call your computer or read the data in it.
- **Electronic Reports:** For a detailed explanation of United Concordia's reports, please refer to the "Reports" section of this chapter.

Electronic claims can be submitted in two ways:

- Through your clearinghouse/vendor
- Through United Concordia's Speed *e*Claim®

Electronic Data Interchange (EDI)

Electronic claims can be submitted to United Concordia through a clearinghouse or vendor that collects the claims from your office and forwards them to United Concordia. Also, electronic claims can be submitted directly to us if your practice management software allows for a direct connection to United Concordia. For more information on direct electronic claims submission, please visit our website.

Clearinghouse/Vendor

If you are using your clearinghouse/vendor, contact them and ask for United Concordia's payer ID. If you have any questions about electronic claim submission, please contact Dental Electronic Services. The United Concordia claims system will automatically pay you for the reimbursable ADA procedure codes. If you are submitting claims for Highmark Wholecare Medicaid, the claims processing is handled by a third-party vendor, Skygen USA, please use your Skygen USA payer ID.

Speed eClaim®

Participating and non-participating dentists can submit claims electronically to United Concordia free of charge, using Speed *e*Claim®. If you have Internet access, you can use Speed *e*Claim® to submit claims directly to United Concordia as paperless processing. Please ensure you use the latest version of your web browser. This real-time processing feature provides you with immediate processing results. You can also run daily reports summarizing your practice's activities, including the number of claims submitted, finalized and/or pending. You can obtain immediate access to Speed *e*Claim® or ***MyPatients'Benefits*** by registering on our website then log on with your username and password and click Speed *e*Claim®.

How to Become Eligible to Submit Electronic Claims

Use of the National Provider Identifier (NPI) is a government mandated requirement for electronic health care transactions. In addition, individual states may require use of the NPI for paper claims. To minimize potential claim processing errors and delays in payment, United Concordia encourages **all** dentists to obtain NPIs.

There are three basic types of NPI's available:

- ***Individual (entity type 1)*** includes sole proprietors, providing health care services. An application for an Entity Type 1 NPI is completed using the individual dentists' social security number. Only one NPI will be allowed for an individual dentist.

- ***Organizations (entity type 2)*** include group practices, professional corporations, clinics, and incorporated individuals. Application for an Entity Type 2 NPI is completed using the organization's Employer Identification Number. A dental practice that is incorporated is considered an Entity Type 2, even if it employs only one dentist.
- ***Subpart*** NPI's are given to components of organizations, such as affiliated sites that operate independently from the "parent organization", conducts their own HIPAA standard transactions, certified by the State separately from the "parent" organization and must be uniquely identified in HIPAA standard transactions.

Here are three simple and free ways to apply for your NPI:

1. Follow the online process at: www.nppes.cms.hhs.gov
2. Download the paper application from our website at www.UnitedConcordia.com
3. Contact the NPI enumerator at:
   - (800) 465-3203 or
   - customerservice@npienumerator.com

As soon as you receive your NPI, submit it along with your entity type (1 or 2), National Plan and Provider Enumeration System (NPPES) confirmation, address, and your United Concordia Provider Number to Provider Data Management.

Submitting Claims Requiring Attachments

United Concordia has developed attachment vendor relationships which give you more options for providing claims attachment information for your electronic claim submissions. This process saves dental offices time and money by accelerating processing and eliminating the need for duplicating and mailing X-rays.

Offices using a web-based attachment service can send X-rays, periodontal charts, intra-oral pictures, narratives, and Explanation of Benefits (EOBs) electronically to post to the vendor's repository. United Concordia can access these repositories and view attachments required to adjudicate electronically submitted claims. Dental offices can also access their vendor's repository to view their submitted attachments.

The following are the electronic attachment vendors that work with United Concordia:

- **Vyne Dental (Formerly NEA and RSS)**
  - For information or support, visit the Vyne Dental website at www.vynedental.com, or call (800)782-5150.
- **DentalXchange (DXC)**
  - For information or support, visit the DXC website at www.dentalxchange.com, or call (800) 576-6412, extension 452.
- **Change Healthcare (CHC)**
  - For information or support, send emails to dentalsupport@changehealthcare.com, or call (888) 255-7293

Add X-rays to a Rejected Claim – **"C" Rejections Only**

A new capability was added to submit attachments for 'C' type rejections though the Provider Portal.

- Access ***MyPatients'*** *Benefits* and select the attachment icon for the rejected claim.
- Access the Add X-rays to Rejected Claim Tile and key the rejected claim number.

  Any questions concerning electronic claims submission may also be directed to the United Concordia Electronic Services department at (800) 633-5430, Monday through Friday from 8:00 a.m. to 5:00 p.m. EST.

Important Rules and Regulations of the Standards for Electronic Transactions

When conducting an electronic transaction covered under the Standards for Electronic Transactions, a covered entity must report standard dental codes that are valid at the time the health care is provided. According to the 837 Dental Electronic Claim Guide, only CDT (Current Dental Terminology) codes can be submitted on this transaction. CPT and HCPC codes that can be covered under dental benefits cannot be submitted on the 837 Dental Electronic Claim Transaction but can be submitted on the 837 Professional Electronic Claim Transaction. Please note that National Modifiers cannot be submitted on the 837 Dental Claim Transaction, as the American Dental Association (ADA) does not currently recognize the use of modifiers with their CDT codes. However, National modifiers can be submitted on the 837 Professional Claim Transaction.

The HIPAA regulations require a health care provider who uses electronic media to transmit health information in connection with one of the HIPAA transactions to do so in compliance with the regulations. United Concordia can accept and transmit the following HIPAA-compliant transactions:

Accepted Transactions:

- 270-Health Care Eligibility Inquiry
- 276-Health Care Claim Status Requested
- 837-Health Care Claim (Dental and Professional)

Transmitted Transactions:

- 271-Health Care Eligibility Benefit Response
- 277-Health Care Claim Status Response
- 835-Health Care Claim Payment / Advice

Transaction Responses

If you send your electronic claims directly to United Concordia via the HIPAA 837D transaction, you will receive a 999 Functional Acknowledgement transaction response and a 277CA transaction response. If you utilize a clearinghouse or vendor, these responses are sent to the clearinghouse or vendor who is then responsible for passing the information back to your office. Below is a list of the transaction responses and a brief explanation of their purpose.

999 Implementation Acknowledgement for Healthcare Insurance

If you bill directly to us, after you transmit a file of claims, you will receive a 999 Acknowledgement Response, which will confirm receipt of your claims. If you use a clearinghouse or vendor, they receive the 999 Functional Acknowledgement response from us.

277 Healthcare Claims Acknowledgement

Within 24 hours after your claims are submitted and accepted through the 999 Acknowledgement transaction process, they are subject to a set of edits in our computer system to make sure that all the information is reported correctly. The results of this edit check are outlined on the 277 Claims Acknowledgement transaction file, which indicates whether all, none or some of the claims were accepted. If the entire file or some of the claims are rejected, you must correct the errors identified and resubmit the file or corrected claims for processing.

If you bill directly to us, it is necessary that you retrieve this transaction response. If you use a clearinghouse or vendor, it is their responsibility to retrieve this transaction response and pass it on to you.

835 Healthcare Claim Payment/Advice

United Concordia provides a weekly 835 Healthcare Claim Payment/Advice transaction to assist in your accounts receivable process. Please contact Dental Electronic Services for more information on receiving this transaction. Some of the information contained in this report includes:

- National Provider Identifier (NPI) of the dentist or group receiving payment.
- Patient's name, patient control number, service rendered, date of service and billed charge.
- Allowed amount for the service.
- Actual payment made for the service.
- Amount applied to the patient's deductible, if applicable
- Check number and issue date.
- Reason for rejection of denied service.

Dental Electronic Services works closely with all dentists, vendors and clearinghouses that receive or transmit electronic transactions. If you wish to obtain information on submitting electronic transactions, visit our website.

Claim Submission Guidelines

Claim Filing Deadline

We recommend that you send the claim form to United Concordia as soon as possible after the service is completed, typically within 60-90 days of the date of service. (Timely filing deadlines may vary by contract.)

- **Highmark Wholecare Claim Filing Deadline**: Claims submitted more than 180 days after the date in which the service was provided will be denied.
- **Highmark Health Options Claim Filing Deadline**:
  - **DE Adult Medicaid:** Claims submitted more than 120 days after the date in which the service was provided will be denied.
  - **DE Children's Medicaid:** Claims submitted more than 120 days after the date in which the service was provided will be denied.
  - **WV Medicaid and CHIP:** Claims submitted more than 365 days after the date in which the service was provided will be denied.

Contract ID Number

Due to federal and state laws, United Concordia has taken steps to protect our member's privacy and reduce potential for identity theft. One of the steps we have taken is redacting our member's social security numbers when the social security number is our member's contract identification number. In most states we are redacting the social security numbers by replacing all numbers except for the last four numbers of the social security number with X's (XXX-XX-1234). However, some states require the entire number to be replaced with X's (XXX-XX-XXXX) and other states require removing the number completely on all communications including the member's Dental Insurance Identification card. Some of our customers also require the use of unique identification numbers that are not the members' social security number.

While insurers have to protect their members' social security numbers to be compliant with state and federal laws, it is becoming more difficult for a dentist to know what identification number to report when submitting a claim. However, it is just as important that you report the correct identification number when submitting claims to ensure the privacy of your patient's records. Reporting an incorrect identification number could cause your patient's protected health information to be sent to another United Concordia member as the number reported could be a valid contract identification number for another of our members. In order to protect your patient's information, it is important to submit the correct identification number and here's how:

- Ask for your patient's current Dental Insurance Identification card and verify with them that the information is correct and valid.
- If the identification number is reported on the card as XXX-XX-XXXX, report the insured's Social Security Number
- If the identification number is reported on the card as XXX-XX-last 4 numbers of Insured's Social Security Number, report all 9 numbers of the insured's Social Security Number (do not report any X's)
- If a number is reported on the identification card, report the entire number including any letters as the insured's identification number. (Unique member identification numbers often have one or more letters within the number)
- A SSN is not required if you have a patient's DOB and unique member identification number.

If you have any doubts about having the correct identification number on file, you can verify your patient's eligibility through ***MyPatients'****Benefits* which is available on our website. Simply click on the Dentist button at the top of our home page and select ***MyPatients'****Benefits*.

Signature Requirements

Dentists and patients should sign all claim forms submitted to United Concordia for services rendered to United Concordia subscribers. Failure to supply the necessary signature may result in delayed payment or denial of the claim. Therefore, it is important for you to review the following information to assure that claims submitted to United Concordia are in compliance with these requirements.

There are three important signature fields on claims submitted to United Concordia:

- Treatment Plan / Release of Information
- Assignment of Benefits
- Dentist's Signature

Treatment Plan / Release of Information

There are two acceptable methods for completing this field:

- **Option 1: Patient or Guardian Signature** - If the patient has reviewed the treatment plan and authorizes the release of information related to their claim, please have the patient or guardian sign his or her full name.
- **Option 2: Signature On File** - United Concordia will also accept the phrase "signature on file" entered in this field. Please remember if you wish to use this method, you must obtain a release from the patient using the text as found in the signature block and retain the release in the patient's file.

Assignment of Benefits

If you are a participating dentist, it is not necessary to have the patient's signature or "signature on file" entered in this block. Claim payments will automatically be mailed to the participating dentist and non-participating provider if approval was granted.

Dentist's Signature

The treating dentist or his/her authorized representative should sign the claim form. We can also accept a computer-scanned signature or stamped facsimile.

Supporting Documentation

Dentists are requested to submit radiographs used for diagnosis and treatment planning when submitting claims for certain services. All radiographs submitted (including copies) should be pre-treatment unless otherwise noted. They should be of diagnostic quality and mounted properly with the left and right sides clearly marked. They should be identified with the dentist's name and address, the patient's name and identification number and the date the radiographs were taken. If a copy of the radiographs is submitted, left or right should be marked on the copy.

Note: United Concordia will only return radiographs/photos if a self-addressed, stamped envelope is included for each claim or inquiry, and we recommend always submitting duplicates. If, for some reason, radiographs are not available, a brief explanation should be included on the claim form. If submitting claims electronically, please provide a brief explanation in the remarks field. You should also submit any patient specific information related to the treatment that you feel should be considered.

Please refer to the Diagnostic Materials Requirements Chart in the Policies, Limitations and Exclusions Section for a detailed listing of procedures that require submission of diagnostic materials.

Note: It is United Concordia's intent to request only those radiographs that are generally taken as part of diagnosis and treatment planning. If, for some reason, the radiographs listed were not taken or are not available, a brief explanation should be included with the claim.

Other Supporting Documentation

Occasionally, additional supporting documentation is necessary. Below is a list of additional information that must be documented on the claim form:

- Orthodontic claims - indicate the total fee and estimated length of treatment.
- Coordination of Benefits claims - indicate the amount paid by the primary insurance company and provide a copy of the primary Dental Explanation of Benefits (DEOB)
- "By report" procedure - include a brief narrative statement explaining why the service was necessary and/or any unusual circumstances.

Third Party Liability (TPL)

When a dental procedure is necessary due to an accident, e.g. job related, automotive, etc., the claim must be reviewed for possible Third-Party Liability (TPL). Please document as much information about the accident as possible when submitting TPL claims. Please be aware that there may be an additional delay while United Concordia contacts the patient for additional information for TPL.

Claim Review Process

United Concordia is responsible for ensuring that payment for services the members receive is cost-effective. United Concordia's dental review program helps fulfill this responsibility. This program consists of pre-payment and post-payment review. The pre-payment program is briefly described in this section.

Appointment Wait Time

Waiting Time Standards

Although we expect your appointment wait times to be reasonable, United Concordia does not impose or require that specific appointment wait times are met because we understand your appointment availability may vary due to the time of year or your current

staffing situation. However, numerous states have passed legislation that designates appointment wait time requirements and obligates carriers to determine actual wait times for network dentists and report the results.

Dental offices must meet the following state-specific appointment timeframe requirements, by state to comply. United Concordia issues surveys to network dentists to obtain actual wait times. Please respond to our inquiries timely.

Delaware

Appointment Type	Timeframe Requirement
Emergent Appointments	immediately upon request or referral to an emergency facility
Urgent Appointments	within 48 hours of request
Routine Appointment with Dentist	within 21 calendar days of request
Routine Appointment with Specialists	within 21 calendar days of request

Pennsylvania

Appointment Type	Timeframe Requirement
Emergent Appointments	immediately upon request or referral to an emergency facility
Urgent Appointments	within 24 hours of request
Routine Appointment with Dentist or Pediatric Dentist	within 15 business days of request
Routine Appointment with all other Specialists	Within 10 business days of request

West Virginia

Appointment Type	Timeframe Requirement
Emergent Appointments	Immediately (24 hours) upon request or referral to an emergency facility
Urgent Appointments	within 48 hours of request
Routine Appointment with Dentist	within 21 calendar days of request
Routine Appointment with Specialists	within 21 calendar days of request

Review by Dental Advisors

Dental Advisor Review

The Dental Advisors provide professional opinions on patterns of practice and supply professional input into the development of new claims processing procedures and policies. United Concordia's Dental Advisors are licensed dentists who represent the dental community at large. These Advisors are in active dental practice or are retired former-practitioners and serve United Concordia on a part-time basis. Among the Dental Advisors are several general dentists, oral surgeons, orthodontists and periodontists.

The Dental Advisors render opinions by reviewing claims, reports, correspondence and diagnostic information such as radiographs. Following their review, the claim is processed based on the Dental Advisor's recommendation and the member's dental benefits. Should you have questions concerning claims previously reviewed by a Dental Advisor, please contact United Concordia at (800) 772-1133 between the hours of 8:00 A.M. and 4:15 P.M. Eastern Time. You may also obtain the criteria used to create the determination of your claim by submitting a written request to:

United Concordia Companies, Inc. Dental Advisor Review
PO Box 69420
Harrisburg, PA 17106-9420

Standard Policy and Procedure

Section 6

United Concordia administers dental benefit packages that place limitations and exclusions on certain benefits. **These exclusions and limitations may vary by state due to regulatory requirements and by group customer based on coverage purchased.** If you would like to know the exclusions and limitations for particular group contracts under which your members are covered, you may use ***MyPatients****'Benefits* or the *Provider Web Portal* at www.SkygenUSA.com to obtain information specific to that contract or refer to the plan specific benefit grids on the website.

The policies and limitations listed within this section are used in administering dental benefits for Medical Assistance dental programs and are subject to the group's contract and state specific benefit requirements for Medicaid.

Procedures should be reported using the American Dental Association's current dental terminology procedure codes. Procedures that are an inherent part of another procedure are considered to be integral and not eligible for separate payment. Integral procedures are not billable to the member by a participating United Concordia dentist or any other dentist who participates with the states Medical Assistance Programs.

Dental coverage varies by contract. To verify if a procedure is covered under a specific contract, please contact Dental Customer Service at the phone number listed on the member's identification card.

General Policies

All covered procedures are subject to the following general policies:

- Dental services must be dentally/medically necessary and meet accepted standards of dental practice, as defined by United Concordia, **which requires any tooth or teeth to have acceptable prognosis and meet United Concordia's definition of dental/medical necessity for the reported code as defined by the current ADA Current Dental Terminology codebook**. Dental services determined not to meet United Concordia's definition of dental/medical necessity are not billable to the patient by a participating dentist unless the dentist notifies the patient of his or her potential financial liability prior to treatment and the patient chooses to receive the treatment (financial agreement). Participating dentists should document such notification specifically (with the date, tooth number, service, potential financial liability, and signature of the patient) in the patient's record.
- Procedures that are part of a service but are reported as separate services; reported in a treatment sequence that is not appropriate; misreported or that represent a procedure other than the one reported. Procedures that are routinely provided in conjunction with or as part of another procedure are considered as integral (for example: local anesthesia). Participating dentists may not bill a patient for a service denied because it is considered integral to another service, reported in an inappropriate treatment sequence, or misreported.
- Procedures should be reported using the American Dental Association's current dental terminology procedure codes. If a procedure code is not available to report a specific service, a complete description of the procedure provided, including applicable tooth numbers should be reported.
- Participating dentists may not bill United Concordia or the member for the completion of claim forms and submission of required information for determination of benefits.
- Infection control procedures and fees associated with Occupational Safety and Health Administration (OSHA) and/or other Governmental agency compliance are considered part of the dental procedures provided and may not be billed separately by a participating dentist.
- For reporting and benefit purposes, the completion date for:
  - Crowns, inlays, onlays, buildups, post and cores, and fixed partial dentures is the cementation date.
  - Removable prosthetics is the insertion date.
  - Root canal therapy is the date the tooth is sealed.
- Time limitations are applied based upon consecutive days, months, or years.
- Missed appointments (D9986) and cancelled appointments (D9987) are not reimbursable benefits and providers are prohibited from billing Medicaid members who miss scheduled appointments.
- Medical Assistance networks do not have referral requirements.

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

Members covered under EPSDT are entitled to receive any medically necessary service. If the service is medically necessary (Plan) will cover the cost of the service. If a code necessary for the member's treatment is not a covered

benefit, submit a pre-authorization for the service and include a letter of medical necessity and any additional documentation to support the medical necessity.

Position Statements

The following statements reflect the position of United Concordia in regard to specific subjects. These statements are used in administering dental benefits.

Placement of Restorations

The standard group and individual dental contract provide coverage for restorations determined to be necessary to treat diseased or accidentally broken teeth. Teeth with craze lines or incomplete fractures are not considered broken teeth. The determination of necessity is founded upon and updated to reflect current, scientific literature and is implemented through the professional opinion of Dentist Advisors, who are engaged in active clinical practice.

The placement of restorations due to caries should be limited to those cases where the lesion has progressed into the dentin. In cases where this has not occurred, other more conservative approaches, such as the use of fluoride and sealants should be considered to avoid destroying tooth structure. Under the terms of the dental contract, sealants are considered a preventive service, not a restorative service. This position is supported by dental school curricula, as well as current research. The International Symposium on the Criteria for the Placement and Replacement of Dental Restorations concurs. To date, we are not aware of any scientific studies that contradict or discredit this position.

Overhead Expenses

Charges itemized and distinguished from the professional service provided are considered overhead expenses. These include, but are not limited to, charges such as facility and room fees, heat, light, rent, equipment, lab fees, OSHA and/or HIPAA compliance, sterilization, and sanitation, completing insurance forms, and office staff. Overhead expenses should not be billed separately to United Concordia. Additionally, the Participating Dentist Agreement prohibits a Participating Dentist from billing or collecting such charges from the member.

Amalgam

Dental amalgam is the most thoroughly researched and tested dental restorative material in use today. While it does contain mercury (a known toxin), this element is "bound" to other components of amalgam that make it safe for use. No study has ever demonstrated that the mercury contained in dental amalgam has caused any health problems or specific chronic diseases in any person studied, with the rare exception of the member who is truly allergic to any of the metals contained in amalgam alloy.

A recent independent survey of over 950 scientific and medical studies concluded that amalgam was "safe, effective, and cost efficient". The ADA Research Foundation notes that amalgam is the "strongest and most durable direct restoration for large load-bearing restorations on posterior teeth." Government funded studies concluded in 2006 found no evidence that dental amalgam causes brain injury or neurological problems in children. Similar supportive statements have been released by the Federal Drug Administration (FDA), National Institutes of Health (NIH), U.S. Public Health Service (USPHS), Centers for Disease Control (CDC) and the World Health Organization (WHO). There are some dentists and lay people who oppose the use of dental amalgam and cite alleged or unproven adverse effects of the amalgam alloy and promote the use of alternative materials claimed to be more safe or effective. Some of these alternative materials to dental amalgam, in fact, contain components that have been shown to be potentially hazardous to humans.

Documentation Required for Specific Services

Some covered procedures require the submission of diagnostic materials, such as periodontal charting, radiographs, and/or a brief narrative report of the specific service(s) performed and any factors that may have affected the care provided. Where applicable, these requirements are indicated on the list of covered procedures. If radiographs are required, dentists are requested to submit all radiographs used for diagnosis and treatment planning.

It is our intent to request only those radiographs that are generally taken as part of diagnosis and treatment planning. If, for some reason, radiographs were not taken or are not available, a brief explanation should be included with the claim. If submitting claims electronically, please provide a brief explanation in the remarks field.

- **Report required** means that these services will be paid only in applicable circumstances and documentation of the circumstances must be submitted with the claim.
- **Periodontal charting required** means that complete periodontal charting must be submitted for review.
- **Prior Authorization required** means that an approved Prior Authorization must be obtained.
- **Radiograph required** means that a radiograph must be submitted for review.

Procedure Code Reporting
The Procedure Code Reporting Chart provides a listing of those procedure codes that require specific information when they are reported. (To verify if a member has coverage for a specific procedure, contact Dental Customer Service at the phone number listed on the member's identification card.)

The columns and symbols used in the chart are described as follows:

Column 1: Procedure Code - Lists the applicable ADA procedure code.

Column 2: Tooth/Arch/Quadrant - Indicates whether a tooth number, arch or, quadrant indicator is required for that procedure.

- T = the specific tooth number is required when submitting claims for that procedure. Use numbers 1-32 for permanent teeth or letters A-T for primary teeth.
- A = the arch (maxillary or mandibular) is required when submitting claims for that procedure
- Q = the quadrant is required when submitting claims for that procedure. The following designations may be used to identify quadrants:
    - UL = Maxillary Left
    - UR = Maxillary Right
    - LL = Mandibular Left
    - LR = Mandibular Right
- T/A = either the tooth or arch is required when submitting claims for that procedure
- T/Q = either the tooth/teeth or quadrant is required when submitting claims for that procedure

  T/A/Q = either the tooth, arch or quadrant is required when submitting claims for that procedure

Column 3: Surface - Indicates if the surface of the tooth is required for that procedure.

- Yes = tooth surface(s) is required when submitting claims for that procedure
- Blank = tooth surface(s) is not required when submitting claims for that procedure

Procedure Code	Tooth/Arch/Quad	Surface
D1351	T	
D1352	T	
D1353	T	
D1354	T	
D1510	Q	
D1516	T	
D1517	T	
D1520	Q	
D1526	T	
D1527	T	
D1551	A	
D1552	A	
D1553	Q	
D1556	Q	
D1557	A	
D1558	A	
D1575	Q	
D2140	T	Yes
D2150	T	Yes
D2160	T	Yes
D2161	T	Yes
D2330	T	Yes
D2331	T	Yes
D2332	T	Yes
D2335	T	Yes
D2390	T	
D2391	T	Yes
D2392	T	Yes
D2393	T	Yes
D2394	T	Yes
D2410	T	Yes
D2420	T	Yes
D2430	T	Yes
D2510	T	Yes
D2520	T	Yes

Procedure Code	Tooth/Arch/Quad	Surface
D2530	T	Yes
D2542	T	Yes
D2543	T	Yes
D2544	T	Yes
D2610	T	Yes
D2620	T	Yes
D2630	T	Yes
D2642	T	Yes
D2643	T	Yes
D2644	T	Yes
D2650	T	Yes
D2651	T	Yes
D2652	T	Yes
D2662	T	Yes
D2663	T	Yes
D2664	T	Yes
D2710	T	
D2712	T	
D2720	T	
D2721	T	
D2722	T	
D2740	T	
D2750	T	
D2751	T	
D2752	T	
D2753	T	
D2780	T	
D2781	T	
D2782	T	
D2783	T	
D2790	T	
D2791	T	
D2792	T	
D2794	T	
D2799	T	

Procedure Code	Tooth/Arch/Quad	Surface
D2910	T	
D2915	T	
D2920	T	
D2921	T	
D2929	T	
D2930	T	
D2931	T	
D2932	T	
D2933	T	
D2934	T	
D2940	T	
D2941	T	
D2949	T	
D2950	T	
D2951	T	
D2952	T	
D2953	T	
D2954	T	
D2955	T	
D2957	T	
D2960	T	
D2961	T	
D2962	T	
D2971	T	
D2975	T	
D2980	T	
D2981	T	
D2982	T	
D2983	T	
D2990	T	Yes
D2999	T	
D3110	T	
D3120	T	
D3220	T	
D3221	T	

Procedure Code	Tooth/Arch/Quad	Surface
D3222	T	
D3230	T	
D3240	T	
D3310	T	
D3320	T	
D3330	T	
D3331	T	
D3332	T	
D3333	T	
D3346	T	
D3347	T	
D3348	T	
D3351	T	
D3352	T	
D3353	T	
D3355	T	
D3356	T	
D3357	T	
D3410	T	
D3421	T	
D3425	T	
D3426	T	
D3428	T	
D3429	T	
D3430	T	
D3431	T	
D3432	T	
D3450	T	
D3460	T	
D3471	T	
D3472	T	
D3473	T	
D3501	T	
D3502	T	
D3503	T	

Procedure Code	Tooth/Arch/Quad	Surface
D3920	T	
D3921	T	
D3950	T	
D3999	T	
D4210	Q	
D4211	T	
D4212	T	
D4230	Q	
D4231	T	
D4240	Q	
D4241	T	
D4245	Q	
D4249	T	
D4260	Q	
D4261	T	
D4263	T	
D4264	T	
D4265	T	
D4266	T	
D4267	T	
D4268	T	
D4270	T	
D4273	T	
D4274	T	
D4275	T	
D4276	T	
D4277	T	
D4278	T	
D4283	T	
D4285	T	
D4341	Q	
D4342	T	
D4381	T	
D4921	Q	
D4999	T/Q	

Procedure Code	Tooth/Arch/Quad	Surface
D5211	T	
D5212	T	
D5213	T	
D5214	T	
D5221	T	
D5222	T	
D5223	T	
D5224	T	
D5225	T	
D5226	T	
D5227	A	
D5228	A	
D5282	T	
D5283	T	
D5284	Q	
D5286	Q	
D5520	T	
D5630	T	
D5640	T	
D5650	T	
D5660	T	
D5725	A	
D5765	A	
D5899	T/A	
D5999	A	
D6010	T	
D6011	T	
D6012	T	
D6013	T	
D6040	Q/A	
D6050	T	
D6051	T	
D6056	T	
D6057	T	
D6058	T	

Procedure Code	Tooth/Arch/Quad	Surface
D6059	T	
D6060	T	
D6061	T	
D6062	T	
D6063	T	
D6064	T	
D6065	T	
D6066	T	
D6067	T	
D6068	T	
D6069	T	
D6070	T	
D6071	T	
D6072	T	
D6073	T	
D6074	T	
D6075	T	
D6076	T	
D6077	T	
D6081	T	
D6082	T	
D6083	T	
D6084	T	
D6085	T	
D6086	T	
D6087	T	
D6088	T	
D6090	T/A	
D6092	T	
D6093	T	
D6094	T	
D6095	T	
D6097	T	
D6098	T	
D6099	T	

Procedure Code	Tooth/Arch/Quad	Surface
D6100	T	
D6101	T	
D6102	T	
D6103	T	
D6104	T	
D6120	T	
D6121	T	
D6122	T	
D6123	T	
D6194	T	
D6195	T	
D6198	T	
D6199	T	
D6205	T	
D6210	T	
D6211	T	
D6212	T	
D6214	T	
D6240	T	
D6241	T	
D6242	T	
D6243	T	
D6245	T	
D6250	T	
D6251	T	
D6252	T	
D6253	T	
D6545	T	
D6548	T	
D6549	T	
D6600	T	Yes
D6601	T	Yes
D6602	T	Yes
D6603	T	Yes
D6604	T	Yes

Procedure Code	Tooth/Arch/Quad	Surface
D6605	T	Yes
D6606	T	Yes
D6607	T	Yes
D6608	T	Yes
D6609	T	Yes
D6610	T	Yes
D6611	T	Yes
D6612	T	Yes
D6613	T	Yes
D6614	T	Yes
D6615	T	Yes
D6624	T	
D6634	T	
D6710	T	
D6720	T	
D6721	T	
D6722	T	
D6740	T	
D6750	T	
D6751	T	
D6752	T	
D6753	T	
D6780	T	
D6781	T	
D6782	T	
D6783	T	
D6784	T	
D6790	T	
D6791	T	
D6792	T	
D6793	T	
D6794	T	
D6930	T	
D6980	T	
D6985	T	

Procedure Code	Tooth/Arch/Quad	Surface
D6999	T	
D7111	T	
D7140	T	
D7210	T	
D7220	T	
D7230	T	
D7240	T	
D7241	T	
D7250	T	
D7251	T	
D7270	T	
D7272	T	
D7280	T	
D7282	T	
D7283	T	
D7290	T	
D7291	T	
D7295	T	
D7296	T	
D7297	Q	
D7310	T/Q	
D7311	T	
D7320	T/Q	
D7321	T	
D7510	T/A	
D7921	T/A/Q	
D7922	T	
D7953	T	
D7971	T	
D7995	Q	
D8696	A	
D8697	A	
D8698	A	
D8699	A	
D8701	A	

Procedure Code	Tooth/Arch/Quad	Surface
D8702	A	
D8703	A	
D8704	A	
D8999	A	
D9110	T/A/Q	
D9120	T	
D9910	T	
D9911	T	

Procedure Code	Tooth/Arch/Quad	Surface
D9970	T	
D9971	T	
D9972	A	
D9973	T	
D9974	T	
D9975	A	
D9999	T/Q/A	

Highmark Wholecare Medicaid

Highmark Wholecare offers a full dental benefits package to its members. To confirm the members dental benefit package, please consult the *Provider Web Portal* at www.SkygenUSA.com. As in most dental programs, limitations and exclusions are placed on member benefits. The following section will identify the limitations and exclusions for your patients who receive benefits through the Pennsylvania Medical Assistance program.

The policies and limitations listed within this section will be used to administer dental benefits for Highmark Wholecare Medicaid members. They reflect current and acceptable practices within the dental community while ensuring that cost-effective measures are applied according to the dental contract. Please refer to the following for additional information: Dental Care Provider Information - Commonwealth of Pennsylvania

This section applies only to Dental Providers and Physicians. PHDHPs should refer to the below section specific to benefits billable by PHDHP's.

Benefits and Exclusions

- All covered services are subject to the following general policies: All dental procedures are considered to be outpatient procedures. These procedures are not compensable on an inpatient basis unless there is medical justification which is documented in the patient's medical record.
- Dentist and Physician are the only provider types eligible to receive payment for dental services.
- Dentist who is a board certified or board eligible orthodontist is the only provider type eligible for payment of orthodontic service.
- Physician is the only provider type eligible for the anesthesia allowance when provided in a hospital short procedure unit, ambulatory surgical center, emergency room or inpatient hospital.
- Maximum allowance for any combination of dental radiographs, per patient per provider per calendar year is $69.00

Prior Authorizations

A prior authorization is required for those services for which the Pennsylvania Department of Human Services recommends prior authorization, requires prior authorizations and has granted approval to United Concordia to require prior authorization.

Prior authorization is required for orthodontics, crowns, surgical extraction(s) of impacted tooth/teeth, and periodontal services (except full mouth debridement which requires post- operative review). All dental procedures are considered to be outpatient procedures. These procedures are not compensable on an inpatient basis unless there is medical justification, which is documented, in the patient's medical record.

"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 Policies, Limitations and Exclusions section for prior authorization requirements. For additional information on Prior Authorizations, please see Section 6, Claim Submission Guidelines.

If a member is referred to a non-participating provider, it will be the responsibility of the non-participating provider to request a prior authorization via the Specialized Service Unit before the non-participating dentist may render any services.

Requesting a Prior Authorization

Prior authorizations can be requested electronically through the *Provider Web Portal* at www.SkygenUSA.com or in writing by completing an ADA claim form and checking the box marked Pre-Treatment Estimate. If requesting the prior authorization in writing, the request must be mailed to the address below along with any required supplemental information. Your office will receive a Prior Authorization Notification detailing the approved services and the plan payment amounts.

Mail the prior authorization to:
Pre-Authorizations
PO Box 2170
Milwaukee, WI 53201

Prior authorizations are subject to the following conditions:

- Allowances may be reduced by entitlement to other insurance benefits.
- Total benefit maximums may not be exceeded. Actual dates of service may alter benefits payable.
- Allowances may vary if plan benefits change prior to treatment.
- The patient must be eligible for benefits when the services are deemed incurred. An expense is incurred when a service is performed. Section 8.7.2 of the PA Promise 837 Dental Handbook is specific to eligibility: When billing DHS for a prior authorized custom-made crown or denture for which the impression was taken while the recipient was eligible, but was not inserted in the recipient's mouth before the recipient became ineligible, the dentist must use the date of impression for the date of service. Include the date the appliance was inserted in the Remarks Section of the ADA Claim Form.
- Allowances may vary based on results of post-treatment clinical review.

Once the prior authorization is finalized, both the dentist and member will be notified within two (2) business days. **A prior authorization is not a guarantee of payment but indicates how much would be payable given the information available at the time the determination is processed.** When the predetermined services have been provided, use one of the following methods to request payment.

- **Electronic Claims** – Simply include the claim number printed on the Prior Authorization Notification and Request for Payment Form in the remarks field of your electronic claim request for payment.
- **Return via Mail** - Mail the form titled Dental Prior Authorization Notification and Request for Payment with the completed date(s) of service(s) entered in the 'Service Date(s)' column. Dates should only be entered if the service has been completed. Do not attach additional claim forms to the Dental Prior Authorization Notification and Request for Payment Form if submitting a request for payment via mail. Submitting a new claim form may delay payment or possibly result in unnecessary requests for supporting documentation.

A prior authorization will remain valid for 365 days from the date of approval. The Dental Prior Authorization Notification and Request for Payment form contains the date that the preauthorization is approved through. **Services performed after the approval has expired will be subject to another review and should be submitted with the appropriate radiographs and supporting documentation for payment consideration.**

Timeframes and Written Notification

The following are the standards for prior authorizations:

- **Standard Decision (Non-Urgent Prior Authorization)** – Non-urgent prior authorization requests referred to a Dentist Advisor for approval, or to a physician for a denial determination, will be completed within two (2) business days of the receipt of the request. Written notification of the decision will be sent to the dentist within two (2) business days of the decision.
- **Expedited Decision (Urgent Prior Authorization)** – Urgent prior authorizations will be completed, and dentists will be notified of a decision, within twenty-four (24) hours Providers are responsible for serving as the member's representative and conveying prior authorization decisions as appropriate.
- **Expiration of Prior Authorizations** – Prior Authorizations are valid for 365days from the date of approval. Approved treatment must be rendered within this time frame, or a new prior authorization will need to be submitted for clinical review.
- **Request for Additional Information** - If a request for prior authorization is received with incomplete information, the provider and the member will be notified that additional information is needed for review, using the "Request for Additional Information" letter template. The provider will have 14 calendar days to submit the additional information. Once additional information is received, a decision will be made within two (2) business days. If the requested information is not received within the established time frame, a decision will be made by reviewing the available information.

Benefit Limit Exceptions (BLE)

A benefit limit exception assures consistent coverage determinations for members aged 21 years and older who have the Adult Medicaid plan. This does not apply to members under the age of 21 or members residing in a nursing home or an intermediate care facility.

A BLE request must be submitted for one of the following dental services:

- Additional oral evaluations (D0120) above the one per 180-day limit
- Additional prophylaxis (D1110) above the one per 180-day limit

- Additional dentures above the lifetime limit of one per upper arch, full or partial, regardless of procedure code (D5110, D5130, D5211, D5213) and one per lower arch, full or partial, regardless of procedure code (D5120, D5140, D5212, D5214)
- Crowns and adjunctive services (D2710, D2721, D2740, D2751, D2791, D2952, D2954)
- Periodontic services (D4210, D4341, D4342, D4355, D4910)
- Endodontic services (D3310, D3320, D3330, D3410, D3421, D3425, D3426, D3471, D3472, D3473, D3501, D3502, D3503, D3921) *

*Note: Root canals do not require prior authorization or BLE authorization if submitted by an Endodontist. If submitted by a general dentist, only a preauthorization is required.

A BLE request may be submitted on a prospective or retrospective basis, but retrospective requests must be received no later than 60 days from the date of the claim rejection.

Benefit Limit Criteria to be reviewed:

- The member has a serious chronic systemic illness or other serious health condition, and denial of the exception will jeopardize the member's life.
- The member has a serious chronic systemic illness or other serious health condition, and denial of the exception will result in the rapid, serious deterioration of the member's health.
- Granting the exception is a cost-effective alternative for the Health Plan.
- Granting the exception is necessary in order to comply with Federal law.
- The member has a pregnancy diagnosis.

Written notification of the decision for a prospective BLE request will be issued as expeditiously as the member's health care condition requires, but no later than 21 calendar days from the date of receipt.

Written notification of the decision for a retrospective BLE request will be issued within 30 calendar days from the date of receipt.

Please note that the provider may not seek payment from the member for a service that is over a benefit limit unless:

1. The provider informed the member before providing the service that the service may be above the benefit limit, in which case it would not be covered unless an exception is granted;
2. The provider submitted a request for an exception to the benefit; and
3. The BLE request was denied.

Medical Conditions considered for a Benefit Limit Exception

If a dental BLE request identifies that the member has one of the conditions listed below as indicated on the BLE request form, Highmark Wholecare will review the member's medical and dental claim history to determine if the condition was previously identified on a claim. If the condition was **previously identified on a claim via a letter from the PCP or medical record history,** Highmark Wholecare will not require additional supporting medical record documentation. If one of the medical conditions below was not previously identified on a claim or if the BLE request is being submitted for a condition that is not listed below and there is no supporting documentation, Highmark Wholecare will notify your office with a specific additional information letter requesting additional medical record information to be submitted to Highmark Wholecare within 15 days.

Medical Conditions:

- Diabetes
- Coronary Artery Disease or risk factors for the disease
- Cancer of the Face, Neck and Throat (does not include stage 0 or stage 1 non-invasive basal or sarcoma cell cancers of the skin)
- Intellectual Disability
- Current Pregnancy including post-partum period.
- Chemo and Radiation
- Immunocompromised
- HIV
- Transplant Recipient

Program Exception

Under extraordinary circumstances, Highmark Wholecare will pay for a medical service or item that is not one for which the MA Program has an established fee or will expand the limits for services or items that are listed on the MA Program Fee Schedule. If a provider concludes that lack of the service or item would impair the beneficiary's health, the provider may request an 1150 Administrative Waiver or Program Exception (PE).

Services and items not listed on the MA Program Fee Schedule require an 1150 Administrative Waiver. An 1150 Administrative Waiver is also required for the expansion of the limits for services and items that are listed on the MA Program Fee Schedule. The Program Exception request for dental services must be performed as part of a complete dental treatment program and must be accompanied by a detailed treatment plan.

The treatment plan must include all of the following:

- pertinent dental history;
- pertinent medical history, if applicable;
- the strategic importance of the tooth;
- the condition of the remaining teeth;
- the existence of all pathological conditions;
- preparatory services performed and completion date(s);
- documentation of all missing teeth in the mouth;
- the oral hygiene of the mouth;
- all proposed dental work;
- identification of existing crowns, periodontal services, etc.
- identification of the existence of full and/or partial denture(s), with the date of initial insertion;
- the periodontal condition of the teeth, including pocket depth, mobility, osseous level, vitality and prognosis; and
- identification of abutment teeth by number.

When an MA beneficiary has the need for a service(s) or item(s) requiring a 1150 Administrative Waiver, the dentist completes the 1150 Waiver section of the Outpatient Service Authorization Request (MA 97). The dentist submits the MA-97 form, all required radiographs and information to justify medical necessity for the services in an envelope large enough to accommodate all of the required documentation without folding to:

Highmark Wholecare Predeterminations
P.O. Box 2170
Milwaukee, PA 53201

All radiographs should be placed in the X-ray envelope (ENV 98) prior to mailing. Upon receipt of the required documentation, UCD will either approve or disapprove the request for a program exception. The dentist is notified of the approval or denial on the "Program Exception Notice" (MA 481). If the request is approved, the dentist may bill UCD after the service is rendered. The ADA Claim Form is completed in accordance with the instructions for completing claim forms in this handbook. The MA 97 is a snap set form. The original (UCD Copy) is to be submitted for processing, while the copy (Provider Copy) is to be retained in the beneficiary's dental record. Instructions for completing the form can also be found on the back of the MA 97 cover page. The form can be referenced on the DHS website.

- Item 1. Prior Authorization (LEAVE BLANK)
- Item 2. 1150 Waiver (Program Exception) (MUST) Place a checkmark in this block.

Hospitalization / Short Procedure Unit (SPU) Procedure

Authorization is required for dental procedures performed in a hospital setting. SPU requests are reviewed based on medical necessity. Dentists are required to administer services at a participating Highmark Wholecare hospital or affiliate. In certain instances, a non-participating facility maybe authorized if deemed medically necessary. Providers are instructed to contact United Concordia at (866) 568-5467 to learn of a hospital's participatory status.

Hospital authorization is facilitated through United Concordia Customer Service. The Customer Service representative acts as a liaison between Highmark Wholecare and the provider. The following procedures should be followed:

- Provider/Dental office completes authorization form and faxes to the attention of Highmark Wholecare Service Unit SPU Representative at (866) 241-6679; at least two weeks prior to the surgery date, when possible.
- The Highmark Wholecare Service Unit SPU Representative will fax the approved authorization form to the provider office.
- Providers must give the authorization form (number) to the facility in which the procedures will be performed in order to ensure proper reimbursement.
- Providers must make the Highmark Wholecare Service Unit SPU Representative aware of procedure dates changes as soon as possible to avoid delays in reimbursement.

For your convenience, a copy of the Highmark Wholecare Short Procedure Unit Form is located on the United Concordia Website.

Diagnostic Material Requirements

The following requirements are applicable to the provision of covered services to Highmark Wholecare members.

When covered, the procedures listed on the following chart require submission of diagnostic materials for review. Dentists are requested to submit diagnostic materials used for diagnosis and treatment planning.

All radiographs submitted (including copies) should be pre-treatment unless otherwise noted. They should be of diagnostic quality and mounted properly with the left and right sides clearly marked. They should be identified with the dentist's name and address, the patient's name and identification number and the date the radiographs were taken. (If a copy of the radiographs is submitted, left or right should be marked on the copy.)

If, for some reason, radiographs are not available, a brief explanation should be included on the claim form. If submitting claims electronically, please provide a brief explanation in the remarks field.

MINIMUM REQUIREMENTS FOR DIAGNOSTIC MATERIALS FOR MANUAL CLINICAL REVIEW

Chart Key: *Please refer to the below indicators within the chart to determine the appropriate documentation REQUIRED for review.*	
X	Required
A	A post-endodontic treatment, diagnostic x-ray ***IN ADDITION*** to a pre-treatment diagnostic x-ray of the tooth.
B	Pre-treatment, diagnostic x-ray(s) of the area of implant placement and the adjacent teeth is required. ***IN ADDITION*** to a pre-treatment diagnostic x-ray of the tooth.
C	X-ray(s) of all the teeth in the arch (Full Mouth Series or Panoramic) are required. ONLY for plans that apply an Alternate Benefit Provision (ABP) ***IN ADDITION*** to a pre-treatment diagnostic x-ray of the tooth.
D	Is ***ONLY*** required if reported with a service where deep sedation/general anesthesia, inhalation of nitrous oxide/analgesia, IV moderate (conscious) sedation/analgesia, or non-IV conscious sedation anesthesia may not be the typical standard of care and deep sedation/general anesthesia, inhalation of nitrous oxide/analgesia, IV moderate (conscious) sedation/analgesia, or non-IV conscious sedation is being recommended by the provider because of complex medical issues and/or treatment needs.

Diagnostic/ Pre-treatment x-ray

- Periapical (PA) and/or Bitewing (BW) x-ray(s) are preferred.
- A panoramic x-ray will be accepted in certain instances:
  - Panoramic x-ray(s) are of limited diagnostic specificity for review of any procedures outside of Implant Services (D6000-D6199), Oral Surgery (D7000-D7999) and Orthodontics (D8000-D8999). Panoramic x-rays are only preferred in addition to or instead of a periapical x-ray for review of certain Implant Services (D6000-D6199), Oral Surgery (D7000-D7999) and Orthodontic (D8000-D8999) codes.

Periodontal Charting

- Complete and legible 6-point Periodontal Charting of the tooth/teeth.

Written Documentation

- Chart/progress notes are preferred.
- If no chart/ progress notes are available, information in Box 35 of the ADA claim form/note field in an Electronic Data Interface submission, or a narrative are all accepted as forms of "written documentation".

Written documentation may be required when manual clinical review is necessary as part of benefit determination for any "by report" or "unspecified" dental service (D0160, D0321, D0502, D0999, D1999 D2999, D3999, D4999, D5899, D6090, D6095, D6999, D7291, D7950, D7995, D7999, D9930, D9999) and certain endodontic and surgical services.

DENTAL SERVICE	Diagnostic/ Pre-treatment	Periodontal Charting	Written Documentation

	x-ray		
Detailed and extensive oral evaluation – problem focused, by report (D0160)			X
Crown (D2710, D2721, D2740, D2751, D2791)	X		
Core buildup (D2950)	X		
Gingivectomy or gingivoplasty (D4210)	X	X	
Periodontal scaling and root planing (D4341, D4342)	X	X	
Complete Dentures (D5110-D5140)	C		X
Immediate Denture (D5130, D5140)	C		X
Partial Denture (D5211-5214)	C		X
Removal of Impacted Tooth (D7220-D7250)	X		X
Surgical access of an unerupted tooth (D7280)			X
Placement of device to facilitate eruption of impacted teeth (D7283)			X
Deep sedation/general anesthesia (D9222, D9223)			D
Inhalation of nitrous oxide/analgesia, anxiolysis (D9230)			D
Intravenous moderate (conscious) sedation/analgesia - first 15 minutes (D9239, D9243)			D
Non-intravenous conscious sedation (D9248)			D
Treatment of complications (post-surgical) - unusual circumstances, by report (D9930)			X
Custom sleep apnea appliance (D9947)			X

FOR ALL SERVICES:
Submission of additional x-rays (outside of required), written documentation (chart notes/narratives/periodontal charting/specialist letters/etc.) when not specifically required, photographs, and other diagnostic materials outside of required diagnostic materials listed is optional and should corroborate with evidence presented in required materials.

Children's Benefit Coverage - Benefits and Limitations

For a full listing of covered benefits and limitations, please reference the benefit grid on the United Concordia website. This plan is for recipients in Pennsylvania who are 20 and younger. There is no copayment or maximum for this plan.

Diagnostic Procedure Benefits and Limitations

- Periodic oral evaluations (D0120) are eligible once per 180 days.
- Limited oral evaluation (D0140) is eligible 1 per day.
- Oral evaluation (D0145) is covered 1 per 180 days under age 3.
- Comprehensive oral evaluations (D0150) are eligible 1 per patient, per dentist, per lifetime.
- Detailed and extensive oral evaluation (D0160) and re-evaluation-limited (D0170) are only eligible for cleft palate under the age of 21. Complete initial examination at Diagnostic Clinic only (cleft palate) involving all licensed staff (limit 1 per patient). This procedure code can only be billed by one member of the Cleft Palate Treatment Team and is inclusive of all providers.
- Screening of a patient (D0190) is eligible 1 per patient per year.
- Assessment of a patient (D0191) is eligible 1 per patient per year.
- A complete series of radiographs (D0210) is eligible one time in a 5-year period.
- One panoramic radiograph (D0330) is covered in a 5-year period.
- Cephalometric radiographic image (D0340) is payable for individuals under 21 years of age only.

Preventive Procedure Benefits and Limitations

- One routine prophylaxis (D1110 or D1120) is eligible per 180 days.
- Six topical fluoride varnish (D1206) is eligible per calendar year until the age of 21.
- One topical fluoride application (D1208) is eligible per 180 days until the age of 21.
- Nutritional counseling for control of dental disease (D1310) is eligible once per 180 days.
- Tobacco counseling for the control and prevention of oral disease (D1320) is eligible 70 times per calendar year per patient.
- Oral hygiene instructions (Procedure Code D1330) are eligible once per 180 days.
- Fixed unilateral space maintainers (D1510) are eligible one per quadrant on posterior primary teeth.
- Fixed bilateral space maintainers (D1516 and D1517) are eligible 1 per arch on posterior primary teeth. Passive appliances

designed to prevent tooth movement for posterior teeth only. A bilateral space maintainer must maintain spaces for permanent successors to prematurely lost posterior deciduous teeth occurring bilaterally in the maxillary or mandibular arch.

- Sealants (D1351) are to be considered for payment for 1st and 2nd permanent molars and bicuspids once these fully erupted for children under twenty-one (21) years of age, one per lifetime.

Restorative Procedure Benefits and Limitations

- Amalgam and Composite-Based Resin Restorations (D2140, D2150, D2160, D2161; D2330-D2335; D2391-D2394)
  - Resin (composite) restorations are covered when performed on anterior or posterior teeth. Two or more restorations on the same surface of a tooth are considered as one restoration.
  - The fees for restoration and filling include local anesthesia, polishing, bonding agents, cement bases, acid etch, light cured material and the necessary medications where indicated.
- Crowns (D2390; D2930-D2934; D2710, D2721, D2740, D2751, D2791)
  - Crowns (D2390; D2929– D2934) are payable for individuals under 21 years of age only.
  - Procedure codes D2390; D2930 - D2934 are crowns for primary or developing permanent teeth only and are not compensable with construction of a permanent crown.
  - Crowns and post and cores are payable only when necessary due to decay or tooth fracture. Individuals aged 21 and older are eligible for crowns under certain situations and criteria.
  - Procedure codes D2710, D2721, D2740, D2751 and D2791 are compensable only for fully developed permanent teeth and primary teeth with no permanent successors. Payment is not made for prefabricated and/or self-curing dental materials.
  - Crowns are indicated for teeth that cannot be restored using filling materials. Crowns should not be recommended for teeth that have poor prognosis (periodontally compromised, unrestorable, or have chronic infections). Crowns should be placed on decay-free tooth structure and have good marginal integrity.
  - Application of hydroxyapatite (D2991) is eligible 1 per tooth per lifetime.
- For individuals under age 21, crown coverage is limited to one crown per tooth, per five years. Procedure Code D2710; crown - resin-based composite (indirect) is limited to one crown per three years. Crowns are limited to one crown per tooth per time limitation, regardless of code.
- For an individual age 21 years of age and older residing in a nursing facility or in an intermediate care facility (ICF/MR) (ICF/ORC), crown coverage is limited to one crown per tooth for five years and is limited to four per calendar year with no more than two crowns per arch. Procedure Code D2710; crown - resin-based composite (indirect) is limited to one crown per three years.
- Individuals age 21 years of age and older, who do not reside in a nursing facility, or in an intermediate care facility (ICF/MR) (ICF/ORC), are eligible for crowns and adjunctive crown services (D2710, D2721, D2740, D2751, D2791, D2910, D2915, D2920, D2952, D2954, D2980) only if the health plan approves a dental Benefit Limit Exception request.

Endodontic Procedure Benefits and Limitations

- Root canals (D3310-D3330) are not covered in the following situations: Intentional (elective) endodontics, third molar (unless it is an abutment tooth), teeth with advanced periodontal disease, teeth with subosseous and/or furcation carious involvement, teeth which cannot be restored with conventional methods and teeth which have received prior endodontics treatment.
- Endodontic treatment should not be performed on teeth with a poor restorative or periodontal prognosis.
- Individuals age 21 years of age and older who do not reside in a nursing facility, or in an intermediate care facility (ICF/MR) (ICF/ORC), are eligible for root canals (D3310, D3320, D3330, D3410, D3421, D3425, D3426, D3471, D3472, D3473, D3501, D3502, D3503, D3921) only if the health plan approves a Dental Benefit Limit Exception request.

Periodontic Procedure Benefits and Limitations

- For individuals under age 21 and 21 years of age and older who reside in a nursing facility, or an intermediate care facility (ICF/MR) (ICF/ORC), gingivectomy or gingivoplasty is limited to no more than four different quadrant reimbursements within a 24-month period.
- For individuals under age 21 and 21 years of age and older who reside in a nursing facility, or an intermediate care facility (ICF/MR) (ICF/ORC), periodontal scaling and root planing is limited to no more than two different quadrants on a single date of service with no more than four different quadrant reimbursements within a 24-month period.
- For individuals under age 21 and 21 years of age and older who reside in a nursing facility, or an intermediate care facility (ICF/MR) (ICF/ORC), up to four periodontal maintenance procedures, or any combination of routine prophylaxes and periodontal maintenance procedures totaling four, may be paid within a consecutive 12-month period.
- Periodontal maintenance is generally covered when performed following active periodontal treatment.
- For individuals under age 21 and 21 years of age and older who reside in a nursing facility, or an intermediate care facility

(ICF/MR) (ICF/ORC), full mouth debridement to enable comprehensive evaluation and diagnosis is limited to one treatment per 365 days. Not compensable on same date as prophylaxis or other periodontal procedure.

- In cases of periodontal disease, a baseline periodontal evaluation should be recorded in the patient's chart, including the recording or 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.
- Individuals age 21 years of age and older who do not reside in a nursing facility, or in an intermediate care facility (ICF/MR) (ICF/ORC), are eligible for periodontal services (D4210, D4341, D4355, D4910), only if the health plan approves a dental Benefit Limit Exception request.
- Full mouth debridement (D4355) requires a post-operative review through the prior authorization program.

Prosthetic Procedure Benefits and Limitations

- For individuals under age 21, complete dentures are limited to 1 per denture arch per 5 years regardless of procedure codes. Prior authorizations are not required. When a request is within the frequency limitation timeframe, it is reviewed, and a determination is made based on medical necessity.
- For individuals under age 21, partial dentures are limited to 1 per arch every 5 years regardless of procedure code. Prior authorizations are not required. Denture requests are reviewed for frequency limitations only.
- Replacement of removable prostheses (Procedure Codes D5110 – D5214) is covered only if the existing removable prostheses were inserted within the specified time limitation prior to the replacement and satisfactory evidence is presented that the existing removable prostheses cannot be made serviceable.
- 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 dentures 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.
- The fees for dentures and partial dentures include all necessary adjustments and/or denture relines during the six-month period following insertion of the denture.
- Individuals aged 21 years of age and older – relining of dentures is limited to one per arch, regardless of procedure code, every two years, for either full or partial dentures.
- A chair side reline – includes the use of light cured, self-curing and/or cold cure material in which the reline material is utilized as the impression material.
- Laboratory reline – includes the use of an impression material technique from which a model is poured, mounted and upon which the reline material is cured. The reline material is not utilized as the impression material.
- The use of tissue conditioners and temporary liners is not compensable.
- For individuals aged 21 years of age and older residing in a nursing facility or in an intermediate care facility (ICF/MR) (ICF/ORC), complete dentures are limited to one per arch, regardless of procedure code, every five years.
- For individuals age 21 years of age and older residing in a nursing facility or in an intermediate care facility (ICF/MR) (ICF/ORC), partial dentures must include one anterior tooth and/or three posterior teeth (excluding third molars) on the denture all of which must be anatomically correct (natural size, shape and color) to be compensable; limited to one per arch, regardless of procedure code, every five years. Prior authorizations are not required. Denture requests are reviewed for frequency limitations only.
- Individuals age 21 years of age and older who do not reside in a nursing facility, or in an intermediate care facility (ICF/MR) (ICF/ORC), are limited to one (full or partial denture) per upper arch, regardless of procedure (D5110, D5130, D5211, D5213) and one (full or partial denture) per lower arch, regardless of procedure code (D5120, D5140, D5212, D5214) per lifetime. The health plan will review claims payment history for dates of service on and after March 1, 2004, to determine if the recipient previously received a denture for the arch. Partial dentures must include one anterior tooth and/or three posterior teeth (excluding third molars) on the denture. All must be anatomically correct (natural size, shape and color) to be compensable. Prior authorizations are not required. Denture requests are reviewed for frequency limitations only. Additional dentures require a Benefit Limit Exception request.
- Replace missing or broken teeth (D5520) is limited to 3 teeth.
- Replace broken teeth (D5640) is limited to 3 teeth.

Oral Surgery Procedure Benefits and Limitations

- An assistant surgeon should bill using Procedure Code D7999. The procedure code indicating the actual surgery performed must be entered in the "Remarks" section of the claim form.
- 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 Pennsylvania dental board permit holder.

- Alveoloplasty (D7310 and D7320) bill per quadrant with one quadrant equal to 4 or more teeth.
- Tooth reimplantation and/or stabilization (D7270) is payable for individuals under 21 years of age only.

Orthodontic Procedure Benefits and Limitations

- Comprehensive Orthodontic Treatment of the Adolescent Dentition (D8080) is allowed once per lifetime under 21 years of age. This service requires prior authorization.
- Appliance Therapy (D8210 and D8220) is allowed 1 per lifetime per arch, under 21 years of age.
- Pre-orthodontic treatment (D8660) is allowed 1 per year per provider under 21 years of age.
- Periodic Orthodontic Treatment (D8670) is allowed 24 per lifetime, under age 23.
- Orthodontic Retention (D8680) is allowed 1 per lifetime, under age 23.
- Replacement of lost or broken retainer (D8703 – D8704) 1 per day under age 23.

Adjunctive General Procedure Benefits and Limitations

- Procedure Codes (D9222, D9223, D9230, D9243 and D9248) administered by a dentist or a Certified Registered Nurse Anesthetist (CRNA) under the supervision of a dentist in an office or dental clinic setting require a prior authorization with the submission of a narrative.
- Dentists are not eligible for payment of anesthesia/sedation services when performed in a Short Procedure Unit (SPU), hospital emergency room, inpatient or Ambulatory Surgical Center (ASC).
- Procedure Codes (D9222, D9223, D9230, D9243and D9248) administered by an anesthesiologist or a CRNA under the supervision of an anesthesiologist in any setting should be submitted to Highmark Wholecare on a CMS 1500 form to the following address for processing:

  Highmark Wholecare
  PO Box 69360
  Harrisburg, PA 17106-9360
- Procedure Codes (D9223, D9230, D9243 and D9248) are covered procedures when prior authorized and when performed in conjunction with a compensable surgical procedure. Procedure Code (D9230) is only compensable for eligible individuals under 21 years of age.
- Procedure Code (D9230 and D9248) are compensable in conjunction with the dental treatment of the mentally, physically or medically compromised individual or those whose psychological or emotional maturity limit the ability to undergo successful dental treatment.
- Payment for any one of the following procedure codes: (D9222, D9223, D9243, D9248 and D9920) precludes payment for any of the remaining codes on the same date of service.
- The person responsible for the administration of the Deep Sedation/General Anesthesia, Analgesia, Anxiolysis, Inhalation of Nitrous Oxide, Intravenous Conscious Sedation and Non-intravenous Sedation must be in compliance with all rules, regulations, certifications and licensure by the Pennsylvania State Board of Dentistry. A copy of the anesthesia permit must be submitted to the Department upon renewal.
- Behavior management by report (Procedure Code D9920) is eligible four (4) times per calendar year. However, additional limitations imposed under the MA FFS program require the patient have a developmental disability with onset prior to 18 as a qualification for eligibility.
- 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. Calling in a prescription is not a procedure for palliative treatment. Palliative treatment is a procedure performed to ameliorate pain during an office visit.

Please refer to the Dental MA Fee Schedule for tobacco cessation treatment benefits. In addition, refer to the Highmark Wholecare website (Highmark Wholecare) for additional information on tobacco cessation.

Adult Medicaid Benefit Coverage – Benefits and Limitations

For a full listing of covered benefits and limitations, please reference the benefit grid on the United Concordia website. This plan is for recipients in Pennsylvania who are 21 and older. There is no copayment or maximum for this plan.

Diagnostic Procedure Benefits and Limitations

- Periodic oral evaluations (D0120) are eligible once per 180 days.
- Limited oral evaluation (D0140) is eligible 1 per day.
- Comprehensive oral evaluations (D0150) are eligible 1 per patient, per dentist, per lifetime.
- Detailed and extensive oral evaluation (D0160) and re-evaluation-limited (D0170) are only eligible for cleft palate under the

age of 21. Complete initial examination at Diagnostic Clinic only (cleft palate) involving all licensed staff (limit 1 per patient). This procedure code can only be billed by one member of the Cleft Palate Treatment Team and is inclusive of all providers.

- Screening of a patient (D0190) is eligible 1 per patient per year.
- Assessment of a patient (D0191) is eligible 1 per patient per year.
- A complete series of radiographs (D0210) is eligible one time in a 5-year period.
- One panoramic radiograph (D0330) is covered in a 5-year period.
- Cephalometric radiographic image (D0340) is payable for individuals under 21 years of age only.

Preventive Procedure Benefits and Limitations

- One routine prophylaxis (D1110 or D1120) is eligible per 180 days.
- Six topical fluoride varnish (D1206) is eligible per calendar year until the age of 21.
- One topical fluoride application (D1208) is eligible per 180 days until the age of 21.
- Nutritional counseling for control of dental disease (D1310) is eligible once per 180 days.
- Tobacco counseling for the control and prevention of oral disease (D1320) is eligible 70 times per calendar year per patient.
- Oral hygiene instructions (Procedure Code D1330) are eligible once per 180 days.
- Fixed unilateral space maintainers (D1510) are eligible one per quadrant on posterior primary teeth.
- Fixed bilateral space maintainers (D1516 and D1517) are eligible 1 per arch on posterior primary teeth. Passive appliances designed to prevent tooth movement for posterior teeth only. A bilateral space maintainer must maintain spaces for permanent successors to prematurely lost posterior deciduous teeth occurring bilaterally in the maxillary or mandibular arch.
- Sealants (D1351) are to be considered for payment for 1st and 2nd permanent molars and bicuspids once these fully erupted for children under twenty-one (21) years of age, one per lifetime.

Restorative Procedure Benefits and Limitations

- Amalgam and Composite-Based Resin Restorations (D2140, D2150, D2160, D2161; D2330-D2335; D2391-D2394)
  - Resin (composite) restorations are covered when performed on anterior or posterior teeth. Two or more restorations on the same surface of a tooth are considered as one restoration.
  - The fees for restoration and filling include local anesthesia, polishing, bonding agents, cement bases, acid etch, light cured material and the necessary medications where indicated.
- Crowns (D2390; D2930-D2934; D2710, D2721, D2740, D2751, D2791)
  - Crowns (D2390; D2929– D2934) are payable for individuals under 21 years of age only.
  - Procedure codes D2390; D2930 - D2934 are crowns for primary or developing permanent teeth only and are not compensable with construction of a permanent crown.
  - Crowns and post and cores are payable only when necessary due to decay or tooth fracture. Individuals aged 21 and older are eligible for crowns under certain situations and criteria.
  - Procedure codes D2710, D2721, D2740, D2751 and D2791 are compensable only for fully developed permanent teeth and primary teeth with no permanent successors. Payment is not made for prefabricated and/or self-curing dental materials.
  - Crowns are indicated for teeth that cannot be restored using filling materials. Crowns should not be recommended for teeth that have poor prognosis (periodontally compromised, unrestorable, or have chronic infections). Crowns should be placed on decay-free tooth structure and have good marginal integrity.
- Application of hydroxyapatite (D2991) is eligible 1 per tooth per lifetime.
- For individuals under age 21, crown coverage is limited to one crown per tooth, per five years. Procedure Code D2710; crown - resin-based composite (indirect) is limited to one crown per three years. Crowns are limited to one crown per tooth per time limitation, regardless of code.
- For an individual age 21 years of age and older residing in a nursing facility or in an intermediate care facility (ICF/MR) (ICF/ORC), crown coverage is limited to one crown per tooth for five years and is limited to four per calendar year with no more than two crowns per arch. Procedure Code D2710; crown - resin-based composite (indirect) is limited to one crown per three years.
- Individuals age 21 years of age and older, who do not reside in a nursing facility, or in an intermediate care facility (ICF/MR) (ICF/ORC), are eligible for crowns and adjunctive crown services (D2710, D2721, D2740, D2751, D2791, D2952, D2954,) only if the health plan approves a dental Benefit Limit Exception request.

Endodontic Procedure Benefits and Limitations

- Root canals (D3310-D3330) are not covered in the following situations: Intentional (elective) endodontics, third molar (unless it is an abutment tooth), teeth with advanced periodontal disease, teeth with subosseous and/or furcation carious involvement, teeth which cannot be restored with conventional methods and teeth which have received prior endodontics treatment.

- Endodontic treatment should not be performed on teeth with a poor restorative or periodontal prognosis.
- Individuals age 21 years of age and older who do not reside in a nursing facility, or in an intermediate care facility (ICF/MR) (ICF/ORC), are eligible for root canals (D3310, D3320, D3330, D3410, D3421, D3425, D3426), only if the health plan approves a Dental Benefit Limit Exception request.

Periodontic Procedure Benefits and Limitations

- For individuals under age 21 and 21 years of age and older who reside in a nursing facility, or an intermediate care facility (ICF/MR) (ICF/ORC), gingivectomy or gingivoplasty is limited to no more than four different quadrant reimbursements within a 24-month period.
- For individuals under age 21 and 21 years of age and older who reside in a nursing facility, or an intermediate care facility (ICF/MR) (ICF/ORC), periodontal scaling and root planing is limited to no more than two different quadrants on a single date of service with no more than four different quadrant reimbursements within a 24-month period.
- For individuals under age 21 and 21 years of age and older who reside in a nursing facility, or an intermediate care facility (ICF/MR) (ICF/ORC), up to four periodontal maintenance procedures, or any combination of routine prophylaxes and periodontal maintenance procedures totaling four, may be paid within a consecutive 12-month period.
- Periodontal maintenance is generally covered when performed following active periodontal treatment.
- For individuals under age 21 and 21 years of age and older who reside in a nursing facility, or an intermediate care facility (ICF/MR) (ICF/ORC), full mouth debridement to enable comprehensive evaluation and diagnosis is limited to one treatment per 365 days. Not compensable on same date as prophylaxis or other periodontal procedure.
- In cases of periodontal disease, a baseline periodontal evaluation should be recorded in the patient's chart, including the recording or 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.
- Individuals age 21 years of age and older who do not reside in a nursing facility, or in an intermediate care facility (ICF/MR) (ICF/ORC), are eligible for periodontal services (D4210, D4341, D4355, D4910), only if the health plan approves a dental Benefit Limit Exception request.
- Full mouth debridement (D4355) requires a post-operative review through the prior authorization program.

Prosthetic Procedure Benefits and Limitations

- For individuals under age 21, complete dentures are limited to 1 per denture arch per 5 years regardless of procedure codes. Prior authorizations are not required. When a request is within the frequency limitation timeframe, it is reviewed, and a determination is made based on medical necessity.
- For individuals under age 21, partial dentures are limited to 1 per arch every 5 years regardless of procedure code. Prior authorizations are not required. Denture requests are reviewed for frequency limitations only.
- Replacement of removable prostheses (Procedure Codes D5110 – D5214) is covered only if the existing removable prostheses were inserted within the specified time limitation prior to the replacement and satisfactory evidence is presented that the existing removable prostheses cannot be made serviceable.
- 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 dentures 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.
- The fees for dentures and partial dentures include all necessary adjustments and/or denture relines during the six-month period following insertion of the denture.
- Individuals aged 21 years of age and older – relining of dentures is limited to one per arch, regardless of procedure code, every two years, for either full or partial dentures.
- A chair side reline – includes the use of light cured, self-curing and/or cold cure material in which the reline material is utilized as the impression material.
- Laboratory reline – includes the use of an impression material technique from which a model is poured, mounted and upon which the reline material is cured. The reline material is not utilized as the impression material.
- The use of tissue conditioners and temporary liners is not compensable.
- For individuals aged 21 years of age and older residing in a nursing facility or in an intermediate care facility (ICF/MR) (ICF/ORC), complete dentures are limited to one per arch, regardless of procedure code, every five years.
- For individuals age 21 years of age and older residing in a nursing facility or in an intermediate care facility (ICF/MR) (ICF/ORC), partial dentures must include one anterior tooth and/or three posterior teeth (excluding third molars) on the denture all of which must be anatomically correct (natural size, shape and color) to be compensable; limited to one per arch,

regardless of procedure code, every five years. Prior authorizations are not required. Denture requests are reviewed for frequency limitations only.

- Individuals age 21 years of age and older who do not reside in a nursing facility, or in an intermediate care facility (ICF/MR) (ICF/ORC), are limited to one (full or partial denture) per upper arch, regardless of procedure (D5110, D5130, D5211, D5213) and one (full or partial denture) per lower arch, regardless of procedure code (D5120, D5140, D5212, D5214) per lifetime. The health plan will review claims payment history for dates of service on and after March 1, 2004, to determine if the recipient previously received a denture for the arch. Partial dentures must include one anterior tooth and/or three posterior teeth (excluding third molars) on the denture. All must be anatomically correct (natural size, shape and color) to be compensable. Prior authorizations are not required. Denture requests are reviewed for frequency limitations only. Additional dentures require a Benefit Limit Exception request.
- Replace missing or broken teeth (D5520) is limited to 3 teeth.
- Replace broken teeth (D5640) is limited to 3 teeth.

Oral Surgery Procedure Benefits and Limitations

- An assistant surgeon should bill using Procedure Code D7999. The procedure code indicating the actual surgery performed must be entered in the "Remarks" section of the claim form.
- 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 Pennsylvania dental board permit holder.
- Alveoloplasty (D7310 and D7320) bill per quadrant with one quadrant equal to 4 or more teeth.
- Tooth reimplantation and/or stabilization (D7270) is payable for individuals under 21 years of age only.

Adjunctive General Procedure Benefits and Limitations

- Procedure Codes (D9222, D9223, D9230, D9243 and D9248) administered by a dentist or a Certified Registered Nurse Anesthetist (CRNA) under the supervision of a dentist in an office or dental clinic setting require a prior authorization with the submission of a narrative.
- Dentists are not eligible for payment of anesthesia/sedation services when performed in a Short Procedure Unit (SPU), hospital emergency room, inpatient or Ambulatory Surgical Center (ASC).
- Procedure Codes (D9222, D9223, D9230, D9243and D9248) administered by an anesthesiologist or a CRNA under the supervision of an anesthesiologist in any setting should be submitted to Highmark Wholecare on a CMS 1500 form to the following address for processing:

  Highmark Wholecare
  PO Box 69360
  Harrisburg, PA 17106-9360
- Procedure Codes (D9223, D9230, D9243 and D9248) are covered procedures when prior authorized and when performed in conjunction with a compensable surgical procedure. Procedure Code (D9230) is only compensable for eligible individuals under 21 years of age.
- Procedure Code (D9230 and D9248) are compensable in conjunction with the dental treatment of the mentally, physically or medically compromised individual or those whose psychological or emotional maturity limit the ability to undergo successful dental treatment.
- Payment for any one of the following procedure codes: (D9222, D9223, D9243, D9248 and D9920) precludes payment for any of the remaining codes on the same date of service.
- The person responsible for the administration of the Deep Sedation/General Anesthesia, Analgesia, Anxiolysis, Inhalation of Nitrous Oxide, Intravenous Conscious Sedation and Non-intravenous Sedation must be in compliance with all rules, regulations, certifications and licensure by the Pennsylvania State Board of Dentistry. A copy of the anesthesia permit must be submitted to the Department upon renewal.
- Behavior management by report (Procedure Code D9920) is eligible four (4) times per calendar year. However, additional limitations imposed under the MA FFS program require the patient have a developmental disability with onset prior to 18 as a qualification for eligibility.
- 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. Calling in a prescription is not a procedure for palliative treatment. Palliative treatment is a procedure performed to ameliorate pain during an office visit.

Please refer to the Dental MA Fee Schedule for tobacco cessation treatment benefits. In addition, refer to the Highmark Wholecare website (Highmark Wholecare) for additional information on tobacco cessation.

Orthodontic Services

***Please note that Medical Assistance requires Ortho to be medically necessary.**

Highmark Wholecare covers orthodontic treatment when all the following conditions exist:

- The determination of Handicapping Malocclusion results from either a qualifying score of 25 or above on the Salzmann Index Evaluation or the demonstration of case symptoms by the submitted documentation that indicates medical necessity treatment for Handicapping Malocclusion in the opinion of the professional reviewer.
- The orthodontic treatment involves appliance therapy.
- The recipient has a fully erupted set of permanent teeth.
- The recipient is 20 years of age or younger except, if the recipient is 21 years of age or older but was receiving orthodontic services through the Medical Assistance Program when the recipient turned 21 years of age.

It is important that you review the Orthodontic Benefits prior to billing for orthodontic services. Understanding this information will help ensure timely and accurate payment for your orthodontic services. Orthodontic treatment must be performed by a Board Certified, Board Eligible or Board Educated Orthodontist. 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 not receive payment for the final period of eligibility.

Orthodontic Procedure Benefits and Limitations

- Orthodontic treatment must be performed by a Board Certified, Board Eligible or Board Educated Orthodontist.
- Retainers are considered part of comprehensive treatment and may not be billed separately. Retainer maintenance visits are part of comprehensive orthodontic treatment.
- Replacement of lost or broken retainers are eligible 1 appliance per arch per lifetime.
- 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 not receive payment for the final period of eligibility.

Payment Orthodontic Services

Payments for Orthodontic Services are generally issued as follows:

- Total orthodontic case rate pays at $3,500.12.
- Twenty-five (25) percent of the total amount payable will be paid upon placement of the bands or appliance as the initial payment. Note: All orthodontic services must have a prior authorization approval accompanying the filed claim.
- The remaining seventy-five (75) percent, including the pre-orthodontic care, is paid in equal monthly payments, and one final payment based on the estimated length of the treatment and the patient's benefits.
- The Highmark Wholecare member must be enrolled with Highmark Wholecare during each month that payment is made.
- Monthly payments are NOT automatically processed. It is necessary to submit claims for monthly payments.

The Highmark Wholecare member must be enrolled on the date of banding or appliance placement to receive payment for these services. If the patient is enrolled after appliance placement, they may be eligible to receive monthly payments for treatment "in progress."

As soon as the patient becomes eligible for Highmark Wholecare orthodontic benefits, you should submit an authorization request for the orthodontic treatment "in progress." ***Be sure to include procedure code D8999 to indicate a continuity of care case, the diagnosis, the original approved prior authorization, treatment plan, total fee, amount paid to date on the orthodontic treatment by the prior dental carrier, banding or appliance date and estimated total duration of treatment on the claim (D8670 and total quantity remaining).*** A treatment plan will be created by calculating the amount the plan will cover for the remaining treatment in monthly payments. The Dental Explanation of Benefits (DEOB) indicates the amount the plan will cover for the remainder of the **"in progress"** treatment.

Transferring from another Dentist

If the patient transfers to a different dentist, the new dentist must submit a claim indicating the total remaining months of treatment, total fee, and the banding date if the patient was rebanded. Payment for services provided by the new dentist will be calculated based on the remaining orthodontic benefits and remaining length of treatment.

Please remember:

- It is the **dentist's responsibility** to notify United Concordia's Customer Service at (866) 568-5467 if orthodontic treatment is discontinued, completed sooner than anticipated, or if the patient transfers to another dentist.
- If you are rebanding the transfer patient, please indicate that the patient was rebanded and the rebanding date.
- If the patient was not rebanded, please indicate the date the new dentist assumed responsibility for the treatment plan.
- The office will be contacted by telephone for any missing information. The development may create a delay in

the processing of the orthodontic claim.

Billing Orthodontic Services

The following instructions and sample forms will help you in preparing orthodontic claims and understanding payment for orthodontic services.

Billing For New Orthodontic Patients

Please submit a complete treatment plan for all Highmark Wholecare members beginning orthodontic treatment. You must use the ADA claim form. Always print or type the necessary information when using a paper claim form. Clear, concise reporting on the claim will help avoid any misinterpretation of the information. Incorrect information may result in incorrect payment or claim denials. Since missing information may delay the processing of your claim, be certain no information is omitted.

How to Complete a Dental Claim Form for New Orthodontic Patients

Please adhere to the following guideline when completing a Dental Claim form:

- Use a separate line for each service being provided and billed.
- D8080 and D8670 must be included with quantity and cost on the claim for authorization.
- Enter the five-digit alpha-numeric procedure code for each service.
- Include a completed Salzmann Index.
- Include a Cephalometric radiographic image.
- Include images of study models.
- Include a panoramic radiograph.
- List diagnostic services using a separate line for each procedure. Enter the description of the service, date of service (if not prior authorizing), procedure code number, and fee charged. Use the amounts paid column, only if the subscriber has paid the dentist directly, and indicate the amount paid.
- List the total treatment plan as indicated by the appropriate procedure code. Report the total case fee, excluding diagnostic services. This fee should include retention and case finishing procedures that should not be reported or billed separately.
- Report the anticipated length of active treatment in months as well as the initial banding date if applicable. For reporting purposes, the length of estimated treatment should include the month the patient was banded.

Billing for a New Patient in Progress

The following instructions are applicable to new patients who have not had previous dental coverage, who had orthodontic treatment initiated prior to becoming eligible for orthodontics and it was not paid by another carrier. Please prepare a complete treatment plan following the same guidelines specified for new patients, except for the following:

- Do not list any services rendered before the patient became eligible. This will usually include diagnostics. A banding date will be required to determine the number of months prior to coverage.
- Submit a copy of the approved prior authorization for the orthodontic treatment plan. On the claim form, list the following information:
- Starting date of treatment (banding date).
- The total treatment plan as indicated by the appropriate procedure code. On this line also include total case fee, excluding diagnostics. This fee includes retention and case finishing procedures that should not be listed or billed separately.
- Total length of treatment in months.

Orthodontic Inquiries

Should you have any questions regarding the determination of payment to you, please contact Government Business Operations at (866) 568-5467. To request a Salzman Index Form, please visit the United Concordia website.

PHDHP Benefits and Limitations

- A complete series of radiographs (D0210) is eligible one time in a five- y e a r period.
- One panoramic radiograph (D0330) is covered in a five (5) year period.
- Intraoral tomosynthesis (D0372-D0374) is covered.
- One routine prophylaxis (D1110 or D1120) is eligible per 180 days.
- Six topical fluoride varnish (D1206) is eligible per calendar year until the age of 21.
- One topical fluoride application (D1208) is eligible per 180 days until the age of 21.
- Nutritional counseling (D1310) and oral hygiene instructions (D1330) are covered 1 per 180 days.
- Sealants (D1351) to be considered for payment for first and second permanent molars.

and bicuspids once these have fully erupted for children under twenty-one (21) years of age, one per lifetime.

- For individuals under age 21 and 21 years of age and older who reside in a nursing facility, or an intermediate care facility (ICF/MR) (ICF/ORC), periodontal scaling and root planning (D4341 – D4342) is limited to no more than two different quadrants on a single date of service with no more than four different quadrant reimbursements within a 24-month period. For individuals under age 21 and 21 years of age and older who reside in a nursing facility, or an intermediate care facility (ICF/MR) (ICF/ORC), up to four periodontal maintenance procedures, or any combination of routine prophylaxes and periodontal maintenance procedures totaling four, may be paid within a consecutive 12-month period.
- Periodontal maintenance (D4910) is generally covered when performed following active periodontal treatment.
- For individuals under age 21 and 21 years of age and older who reside in a nursing facility, or an intermediate care facility (ICF/MR) (ICF/ORC), full mouth debridement (D4355) to enable comprehensive evaluation and diagnosis is limited to one treatment per 365 days. Not compensable on same date as prophylaxis or other periodontal procedure.
- In cases of periodontal disease, a baseline periodontal evaluation should be recorded in the patient's chart, including the recording or 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.

Highmark Health Options Delaware Medicaid

Highmark Health Options Delaware offers members aged 21 and older, an Adult Benefit package with a $1,000 maximum and an Adult Emergency Dental Benefit package that allows the members an extra $1,500 dollars to use towards emergency dental care. This plan also offers a full benefit package for Children's Medicaid for all members 20 years and younger and HHO offers the Delaware Healthy Children Program (DHCP) for uninsured members 18 years and younger (effective 01/01/2025). As in most dental programs, limitation and exclusions are placed on member benefits.

The policies and limitations listed within this section will be used to administer dental benefits for Highmark Health Options Medicaid members. They reflect current and acceptable practices within the dental community while ensuring that cost-effective measures are applied according to the dental contract. Please refer to the following for additional information: Division of Medicaid & Medical Assistance - Delaware

This section applies only to Dental Providers and Physicians.

Benefits and Exclusions – General Policies

All covered services are subject to the following general policies:

- All dental procedures are considered to be outpatient procedures. These procedures are not compensable on an inpatient basis unless there is medical justification which is documented in the patient's medical record.
- Dentist and Physician are the only provider types eligible to receive payment for dental services.
- Dentist who is a board certified or board eligible orthodontist is the only provider type eligible for payment of orthodontic service.

Copayment

Effective 12/01/2024, all Adult Dental Medicaid members will have a $3 copay for each visit. The children's Medicaid plan does not have a copayment. In accordance with 42 CFR 447.52(e), participating providers cannot refuse to provide dental services when a member is unable to pay the applicable copayment amount at the time of service.

Balance Billing

Providers may not balance bill members for the difference between the provider's charge and the allowed amount. If a member needs or desires services that are not covered under their Medicaid dental benefits, they do have the option to pay out of pocket; however, prior to the provision of services, the provider must document that the member understands that the services are either not a covered benefit as defined by the State, are not medically necessary, or could deny on frequency limitations, and therefore will not be reimbursed by their Medicaid plan. This documentation must include a written itemized cost estimate for the services, and the member will need to sign and date the estimate showing that they have been informed and agree to be financially responsible. Our My Patients' Benefits (ref. page 96 of the Dental Reference Guide) web portal allows access to your patient's eligibility benefits, claim status, maximums/deductibles, procedure history to assist with determining payment eligibility for codes with frequency limitations, procedure code information, orthodontic information, as well as State fee schedule information. You also have the ability to call our Provider Service Department to obtain this information.

Prompt Payment

Dentist agrees to report all covered services for eligible members on a timely basis following the date the services were rendered using an ADA claim form or other form acceptable to United Concordia. Payment for Clean Claims for which periodic interim payments are not made and that are submitted by Dentist on behalf of D-SNP members shall be issued, mailed or otherwise transmitted to Dentist

within thirty (30) days of receipt. If payment is not issued, mailed or otherwise transmitted to Dentist within thirty (30) days of receipt of the Clean Claim, interest shall be paid for the period beginning on the day after the required payment date and ending on the date on which payment is made. Interest is paid at the rate used for Title 31 U.S. Code §3902(a) and is determined by the applicable rate on the day of payment. Interest rates are set by the U.S. Treasury Department on a 6-month basis, effective every January 1 and July 1 and are published at http://fms.treas.gov/prompt/rates.htm. For the purposes of this section, "Clean Claim" means a claim that has no defect or impropriety (including any lack of any required substantiating documentation) or particular circumstance requiring special treatment that prevents timely payment from being made on the claim.

Physician Incentive Disclosure

Dentist agrees to furnish United Concordia or MCOs, as United Concordia shall direct, with any information necessary for Medicare Advantage Organization's (MAO) to meet physician incentive disclosure obligations under 42 CFR §422.210.

Compliance with Medicare Advantage Organization (MAO) Contract

Dentist agrees to comply with MCOs' policies and procedures, including any reporting obligations required by CMS, in performing his/her responsibilities under the Agreement. Dentist agrees to provide United Concordia all information necessary for MCOs to meet data reporting and submission obligations to CMS and data necessary for the MCOs to meet reporting requirements under 42 CFR §422.516 and §422.310.

Children's Medicaid Benefit Coverage - Benefits and Limitations

For a full listing of covered benefits and limitations, please reference the benefit grid on the United Concordia website. This plan is for recipients in Delaware who are 20 and younger. There is no copayment or maximum for this plan.

Diagnostic Procedure Benefits and Limitations

- Periodic oral evaluations (D0120) are eligible 1 per 180 days.
- Limited oral evaluation (D0140) is not to be billed with other exams.
- Oral evaluation and counseling (D0145) are eligible 1 per 180 days under age 3.
- Comprehensive oral evaluations (D0150) are eligible 1 in 2 years, per provider.
- Extensive oral evaluation (D0160) is covered.
- Re-evaluation-limited (D0170) must include narrative on claim.
- Periodontal Evaluation (D0180) are eligible 1 per 2 years, age 14-20 only.
- Screening of a patient (D0190) is eligible for patients under age 21. Code limited to Division of Public Health (DPH) contracted providers only.
- Assessment of a patient (D0191) is eligible for patients under age 21. Code limited to Division of Public Health (DPH) contracted providers only.
- Complete series of radiographs (D0210) is eligible 1 time in a 3-year period.
- Panoramic radiograph (Procedure Code D0330) is covered 1 in a 3-year period, age 5-20 only.
- Bitewing x-rays (D0270-D0277) are covered 4 bitewings in a 6-month period. D0277 cannot be billed with D0210 or another bitewing code.
- Periapical x-rays are eligible. D0220 is covered 15 per year, D0240 is eligible 2 per day.

Preventive Procedure Benefits and Limitations

- Routine prophylaxis (D1110 or D1120) is eligible 1 per 180 days.
- Topical fluoride varnish (D1206) is eligible 1 per 180 days under the age of 21.
- Topical fluoride application (D1208) is eligible 1 per 180 days under the age of 21.
- Sealants (D1351) are to be considered for payment for ages 2-6 on primary molars only, ages 5-15 on permanent molars and premolars only, and ages 5-16 are allowed on tooth numbers 1, 16, 17, and 32. Sealants are limited to 8 sealants in a 12-month period and only eligible on the same tooth 1 in a 5 years period.
- Interim Caries Arresting Medication (D1354) is eligible 1 per 180 days, 2 times per tooth.
- Fixed unilateral space maintainers (D1510) is eligible ages 2-9. Quadrants must be billed.

Restorative Procedure Benefits and Limitations

- Amalgam and Composite-Based Resin Restorations (D2140, D2150, D2160, D2161; D2330-D2335; D2391-D2394)
  - Resin (composite) restorations are covered when performed on anterior or posterior teeth. Two or more restorations on the same surface of a tooth are considered as one restoration.
  - The fees for restoration and filling include local anesthesia, polishing, bonding agents, cement bases, acid etch, light cured material and the necessary medications where indicated.
- Crowns (D2390; D2710, D2721, D2740, D2751, D7252, D2791, D2792, D2799, D2920; D2930-D2957)

- Crowns (Procedure Codes D2390; D2929– D2934) are payable for individuals under 21 years of age only.
- Procedure codes D2929 and D2930 are crowns for primary or developing permanent teeth only and are not compensable with construction of a permanent crown. D2929 is only limited to tooth numbers C, D, E, F, G, H, M, N, O, P, Q, R and only allowed 1 per tooth per lifetime. D2930 is eligible 1 per 5 years. (*check the members benefit plan to ensure age-appropriate coverage for the benefit prior to rendering care*)
- Crowns and post and cores are payable only when necessary due to decay or tooth fracture.
- Crowns are indicated for teeth that cannot be restored using filling materials. Crowns should not be recommended for teeth that have poor prognosis (periodontally compromised, unrestorable, or have chronic infections). Crowns should be placed on decay-free tooth structure and have good marginal integrity.

Endodontic Procedure Benefits and Limitations

- Pulp Cap (D3110-D3120) are eligible once per lifetime per tooth (primary and permanent)
- Pulpotomy (D3220) for ages 1-10 only.
- Pulpal Procedures (D3221 and D3222) for ages 6-20 only and are not billable same day as Endodontic therapy. D3230 for ages 2-6 only and is not billable same day as Endodontic therapy. D3240 for ages 2-9 only and is not billable same day as Endodontic therapy.
- Root canals (D3310-D3330) are not covered in the following situations: Intentional (elective) endodontics, third molar (unless it is an abutment tooth), teeth with advanced periodontal disease, teeth with subosseous and/or furcation carious involvement, teeth which cannot be restored with conventional methods and teeth which have received prior endodontics treatment.
- Retreatments (D3346-D3348) are covered benefits.
- Apicoectomy (D3410-D3430) are covered but only billable by oral surgeons or endodontists; ages 9-20 only.
- Endodontic treatment should not be performed on teeth with a poor restorative or periodontal prognosis.

Periodontic Procedure Benefits and Limitations

- Gingivectomy (D4210-D4212) are eligible for members ages 13-20 only and require a preauthorization.
- Osseous surgery (D4260-D4261, D4263-D4264, D4265-D4267) are eligible for members ages 15-20 and require a preauthorization.
- Tissue grafts (D4270-D4276) are eligible for ages 8-20 and require a preauthorization.
- Splints (D4322-D4323) are eligible for ages 13-20.
- Scaling and root planning (D4341-D4342) are eligible for ages 14-20 and are allowed 1 per 2 years. Maximum of 2 quadrants billed in 1 day. D4342 is not billable with D4355.
- Full mouth debridement (D4355) is eligible 1 per 3 years and cannot be billed with D1110, D4341-D4342. Only eligible for ages 14-20.
- Periodontal maintenance (D4910) is eligible for ages 14-20 and is allowed 1 time in 3 months. This can alternate with D1110.

Removable Prosthodontic Procedure Benefits and Limitations

- Complete dentures (D5110-D5120) are for individuals ages 14-20 and require a preauthorization. Complete dentures are limited to 1 in 5 years or within 3 years of a partial
- Partial dentures resin based (D5211-5212) are for individuals ages 14-20 and require a preauthorization. Partial dentures are limited to 1 in 5 years.
- Partial dentures (D5213-D5226) are for individuals ages 16-20 and require a preauthorization. Partial dentures are limited to 1 in 5 years.
- Adjustments (D5410-D5422) are for individuals ages 14-20 and are covered 1 every 12 months. Denture adjustments are not billable within 6 months of delivery of interim, partial or complete dentures. Adjustments within 6 months of delivery are to be considered integral to denture placement.
- Denture repair (D5511-D5512; D5620-D5640) are eligible for ages 14-20.
- Replace missing or broken teeth (D5520) is eligible for ages 14-20.
- Replace broken teeth (D5640) is eligible for ages 14-20.
- Add clasp or tooth (D5650-D5660) are eligible for ages 14-20.
- Denture reline (D5730-D5761) are eligible for ages 14-20. Reline codes (D5740-D5741) are not billable within 6 months of D5211, D5212, D5213, D5214, D5225, D5226. Bill when chair side. Bill if sent to outside laboratory. Reline code (D5760) is not billable for 6 months after inserting any partial denture.
- Interim denture (D5820-D5821) is eligible for ages 7-10 and preauthorization is required. Includes retentive/clasping material, rests and teeth.
- Tissue conditioning (D5850-D5851) is eligible for ages 14-20 and not billable within 6 months of any denture.

Maxillofacial Prosthetics Benefits and Limitations

- Trismus appliance (D5937) (not for TMD) is eligible for ages 1-20 with preauthorization.
- Carriers; fluoride gel carrier (D5986) is eligible for ages 1-20 with preauthorization for patients undergoing radiation. Vesiculobullous disease medicament carrier (D5991) is eligible for ages 1-20 with preauthorization.

Fixed Prosthodontic Procedure Benefits and Limitations

- Pontic (D6211-D6242) and Crowns (D6751-D6792) are covered for members ages 14-20 and preauthorization is required. These services are eligible 1 in 5 years and only allowable when missing 1 anterior tooth in the maxillary or mandibular arch.
- Recement (D6792) and repair (D6980) are eligible for ages 14-20.

Oral Surgery Procedure Benefits and Limitations

- Extraction (D7111) is limited to primary dentition.
- Extraction (D7140) requires preauthorization.
- Surgical removals/procedures (D7210, D7220, D7250) must be preauthorized if ortho related.
- Removal of tooth (D7230-D7241) is not covered for tooth 1, 16, 17, 32 and is only eligible for members ages 12-20.
- Re-implantation/transplantation (D7270 – D7272) is covered for ages 5-20.
- Surgical access of a unerupted tooth (D7280) and device placement for impacted tooth (D7283) is covered for ages 8-20 and a preauthorization is required.
- Alveoloplasty (D7310 and D7320) bill per quadrant with one quadrant equal to 4 or more teeth. Covered for ages 14-20 only.
- I&D of abscess (D7510-D7521) covered for all ages.
- Frenulectomy (D7961-D7662) covered for all ages.
- Excision (D7970-D7971) covered for ages 14-20. D7970 requires preauthorization.

Orthodontic Procedure Benefits and Limitations

- Limited orthodontic treatment (D8020) is covered 1 per lifetime. Panorex (D0330) and photographs should be submitted with claim.
- Comprehensive orthodontic treatment (D8090) is covered 1 per lifetime.

Adjunctive General Procedure Benefits and Limitations

- Palliative treatment (D9110) is rendered to a patient for the immediate relief of pain.
- Procedure Codes (D9222, D9223, D9230, D9239, D9243 and D9248) can be administered only by a dentist who holds a state permit (restricted permit I, restricted permit II, or unrestricted) are permitted to administer and bill for anesthesia services allowed under their state specific permit. Dentists providing anesthesia for members in a dental office must bill using their NPI as performing provider and the dental group NPI for reimbursement.
- If a dentist requires a member have anesthesia performed at a location outside of their practice, the following must be met:
  - The dentist must verify the individual administering the anesthesia is enrolled in the Delaware Medical Assistance Program (DMAP) and has the appropriate state license and permits to perform the procedure.
  - The procedure must meet the medical necessity criteria listed below.
    - When determining medical necessity for the use of dental anesthesia (Nitrous Oxide, Minimal Sedation, Moderate Sedation, or Deep Sedation/General Anesthesia) one of the following criteria must be met:
    - A precooperative child six years of age or under.
    - A child under the age of 7 that has carious lesions (baby bottle syndrome) which require multiple restorations, extractions, crowns.
    - Child of any age with a diagnosed physical, developmental, or emotional disability.
    - Children with documented acute situational anxiety where a physical, mental, or medical condition precludes other behavior management choices.
    - Surgical extractions for permanent teeth using codes: D7210, D7220, D7230, D7240, D7241, and D7250 NOT partial bony and bony impacted wisdom teeth, these must be submitted to the MCO.
    - The following codes (D9220, D9221, D9230, D9241, D9242, and D9248) require documentation on the dental claim listing the criteria for medically necessary anesthesia.
  - The dentist completing the restorative procedure must include the hospital call (D9420) on the dental claim submitted for payment.

Delaware Healthy Children Program (DHCP) Benefit Coverage - Benefits and Limitations

For a full listing of covered benefits and limitations, please reference the benefit grid on the United Concordia website. This low cost plan is for uninsured recipients in Delaware who are 18 and younger. There is no copayment or maximum for this plan.

Diagnostic Procedure Benefits and Limitations

- Periodic oral evaluations (D0120) are eligible 1 per 180 days.
- Limited oral evaluation (D0140) is not to be billed with other exams.
- Oral evaluation and counseling (D0145) are eligible 1 per 180 days under age 3.
- Comprehensive oral evaluations (D0150) are eligible 1 in 2 years, per provider.
- Extensive oral evaluation (D0160) is covered.
- Re-evaluation-limited (D0170) must include narrative on claim.
- Periodontal Evaluation (D0180) are eligible 1 per 2 years, age 14-20 only.
- Screening of a patient (D0190) is eligible for patients under age 21. Code limited to Division of Public Health (DPH) contracted providers only.
- Assessment of a patient (D0191) is eligible for patients under age 21. Code limited to Division of Public Health (DPH) contracted providers only.
- Complete series of radiographs (D0210) is eligible 1 time in a 3-year period.
- Panoramic radiograph (Procedure Code D0330) is covered 1 in a 3-year period, age 5-20 only.
- Bitewing x-rays (D0270-D0277) are covered 4 bitewings in a 6-month period. D0277 cannot be billed with D0210 or another bitewing code.
- Periapical x-rays are eligible. D0220 is covered 15 per year, D0240 is eligible 2 per day.

Preventive Procedure Benefits and Limitations

- Routine prophylaxis (D1110 or D1120) is eligible 1 per 180 days.
- Topical fluoride varnish (D1206) is eligible 1 per 180 days under the age of 21.
- Topical fluoride application (D1208) is eligible 1 per 180 days under the age of 21.
- Sealants (D1351) are to be considered for payment for ages 2-6 on primary molars only, ages 5-15 on permanent molars and premolars only, and ages 5-16 are allowed on tooth numbers 1, 16, 17, and 32. Sealants are limited to 8 sealants in a 12-month period and only eligible on the same tooth 1 in a 5 years period.
- Interim Caries Arresting Medication (D1354) is eligible 1 per 180 days, 2 times per tooth.
- Fixed unilateral space maintainers (D1510) is eligible ages 2-9. Quadrants must be billed.

Restorative Procedure Benefits and Limitations

- Amalgam and Composite-Based Resin Restorations (D2140, D2150, D2160, D2161; D2330-D2335; D2391-D2394)
  - Resin (composite) restorations are covered when performed on anterior or posterior teeth. Two or more restorations on the same surface of a tooth are considered as one restoration.
  - The fees for restoration and filling include local anesthesia, polishing, bonding agents, cement bases, acid etch, light cured material and the necessary medications where indicated.
- Crowns (D2390; D2710, D2721, D2740, D2751, D7252, D2791, D2792, D2799, D2920; D2930-D2957)
- Crowns (Procedure Codes D2390; D2929– D2934) are payable for individuals under 21 years of age only.
- Procedure codes D2929 and D2930 are crowns for primary or developing permanent teeth only and are not compensable with construction of a permanent crown. D2929 is only limited to tooth numbers C, D, E, F, G, H, M, N, O, P, Q, R and only allowed 1 per tooth per lifetime. D2930 is eligible 1 per 5 years. (*check the members benefit plan to ensure age-appropriate coverage for the benefit prior to rendering care*)
- Crowns and post and cores are payable only when necessary due to decay or tooth fracture.
- Crowns are indicated for teeth that cannot be restored using filling materials. Crowns should not be recommended for teeth that have poor prognosis (periodontally compromised, unrestorable, or have chronic infections). Crowns should be placed on decay-free tooth structure and have good marginal integrity.

Endodontic Procedure Benefits and Limitations

- Pulp Cap (D3110-D3120) are eligible once per lifetime per tooth (primary and permanent)
- Pulpotomy (D3220) for ages 1-10 only.
- Pulpal Procedures (D3221 and D3222) for ages 6-20 only and are not billable same day as Endodontic therapy. D3230 for ages 2-6 only and is not billable same day as Endodontic therapy. D3240 for ages 2-9 only and is not billable same day as Endodontic therapy.
- Root canals (D3310-D3330) are not covered in the following situations: Intentional (elective) endodontics, third molar (unless it is an abutment tooth), teeth with advanced periodontal disease, teeth with subosseous and/or furcation carious involvement, teeth which cannot be restored with conventional methods and teeth which have received prior endodontics treatment.

- Retreatments (D3346-D3348) are covered benefits.
- Apicoectomy (D3410-D3430) are covered but only billable by oral surgeons or endodontists; ages 9-20 only.
- Endodontic treatment should not be performed on teeth with a poor restorative or periodontal prognosis.

Periodontic Procedure Benefits and Limitations

- Gingivectomy (D4210-D4212) are eligible for members ages 13-20 only and require a preauthorization.
- Osseous surgery (D4260-D4261, D4263-D4264, D4265-D4267) are eligible for members ages 15-20 and require a preauthorization.
- Tissue grafts (D4270-D4276) are eligible for ages 8-20 and require a preauthorization.
- Splints (D4322-D4323) are eligible for ages 13-20.
- Scaling and root planning (D4341-D4342) are eligible for ages 14-20 and are allowed 1 per 2 years. Maximum of 2 quadrants billed in 1 day. D4342 is not billable with D4355.
- Full mouth debridement (D4355) is eligible 1 per 3 years and cannot be billed with D1110, D4341-D4342. Only eligible for ages 14-20.
- Periodontal maintenance (D4910) is eligible for ages 14-20 and is allowed 1 time in 3 months. This can alternate with D1110.

Removable Prosthodontic Procedure Benefits and Limitations

- Complete dentures (D5110-D5120) are for individuals ages 14-20 and require a preauthorization. Complete dentures are limited to 1 in 5 years or within 3 years of a partial
- Partial dentures resin based (D5211-5212) are for individuals ages 14-20 and require a preauthorization. Partial dentures are limited to 1 in 5 years.
- Partial dentures (D5213-D5226) are for individuals ages 16-20 and require a preauthorization. Partial dentures are limited to 1 in 5 years.
- Adjustments (D5410-D5422) are for individuals ages 14-20 and are covered 1 every 12 months. Denture adjustments are not billable within 6 months of delivery of interim, partial or complete dentures. Adjustments within 6 months of delivery are to be considered integral to denture placement.
- Denture repair (D5511-D5512; D5620-D5640) are eligible for ages 14-20.
- Replace missing or broken teeth (D5520) is eligible for ages 14-20.
- Replace broken teeth (D5640) is eligible for ages 14-20.
- Add clasp or tooth (D5650-D5660) are eligible for ages 14-20.
- Denture reline (D5730-D5761) are eligible for ages 14-20. Reline codes (D5740-D5741) are not billable within 6 months of D5211, D5212, D5213, D5214, D5225, D5226. Bill when chair side. Bill if sent to outside laboratory. Reline code (D5760) is not billable for 6 months after inserting any partial denture.
- Interim denture (D5820-D5821) is eligible for ages 7-10 and preauthorization is required. Includes retentive/clasping material, rests and teeth.
- Tissue conditioning (D5850-D5851) is eligible for ages 14-20 and not billable within 6 months of any denture.

Maxillofacial Prosthetics Benefits and Limitations

- Trismus appliance (D5937) (not for TMD) is eligible for ages 1-20 with preauthorization.
- Carriers; fluoride gel carrier (D5986) is eligible for ages 1-20 with preauthorization for patients undergoing radiation. Vesiculobullous disease medicament carrier (D5991) is eligible for ages 1-20 with preauthorization.

Fixed Prosthodontic Procedure Benefits and Limitations

- Pontic (D6211-D6242) and Crowns (D6751-D6792) are covered for members ages 14-20 and preauthorization is required. These services are eligible 1 in 5 years and only allowable when missing 1 anterior tooth in the maxillary or mandibular arch.
- Recement (D6792) and repair (D6980) are eligible for ages 14-20.

Oral Surgery Procedure Benefits and Limitations

- Extraction (D7111) is limited to primary dentition.
- Extraction (D7140) requires preauthorization.
- Surgical removals/procedures (D7210, D7220, D7250) must be preauthorized if ortho related.
- Removal of tooth (D7230-D7241) is not covered for tooth 1, 16, 17, 32 and is only eligible for members ages 12-20.
- Re-implantation/transplantation (D7270 – D7272) is covered for ages 5-20.
- Surgical access of a unerupted tooth (D7280) and device placement for impacted tooth (D7283) is covered for ages 8-20 and a preauthorization is required.
- Alveoloplasty (D7310 and D7320) bill per quadrant with one quadrant equal to 4 or more teeth. Covered for ages 14-20

only.
- I&D of abscess (D7510-D7521) covered for all ages.
- Frenulectomy (D7961-D7662) covered for all ages.
- Excision (D7970-D7971) covered for ages 14-20. D7970 requires preauthorization.

Orthodontic Procedure Benefits and Limitations

- Limited orthodontic treatment (D8020) is covered 1 per lifetime. Panorex (D0330) and photographs should be submitted with claim.
- Comprehensive orthodontic treatment (D8090) is covered 1 per lifetime.

Adjunctive General Procedure Benefits and Limitations

- Palliative treatment (D9110) is rendered to a patient for the immediate relief of pain.
- Procedure Codes (D9222, D9223, D9230, D9239, D9243 and D9248) can be administered only by a dentist who holds a state permit (restricted permit I, restricted permit II, or unrestricted) are permitted to administer and bill for anesthesia services allowed under their state specific permit. Dentists providing anesthesia for members in a dental office must bill using their NPI as performing provider and the dental group NPI for reimbursement.
- If a dentist requires a member have anesthesia performed at a location outside of their practice, the following must be met:
  - The dentist must verify the individual administering the anesthesia is enrolled in the Delaware Medical Assistance Program (DMAP) and has the appropriate state license and permits to perform the procedure.
  - The procedure must meet the medical necessity criteria listed below.
    - When determining medical necessity for the use of dental anesthesia (Nitrous Oxide, Minimal Sedation, Moderate Sedation, or Deep Sedation/General Anesthesia) one of the following criteria must be met:
    - A precooperative child six years of age or under.
    - A child under the age of 7 that has carious lesions (baby bottle syndrome) which require multiple restorations, extractions, crowns.
    - Child of any age with a diagnosed physical, developmental, or emotional disability.
    - Children with documented acute situational anxiety where a physical, mental, or medical condition precludes other behavior management choices.
    - Surgical extractions for permanent teeth using codes: D7210, D7220, D7230, D7240, D7241, and D7250 NOT partial bony and bony impacted wisdom teeth, these must be submitted to the MCO.
    - The following codes (D9220, D9221, D9230, D9241, D9242, and D9248) require documentation on the dental claim listing the criteria for medically necessary anesthesia.
  - The dentist completing the restorative procedure must include the hospital call (D9420) on the dental claim submitted for payment.

Adult Emergency Dental Benefit Coverage

Highmark Health Options offers adult members an emergency dental benefit allowing an additional $1,500 per year beyond the $1,000 annual benefit limit that may be authorized on an emergency basis through the review process of DHSS.

DHSS defines an emergency basis as:

a) An unforeseen or sudden occurrence demanding immediate remedy or action, without which a reasonable licensed dental professional would predict a serious health risk or rapid decline in oral health; or,
b) When an individual's dental care needs exceed the $1,000 per year dental benefit limit, and postponement of treatment until the next benefit year would result in tooth loss or exacerbation of an existing medical condition.

To access the additional $1,500 per year dental benefit, the Participating Provider must submit the below information. Except in cases of an emergency as defined in a) above, submit for a prior authorization, a comprehensive treatment plan which anticipates the preventive, therapeutic and restorative needs for the Covered Individual prior to rendering services,

- ✓ Complete record of existing restoration, conditions, and diagnoses
- ✓ Comprehensive periodontal assessment record
- ✓ Diagnostic full mouth series of x-rays
- ✓ Intra- and extra-oral images that support the diagnosis and treatment plan, if applicable

In most situations, appropriate documentation to be submitted with the prior authorization for a type b) situation will be:

- For General Dentists: a narrative of the proposed treatment, X-rays (full mouth or panorex) and periodontal records (when applicable)
- For Oral Surgeons: a narrative of the proposed treatment and X-rays (full mouth or panorex)

In situations where a recipient presents with an unforeseen or sudden occurrence, provide diagnostic quality pre- and post-

operative radiographs and images of the affected area along with a detailed narrative supporting the provider's rationale for immediate services. Only Covered Services and/or services that meet clinical practice guidelines and that are included in the DMMA fee schedule will be approved.

All members are eligible for emergency dental services without prior authorization when the member is experiencing an emergency medical condition.

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

Emergency dental services shall be defined as services that relieve pain, reduce swelling, or treat evidence of infection or trauma due to an acute oral disease, infection, or facial injury of a specific tooth or several teeth, or supporting structure.

Adult Medicaid Benefit Coverage – Benefits and Limitations

For a full listing of covered benefits and limitations, please reference the benefit grid on the United Concordia website. This plan is for recipients in Delaware who are age 21 and older. There is a $3 copayment for every visit and a $1,000 benefit maximum.

Diagnostic Procedure Benefits and Limitations

- Periodic oral evaluations (D0120) are eligible 1 per 180 days.
- Limited oral evaluation (D0140) is not to be billed with other exams.
- Comprehensive oral evaluations (D0150) are eligible 1 in 2 years.
- Extensive oral evaluation (D0160) is covered.
- Re-evaluation-limited (D0170) must include narrative on claim.
- Periodontal Evaluation (D0180) are eligible 1 per 2 years.
- Complete series of radiographs (D0210) is eligible 1 time in a 3-year period.
- Panoramic radiograph (D0330) is covered 1 in a 3-year period. Either D0330 or D0210 maybe used once in a 3-year period.
- Bitewing x-rays (D0270-D0277) are covered 4 bitewings in a 6-month period. D0277 cannot be billed with D0210 or another bitewing code.
- Periapical x-rays are eligible. D0220 is covered 15 per year, D0240 is eligible 2 per day.

Preventive Procedure Benefits and Limitations

- Routine prophylaxis (D1110) is eligible 1 per 180 days.
- Topical fluoride varnish (D1206) is eligible 1 per year. Shares a frequency with D1208.
- Topical fluoride application (D1208) is eligible 1 per year. Shares a frequency with D1206.
- Interim Caries Arresting Medication (D1354) is eligible 1 per tooth every 180 days for up to 2 years.

Restorative Procedure Benefits and Limitations

- Amalgam and Composite-Based Resin Restorations (D2140, D2150, D2160, D2161; D2330-D2335; D2391-D2394) restorations are covered when performed on anterior or posterior teeth. Two or more restorations on the same surface of a tooth are considered as one restoration. Same tooth and surface covered 1 in 2 years.
- Recement crown (D2920) is covered same tooth and surface 1 in 2 years.

Periodontic Procedure Benefits and Limitations

- Scaling and root planning (D4341-D4342) require preauthorization. Maximum of 2 quadrants billed in 1 day.
- Full mouth debridement (D4355) is eligible 1 per 3 years and cannot be billed with D1110, D4341-D4342.
- Periodontal maintenance (D4910) is allowed 1 time in 3 months. This can alternate with D1110.

Removable Prosthodontic Procedure Benefits and Limitations

- Denture repair (D5511-D5512; D5620-D5640) are covered.
- Replace missing or broken teeth (D5520) is covered.
- Replace broken teeth (D5640) is covered.
- Add clasp or tooth (D5650-D5660) is covered.
- Denture reline (D5750-D5751) is covered 1 in 2 years.

Fixed Prosthodontic Procedure Benefits and Limitations

- Recement (D6792) and repair (D6980) is covered, narrative on claim.

Oral Surgery Procedure Benefits and Limitations

- Extraction (D7140) is covered.
- Surgical removals/procedures (D7210, D7220, D7250) are covered.
- Surgical incisions (D7510-D7521) are covered.

Adjunctive General Procedure Benefits and Limitations

- Palliative treatment (D9110) is rendered to a patient for the immediate relief of pain and is eligible 2 times per year. May not be billed D0120 or D0150. May not be used in conjunction with restorative codes on same tooth or denture repair services.
- Procedure Codes (D9222, D9223, D9230, D9239, D9243 and D9248) require preauthorization.

Prior Authorizations

A prior authorization is required for those services for which the Delaware Department of Medicaid & Medical Assistance recommends prior authorization, requires prior authorizations and has granted approval to United Concordia to require prior authorization.

Prior authorization is required for anesthesia, orthodontics, crowns, surgical extraction(s) of impacted tooth/teeth, periodontal services (except full mouth debridement which requires post- operative review), and use of the emergency benefit for adults. All dental procedures are considered to be outpatient procedures. These procedures are not compensable on an inpatient basis unless there is medical justification, which is documented, in the patient's medical record.

Prior authorization is required under the member's medical coverage with Highmark Health Options for DE Medicaid members who need to be seen in a hospital facility for dental services. The prior authorization should be submitted under medical for codes 41899 and 00170.

Requesting a Prior Authorization

Prior authorizations can be requested electronically through using our free Speed eClaim® system available on our website or by contacting your Clearinghouse/Vendor for availability of Real-time Claim Transaction Processing or in writing by completing an ADA claim form and checking the box marked Pre-Treatment Estimate. If requesting the prior authorization in writing, the request must be mailed to the address below along with any required supplemental information. Your office will receive a Dental Explanation of Benefits (DEOB) detailing the approved services and the plan payment amounts.

Mail the prior authorization to:
Pre-Authorizations
PO Box 69455
Harrisburg, PA 17106

A prior authorization is not a guarantee of payment but indicates how much would be payable given the information available at the time the determination is processed. When the predetermined services have been provided, use one of the following methods to request payment.

- **Electronic Claims** – Simply include the claim number printed on the Prior Authorization Notification and Request for Payment Form in the remarks field of your electronic claim request for payment.
- **Return via Mail** - Mail the form titled Dental Prior Authorization Notification and Request for Payment with the completed date(s) of service(s) entered in the 'Service Date(s)' column. Dates should only be entered if the service has been completed. Do not attach additional claim forms to the Dental Prior Authorization Notification and Request for Payment Form if submitting a request for payment via mail. Submitting a new claim form may delay payment or possibly result in unnecessary requests for supporting documentation.

A prior authorization will remain valid for 365 days from the date of approval. The Dental Prior Authorization Notification and Request for Payment form contains the date that the preauthorization is approved through. **Services performed after the approval has expired will be subject to another review and should be submitted with the appropriate radiographs and supporting documentation for payment consideration.**

Timeframes and Written Notification

The following are the standards for prior authorizations:

- **Standard Decision (Non-Urgent Prior Authorization)** – Non-urgent prior authorization requests referred to a Dentist Advisor for approval, or to a physician for a denial determination, will be completed within seven (7) business days of the receipt of the request. Written notification of the decision will be sent to the dentist within two (2) business days of the decision.

- **Request for Additional Information** - If a request for prior authorization is received with incomplete information, the provider and the member will be notified that additional information is needed for review, using the "Request for Additional Information" letter template. The provider will have 14 calendar days to submit the additional information. Once additional information is received, a decision will be made within two (2) business days. If the requested information is not received within the established time frame, a decision will be made by reviewing the available information.
- **Expiration of Prior Authorizations** – Prior Authorizations are valid for 365 days from the date of approval. Approved treatment must be rendered within this time frame, or a new prior authorization will need to be submitted for clinical review.

Diagnostic Material Requirements

The following requirements are applicable to the provision of covered services to Delaware Division of Medicaid and Medical Assistance members.

When covered, the procedures listed on the following chart require submission of diagnostic materials for review. Dentists are requested to submit diagnostic materials used for diagnosis and treatment planning.

All radiographs submitted (including copies) should be pre-treatment unless otherwise noted. They should be of diagnostic quality and mounted properly with the left and right sides clearly marked. They should be identified with the dentist's name and address, the patient's name and identification number and the date the radiographs were taken. (If a copy of the radiographs is submitted, left or right should be marked on the copy.)

If, for some reason, radiographs are not available, a brief explanation should be included on the claim form. If submitting claims electronically, please provide a brief explanation in the remarks field.

MINIMUM REQUIREMENTS FOR DIAGNOSTIC MATERIALS FOR MANUAL CLINICAL REVIEW

Chart Key: *Please refer to the below indicators within the chart to determine the appropriate documentation REQUIRED for review.*	
X	Required
A	A post-endodontic treatment, diagnostic x-ray ***IN ADDITION*** to a pre-treatment diagnostic x-ray of the tooth.
B	Pre-treatment, diagnostic x-ray(s) of the area of implant placement and the adjacent teeth is required. ***IN ADDITION*** to a pre-treatment diagnostic x-ray of the tooth.
C	X-ray(s) of all the teeth in the arch (Full Mouth Series or Panoramic) are required. ONLY for plans that apply an Alternate Benefit Provision (ABP) ***IN ADDITION*** to a pre-treatment diagnostic x-ray of the tooth.
D	Is ***ONLY*** required if reported with a service where deep sedation/general anesthesia, inhalation of nitrous oxide/analgesia, IV moderate (conscious) sedation/analgesia, or non-IV conscious sedation anesthesia may not be the typical standard of care and deep sedation/general anesthesia, inhalation of nitrous oxide/analgesia, IV moderate (conscious) sedation/analgesia, or non-IV conscious sedation is being recommended by the provider because of complex medical issues and/or treatment needs.

Diagnostic/ Pre-treatment x-ray

- Periapical (PA) and/or Bitewing (BW) x-ray(s) are preferred.
- A panoramic x-ray will be accepted in certain instances:
  - Panoramic x-ray(s) are of limited diagnostic specificity for review of any procedures outside of Implant Services (D6000-D6199), Oral Surgery (D7000-D7999) and Orthodontics (D8000-D8999). Panoramic x-rays are only preferred in addition to or instead of a periapical x-ray for review of certain Implant Services (D6000-D6199), Oral Surgery (D7000-D7999) and Orthodontic (D8000-D8999) codes.

Periodontal Charting

- Complete and legible 6-point Periodontal Charting of the tooth/teeth.

Written Documentation

- Chart/progress notes are preferred.
- If no chart/ progress notes are available, information in Box 35 of the ADA claim form/note

field in an Electronic Data Interface submission, or a narrative are all accepted as forms of "written documentation".

Written documentation may be required when manual clinical review is necessary as part of benefit determination for any "by report" or "unspecified" dental service (D0160, D0321, D0502, D0999, D1999 D2999, D3999, D4999, D5899, D6090, D6095, D6999, D7291, D7950, D7995, D7999, D9930, D9999) and certain endodontic and surgical services.

DENTAL SERVICE	Diagnostic/ Pre-treatment x-ray	Periodontal Charting	Written Documentation
Unspecified diagnostic procedure, by report (D0999)			X
Crown (D2710, D2740, D2751, D2752, D2791, D2792, D2799)	X		
Core buildup (D2950)	X		
Post and Core (D2953, D2957)	A		
Unspecified restorative procedure, by report (D2999)			X
Unspecified endodontic procedure, by report (D3999)			X
Gingivectomy or gingivoplasty (D4210, D4211)	X	X	
Osseous surgery (D4260, D4261)	X	X	
Bone replacement graft – retained natural tooth (D4263, D4264)	X	X	
Biological materials (D4265)	X		
Guided tissue regeneration (D4266, D4267)	X		
Pedicle soft tissue graft (D4270)	X		
Subepithelial connective tissue graft (D4273)	X		
Mesial/distal wedge procedure, single tooth (D4274)	X	X	
Tissue graft (D4275, D4276)	X		
Splint intra/extra coronal (D4322, D4323)	X		
Unspecified periodontal procedure, by report (D4999)			X
Denture (D5110, D5120, D5211, D5212, D5213, D5214, D5225, D5226, D5670, D5810, D5811, D5820, D5821)	X		
Unspecified removable prosthodontic procedure, by report (D5899)			X
Trismus appliance (D5937)			X
Vesiculobullous disease medicament carrier (D5991)			X
Unspecified maxillofacial prosthesis, by report (D5999)			X
Pontic (D6211, D6212, D6241, D6242)	X		X
Retainer (D6545)	X		X
Crown (D6751, D6752, D6791, D6792)	X		X
Unspecified fixed prosthodontic procedure, by report (D6999)			X
Surgical access of unerupted tooth (D7280)	X		X
Luxate tooth to aid eruption (D7282)	X		X
Device placement for impacted tooth (D7283)	X		X
Excision of hyperplastic tissue (D7970)			X
Unspecified oral surgery procedure, by report (D7999)			X
Deep sedation/general anesthesia (D9222, D9223)			D
Inhalation of nitrous oxide/analgesia, anxiolysis (D9230)			D
Intravenous moderate (conscious) sedation/analgesia - first 15 minutes (D9239, D9243)			D
Non-intravenous conscious sedation (D9248)			D
Unspecified adjunctive procedure, by report (D9999)			X

FOR ALL SERVICES:

Submission of additional x-rays (outside of required), written documentation (chart notes/narratives/periodontal charting/specialist letters/etc.) when not specifically required, photographs, and other diagnostic materials outside of required diagnostic materials listed is optional and should corroborate with evidence presented in required materials.

Orthodontic Services

***Please note that Medical Assistance requires Ortho to be medically necessary.**

Delaware Medical Assistance Program (DMAP) does not require prior authorization for the **initial diagnostic visit** for orthodontic treatment. Providers will be reimbursed for the initial diagnostic visit irrespective of its decision to approve or deny comprehensive treatment.

- Diagnostic records for comprehensive treatment (pre-orthodontic treatment D8660) are to be paid once to the same orthodontic provider/practice.
- An eligible member is allowed 2 pre-orthodontic treatment records per lifetime.
  - If it is determined that the condition of the member's dentition has changed and may now qualify, submit a request for prior authorization.

All other orthodontic care must receive prior approval. Providers should not begin comprehensive treatment prior to receiving approval. Claims that did not receive prior approval will not be considered for payment.

D8660, D8090, D8670 and D8680 are only covered for Orthodontist and Periodontists that have an orthodontic taxonomy registered with Delaware Medical Assistance Program (DMAP).

Orthodontic Procedure Benefits and Limitations

Limited Orthodontics

- Limited orthodontic treatment (D8020) is covered 1 per lifetime. Panorex (D0330) and photographs should be submitted with claim.

The following criteria must be met to submit a claim:

- Cross bite of first molar with midline deviation.
- Anterior cross bite associated with clinically apparent severe gingival inflammation or gingival recession or severe enamel wear.
- Impaction causing direct damage to the root of permanent tooth.

Limited orthodontic treatment of transitional dentition is orthodontic treatment with a limited objective, not involving the entire dentition. It may be directed at the only existing problem, or at only one aspect of a larger problem in which a decision is made to defer or forego more comprehensive therapy. This may require brackets or bands on one arch in addition to other modalities. Note: Upper and lower braces exceed the scope of Limited Orthodontics and should be submitted under comprehensive if the member meets the criteria.

Comprehensive Orthodontics

- Comprehensive orthodontic treatment (D8090) is covered 1 per lifetime.

The following criteria must be met to submit a claim:

- Permanent dentition only. Primary and transitional dentition cases will not be reviewed.
- A score of 26 or above on the Delaware Special Dental Orthodontic Evaluation Form.
- When a score of 26 has not been reached but one of the 5 exceptions can be clearly demonstrated.
- When an impacted permanent tooth has caused visible damage to the root of another permanent tooth. (Must be included in the report as well as demonstrate existing damage to root of tooth.)
- When a child has been approved for orthodontic treatment by another state Medicaid program and has been receiving active and consistent treatment.

Prior authorization is required, and the below information must be submitted:

- Delaware Special Dental Orthodontic Form
- Treatment plan that includes:
  - Cost of treatment
  - Treatment plan
- Photographs
- Panoramic X-ray (D0330)
- Cephalometric X-ray (D0340)
- Digital Models

- Orthognathic surgery cases: The member must be evaluated by an oral surgeon prior to submission for comprehensive orthodontics. The oral surgeon's report must be submitted with the prior authorization for review. If this report is not included, the case will be denied.

Prior to application of braces, the orthodontist must assure that the member has seen a general dentist and is free of all active caries, periodontal disease and maintains good oral hygiene. Members who have poor oral hygiene, active caries, or have not been to a dentist for their six-month checkup will be denied orthodontic treatment until such time as their condition changes.

Payment Orthodontic Services

The following orthodontia pre-authorization submission guidelines should be used for any member being considered for orthodontia treatment.

Standard Authorization Requests

Submit an authorization form with the following:

- Procedure Code D8090
- Include the **full treatment fee**
- Total length of treatment

Continuity of Care Authorization Requests

- D8090 Prior Authorization Approval
- Banding Date of Service
- Total Charge of treatment
  - Amount paid at time of transition
- Total Approved Months
  - Number of months paid at time of transition

To make this process seamless for your office, you do not need to submit monthly claims. United Concordia will set up all orthodontia cases for automatic monthly payments. You will receive the initial payment of 25% of the total case rate when the member is initially banded, and the remaining amounts will be paid monthly until the treatment is completed. Payments will begin once we receive the first claim with the banding date for the braces.

- If the member turns twenty-one (21) during treatment, the monthly payment after the month in which they turn twenty-one will be denied due to age. In this scenario, if the member is still in treatment, please submit your claim for payout to DMMA through DMAP.
- Loss of Coverage – if a member loses eligibility while in active orthodontic treatment for three consecutive months, please submit your claim for payout to DMMA through DMAP.
- If a member discontinues treatment with no intention of finishing, please notify customer service to notify us that the patient's care is being discontinued to avoid any potential overpayments.

Following are the diagnostic materials that are required to be submitted along with the orthodontia pre-authorization:

- A completed ADA Dental Claim Form available at ada.org or an electronic claims transaction must be submitted with the ortho treatment plan indicating preauthorization.
  - Procedure Code
  - Provider's Fee for the Procedure
  - Length of Treatment
- A completed Delaware Special Orthodontic Evaluation Form (copied below).

Link to DE Special Dental Orthodontic Evaluation Form on the DE Health and Social Services Website

- Facial and Intraoral Photos
  - Facial: Include frontal, left and right-side views
  - Intraoral: Include upper and lower arch (open), frontal view, left and right-side views (closed)
- Digital Images of Study Models (articulated in centric relation)
  - Include front and back views, left and right-side views and full upper and lower arch occlusal view

Highmark Health Options West Virginia Medicaid

Highmark Health Options West Virginia offers Adult Dental Benefit package, along with an Adult Emergency Plan, for members aged 21 and older, a Child's Dental Benefit package for MA members under the age of 21, and the Children's Health Insurance Program (CHIP) for members under the age of 18 who are not eligible for Medicaid. As in most dental programs, limitations and exclusions are placed on

member benefits. The following section will identify the limitations and exclusions for your patients who receive benefits through the WV Medicaid and CHIP program.

The policies and limitations listed within this section will be used to administer dental benefits for Highmark Health Options Medicaid members. They reflect current and acceptable practices within the dental community while ensuring that cost-effective measures are applied according to the dental contract. Please refer to the following for additional information: West Virginia Department of Human Services (DoHS)

This section applies only to Dental Providers and Physicians.

Benefits and Exclusions – General Policies

All covered services are subject to the following general policies:

- All dental procedures are considered to be outpatient procedures. These procedures are not compensable on an inpatient basis unless there is medical justification which is documented in the patient's medical record.
- Procedures that are an inherent part of another procedure are considered to be integral and not eligible for separate payment. Integral procedures are not billable to the member by a dentist or any other dentist who participates in the WV Medicaid Program.
- Doctor of Dental Medicine (DDM), Doctor of Dental Surgery (DDS) and Doctor of Oral Maxillofacial Surgery (OMS) are the only provider types eligible to provide general dental, orthodontic and oral/maxillofacial surgery services to members and receive payment for dental services. Per chapter 505.3 of the BMS Provider Manual, dental hygienists are not eligible to receive direct reimbursement for services.
- Some covered procedures require the submission of diagnostic materials, such as periodontal charting, radiographs, and/or a brief narrative report of the specific service(s) performed and any factors that may have affected the care provided.
- A prior authorization must be obtained when service limits are exceeded.
- Accident-Related Dental Services: The Least Expensive Professional Acceptable Alternative Treatment (LEPAAT) for accident-related dental services is covered when provided within 6 months of an accident and required to restore damaged tooth structures. The initial treatment must be provided within 72 hours of the accident. Biting and chewing accidents are not covered. Services provided more than 6 months after the accident are not covered. Note: For children under the age of 16, the 6-month limitation may be extended if a treatment plan is provided within the initial 6 months and approved by WVCHIP.
- Emergency Dental Services: Medically necessary adjunctive services that directly support the delivery of dental procedures, which, in the judgment of the dentist, are necessary for the provision of optimal quality therapeutic and preventive oral care to patients with medical, physical or behavioral conditions. These services include, but are not limited to sedation, general anesthesia, and utilization of outpatient or inpatient surgical facilities. Contact WVCHIP for more information.
- Orthodontic Services: Orthodontic services are covered if medically necessary for a WVCHIP member whose malocclusion creates a disability and impairs their physical development. Treatment is routinely accomplished through fixed appliance therapy and maintenance visits. All requests for treatment are subject to prior authorization by WVCHIP dental consultants. Prior authorization is dependent on diagnosis, degree of impairment and medical documentation submitted. Failure to obtain prior authorization before service is performed will result in the family being responsible for amounts above and beyond their copayment requirements.
- Services Not Covered: Treatment for temporomandibular joint (TMJ) disorders; intraoral prosthetic devices; onlays/inlays; gold restorations; precision attachments; replacement crowns only covered every 5 years; cosmetic dentistry; dental implants; experimental procedures; splinting; any other procedure no listed as covered.

Copayment

There is a Copayment for the CHIP Premium plan only. A $25 copayment for non-preventive services with a maximum copay of $100/per child or $150/per family per benefit year. The $25 copay is per visit, not per procedure. There is no maximum for the CHIP plan. Children who are members of federally recognized American Indian or Native Alaskan tribes are not required to pay co-payments once enrolled in CHIP.

The Adult Medicaid plan has a $2,500 comprehensive maximum every 2 fiscal years. There is no copayment for the adult Medicaid plan.

Balance Billing

Providers may not balance bill members for the difference between the provider's charge and the allowed amount. If a member needs or desires services that are not covered under their Medicaid dental benefits, they do have the option to pay out of pocket; however, prior to the provision of services, the provider must document that the member understands that the services are either not a covered benefit as defined by the State, are not medically necessary, or could deny on frequency limitations, and therefore will not be reimbursed by their Medicaid plan. This documentation must include a written itemized cost estimate for the services, and the member will need to sign and date the estimate showing that they have been informed and agree to be financially responsible. Our My Patients' Benefits (ref. page 96 of the Dental Reference Guide) web portal allows access to your patient's eligibility benefits, claim status, maximums/deductibles, procedure history to assist with determining payment eligibility for codes with frequency limitations, procedure code information, orthodontic

information, as well as State fee schedule information. You also have the ability to call our Provider Service Department to obtain this information.

Children's Medicaid Benefit Coverage - Benefits and Limitations

For a full listing of covered benefits and limitations, please reference the benefit grid on the United Concordia website. This plan is for recipients in West Virginia who are under age 21. There is no copayment or maximum for this plan.

Diagnostic Procedure Benefits and Limitations

- Periodic oral evaluations (D0120) are eligible 1 per 180 days.
- Limited oral evaluation (D0140) is not to be billed with other exams.
- Oral evaluation and counseling (D0145) are eligible 1 per 180 days.
- Comprehensive oral evaluations (D0150) are eligible 1 per year.
- Complete series of radiographs (D0210) is eligible 1 time in a 3-year period.
- Panoramic radiograph (Procedure Code D0330) is covered 1 in a 3-year period.
- Bitewing x-rays (D0270-D0277) are covered 1 per calendar year except D0270 that is covered 4 per year.
- Periapical x-rays are eligible. D0220 is covered 1 per day, D0240 is covered 2 per year.
- Intraoral tomosynthesis (D0373-D0389) is covered 1 per year.
- 3D facial surface scan (D0801-D0804) is covered 1 per year.

Other radiographs are covered in accordance with the benefit plan as outlined on the United Concordia website.

Preventive Procedure Benefits and Limitations

- Routine prophylaxis (D1110 or D1120) is eligible 1 per 180 days. 1 additional cleaning is covered with pregnancy diagnosis.
- Topical fluoride varnish (D1206) is eligible 1 per 180 days.
- Topical fluoride application (D1208) is eligible 1 per 180 days.
- Tobacco counseling for the control and prevention of oral disease (D1320) is eligible 2 per year.
- Sealants (D1351) are covered 1 sealant per tooth per 3 years. Sealant repair (D1353) is covered 1 sealant repair per tooth per 2 years.
- Interim Caries Arresting Medication (D1354) is covered 2 per tooth per year.
- Fixed unilateral space maintainers (D1510-D1575) are covered 1 per year except D1510 and D1575 that are covered 4 per year.
- Vaccines (D1781-D1783) are covered.

Restorative Procedure Benefits and Limitations

- Amalgam and Composite-Based Resin Restorations (D2140, D2150, D2160, D2161; D2330-D2335; D2391-D2394)
  - Resin (composite) restorations are covered when performed on anterior or posterior teeth. 5 surfaces per tooth number per 3 years.
  - The fees for restoration and filling include local anesthesia, polishing, bonding agents, cement bases, acid etch, light cured material and the necessary medications where indicated.
- Crowns (D2390; D2710, D2721, D2740, D2751, D7252, D2791, D2792, D2799, D2920; D2930-D2957)
- Crowns (D2390; D2929– D2934) are covered 1 per tooth per year. Crowns (D2710-D2751) are covered 1 per tooth per 5 years.
- Procedure codes D2929 and D2930 are crowns for primary or developing permanent teeth only and are not compensable with construction of a permanent crown. D2929 is allowed 1 per tooth per year. D2930 is eligible 1 per tooth per 3 years. (*check the members benefit plan to ensure age-appropriate coverage for the benefit prior to rendering care*)
- Crowns and post and cores are payable only when necessary due to decay or tooth fracture.
- Crowns are indicated for teeth that cannot be restored using filling materials. Crowns should not be recommended for teeth that have poor prognosis (periodontally compromised, unrestorable, or have chronic infections). Crowns should be placed on decay-free tooth structure and have good marginal integrity.

Endodontic Procedure Benefits and Limitations

- Pulp Cap (D3120) is covered 1 per tooth per 3 years.
- Pulpotomy (D3220) is covered 1 per tooth per 3 years.
- Root canals (D3310-D3330) are covered 1 per tooth per lifetime.
- Retreatments (D3346-D3348) are covered 1 per tooth per lifetime.

- Apexification (D3351-D3353) are covered 1 tooth per lifetime except D3352 is covered 3 treatments per tooth per lifetime.
- Apicoectomy (D3410-D3421) are covered 1 per tooth per lifetime.

Endodontic treatment should not be performed on teeth with a poor restorative or periodontal prognosis.

Periodontic Procedure Benefits and Limitations

- Gingivectomy (D4210-D4211) is covered 1 quadrant per year.
- Osseous surgery (D4260-D4261) is covered 1 quadrant per year.
- Scaling and root planning (D4341-D4342; D4346) is covered 1 quadrant per year except D4346 which is covered 1 per 2 years.
- Full mouth debridement (D4355) is eligible 1 per 6 months.
- Periodontal maintenance (D4910) is eligible 1 per calendar year.

Removable Prosthodontic Procedure Benefits and Limitations

- Complete dentures (D5110-D5120) are covered 1 per arch per 5 years.
- Immediate dentures (D5130-D5140) are covered 1 per arch per 5 years.
- Partial dentures (D5213-D5214; D5282-D5284; D5286) are covered 1 per arch per 5 years.
- Adjustments (D5410-D5422) are covered 3 per year.
- Denture repair (D5511-D5512; D5611-D5622) is covered 2 per year per arch.
- Replace missing or broken teeth (D5520) is covered 2 per year per tooth.
- Add clasp or tooth (D5630-D5640; D5650-D5660) is covered 2 per year.
- Rebase (D5710-D5721) is covered 1 per 5 years.
- Reline (D5730-D5761) is covered 1 per 2 years.

Other removable prosthodontics are covered in accordance with the benefit plan as outlined on the United Concordia website.

Maxillofacial Prosthetics Benefits and Limitations

- Trismus appliance (D5937) (not for TMD) is covered.

Other maxillofacial prosthetics are covered in accordance with the benefit plan as outlined on the United Concordia website.

Fixed Prosthodontic Procedure Benefits and Limitations

- Pontic (D6211; D6241) is covered 1 in 5 years.
- Retainer (D6545) is covered 1 in 5 years.
- Recement (6930) is covered 1 per calendar year.

Oral Surgery Procedure Benefits and Limitations

- Extraction (D7140) is covered 1 per tooth per lifetime.
- Surgical removals/procedures (D7210, D7220 -D7240) are covered 1 per tooth per lifetime.
- Oroantral fistula closure (D7260) is covered.
- Re-implantation/transplantation (D7270) is covered.
- Surgical access of a unerupted tooth (D7280) is covered. Device placement for impacted tooth (D7283) is covered.
- Biopsy (D7285-D7286) is covered.
- Alveoloplasty (D7310 and D7320) is covered 1 quadrant per lifetime.

Other oral surgery procedures are covered in accordance with the benefit plan as outlined on the United Concordia website.

Orthodontic Procedure Benefits and Limitations

- Limited orthodontic treatment (D8010 – D8040) is covered 2 per year.
- Comprehensive orthodontic treatment (D8070 - D8090) is covered 1 per lifetime.
- Removeable appliance therapy (D8210) is covered 2 per lifetime.
- Fixed appliance therapy (D8220) is covered 2 per year.
- Orthodontic retention (D8680) is covered.
- Removal of fixed orthodontic appliance (D8695) is covered.
- Repair of orthodontic appliance (D8696-D8697; D8701-D8702) is covered 1 per lifetime.
- Re-cement or re-bond (D8698-D8699) is covered 1 per lifetime.
- Replacement of retainer (D8703-D8704) is covered 1 per lifetime.

Adjunctive General Procedure Benefits and Limitations

- Procedure Codes (D9222, D9223, D9230, D9239, D9243 and D9248) can be administered only by a dentist who holds a state permit (restricted permit I, restricted permit II, or unrestricted) are permitted to administer and bill for anesthesia services allowed under their state specific permit. Dentists providing anesthesia for members in a dental office must bill using their NPI as performing provider and the dental group NPI for reimbursement.
- Consultation (D9310) is covered.
- Other drugs and/or medicaments (D9630) is covered.
- Occlusal guard (D9944-D9951) are covered.
- The dentist completing the restorative procedure must include the hospital call (D9420) on the dental claim submitted for payment.

CHIP Benefit Coverage - Benefits and Limitations

For a full listing of covered benefits and limitations, please reference the benefit grid on the United Concordia website. This plan is for recipients in West Virginia who are under age 19 and not eligible for Medicaid. There is a $25 copayment for non-preventive services with a maximum copay of $100/per child or $150/per family per benefit year. The $25 copay is per visit, not per procedure. There is no maximum for the CHIP plan. Children who are members of federally recognized American Indian or Native Alaskan tribes are not required to pay co-payments once enrolled in CHIP.

Diagnostic Procedure Benefits and Limitations

- Periodic oral evaluations (D0120) are eligible 1 per 180 days.
- Limited oral evaluation (D0140) is not to be billed with other exams.
- Oral evaluation and counseling (D0145) are eligible 1 per 180 days.
- Comprehensive oral evaluations (D0150) are eligible 1 per year.
- Complete series of radiographs (D0210) is eligible 1 time in a 3-year period.
- Panoramic radiograph (Procedure Code D0330) is covered 1 in a 3-year period.
- Bitewing x-rays (D0270-D0277) are covered 1 per calendar year except D0270 that is covered 4 per year.
- Periapical x-rays are eligible. D0220 is covered 1 per day, D0240 is covered 2 per year.
- Intraoral tomosynthesis (D0373-D0389) is covered 1 per year.
- 3D facial surface scan (D0801-D0804) is covered 1 per year.

Other radiographs are covered in accordance with the benefit plan as outlined on the United Concordia website.

Preventive Procedure Benefits and Limitations

- Routine prophylaxis (D1110 or D1120) is eligible 1 per 180 days. 1 additional cleaning is covered with pregnancy diagnosis.
- Topical fluoride varnish (D1206) is eligible 1 per 180 days.
- Topical fluoride application (D1208) is eligible 1 per 180 days.
- Tobacco counseling for the control and prevention of oral disease (D1320) is eligible 2 per year.
- Sealants (D1351) are covered 1 sealant per tooth per 3 years. Sealant repair (D1353) is covered 1 sealant repair per tooth per 2 years.
- Interim Caries Arresting Medication (D1354) is covered 2 per tooth per year.
- Fixed unilateral space maintainers (D1510-D1575) are covered 1 per year except D1510 and D1575 that are covered 4 per year.
- Vaccines (D1781-D1783) are covered.

Restorative Procedure Benefits and Limitations

- Amalgam and Composite-Based Resin Restorations (D2140, D2150, D2160, D2161; D2330-D2335; D2391-D2394)
  - Resin (composite) restorations are covered when performed on anterior or posterior teeth. 5 surfaces per tooth number per 3 years.
  - The fees for restoration and filling include local anesthesia, polishing, bonding agents, cement bases, acid etch, light cured material and the necessary medications where indicated.
- Crowns (D2390; D2710, D2721, D2740, D2751, D7252, D2791, D2792, D2799, D2920; D2930-D2957)
- Crowns (D2390; D2929– D2934) are covered 1 per tooth per year. Crowns (D2710-D2751) are covered 1 per tooth per 5 years.
- Procedure codes D2929 and D2930 are crowns for primary or developing permanent teeth only and are not compensable with construction of a permanent crown. D2929 is allowed 1 per tooth per year. D2930 is eligible 1 per tooth per 3 years. (*check the members benefit plan to ensure age-appropriate coverage for the benefit prior to rendering care*)

- Crowns and post and cores are payable only when necessary due to decay or tooth fracture.
- Crowns are indicated for teeth that cannot be restored using filling materials. Crowns should not be recommended for teeth that have poor prognosis (periodontally compromised, unrestorable, or have chronic infections). Crowns should be placed on decay-free tooth structure and have good marginal integrity.

Endodontic Procedure Benefits and Limitations

- Pulp Cap (D3120) is covered 1 per tooth per 3 years.
- Pulpotomy (D3220) is covered 1 per tooth per 3 years.
- Root canals (D3310-D3330) are covered 1 per tooth per lifetime.
- Retreatments (D3346-D3348) are covered 1 per tooth per lifetime.
- Apexification (D3351-D3353) are covered 1 tooth per lifetime except D3352 is covered 3 treatments per tooth per lifetime.
- Apicoectomy (D3410-D3421) are covered 1 per tooth per lifetime.

Endodontic treatment should not be performed on teeth with a poor restorative or periodontal prognosis.

Periodontic Procedure Benefits and Limitations

- Gingivectomy (D4210-D4211) is covered 1 quadrant per year.
- Osseous surgery (D4260-D4261) is covered 1 quadrant per year.
- Scaling and root planning (D4341-D4342; D4346) is covered 1 quadrant per year except D4346 which is covered 1 per 2 years.
- Full mouth debridement (D4355) is eligible 1 per 6 months.

Removable Prosthodontic Procedure Benefits and Limitations

- Complete dentures (D5110-D5120) are covered 1 per arch per 5 years.
- Immediate dentures (D5130-D5140) are covered 1 per arch per 5 years.
- Partial dentures (D5213-D5214; D5282-D5284; D5286) are covered 1 per arch per 5 years.
- Adjustments (D5410-D5422) are covered 3 per year.
- Denture repair (D5511-D5512; D5611-D5622) is covered 2 per year per arch.
- Replace missing or broken teeth (D5520) is covered 2 per year per tooth.
- Add clasp or tooth (D5630-D5640; D5650-D5660) is covered 2 per year.
- Rebase (D5710-D5721) is covered 1 per 5 years.
- Reline (D5730-D5761) is covered 1 per 2 years.

Other removable prosthodontics are covered in accordance with the benefit plan as outlined on the United Concordia website.

Maxillofacial Prosthetics Benefits and Limitations

- Trismus appliance (D5937) (not for TMD) is covered.

Other maxillofacial prosthetics are covered in accordance with the benefit plan as outlined on the United Concordia website.

Fixed Prosthodontic Procedure Benefits and Limitations

- Pontic (D6211; D6241) is covered 1 in 5 years.
- Retainer (D6545) is covered 1 in 5 years.
- Recement (6930) is covered 1 per calendar year.

Oral Surgery Procedure Benefits and Limitations

- Extraction (D7140) is covered 1 per tooth per lifetime.
- Surgical removals/procedures (D7210, D7220 -D7240) are covered 1 per tooth per lifetime.
- Oroantral fistula closure (D7260) is covered.
- Re-implantation/transplantation (D7270) is covered.
- Surgical access of a unerupted tooth (D7280) is covered. Device placement for impacted tooth (D7283) is covered.
- Biopsy (D7285-D7286) is covered.
- Alveoloplasty (D7310 and D7320) is covered 1 quadrant per lifetime.

Other oral surgery procedures are covered in accordance with the benefit plan as outlined on the United Concordia website.

Orthodontic Procedure Benefits and Limitations

- Limited orthodontic treatment (D8010 – D8040) is covered 2 per year.

- Comprehensive orthodontic treatment (D8070 - D8090) is covered 1 per lifetime.
- Removeable appliance therapy (D8210) is covered 2 per lifetime.
- Fixed appliance therapy (D8220) is covered 2 per year.
- Orthodontic retention (D8680) is covered.
- Removal of fixed orthodontic appliance (D8695) is covered.
- Repair of orthodontic appliance (D8696-D8697; D8701-D8702) is covered 1 per lifetime.
- Re-cement or re-bond (D8698-D8699) is covered 1 per lifetime.
- Replacement of retainer (D8703-D8704) is covered 1 per lifetime.

Adjunctive General Procedure Benefits and Limitations

- Procedure Codes (D9222, D9223, D9230, D9239, D9243 and D9248) can be administered only by a dentist who holds a state permit (restricted permit I, restricted permit II, or unrestricted) are permitted to administer and bill for anesthesia services allowed under their state specific permit. Dentists providing anesthesia for members in a dental office must bill using their NPI as performing provider and the dental group NPI for reimbursement.
- Consultation (D9310) is covered.
- Other drugs and/or medicaments (D9630) is covered.
- Occlusal guard (D9944-D9951) are covered.
- The dentist completing the restorative procedure must include the hospital call (D9420) on the dental claim submitted for payment.

Adult Medicaid Benefit Coverage - Benefits and Limitations

For a full listing of covered benefits and limitations, please reference the benefit grid on the United Concordia website. This plan is for recipients in West Virginia who are age 21 and older. The Adult Medicaid plan has a $2,500 comprehensive maximum every 2 fiscal years. There is no copayment for the adult Medicaid plan. Adult Medicaid members are also covered for emergency dental care that do not apply towards the maximum.

**Emergency Services covered for adults*

Diagnostic Procedure Benefits and Limitations

- Periodic oral evaluations (D0120) are eligible 1 per 180 days.
- Limited oral evaluation (D0140) is not to be billed with other exams.*
- Comprehensive oral evaluations (D0150) are eligible 1 per calendar year.
- Periodontal Evaluation (D0180) are eligible 1 per 2 years, age 14-20 only.
- Complete series of radiographs (D0210) is eligible 1 time in a 3-year period.
- Periapical x-rays are eligible. D0220 is covered 1 per day. D0230 is covered 8 per 3 months.*
- Panoramic radiograph (Procedure Code D0330) is covered 1 in a 3-year period.
- Bitewing x-rays (D0270-D0277) are covered 1 per year except D0270 that is covered 4 per year.
- Intraoral tomosynthesis (D0373-D0389) is covered 1 per year.
- Accession of tissue (D0474-; D04876) is covered.*
- 3D facial surface scan (D0801-D0804) is covered 1 per year.

Preventive Procedure Benefits and Limitations

- Routine prophylaxis (D1110) is covered 1 per 180 days. 1 additional cleaning is covered with pregnancy diagnosis.
- Interim Caries Arresting Medication (D1354) is covered 2 per tooth per year.
- Vaccines (D1781-D1783) are covered.

Restorative Procedure Benefits and Limitations

- Amalgam and Composite-Based Resin Restorations (D2140, D2150, D2160, D2161; D2330-D2335; D2390-D2394)
  - Resin (composite) restorations are covered when performed on anterior or posterior teeth. 5 surfaces per tooth number per 3 years.
  - The fees for restoration and filling include local anesthesia, polishing, bonding agents, cement bases, acid etch, light cured material and the necessary medications where indicated.
- Crowns (D2390; D2740, D2751, D7252, D2791, D2920; D2931-D2957)
- Crowns (D2390) is covered 1 per tooth every 3 years. (D2920– D2932) are covered 1 per tooth per year. Crowns (D2740-D2752) are covered 1 per tooth per 5 years.
- Procedure codes D2929 and D2930 are crowns for primary or developing permanent teeth only and are not compensable

with construction of a permanent crown. D2929 is allowed 1 per tooth per year. D2931 is eligible 1 per tooth per year. (*check the members benefit plan to ensure age-appropriate coverage for the benefit prior to rendering care*)

- Crowns and post and cores are payable only when necessary due to decay or tooth fracture.
- Crowns are indicated for teeth that cannot be restored using filling materials. Crowns should not be recommended for teeth that have poor prognosis (periodontally compromised, unrestorable, or have chronic infections). Crowns should be placed on decay-free tooth structure and have good marginal integrity.

Endodontic Procedure Benefits and Limitations

- Root canals (D3310-D3330) are covered 1 per tooth per lifetime.
- Retreatments (D3346-D3348) are covered 1 per tooth per lifetime.
- Apicoectomy (D3410-D3421) are covered 1 per tooth per lifetime.

Endodontic treatment should not be performed on teeth with a poor restorative or periodontal prognosis.

Periodontic Procedure Benefits and Limitations

- Gingivectomy (D4210-D4211) is covered 1 quadrant per year.
- Scaling and root planning (D4341-D4342; D4346) is covered 1 quadrant per year except D4346 which is covered 1 per 2 years.
- Full mouth debridement (D4355) is eligible 1 per 6 months.
- Periodontal maintenance (D4910) is covered 1 per year.

Removable Prosthodontic Procedure Benefits and Limitations

- Complete dentures (D5110-D5120) are covered 1 per arch per 5 years.
- Immediate dentures (D5130-D5140) are covered 1 per arch per 5 years.
- Partial dentures (D5211-D5214; D5225-D5226) are covered 1 per arch per 5 years.
- Adjustments (D5410-D5422) are covered 3 per year.
- Denture repair (D5511-D5512; D5520; D5611-D5622) is covered 2 per year per arch.
- Replace broken teeth (D5640) is covered 2 per year.
- Add clasp or tooth (D5650-D5660) is covered 2 per year.
- Rebase (D5710-D5721) is covered 1 per 5 years.
- Reline (D5730-D5761) is covered 1 per 2 years.
- Interim denture (D5810 – D5811) is covered 1 per 5 years. Interim partial denture (D5820-D5821) is covered 1 per lifetime.
- Tissue conditioning (D5850 – D5851) is covered.

Fixed Prosthodontic Procedure Benefits and Limitations

- Recement (6930) is covered 1 per calendar year.

Oral Surgery Procedure Benefits and Limitations

- Extraction (D7140) is covered 1 per tooth per lifetime.*
- Surgical removals/procedures (D7220 -D7240) are covered 1 per tooth per lifetime.*
- Surgical removals/procedures (D7250) are covered 1 per tooth per lifetime.
- Oroantral fistula closure (D7260) is covered.*
- Biopsy (D7285-D7286) is covered.*
- Alveoloplasty (D7320) is covered 1 quadrant per lifetime.
- Excision (D7410 – D7441) is covered.*
- Removal of benign cysts (D7440 – D7461) is covered.*
- Incision and drainage (D7510 – D7520) are covered.*
- Removal/reduction (D7530; D7610 – D7680; D7710 – D7780) is covered*
- Removal/reduction/resection (D7471 – D7473; D7485; D7490) is covered.
- Marsupialization of odontogenic cyst (D7509) is covered 1 per year.
- Suture (D7910 – D7912) are covered up to 1 unit, except D7910 which is covered.*
- Guided tissue regeneration (D7956 – D7957) is covered 1 per year.

Adjunctive General Procedure Benefits and Limitations

- Procedure Codes (D9222, D9223, D9230, D9239, D9243 and D9248) can be administered only by a dentist who holds a state permit (restricted permit I, restricted permit II, or unrestricted) are permitted to administer and bill for anesthesia services allowed under their state specific permit. Dentists providing anesthesia for members in a dental office must bill using their

NPI as performing provider and the dental group NPI for reimbursement.*

- Therapeutic parenteral drug (D9610; D9630) is covered.
- Application of desensitizing medicament (D9910) is covered.
- Consultation (D9310) is covered.
- Occlusal guard (D9944-D9945) are covered.

Prior Authorizations

A prior authorization is required for those services for which the West Virginia Department of Human Services (DoHS) recommends prior authorization, requires prior authorizations and has granted approval to United Concordia to require prior authorization.

Prior authorization is required for anesthesia, orthodontics, crowns, surgical extraction(s) of impacted tooth/teeth, periodontal services (except full mouth debridement which requires post- operative review). All dental procedures are considered to be outpatient procedures. These procedures are not compensable on an inpatient basis unless there is medical justification, which is documented, in the patient's medical record.

WV Medicaid members who need to be seen in a hospital facility for dental services, prior authorization is required under the member's medical coverage with Highmark Health Options. A prior authorization should be submitted under medical for codes 41899 and 00170.

Requesting a Prior Authorization

Prior authorizations must be requested electronically through using our free Speed eClaim® system available on our website or by contacting your Clearinghouse/Vendor for availability of Real-time Claim Transaction Processing. Your office will receive a Dental Explanation of Benefits (DEOB) detailing the approved services and the plan payment amounts.

A prior authorization is not a guarantee of payment but indicates how much would be payable given the information available at the time the determination is processed. When the predetermined services have been provided, use one of the following methods to request payment.

- **Electronic Claims** – Simply include the claim number printed on the Prior Authorization Notification and Request for Payment Form in the remarks field of your electronic claim request for payment.

A prior authorization will remain valid for 365 days from the date of approval. The Dental Prior Authorization Notification and Request for Payment form contains the date that the preauthorization is approved through. **Services performed after the approval has expired will be subject to another review and should be submitted with the appropriate radiographs and supporting documentation for payment consideration.**

Timeframes and Written Notification

The following are the standards for prior authorizations:

- **Standard Decision (Non-Urgent Prior Authorization)** – Non-urgent prior authorization requests referred to a Dentist Advisor for approval, or to a physician for a denial determination, will be completed within two (2) business days of the receipt of the request. Written notification of the decision will be sent to the dentist within two (2) business days of the decision.
- **Expedited Decision (Urgent Prior Authorization)** – Urgent prior authorizations for non-participating provider requests will be completed, and dentists will be notified of a decision, within two (2) business days of request.
- **Expiration of Prior Authorizations** – Prior Authorizations are valid for 365 days from the date of approval. Approved treatment must be rendered within this time frame, or a new prior authorization will need to be submitted for clinical review.
- **Request for Additional Information** - If a request for prior authorization is received with incomplete information, the provider and the member will be notified that additional information is needed for review, using the "Request for Additional Information" letter template. The provider will have three (3) business days to submit the additional information. Once additional information is received, a decision will be made within two (2) business days. If the requested information is not received within the established time frame, a decision will be made by reviewing the available information.

Diagnostic Material Requirements

The following requirements are applicable to the provision of covered services to Highmark Wholecare members.

When covered, the procedures listed on the following chart require submission of diagnostic materials for review. Dentists are requested to submit diagnostic materials used for diagnosis and treatment planning.

All radiographs submitted (including copies) should be pre-treatment unless otherwise noted. They should be of diagnostic quality and mounted properly with the left and right sides clearly marked. They should be identified with the dentist's name and address, the patient's name and identification number and the date the radiographs were taken. (If a copy of the radiographs is submitted, left or right should be marked on the copy.)

If, for some reason, radiographs are not available, a brief explanation should be included on the claim form. If submitting claims electronically, please provide a brief explanation in the remarks field.

MINIMUM REQUIREMENTS FOR DIAGNOSTIC MATERIALS FOR MANUAL CLINICAL REVIEW

Chart Key: *Please refer to the below indicators within the chart to determine the appropriate documentation REQUIRED for review.*	
X	Required
A	A post-endodontic treatment, diagnostic x-ray ***IN ADDITION*** to a pre-treatment diagnostic x-ray of the tooth.
B	Pre-treatment, diagnostic x-ray(s) of the area of implant placement and the adjacent teeth is required. ***IN ADDITION*** to a pre-treatment diagnostic x-ray of the tooth.
C	X-ray(s) of all the teeth in the arch (Full Mouth Series or Panoramic) are required. ONLY for plans that apply an Alternate Benefit Provision (ABP) ***IN ADDITION*** to a pre-treatment diagnostic x-ray of the tooth.
D	Is ***ONLY*** required if reported with a service where deep sedation/general anesthesia, inhalation of nitrous oxide/analgesia, IV moderate (conscious) sedation/analgesia, or non-IV conscious sedation anesthesia may not be the typical standard of care and deep sedation/general anesthesia, inhalation of nitrous oxide/analgesia, IV moderate (conscious) sedation/analgesia, or non-IV conscious sedation is being recommended by the provider because of complex medical issues and/or treatment needs.

Diagnostic/ Pre-treatment x-ray

- Periapical (PA) and/or Bitewing (BW) x-ray(s) are preferred.
- A panoramic x-ray will be accepted in certain instances:
  - Panoramic x-ray(s) are of limited diagnostic specificity for review of any procedures outside of Implant Services (D6000-D6199), Oral Surgery (D7000-D7999) and Orthodontics (D8000-D8999). Panoramic x-rays are only preferred in addition to or instead of a periapical x-ray for review of certain Implant Services (D6000-D6199), Oral Surgery (D7000-D7999) and Orthodontic (D8000-D8999) codes.

Periodontal Charting

- Complete and legible 6-point Periodontal Charting of the tooth/teeth.

Written Documentation

- Chart/progress notes are preferred.
- If no chart/ progress notes are available, information in Box 35 of the ADA claim form/note field in an Electronic Data Interface submission, or a narrative are all accepted as forms of "written documentation".

Written documentation may be required when manual clinical review is necessary as part of benefit determination for any "by report" or "unspecified" dental service (D0160, D0321, D0502, D0999, D1999 D2999, D3999, D4999, D5899, D6090, D6095, D6999, D7291, D7950, D7995, D7999, D9930, D9999) and certain endodontic and surgical services.

DENTAL SERVICE	Diagnostic/ Pre-treatment x-ray	Periodontal Charting	Written Documentation
Unspecified diagnostic procedure, by report (D0999)			X
Crown (D2710, D2740, D2751, D2752, D2791, D2792, D2799)	X		
Core buildup (D2950)	X		
Post and Core (D2953, D2957)	A		
Unspecified restorative procedure, by report (D2999)			X
Unspecified endodontic procedure, by report (D3999)			X
Gingivectomy or gingivoplasty (D4210, D4211)	X	X	
Osseous surgery (D4260, D4261)	X	X	
Bone replacement graft – retained natural tooth (D4263, D4264)	X	X	

Biological materials (D4265)	X		
Guided tissue regeneration (D4266, D4267)	X		
Pedicle soft tissue graft (D4270)	X		
Subepithelial connective tissue graft (D4273)	X		
Mesial/distal wedge procedure, single tooth (D4274)	X	X	
Tissue graft (D4275, D4276)	X		
Splint intra/extra coronal (D4322, D4323)	X		
Unspecified periodontal procedure, by report (D4999)			X
Denture (D5110, D5120, D5211, D5212, D5213, D5214, D5225, D5226, D5670, D5810, D5811, D5820, D5821)	X		
Unspecified removable prosthodontic procedure, by report (D5899)			X
Trismus appliance (D5937)			X
Vesiculobullous disease medicament carrier (D5991)			X
Unspecified maxillofacial prosthesis, by report (D5999)			X
Pontic (D6211, D6212, D6241, D6242)	X		X
Retainer (D6545)	X		X
Crown (D6751, D6752, D6791, D6792)	X		X
Unspecified fixed prosthodontic procedure, by report (D6999)			X
Surgical access of unerupted tooth (D7280)	X		X
Luxate tooth to aid eruption (D7282)	X		X
Device placement for impacted tooth (D7283)	X		X
Excision of hyperplastic tissue (D7970)			X
Unspecified oral surgery procedure, by report (D7999)			X
Deep sedation/general anesthesia (D9222, D9223)			D
Inhalation of nitrous oxide/analgesia, anxiolysis (D9230)			D
Intravenous moderate (conscious) sedation/analgesia - first 15 minutes (D9239, D9243)			D
Non-intravenous conscious sedation (D9248)			D
Unspecified adjunctive procedure, by report (D9999)			X

FOR ALL SERVICES:
Submission of additional x-rays (outside of required), written documentation (chart notes/narratives/periodontal charting/specialist letters/etc.) when not specifically required, photographs, and other diagnostic materials outside of required diagnostic materials listed is optional and should corroborate with evidence presented in required materials.

Orthodontic Services

***Please note that Medical Assistance requires Ortho to be medically necessary.**

West Virginia Department of Human Services (DoHS) covers orthodontic treatment when at least one of the following conditions exist:

- Overjet in excel of 7mm.
- Severe malocclusion associated with dento-facial deformity.
- True anterior open bite.
- Full cusp classification from normal (class II or class III).
- Palatal impingement of lower incisors into the palatal tissue causing tissue trauma.
- Cleft palate, congenital or developmental disorder.
- Anterior crossbite (2 or more teeth and in cases where gingival stripping from the crossbite is demonstrated and not correctable by limited orthodontic treatment).
- Unilateral posterior crossbite with deviation or bilateral posterior crossbite involving multiple teeth including at least one molar.
- True posterior open bite (not involving partially erupted teeth or one or two teeth slightly out of occlusion and not correctable by habit therapy).
- Impacted teeth (cuspids, lateral incisors, and central incisors only).

Orthodontic Procedure Benefits and Limitations

- Orthodontic Services: Orthodontic services are covered if medically necessary for a WVCHIP member whose malocclusion creates a disability and impairs their physical development. Treatment is routinely accomplished through fixed appliance therapy and maintenance visits. All requests for treatment are subject to prior authorization by WVCHIP dental consultants. Prior authorization is dependent on diagnosis, degree of impairment and medical documentation submitted. Failure to obtain prior authorization before service is performed will result in the family being responsible for amounts above and beyond their copayment requirements.
- Doctor of Dental Medicine (DDM), Doctor of Dental Surgery (DDS) and Doctor of Oral Maxillofacial Surgery (OMS) are the only provider types eligible to provide general dental, orthodontic and oral/maxillofacial surgery services to members and receive payment for dental services. Per chapter 505.3 of the BMS Provider Manual, dental hygienists are not eligible to receive direct reimbursement for services.

Payment Orthodontic Services

Payments for Orthodontic Services are generally issued as follows:

- One treatment of comprehensive orthodontia (CDT Codes: D8070, D8080 or D8090) is reimbursed, per member as a one-time full case fee. If the initial orthodontist is unable to complete the member's approved treatment plan, they must refund the uncompleted portions of the treatment plan. The orthodontist who completes the treatment plan, will be paid the remaining case fee.

Transferring Orthodontists

If the patient transfers to a different orthodontist, the new orthodontist must submit a claim. It is the orthodontist's responsibility to notify United Concordia if orthodontic treatment is discontinued or completed sooner than anticipated.

If the patient transfers to a different dentist, the new dentist must submit a preauthorization indicating the remaining treatment, total fee, and the banding date if the patient was rebanded. Payment for services provided by the new dentist will be calculated based on the remaining orthodontic benefits and remaining length of treatment.

Please remember:

- It is the **dentist's responsibility** to notify United Concordia's Customer Service at (844) 789-1722 if orthodontic treatment is discontinued, completed sooner than anticipated, or if the patient transfers to another dentist.
- If you are rebanding the transfer patient, please indicate that the patient was rebanded and the rebanding date.
- If the patient was not rebanded, please indicate the date the new dentist assumed responsibility for the treatment plan.
- The office will be contacted by telephone for any missing information. The development may create a delay in the processing of the orthodontic claim.

Billing Orthodontic Services

The following instructions and sample forms will help you in preparing orthodontic claims and understanding payment for orthodontic services.

Please prepare a complete treatment plan following the same guidelines specified for new patients, except for the following:

- Do not list any services rendered before the patient became eligible. This will usually include diagnostics. A banding date will be required to determine the number of months prior to coverage.
- Submit a copy of the approved prior authorization for the orthodontic treatment plan. List the following information:
  - ✓ Starting date of treatment (banding date).
  - ✓ The total treatment plan as indicated by the appropriate procedure code. On this line also include total case fee, excluding diagnostics. This fee includes retention and case finishing procedures that should not be listed or billed separately.

Quality Assurance

Section 7

Quality Review

Utilization Review

United Concordia's Utilization Review (UR) program is designed to help ensure that procedures reported on behalf of our members are rendered consistent with the provisions of their benefit programs. Because this program can affect any dentist who treats a patient covered by a United Concordia plan, it is important to understand its purpose and how it works.

The Utilization Review Process

Data Collection and Statistical Analysis

Post-payment utilization reviews generally begin with the identification of a potential concern. Most frequently, the concern is identified through statistical analyses and peer comparisons but can occur as the result of an inquiry or complaint received from a patient or another dentist or as the result of discrepancies noted during normal claims processing.

Upon identification, a complete analysis of information available internally at United Concordia, as well as other relevant information, is conducted. This may include a review of prior claim submissions, pending inquiries, or complaints and statistical information.

Professional Consultant Review / Counseling

The analysis may conclude that intervention is required. If so, intervention begins with an educational letter. The letter cites the dentist's exceeded procedure(s) and/or peer comparison in relation to state average. A twelve-month update is subsequently performed to determine if the educational letter was successful or if further intervention is required.

If there appears to be no change in reporting, the dentist is sent a letter which includes a peer comparison to the procedure(s) in question, along with a request for a sample of patient records. The letter always includes the name and telephone number of a contact person and also provides the dentist with the opportunity to discuss any clinical or dental policy related questions with a Dental Director and/or Advisor.

The record review is always conducted by a Dental Director or Advisor, who is a licensed dentist. The Dental Director or Advisor is asked to review the available clinical records and diagnostic materials and render a professional opinion as to whether the records adequately document the services reported.

Upon completion of the record review, the findings are provided to the dentist. If discrepancies are identified, the dentist is provided a detailed report for review and consideration. If the discrepancies result in an overpayment, a refund may be calculated.

Prepayment Monitoring

If problems of a repetitive nature are identified during the record review, a dentist may be required to provide supporting clinical documentation with future claims and/or requests for predetermination, which will be reviewed by a licensed dentist to determine benefit eligibility. In some cases, this action may occur immediately following the data collection and statistical analysis.

Possible Follow-up Actions

- If the problems do not improve over a period of time, the dentist may be terminated from United Concordia network participation.
- If fraudulent billings are identified, the findings will be forwarded to the Special Investigations Unit for further investigation.

Documentation and Record Keeping

Timely, accurate and complete documentation is critical to nearly every aspect of a dental practice. Documentation is also necessary to maintain complete dental records for the patient and is the basis for coding and billing determinations. Most importantly, failure to properly document has the potential to compromise good patient care.
In addition to facilitating high quality patient care, a properly documented dental record accurately denotes what services were provided and why. The dental record may be used to validate:

- The site of service
- The appropriateness of the services provided.
- The accuracy of the billing

Accurate dental record documentation should comply with, at the minimum, the following principles:

- The dental record should be complete and legible.
- The documentation for each service performed should include the reason, any relevant history, physical examination findings, assessment, clinical impression, diagnosis, treatment plan, date and treating dentist, if applicable

  The current version CDT codes reported on the insurance claims form should be supported by documentation in the dental record and chart.

The Special Investigations Unit (SIU)

The role of the SIU is to detect and investigate alleged fraud for all lines of United Concordia business.
The National Health Care Anti-Fraud Association defines fraud as an intentional deception or misrepresentation that the individual or entity makes knowing that the misrepresentation could result in some unauthorized benefit to the individual or the entity, or to some other party.
Examples of fraud include:

- Billing for services not rendered.
- Intentional misreporting of any of the following:
  - Procedure
  - Date of service
  - Identity of the dentist
  - Identity of the patient
- Deliberate performance of unnecessary services for financial gain
- Alteration of patient records and/or claim forms.
- Reporting a more expensive procedure than was actually rendered (Upcoding)

Filing a Complaint

If fraud is suspected, a complaint should be filed with the SIU. The SIU receives allegations of fraud from external sources (subscribers, dentists, other insurance companies and law enforcement agencies), as well as from internal sources (Customer Service representatives and Dental Claims reviewers). The SIU also utilizes various software systems to analyze reporting patterns and detect potential fraudulent behavior.

The allegations may identify an isolated incident (a specific service reported on behalf of a specific patient) or a fraudulent pattern. The SIU conducts a thorough investigation of all allegations to determine investigative merit and the appropriate resolution.

Resolution may include:

- Education
- Professional consultant review
- Overpayment recovery
- Termination from United Concordia network participation
- Referral to the appropriate Federal or State law enforcement agency for prosecution of the individual(s) involved.

The SIU can be contacted at the following:

SIU Mailing Address:
Special Investigations Unit
1800 Center Street, Suite 2B 220
Camp Hill, PA 17011

SIU Toll-Free Fraud Hotline
(877) 968-7455

SIU Fraud Complaint Form Online
www.UnitedConcordia.com

Regulatory Compliance

Dentists have a responsibility to ensure the claims they submit are truthful, accurate and comply with all federal and state contractual regulations.

United Concordia realizes dentists and their staff may make billing mistakes and errors through inadvertence or omission. When United Concordia determines that a billing error, honest mistake, or omission has resulted in an inappropriate payment, United Concordia will request that the practice return the payment. However, the dental practice will not be subject to civil or criminal penalties.

If a dentist knowingly submits a fraudulent claim, United Concordia will rely on federal and state criminal and civil health care fraud laws. These laws cover offenses that are committed with actual knowledge of the falsity of the claim, reckless disregard or deliberate ignorance of the falsity of the claim.

Provider Dispute Mechanism

In the event that a dentist, contracted or non-contracted, has a dispute with United Concordia, the dentist shall file that dispute to United Concordia in writing to the following address:

United Concordia Companies, Inc.
Provide Dispute Resolution
PO Box 69414
Harrisburg, PA 17106-9414

The dispute must be filed within 365 days of the incident that provoked the dispute. United Concordia shall acknowledge receipt of the dispute within 15 working days of receipt of paper or two working days of receipt of an electronic dispute. United Concordia shall gather necessary information to investigate and resolve the dispute. The dentist shall cooperate with this process or be subject to a resolution in favor of the Plan. The Plan shall respond to the dentist with the disposition of the dispute within 45 days of receipt.

Privacy and Security

Health Insurance Portability and Accountability Act (HIPAA)

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) provides baseline protections of individuals' personal health information and establishes standards for the use of health information technology ("Health IT"). HIPAA supports Health IT by, among other things, requiring uniform standards for electronic data interchange (EDI) and code sets and mandating the use of uniform health care identifiers. These standards are established with the goals of reducing health care costs, increasing administrative efficiencies, decreasing paperwork, and improving the use of health information and overall quality of health care.

Transactions and Code Sets

United Concordia is compliant with the current transactions and code sets defined by HIPAA.

HIPAA Privacy

The HIPAA Privacy Rule (the "Privacy Rule") established protection for individuals' personal health information from unauthorized uses or disclosures without impeding the delivery of health care services or payment. The Privacy Rule applies to health plans, health care clearinghouses and dentists who conduct health care transactions electronically. United Concordia is committed to protecting our members' privacy and is compliant with the HIPAA Privacy Rule and other applicable federal and state privacy laws.

HIPAA Security

The HIPAA Security Rule protects the confidentiality, integrity, and security of electronic protected health information ("EPHI") by requiring covered entities to establish appropriate administrative, physical, and technical safeguards to protect such EPHI. United Concordia has implemented the required safeguards pursuant to the Security Rule.

HITECH

The "Health Information Technology for Economic and Clinical Health Act" or (the "HITECH Act") is a part of the American Recovery and Reinvestment Act of 2009 ("ARRA"). The HITECH Act, among other things, amended HIPAA's breach notification requirements, provided individuals with ease of access to electronic health records, and applied certain HIPAA provisions directly to business associates. United Concordia is in compliance with all HITECH provisions applicable to its business.

Clinical Review Criteria

Section 9

Highmark Wholecare Medicaid Review Criteria

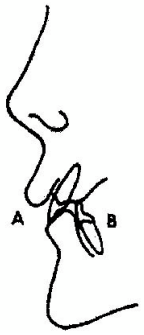
Orthodontic Review Criteria

Orthodontic Services

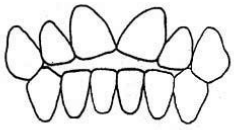
Procedure codes: 8080; 8210; 8220; 8660 - 8680; 8999

1. All requests for orthodontic treatment will be reviewed for medical necessity.
2. In order to bill Medical Assistance (MA) and/or request a prior authorization for orthodontic services, the dental practitioner must be a board certified or board eligible orthodontist.
3. The beneficiary must meet the following regulatory qualifications in order for the request to be considered:
    a. Permanent Dentition (fully erupted)
        i. Orthodontic services are only considered for those beneficiaries with permanent dentition. The beneficiary should present with a fully erupted set of permanent teeth. At least ½ to ¾ of the clinical crown of the tooth must be visible, unless the tooth is congenitally missing or impacted/blocked out.
    b. Age
        i. The beneficiary must be under 21 years of age.
    c. Orthodontic Decision Checklist
        i. The Orthodontic Decision Checklist consists of eight (8) areas for consideration in determining a handicapping malocclusion. If the beneficiary meets one or more considerations in Items 2 through 8 (on the checklist), the Orthodontist must submit the ADA Claim Form, diagnostic study models and x-rays.
4. Inter-Arch Deviation
    a. Anterior Segment
        i. OVERBITE refers to the occlusion of the maxillary incisors on or opposite the labial gingival mucosa of the mandibular incisors, or the mandibular incisors occlude directly on the palatal mucosa back of the maxillary incisors.

        DO NOT CONSIDER OVERBITE unless the LOWER INCISORS IMPINGE ON THE PALATE or the UPPER INCISORS IMPINGE ON OR ARE OPPOSITE THE LOWER GINGIVA.

        ii. OPEN-BITE OF INCISORS refers to vertical interarch dental separation between the maxillary and mandibular incisors when the posterior teeth are in terminal occlusion. Open-bite is recorded in addition to overjet if the incisal edges of the labially protruding maxillary incisors are above the incisal edges of the mandibular incisors when the posterior teeth are in terminal occlusion.

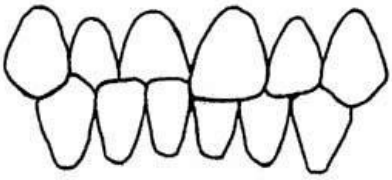
        

        EDGE-TO-EDGE OCCLUSION IS NOT ASSESSED AS OPEN-BITE

        DO NOT CONSIDER OVERJET if distance is less than NINE (9) MILLIMETERS

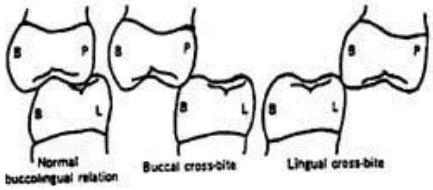
        

        iii. CROSS-BITE OF INCISORS refers to the maxillary incisors that are in lingual relation to their opposing teeth in the mandible when the maxillary and mandibular dental arches are in terminal occlusion



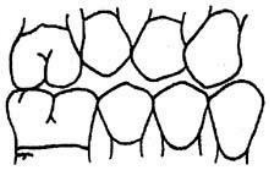
5. Posterior Segment
   a. CROSS-BITE OF POSTERIOR TEETH refers to teeth in the buccal segment that are positioned lingually or buccally out of ENTIRE OCCLUSAL CONTACT with the teeth in the opposing jaw when the rest of the teeth in the dental arches are in terminal occlusion.

      EDGE-TO-EDGE OCCLUSION IS NOT ASSESSED AS CROSS-BITE.



   b. OPEN-BITE OF POSTERIOR TEETH refers to the vertical interdental separation between upper and lower canines, bicuspids, and first molars when the rest of the teeth in the dental arches are in terminal occlusion.

      CUSP-TO-CUSP OCCLUSION IS NOT ASSESSED AS AN OPEN-BITE



****Note: The above section, 1 through 5 are requirements of the PA PROMISe Provider Billing Handbook Chapter 7.**

6. Payment for orthodontic services are subject to the following conditions and requirements:
   a. The orthodontist is board certified or board eligible as defined in § 1149.2 of the 55 Pa. Code.
   b. They are necessary to prevent irreversible damage to the teeth or their supporting structures.
   c. They are necessary to prevent irreversible damage to the teeth or their supporting structures.
   d. They are necessary to treat acute dental problems as evidenced by the following factors:
      i. Dentofacial abnormalities that severely compromise the client's physical health, as manifested by markedly protruding upper jaw and teeth, protruding lower jaw and teeth, the protrusion of upper and lower teeth so that lips cannot be brought together, under-developed lower jaw and receding chin or marked asymmetry of the lower face.
      ii. Obvious difficulty in eating because of the malocclusion, so as to require liquid or semisoft diet, or cause pain in jaw joints during eating, or extreme grimacing or excessive motions of the orofacial muscles during eating because of necessary compensation for anatomic deviations.
      iii. Obvious sever breathing difficulties related to the malocclusion, such as unusually long lower face with downward rotations of the mandible and with lips that cannot be brought together, chronic mouth breathing and postural abnormalities relating to breathing difficulties – for example, head forward and extended, round shouldered.
      iv. Lisping or other speech articulation errors that are directly related to orofacial abnormalities.
   e. The recipient has a fully erupted set of permanent teeth.
   f. The recipient is 20 years or younger except as noted in paragraph (g).
   g. The recipient is 21 years of age or older but was receiving orthodontic services through the MA Program when the recipient turned 21 years of age.

****Note: The above section, 7a through 7g are requirements of the 55 Pa. Code § 1149.55. Payment conditions for orthodontic services.**

7. **Salzmann Evaluation Index**
   a. The recipient scored 25 or higher on the Salzmann Evaluation Index upon examination and evaluation by the orthodontist, or orthodontic treatment was determined to be medically necessary.

b. This assessment record is intended to disclose whether a handicapping malocclusion is present and to assess its severity according to the criteria and weights assigned to them.
    i. **Intra-Arch Deviations**
        1. Rotations must exceed five (5) degrees.
        2. Open spacing counts all visible papilla in maxillary anterior incisors only. These teeth may also be scored as rotated. In all other teeth in each arch, only the tooth is scored as spaced when both mesial and distal papilla are visible. The tooth may also be scored as rotated.
        3. No tooth may be scored as both rotated and crowded.
    ii. **Intra-Arch Deviations Anterior Segment**
        1. Overjet must equal or exceed nine (9) millimeters to score.
        2. Overbite may be both maxillary and mandibular incisors.
        3. Crossbite is not edge to edge.
        4. Open bite is determined from the frontal view.
    iii. **Intra-Arch Deviations Posterior Segment**
        1. The posterior segment relates the maxillary teeth to the mandibular teeth in function.
        2. Class I, II, III.
        3. Open bite.
        4. Cross bite.

c. **Important Tips**
- Patient must be under 21 years of age.
- All permanent teeth must be present and in occlusion.
- Anterior teeth: central and lateral incisors
- Posterior teeth: canines, premolars, and first molars
- Overbite: maxillary or mandibular incisors must be scored individually/separately and then added together for the final overbite scoring.

8. **Overview of Factors for Automatic Approval:**
    a. Cuspid impaction causing damage to adjacent teeth
    b. Overjet of at least 9mm of maxillary incisors
    c. Bilateral posterior cross bite
    d. Mandibular incisors impinging on palatal mucosa
    e. Incisors cross bite of three (3) or more teeth
    f. Full anterior open bite
    g. Cleft palate surgery or orthognathic surgery planned
    h. Salzmann evaluation index score of 25 or greater

Anesthesia/Sedation Review Criteria

Anesthesia Services

Procedure codes: D9222, D9223, D9239, D9243

1. The following reasons constitute acceptable documentation for the condition of the beneficiary or the nature of the oral surgery to justify anesthesia/sedation.
    a. Child is under 5 years of age and more than one simple extraction or surgical extraction is performed.
    b. Beneficiary has medical conditions that preclude the use of local anesthesia.
        i. Severe gag reflexes
        ii. Local anesthesia will be ineffective because of anatomic variation or allergy, or
        iii. Previous failed treatment attempts using oral sedation or nitrous oxide inhalation.
        iv. Member's dental condition requires extensive dental restorative or surgical treatment that cannot be rendered under local anesthesia.
    c. Severe infection at the injection site.
    d. Beneficiaries with intellectual disability, other mental health or physical conditions and who are unmanageable using local anesthesia.
        i. Severe gag reflexes
        ii. Local anesthesia will be ineffective because of anatomic variation or allergy, or
        iii. Previous failed treatment attempts using oral sedation or nitrous oxide inhalation.
        iv. Member's dental condition requires extensive dental restorative or surgical treatment that cannot be rendered under local anesthesia.
    e. Multiple extractions in more than one quadrant. Extractions for impacted teeth. If the treatment is simple or surgical extractions, two or more quadrants must have had at least two teeth extracted per quadrant *or* three or more quadrants had at least one tooth extracted per quadrant.

2. Providers submitting prior authorizations or claims for anesthesia will need to submit documentation to support medical necessity for our Dental Advisor's review.
3. Acceptable documentation to support medical necessity would include:
    - Severe infection at the injection site.
    - Severe cerebral palsy, unmanageable.
    - Severe intellectual disability, unmanageable.
        - A definitive diagnosis and secondary diagnosis along with documentation of the statements under the remarks section must be substantiated in the beneficiary's medical record. These records are subject to review, prior or post service for medical necessity.
4. Unacceptable documentation examples could include:
    - Beneficiary unable to tolerate the procedure.
    - Beneficiary prefers or requests general anesthesia.
    - Beneficiary wants to be asleep.

Crowns Review Criteria

Crown Services

Procedure codes: D2710, D2721, D2740, D2751 and D2791

1. Radiological films for proposed single crowns or abutment teeth must have acceptable views of adjacent and opposing teeth.
2. Single crown criteria:
    a. Molars must have pathological destruction to the tooth by caries or trauma, and must involve four (4) or more surfaces and two (2) or more cusps.
    b. Anterior teeth must have pathologic destruction to the tooth by caries or trauma and must involve four (4) surfaces and at least 50% of the incisal edge.
    c. Bicuspids (premolars) must have pathologic destruction of the tooth by caries or trauma and must involve three (3) or more surfaces and one (1) cusp.
3. When submitting a request for a crown following a root canal, the following conditions must be met:
    a. A one (1) month period of time must elapse between the date a root canal is completed and the date that the request for a crown is submitted.
    b. A periapical file must be taken and submitted to show the root crown of the natural tooth;
    c. The tooth is filled within two (2) millimeters of the radiological apex; and
    d. The root canal filing material is not filled beyond the radiographical apex.
4. Additional crown criteria
    a. The beneficiary must be free from active and advanced periodontal disease.
    b. Crowns must be opposed by teeth in the opposite jaw or be a support for a partial.
    c. Crowns for primary teeth will not be covered if the radiograph indicates imminent exfoliation.
    d. Crowns will not be approved when lesser means of restoration is possible.
    e. The Dentist should impress upon the beneficiary the importance of taking care of a crown. Crowns that are dislodged, broken, or lost are not sufficient justification for replacement.

Complete Dentures Review Criteria

Denture Services

Procedure Codes: D5110, D5120, D5130 and D5140

1. A prior authorization for a denture(s) should be based on:
    a. The total condition of the mouth;
    b. The ability of the beneficiary to adjust to a denture(s); and
    c. The desire of the beneficiary to wear a denture(s).
2. Where essential preparatory services of any type are a part of an approved complete or partial denture treatment plan, those services must be completed before the denture service itself is initiated, including prior authorization of any teeth requiring extraction.
3. The dentist should impress upon the beneficiary the importance of taking care of dentures. Stolen, lost or broken dentures are not sufficient justification for replacement.
4. Dentures must be fabricated for a specific beneficiary with individually positioned teeth, wax up of the entire denture body and conventional laboratory processing.

Partial Dentures

Procedure Codes: D5211, D5212, D5213 and D5214

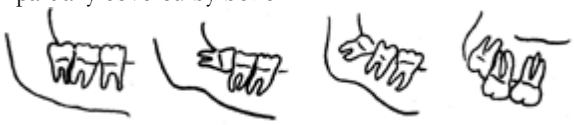
1. The treatment plan must identify all teeth that are going to be placed on the partial denture.
2. Abutment teeth must be at least 509% supported by bone.

3. The dentist should impress upon the beneficiary the importance of taking care of dentures. Stolen, lost or broken dentures are not sufficient justification for replacement.

Surgical Extractions

1. *Procedure Codes: D7220, D7230, D7240, D7250, D7280, and D7283* The surgical extraction is not a simple extraction. Surgical extractions require an incision of overlaying soft tissue, elevation of flap, and/or removal of bone, the removal of teeth, and possibly sectioning of the teeth.
2. Surgical extraction will be for fully developed permanent teeth causing or threatening to cause irreversible damage.
3. Routine removal of impacted or unerupted teeth must be supported by pathology.
    a. Lesions associated with impaction.
    b. Threat of resorption of root of permanent adjacent tooth.
4. Procedure Code Identification
    a. Refer to the following illustrations to determine the appropriate MA Procedure Code for prior authorization
        i. Complete Bony Impaction (D7240) – The occlusal surface of the crown of the tooth is completely encased in bone, and requires bone removal and/or sectioning of the tooth in order to remove the tooth.

        ii. Partial Bony Impaction (D7230) – The occlusal surface of the crown of the tooth is sufficiently covered with bone to require removal of bone and/or sectioning to remove it from its bone crypt. In this case, the crown is partially covered by bone.



        iii. Soft Tissue Impaction (D7220) – The occlusal surface of the crown of the tooth is partially or completely covered by soft tissue, which is incised and/or retracted from bone to remove the tooth.

        iv. Root Recovery (D7250) – Surgical removal of a residual root completely covered by bone. A root remains with bony tissue grown over the space, which was once occupied by the coronal portion of the tooth.

*__Note: If a fee for a tooth extraction was previously paid, no additional payment will be made for a subsequent root recovery involving the same tooth.__

Periodontal Services Review Criteria

Periodontal Services

*Procedure Codes: D4210, D4341, D4342, D4355** and D4910*

1. Gingivectomy or Gingivoplasty – per quadrant (D4210)
    a. The procedure is medically necessary for the correction of severe gingival hyperplasia or hypertrophy associated with drug therapy. Sever gingival hyperplasia interferes with or restricts the ability to perform effective daily oral hygiene procedures.
    b. If the following criteria are met in the professional judgment of the reviewer, this service will be approved:
        i. Comprehensive periodontal evaluation (e.g., description of periodontal tissues, pocket depth chart, tooth mobility mucogingival relationships); and
        ii. Pertinent medical and dental history (e.g., medications); and
        iii. Objective evidence of severe gingival hyperplasia restricting the ability to perform effective daily oral hygiene procedures; or
        iv. Other documentation of objective evidence of clinical condition whose severity is consistent with above criteria.

v. Exceptions to established limits may be granted if documentation presented indicates recurrence of severe gingival hyperplasia within a two-year (2) period due to inability to alter medications.

2. Periodontal scaling and root planning – per quadrant (D4341, D4342).
    a. This procedure is medically necessary to:
        i. Reduce clinical inflammation as evidenced by edema, erythema of the gingival, generalized bleeding on probing, spontaneous bleeding reported by beneficiary, or by purulent gingival discharge;
        ii. Effectuate microbial shifts to a less pathogenic, subgingival flora;
        iii. Reduce probing depths when pocket depth is equal to or greater than 5mm or in the presence of clinical inflammation (see *i* above) following routine prophylaxis; and/or
    b. Gain clinical attachment. If the following criteria are met in the professional judgment of the reviewer, this service will be approved:
        i. Comprehensive periodontal evaluation (e.g., description of periodontal tissue, pocket depth chart, tooth mobility, mucogingival relationships); and
        ii. Current diagnostic radiographs demonstrating evidence of bone loss; and
        iii. Narrative/documentation of clinical information, including pocket depth(s) of 5mm or greater except in cases of medication related gingival hyperplasia or persistent inflammation characterized by generalized bleeding on probing (multiple bleeding points present per tooth on at least ½ of the remaining dentition per quadrant); or
        iv. Other documentation of objective evidence of clinical condition whose severity is consistent with above criteria.
3. Exceptions to established limitations will not be granted due to lack of beneficiary compliance and/or continued poor oral hygiene. Full mouth debridement to enable comprehensive periodontal evaluation and diagnosis – the dentist is required to secure post-operative review and approval from the Department through the prior authorization program.
    a. The procedure is medically necessary for removal of subgingival and/or supragingival plaque and calculus which obstructs the ability to perform an oral evaluation. A preliminary procedure that does not preclude need for other procedures.
    b. If the following criteria are met in the professional judgment of the reviewer, this service will be approved:
        i. Radiographs for diagnostic purposes demonstrating evidence of gross calculus buildup (radiographically visible calculus involving at least 75% of remaining dentition); or
        ii. In lieu of radiographs, documentation is presented indicating treatment was provided under general anesthesia or intravenous sedation, or radiographs were not obtainable due to the beneficiary's medical status; or
        iii. Other documentation of objective evidence of clinical condition whose severity is consistent with above criteria.
        iv. Exception to established limitations may be granted if objective evidence is presented indicating beneficiary is unable to perform effective daily oral hygiene procedures due to medical status.
4. Periodontal maintenance procedures following active treatment (this excludes full mouth debridement to enable a comprehensive oral evaluation and diagnosis on a subsequent visit)
    a. The procedure is medically necessary to:
        a. Prevent or minimize the recurrence and progression of periodontal disease in beneficiaries who have been previously treated for periodontitis;
        b. Prevent or reduce the incidence of tooth loss by monitoring the dentition and any prosthetic replacements of the natural teeth; and
        c. Increase the probability of locating and treating, in a timely manner, other diseases or conditions found within the oral cavity.
    b. If the following criteria are met in the professional judgment of the reviewer, this service will be approved:
        a. Documentation of previous periodontal treatment; and
        b. Continuous documentation of significant hard and soft tissue changes (e.g., changes in pocket depth greater than or equal to 2mm); or
        c. Other documentation of objective evidence of clinical condition whose severity is consistent with above criteria.
        d. Exceptions to established limitations will not be granted due to lack of beneficiary compliance and/or continued poor oral hygiene.

**** Note: The Department requires the dentist to secure post-operative review approval for procedure code D4355. The dentist is to submit for post-operative review through the prior authorization program. The procedure name and procedure code must match and accurately describe the requested service(s).**

Endodontic Therapy Review Criteria

Endodontic Services
Procedure Codes: D3310, D3320, D3330, D3471, D3472, D3473, D3501, D3502, D3503, D3921

1. Payment for root canals no longer requires post-operative review for prior authorization approval. Payment for D3921 require prior authorization with an x-ray and narrative indicating the reason for decoronation or submergence of an erupted tooth.
2. Root canals are not covered in the following situations:
    a. Intentional (elective) endodontics;
    b. Third molar (unless it is an abutment tooth);
    c. Teeth with advanced periodontal disease;
    d. Teeth with subosseous and/or furcation carious involvement;
    e. Teeth which cannot be restored with conventional methods (e.g., amalgam, composite or crowns); or Teeth, which have received prior endodontics treatment.

****Note: Root canals do not require prior authorization or BLE authorization if submitted by an Endodontist. If submitted by a general dentist, only a preauthorization is required.**

Adjunctive Services Review Criteria

Procedure Codes - DX99 codes

1. By Report codes, and any dental procedure requiring prior authorization not identified in the above criteria will be reviewed for prior authorization based on medical necessity.

Miscellaneous Services Review Criteria

Procedure Codes – D9947

1. To be considered an eligible service, the following medical necessity criteria must be met:

A. The patient must have a face-to-face clinical evaluation by the treating physician prior to sleep test to assess the patient for obstructive sleep apnea. A dentist is not the treating physician in the context of this clinical examination; AND

B. The patient has had a sleep study test and meets one of the following criteria:
    1. An apnea-hypopnea index (AHI) or respiratory disturbance index (RDI) is greater than or equal to 15 events per hour with a minimum of 30 events; OR
    2. The AHI or RDI is greater than or equal to 5 events and less than or equal to 14 events per hour with a minimum of 10 events AND documentation of:
        a. Excessive daytime sleepiness (documented by either Epworth score of greater than 10 or MSL less than 6), impaired cognition, mood disorder, or insomnia; OR
        b. Hypertension, ischemic heart disease, or history of stroke.
    3. If the AHI or the RDI is greater than 30 and meets either of the following:
        a. The patient is not able to tolerate a positive airway pressure device; OR
        b. The treating provider determines that the use of the positive pressure device is contraindicated.
    4. All sleep tests must be interpreted by a physician who holds either:
        a. Current certification in Sleep Medicine by the American Board of Sleep Medicine (ABSM); OR
        b. Current subspecialty certification in Sleep Medicine by a member of the American Board of Medical Specialists (ABMS); OR
        c. Completed a residency or fellowship training in a program approved by an ABMS board member and has completed all the requirements for subspecialty certification in sleep medicine except the examination itself and only until the time of reporting of the first examination for which the physician is eligible; OR
        d. An active staff membership of a sleep center or laboratory accredited by the American Academy of Sleep Medicine (AASM), Accreditation Commission for Health Care (ACHC) or the Joint Commission (formerly the Joint Commission on Accreditation of Healthcare Organizations [JCAHO]).
    5. Only the treating physician may order an oral appliance;
    6. The patient must be under multidisciplinary care of a qualified dentist and a medical practitioner for baseline evaluation, device selection, and titration, as well as outcome monitoring in order to achieve the best patient outcomes;
    7. The custom-made device must have a mechanism that is hinged or jointed on the sides, front, or palate and have a mechanism that allows for the mandible to be advanced; the device must be able to protrude the patient's mandible beyond the front teeth when adjusted to its maximum protrusion; the device must retain the adjustment setting when removed from the mouth; the device must maintain the adjusted mouth position during sleep and remain in a fixed place during sleep to prevent dislodging the device;
    8. Patients with OSA being treated with an oral appliance should return for periodic follow-up visits with the order provider. The purpose of the follow-up visits is to assess the patient for signs and symptoms of worsening OSA;
    9. Patients with OSA being treated with an oral appliance should undergo polysomnography or an attended cardio-respiratory sleep study with the oral appliance in place after final adjustments of fit have been performed. Repeat sleep study testing can be performed twice a year for follow-up.

Note: Oral appliances are considered medically necessary for the treatment of Obstructive Sleep Apnea Syndrome (OSAS) in children with craniofacial anomalies. Contraindications

A. Temporomandibular joint dysfunction
B. Periodontal disease
C. Severe Sleep Apnea (RDI ≥ 40)

Highmark Health Options DE Medicaid Review Criteria

Restorative Review Criteria

Restorative Services

Procedure codes: D2710, D2740, D2751, D2752, D2791, D2792, D2799

1. Radiological films for proposed single crowns or abutment teeth must be of diagnostic quality
2. Single crown criteria:
    a. Molars must have pathological destruction to the tooth by caries or trauma and must involve three (3) or more surfaces and one cusp.
    b. Anterior teeth must have pathologic destruction to the tooth by caries or trauma and must involve three (3) surfaces and at least 50% of the incisal edge.
    c. Bicuspids (premolars) must have pathologic destruction of the tooth by caries or trauma and must involve three (3) or more surfaces and one (1) cusp.
3. When submitting a request for a crown following a root canal, the following conditions must be met:
    a. A one (1) month period of time must elapse between the date a root canal is completed and the date that the request for a crown is submitted.
    b. A periapical file must be taken and submitted to show the 2 millimeters beyond the apex of the root;
    c. The tooth is filled within two (2) millimeters of the radiological apex; and
    d. The root canal filing material is not filled beyond the radiographical apex.
4. Additional crown criteria
    a. The beneficiary must be free from active and advanced periodontal disease.
    b. Crowns must be opposed by teeth in the opposite jaw or be a support for a partial.
    c. Crowns for primary teeth will not be covered if the radiograph indicates imminent exfoliation.
    d. Crowns will not be approved when lesser means of restoration is possible.
5. Tooth with existing crown with:
    a. Decay (demineralization/dental caries minimally reaching the dentin enamel junction) noted in written documentation and/or evident on x-rays and/or
    b. Missing tooth structure is resultant from an accidental complete fracture, attrition, abrasion, erosion, or abfraction and/or
    c. Non-repairable fracture of the existing restoration and/or
    d. Periodontal pathology resultant from issue with existing restoration (periodontal pocketing and/or periodontal bone loss due to open contact and/or open margin and/or
    e. Existing SSC when the patient is 18+ years old.
6. Anterior Tooth (with no existing crown/onlay) or Posterior Tooth (with no planned/completed RCT and no existing crown/onlay) with:
    a. Clinical diagnosis of Cracked Tooth Syndrome (narrative/chart notes of tooth-specific temperature and/or pressure symptomology and/or some type of specific testing done for diagnosis – i.e. bite-test/tooth sleuth/percussion/temperature testing).
7. Anterior or Posterior Tooth (with planned/completed RCT and no existing crown/onlay) or Anterior Tooth (with no existing crown/onlay) or Posterior Tooth (with no planned/completed root canal and no existing crown/onlay) with:
    a. Missing tooth structure resultant from an accidental complete fracture, attrition, abrasion, erosion, or abfraction and/or Decay (demineralization/dental caries minimally reaching the dentinoenamel junction) and/or non-repairable fracture and/or periodontal pathology (periodontal pocketing and/or periodontal bone loss due to open contact and/or open margin) associated with an existing restoration that is 50% or more of the incisal edge/ one or more cusp(s) or the tooth overall and no Clinical diagnosis of Cracked Tooth Syndrome (narrative/chart notes of tooth-specific temperature and/or pressure symptomology and/or some type of specific testing done for diagnosis – i.e. bite-test/tooth sleuth/percussion/temperature testing). (narrative/chart notes of tooth-specific temperature and/or pressure symptomology and/or some type of specific testing done for diagnosis – i.e. bite-test/tooth sleuth/percussion/temperature testing).

Procedure codes: D2953, D2957

1. Procedure planned/performed meets CDT nomenclature and descriptor for code reported and no other limitation/exclusion listed above applies.
2. It may be necessary in conjunction and can only be approved with an approved D2954 code when there isn't enough tooth structure for a crown and post are placed to aid in retention and stability for a core buildup.

Periodontal Review Criteria

Periodontal Services

Procedure codes: D4210, D4211, D4212, D4260, D4261, D4263, D4264, D4265, D4266, D4267, D4270, D4273, D4274, D4275, D4276, D4322, D4323

1. D4210 reported and at least 3 teeth in the indicated quadrant have confirmed medication-induced or pathologic (non-cosmetic) gingival hyperplasia/hypertrophy (including hypertrophy resultant from orthodontic treatment and/or poor patient hygiene) (evidenced by 4+mm measurement on submitted periodontal charting and written documentation confirming medication/non-iatrogenic causative factor) in the presence of normal bony configuration (evidenced by no loss of attachment/measurement of less than 2mm from CEJ to adjacent alveolar bone on submitted x-ray(s)). Treatment for pocket reduction, altered passive eruption, and cosmetics does not qualify as a dentally necessary condition for this procedure.
2. D4211 reported and at least one tooth in the indicated quadrant has confirmed medication-induced or pathologic (non-cosmetic) gingival hyperplasia/hypertrophy (including hypertrophy resultant from orthodontic treatment and/or poor patient hygiene) (evidenced by 4+mm measurement on submitted periodontal charting and written documentation confirming medication/non-iatrogenic causative factor) in the presence of normal bony configuration (evidenced by no loss of attachment/measurement of less than 2mm from CEJ to adjacent alveolar bone on submitted x-ray(s)). Treatment for pocket reduction, altered passive eruption, and cosmetics does not qualify as a dentally necessary condition for this procedure.
    a. It is necessary for the correction of severe gingival hyperplasia or hypertrophy associated with drug therapy. Sever gingival hyperplasia interferes with or restricts the ability to perform effective daily oral hygiene procedures.
3. Procedure planned/performed meets CDT nomenclature and descriptor for code reported and no other limitation/exclusion listed above applies.
    a. It is necessary for the completion of a restorative procedure and proper placement of a restoration.
4. D4260 reported and at least 3 teeth in the indicated quadrant have periodontal disease (evidenced by loss of attachment as confirmed by radiographic bone loss resulting in measurement of 2mm or greater from CEJ to adjacent alveolar bone on mesial and/or distal and 4+ mm pocket depths) necessitating reshaping of the alveolar process.
5. D4261 reported and at least 1 tooth in the indicated quadrant has periodontal disease (evidenced by loss of attachment as confirmed by radiographic bone loss resulting in measurement of 2mm or greater from CEJ to adjacent alveolar bone on mesial and/or distal and 4+ mm pocket depths) necessitating reshaping of the alveolar process.
    a. It is necessary when non-surgical therapies, such as scaling and root planing, have not resolved moderate to severe periodontitis requiring surgical intervention and or surgical access is necessary for thorough debridement and bone reshaping.
6. D4263, D4264 (2nd site): Procedure planned/performed meets CDT nomenclature and descriptor for code reported and no other limitation/exclusion listed above applies.
    a. It is a necessary periodontal surgery to treat bone defects from disease or injury, supporting regeneration or creating a foundation for implants or (D4364) performed in conjunction with a retained natural tooth in the same quadrant.
7. D4265: Procedure planned/performed meets CDT nomenclature and descriptor for code reported and no other limitation/exclusion listed above applies.
    a. It is necessary in periodontal surgery for defects, ridge preservation, or preparing sites for implants, but it doesn't cover the bone graft or barrier membrane itself, only the biologic aid.
8. D4266: Procedure planned/performed meets CDT nomenclature and descriptor for code reported and no other limitation/exclusion listed above applies.
    a. It is a necessary surgical procedure to regrow lost bone and gum tissue by placing a dissolvable membrane to guide healing, typically for deep periodontal pockets or furcation defects from advanced gum disease.
9. D4267: Procedure planned/performed meets CDT nomenclature and descriptor for code reported and no other limitation/exclusion listed above applies.
    a. It is a necessary periodontal procedure for natural teeth, to regrow lost bone and tissue by using a synthetic membrane that prevents fast-growing gum tissue from filling the defect, requiring later removal
10. D4270: Procedure planned/performed meets CDT nomenclature and descriptor for code reported and no other limitation/exclusion listed above applies.
    a. It is necessary to treat gum recession, cover exposed roots, or increase the amount of attached gum tissue. It is not purely for cosmetic enhancement

11. D4273: Procedure planned/performed meets CDT nomenclature and descriptor for code reported and no other limitation/exclusion listed above applies.
    a. It is necessary when a periodontist or dentist harvests connective tissue—typically from the patient's palate—and transplants it to another area in the mouth to treat gingival recession, increase attached gingiva, or prepare a site for future restorative work.
12. D4274: Procedure planned/performed meets CDT nomenclature and descriptor for code reported and no other limitation/exclusion listed above applies.
    a. It is necessary when a dentist or periodontist removes soft tissue from the mesial or distal aspect of a single tooth, typically to gain access for restorative or periodontal purposes
13. D4275: Procedure planned/performed meets CDT nomenclature and descriptor for code reported and no other limitation/exclusion listed above applies.
    a. It is necessary when a patient requires soft tissue augmentation due to insufficient gum tissue, often to improve periodontal health, cover exposed roots, or prepare a site for future restorative work
14. D4276: Procedure planned/performed meets CDT nomenclature and descriptor for code reported and no other limitation/exclusion listed above applies.
    a. It is necessary in periodontic for treating significant gum recession or complex defects by simultaneously harvesting connective tissue (often from the palate) and repositioning surrounding gum tissue (pedicle flaps) onto a single tooth for optimal root coverage, noted for advanced cases where simpler grafts aren't enough and is typically indicated for advanced recession or complex periodontal defects where single-method grafting would not provide optimal results
15. D4322: Procedure planned/performed meets CDT nomenclature and descriptor for code reported and no other limitation/exclusion listed above applies.
    a. It is a necessary intra-coronal splint for natural teeth or prosthetic crowns to stabilize teeth that are loose (mobile) due to periodontal disease or other issues.
16. D4323: Procedure planned/performed meets CDT nomenclature and descriptor for code reported and no other limitation/exclusion listed above applies.
    a. It is a necessary extra-coronal splint for natural teeth or prosthetic crowns to stabilize teeth that are loose (mobile) due to periodontal disease or other issues.

Prosthodontic Review Criteria

Prosthodontic Services

Procedure codes: D5110, D5120, D5670, D5671, D5810, D5811, D5820, D5821, D5899, D5937, D5991

1. Procedure planned/performed meets CDT nomenclature and descriptor for code reported and no other limitation/exclusion listed above applies.

Procedure codes: D5211, D5212, D5213, D5214, D5225, D5226

1. Abutment teeth must be at least 50% supported by bone.

Fixed Partial Denture / Fixed Dental Prosthesis

Procedure codes: D6211, D6212, D6241, D6242, D6545, D6751, D6752, D6791, D6792

1. Procedure planned/performed meets CDT nomenclature and descriptor for code reported and no other limitation/exclusion listed above applies.
2. Retainer teeth must have no more than 50% bone loss and no furcation involvement.
3. Consider partial denture if teeth are missing in both quadrants in the same arch.

Oral Surgery Review Criteria

Oral Surgery Services

Procedure codes: D7220, D7280, D7282, D7283

1. D7220: Procedure planned/performed meets CDT nomenclature and descriptor for code reported and no other limitation/exclusion listed above applies.
2. D7280, D7282, D7283: Procedure planned/performed meets CDT nomenclature and descriptor for code reported and no other limitation/exclusion listed above applies.

Orthodontic Review Criteria

Orthodontic Services

Procedure codes: D8020, D8090, D8670, D8703, D8704

1. **Limited Orthodontics**
    a. Limited Orthodontic treatment of transitional dentition is orthodontic treatment with a limited objective, not involving the entire dentition. It may be directed at the only existing problem, or at only one aspect of a larger problem in which a decision is made to defer or forego more comprehensive therapy. This may require brackets or bands on one arch in addition to other modalities. Note: Upper and lower braces exceed the scope of Limited Orthodontics and should be submitted under comprehensive if the member meets the criteria.
        i. The beneficiary must meet the following regulatory qualifications in order for the request to be considered:
            1. Cross bite of first molar with midline deviation.
            2. Anterior cross bite associated with clinically apparent severe gingival inflammation or gingival recession or severe enamel wear.
            3. Impaction causing direct damage to the root of permanent tooth.
2. **Comprehensive Orthodontics**
    a. Covered once per lifetime. Comprehensive orthodontics is a covered dental service for Medicaid and DHCP (Delaware Healthy Children Program) eligible individuals who have been diagnosed with a "handicapping" malocclusion.
        i. Prior to application of braces, the orthodontist must assure that the member has seen a general dentist and is free of all active caries, periodontal disease and maintains good oral hygiene. Members who have poor oral hygiene, active caries, or have not been to a dentist for their six-month checkup will be denied orthodontic treatment until such time as their condition changes.
        ii. The beneficiary must meet the following regulatory qualifications in order for the request to be considered:
            1. Permanent dentition only. Primary and transitional dentition cases will not be reviewed.
            2. A score of 26 or above on the Delaware Special Dental Orthodontic Evaluation Form.
            3. When a score of 26 has not been reached but one of the 5 exceptions can be clearly demonstrated.
            4. When an impacted permanent tooth has caused visible damage to the root of another permanent tooth. (Must be included in the report as well as demonstrate existing damage to root of tooth.)
            5. When a child has been approved for orthodontic treatment by another state Medicaid program and has been receiving active and consistent treatment.

Anesthesia Review Criteria

Anesthesia Services

Procedure codes: D9222, D9223, D9230, D9239, D9243, D9248

1. When determining medical necessity for the use of dental anesthesia (Nitrous Oxide, Minimal Sedation, Moderate Sedation, or Deep Sedation/General Anesthesia) one of the following criteria must be met:
    a. A pre-cooperative child six years of age or under.
    b. A child under the age of 7 that has carious lesions (baby bottle syndrome) which require multiple restorations, extractions, crowns.
    c. Child of any age with a diagnosed physical, developmental, or emotional disability.
    d. Children with documented acute situational anxiety where a physical, mental, or medical condition precludes other behavior management choices.

Adjunctive services

Procedure Codes - DX99 codes

1. By Report codes, and any dental procedure requiring prior authorization not identified in the above criteria will be reviewed for prior authorization based on medical necessity.

Highmark Health Options WV Medicaid Review Criteria

Periodontal Review Criteria

Periodontal Services

Procedure codes: D4260, D4261

1. D4260: Reported and at least 3 teeth in the indicated quadrant have periodontal disease (evidenced by loss of attachment as confirmed by radiographic bone loss resulting in measurement of 2mm or greater from CEJ to adjacent alveolar bone on mesial and/or distal and 4+ mm pocket depths) necessitating reshaping of the alveolar process
2. D4261: Reported and at least 1 tooth in the indicated quadrant has periodontal disease (evidenced by loss of attachment as confirmed by radiographic bone loss resulting in measurement of 2mm or greater from CEJ to adjacent alveolar bone on mesial and/or distal and 4+ mm pocket depths) necessitating reshaping of the alveolar process
    a. When non-surgical therapies, such as scaling and root planing, have not resolved moderate to severe periodontitis requiring surgical intervention and or surgical access is necessary for thorough debridement and bone reshaping.
    b. A pre-treatment, diagnostic x-ray of the reported tooth. Periapical (PA) and/or Bitewing (BW) x-ray(s) are preferred unless reporting Prosthodontic, Implant, and Oral Surgery services. IN ADDITION to x-ray, legible and complete periodontal charting is required.

Oral Surgery Review Criteria

Oral Surgery Services

Procedure codes: D7340, D7350, D7490, D7550, D7680, D7780, D7810, D7820, D7830, D7850, D7852, D7858, D7865, D7870, D7872, D7873, D7874, D7876, D7877, D7880, D7912, D7920, D7941, D7943, D7944, D7946, D7947, D7948, D7949, D7950, D7955, D7961, D7962, D7970, D7979, D7980, D7981, D7982, D7991

1. D7340, D7350
    a. Procedure planned/performed meets CDT nomenclature and descriptor for code reported and no other limitation/exclusion listed above applies.
    b. When a patient requires improved access or support for dentures, implants, or when there is insufficient vestibular depth due to anatomical limitations, trauma, or previous surgeries.
2. D7490
    a. Procedure planned/performed meets CDT nomenclature and descriptor for code reported and no other limitation/exclusion listed above applies.
    b. These are primarily done in a hospital / OR setting
    c. Indicated for malignant tumors, aggressive benign tumors, large cysts, or injuries from severe trauma. It is for very large or aggressive pathology, not minor cysts
3. D7550
    a. Procedure planned/performed meets CDT nomenclature and descriptor for code reported and no other limitation/exclusion listed above applies.
    b. It is necessary when a dentist or oral surgeon removes a portion of dead or non-vital bone from the jaw, often due to infection, trauma, or complications from previous dental procedures.
4. D7680
    a. Procedure planned/performed meets CDT nomenclature and descriptor for code reported and no other limitation/exclusion listed above applies.
    b. Indicated for the surgical removal of foreign bodies from facial bones (maxilla, mandible) due to trauma, involving materials like metal, glass, or broken instruments, distinct from soft tissue or routine extractions.
5. D7780
    a. Procedure planned/performed meets CDT nomenclature and descriptor for code reported and no other limitation/exclusion listed above applies.
    b. Indicated as a surgical procedure for complex breaks in facial bones (jaw, cheekbone, etc.) requiring significant manipulation, often with fixation.
    c. It is necessary when a patient experiences a jaw dislocation that cannot be corrected through closed (non-surgical) methods, requiring surgical intervention to realign the joint.
6. D7820
    a. When a patient presents with a dislocated temporomandibular joint (TMJ) or other maxillofacial joint, the provider performs a non-surgical, manual repositioning of the joint back into its normal alignment. It is important to note that this code is only appropriate when the procedure is performed without surgical intervention
7. D7830
    a. Procedure planned/performed meets CDT nomenclature and descriptor for code reported and no other limitation/exclusion listed above applies.

b. It is necessary for forcefully restoring jaw/facial bone movement when conservative methods fail, often due to trauma, surgery, radiation, or conditions like trismus (locked jaw) or ankylosis (stiffness), requiring general anesthesia or sedation to overcome restricted opening

8. D7850
   a. Procedure planned/performed meets CDT nomenclature and descriptor for code reported and no other limitation/exclusion listed above applies.
   b. Surgical removal of articular disc and possible implant disc is placed and when conservative treatment has failed
9. D7852
   a. Procedure planned/performed meets CDT nomenclature and descriptor for code reported and no other limitation/exclusion listed above applies.
   b. It is a necessary surgical procedure that repairs a displaced, torn, or damaged articular disc, focusing on restoring function rather than removing or replacing the disc.
10. D7858
   a. Procedure planned/performed meets CDT nomenclature and descriptor for code reported and no other limitation/exclusion listed above applies.
   b. This is necessary as a joint reconstruction procedure involving the temporomandibular joint (TMJ) used when a patient requires surgical intervention to restore or replace the structure of the TMJ due to trauma, congenital anomalies, degenerative disease, or failed previous treatments.
11. D7865
   a. Procedure planned/performed meets CDT nomenclature and descriptor for code reported and no other limitation/exclusion listed above applies.
   b. This is necessary when a patient requires open joint surgery to repair, reshape, or remove components of the TMJ due to conditions such as ankylosis, degenerative joint disease, or trauma. Unlike less invasive procedures, D7865 is reserved for cases where conservative treatments have failed, and a more extensive surgical intervention is necessary
12. D7870
   a. Procedure planned/performed meets CDT nomenclature and descriptor for code reported and no other limitation/exclusion listed above applies.
   b. This is a necessary procedure involving joint space irrigation (with or without manipulation) to relieve pain, improve jaw mobility, and treat TMJ disorders that haven't responded to conservative care, often used when there's joint fluid or structural issues.
13. D7872
   a. Procedure planned/performed meets CDT nomenclature and descriptor for code reported and no other limitation/exclusion listed above applies.
   b. This is necessary to diagnose and treat TMJ disorders when a provider performs an arthroscopic examination or intervention within the TMJ, typically to address issues such as internal derangement, adhesions, or inflammation that have not responded to conservative therapies.
14. D7874
   a. Procedure planned/performed meets CDT nomenclature and descriptor for code reported and no other limitation/exclusion listed above applies.
   b. It is necessary when a provider performs minimally invasive arthroscopic surgery to reposition and stabilize the articular disc, often to address TMJ dysfunction, pain, or locking that has not responded to conservative therapies.
15. D7876
   a. Procedure planned/performed meets CDT nomenclature and descriptor for code reported and no other limitation/exclusion listed above applies.
   b. It is necessary when a minimally invasive arthroscopic surgical removal of the articular disc or disc fragments is indicated due to TMJ disorders, such as disc displacement, degeneration, or chronic pain unresponsive to conservative therapies, and less invasive treatments have been considered or attempted prior to surgery.
16. D7877
   a. Procedure planned/performed meets CDT nomenclature and descriptor for code reported and no other limitation/exclusion listed above applies.
   b. It is necessary when a provider performs a minimally invasive procedure to remove damaged tissue, adhesions, or debris from within the TMJ using an arthroscope.
17. D7941
   a. Procedure planned/performed meets CDT nomenclature and descriptor for code reported and no other limitation/exclusion listed above applies.

b. It is necessary when a surgical cut is made into the jawbone (mandible) to correct anatomical discrepancies, facilitate prosthetic placement, or treat pathology. Common indications include pre-prosthetic surgery, orthognathic surgery, or access for cyst or tumor removal.

18. D7943
    a. Procedure planned/performed meets CDT nomenclature and descriptor for code reported and no other limitation/exclusion listed above applies.
    b. It is necessary when a surgical cut is made into the jawbone (mandible) to correct anatomical discrepancies, facilitate prosthetic placement, or treat pathology. Common indications include pre-prosthetic surgery, orthognathic surgery, or access for cyst or tumor removal and placing a bone graft.
19. D7944
    a. Procedure planned/performed meets CDT nomenclature and descriptor for code reported and no other limitation/exclusion listed above applies.
    b. It is necessary when a provider needs to surgically section or remove a portion of the jawbone to correct anatomical abnormalities, facilitate other oral surgeries, or prepare for implant placement. Common indications include treatment of jaw deformities, removal of benign tumors, or to assist in orthognathic surgery.
20. D7946
    a. Procedure planned/performed meets CDT nomenclature and descriptor for code reported and no other limitation/exclusion listed above applies.
    b. It is a necessary complex surgical procedure to reposition the entire upper jaw (maxilla) for correcting deformities like severe malocclusion or facial asymmetry, involving bone cuts, repositioning, and fixation, but not the addition of bone graft material.
21. D7947
    a. Procedure planned/performed meets CDT nomenclature and descriptor for code reported and no other limitation/exclusion listed above applies.
    b. It is a necessary complex maxillofacial surgery to reposition the upper jaw for correcting severe malocclusion, facial deformities, or trauma, involving surgical cuts and fixation.
22. D7948
    a. Procedure planned/performed meets CDT nomenclature and descriptor for code reported and no other limitation/exclusion listed above applies.
    b. It is necessary to correct significant midface skeletal issues like severe underdevelopment (hypoplasia) or backward positioning (retrusion) of the upper jaw, often for birth defects, trauma, or developmental conditions.
23. D7949
    a. Procedure planned/performed meets CDT nomenclature and descriptor for code reported and no other limitation/exclusion listed above applies.
    b. It is necessary for repositioning facial bones, typically involving the middle face, often used for severe trauma or congenital issues, and includes obtaining the autograft material for reconstruction.
24. D7950
    a. Procedure planned/performed meets CDT nomenclature and descriptor for code reported and no other limitation/exclusion listed above applies.
    b. It is necessary for significant jawbone augmentation to prepare for implants, dentures, bridges, addressing deficiencies in height, width, or volume, but not for simple socket preservation after an extraction.
25. D7955
    a. Procedure planned/performed meets CDT nomenclature and descriptor for code reported and no other limitation/exclusion listed above applies.
    b. It is necessary for complex reconstructive surgeries to fix significant defects in facial bones or oral tissues, often after trauma, tumor removal, or congenital issues, involving bone grafts (autograft, allograft, or alloplastic) to restore form and function.

Orthodontic Review Criteria

Orthodontic Services

Procedure codes: D8010, D8020, D8030, D8040, D8070, D8080, D8090, D8680, D8695, D8698, D8699, D8703, D8704

Medical Necessity:

Treatment is necessary to resolve a malocclusion (including craniofacial abnormalities and traumatic or pathologic anatomical deviations) that cause pain or suffering, physical deformity, significantly impair essential functions like eating, breathing, speaking, or maintaining oral health, aggravating a condition, or results in further injury or infirmity.

All the following must be submitted:

1. Radiographs: panoramic, and cephalometric
2. Dental Molds: Upper and Lower study casts trimmed to the correct occlusion (digital is acceptable)
3. Photos: Intra and Extra Oral
4. Treatment plan to include findings, diagnosis, length of treatment, and specific code requested.

Must meet at least one of the following criteria:

1. Overjet in excess of 7mm
2. Severe malocclusion associated with dento-facial deformity
3. True anterior open bite
4. Full cusp classification from normal (class II or class III)
5. Palatal impingement of lower incisors into the palatal tissue causing tissue trauma
6. Cleft palate, congenital or developmental disorder
7. Anterior crossbite (2 or more teeth and in cases where gingival stripping from the crossbite is demonstrated and not correctable by limited orthodontic treatment
8. Unilateral posterior crossbite with deviation or bilateral posterior crossbite involving multiple teeth including at least one molar
9. True posterior open bite (Not involving partially erupted teeth or one or two teeth slightly out of occlusion and not correctable by habit therapy)
10. Impacted teeth (cuspids, lateral incisors and central incisors only)

Adjunctive services

Procedure Codes - DX99 codes

1. By Report codes, and any dental procedure requiring prior authorization not identified in the above criteria will be reviewed for prior authorization based on medical necessity.

Support and Automated Services

Section 10

MyPatients'Benefits

Patient information such as eligibility, benefits, claim status, maximums/deductibles, procedure history, procedure code information, orthodontic information and Maximum Allowable Charge schedules can be obtained through ***MyPatients'****Benefits*, an electronic inquiry product offered by United Concordia. ***MyPatients'****Benefits* may be accessed through the Internet with a Web browser of 6.0 or greater.

MyPatients'*Benefits* provides you with immediate access to the following information:

- **Eligibility:** Provides membership information including effective dates, types of plans, cancellation dates and verifies if your office has been selected by the patient as their Primary Dental Office
- **Benefits:** Gives detailed information on a patient's benefits and limitations
- **Claim Status:** Determines if a claim is still in process or has been adjudicated. If the claim has been adjudicated, the check number, amount, date, and payee will be displayed. You can determine what maximums, deductibles or coinsurances have been applied. If a claim is rejected, a rejection description will tell you the reason.
- **Maximum/Deductible:** Gives maximum and deductible calculations and thresholds applicable to the patient.
- **Schedule of Allowances:** Gives full MAC Schedules with or without patient specific information.
- **Add Date of Service to a Predetermination:** Allows you to add the Date of Service to an existing Pre-D via the Provider Portal
- **Service History:** Lets you determine specific services that are on record at United Concordia for a particular patient and the dates they were last provided.
- **Allowance Information:** Provides allowance information for the networks with which the office is associated.
- **Orthodontic Treatment Plan Information:** Gives detailed information on a patient's active orthodontic treatment plan and a printer-friendly version is also available.
- **Help**: A help button is available for assistance within each category

This service is available 24 hours a day, 7 days a week, except when our databases are undergoing scheduled maintenance.

Live Chat

You can chat live with our customer service representatives while logged into your ***MyPatients'****Benefits* account. Live chat allows you to quickly resolve issues and obtain answers to your questions online via chat conversations.

Chats can be transitioned at any time to live web sessions, where our representatives can guide you through ***MyPatients'****Benefit*s in real time. Live web sessions enable our representatives to provide on-screen guidance for faster resolution. Chats can also be upgraded to phone calls with the same representative for more complex discussions.

Live chat is offered from 8 a.m.- 8 p.m. EST.

Provider Check Information

Dentists are able to view check summaries and detail and check related claims for a selected date range online. Provider Check Information is available on our website and may be accessed by clicking on the *Dentists* link on the home page and then clicking on *Reimbursements* at the top of the page. Registered users of ***MyPatients'****Benefits* or Speed *e*Claim® already have access to this feature.

Interactive Voice Response (IVR) System

United Concordia's Customer Service IVR System offers dentists and most subscribers access to information stored in United Concordia's records. You can choose to listen to the information or in most instances, request the information by mail, fax or email.

The IVR System connects you directly to our databases and gives you access to:

- Patient coverage
- Patient benefits
- Claim/predetermination status information.
- Orthodontic information
- Procedure history
- Maximum/deductible accumulations
- DHMO co-payment listings
- Procedure allowances

The IVR System is accessible through our toll-free Customer Service number at (800) 332-0366. The IVR system is available 24 hours a day, 7 days a week, except when our databases are undergoing scheduled maintenance.

Update Provider Information

Dental offices must notify United Concordia if any of the following information changes, including but not limited to:

- National Provider Identifier (NPI) Number and Type
- Practice Address
- Telephone Number
- Fax Number
- Email Address
- Open/Closed Status (Are you accepting new patients?)
- Disability Access
- Languages Spoken
- Adding New Providers

Changes should be submitted to United Concordia via one of the following methods:
Secure online form available on our website
https://www.unitedconcordia.com/pifria.

Email *
ProviderRequests@ucci.com
** (Please Note: HTML documents and secure messages/weblinks are not accepted at this email address.)*

Fax
(844) 235-7261

Mail
Dental Network Operations
PO Box 69404
Harrisburg, PA 17106-9404

Provider Directory Data

United Concordia's provider database contains pertinent information on all individual providers and group accounts who are participating with United Concordia. Your record will be displayed in our provider directory as long as you remain participating or until we receive notification of retirement, death, license suspension/revocation or HHS debarment.

You can now verify or make changes to directory related items via our online report a correction process. Simply visit our website at UnitedConcordia.com and click on Find a Dentist or enter the following into your web browser: www.UnitedConcordia.com/find-a-dentist/. Next, search for your information and select Report a Correction or Verify Information.

Dentist Advisors

United Concordia's dentist advisors make recommendations for approval or denial of benefits or alternate treatment based on professional judgment using the submitted documentation accompanying the claim. Should you have questions concerning claims previously reviewed by a Dentist Advisor, please call (800) 772-1133 to:

- Receive instructions for requesting an appeal.
- Obtain information pertaining to an Advisor determination.
- Make arrangements to discuss a claim with an Advisor.
- Verify procedures to follow when reporting a particular service or treatment plan.
- Obtain information regarding policy, a treatment or procedure.

SKYGEN USA Provider Portal

Highmark Wholecare Providers

Information for Highmark Wholecare members, such as eligibility, benefits, claim status, procedure history, procedure code information, orthodontic information can be referenced on the SKYGEN USA Provider Web Portal.

All that is required to access the portal is a valid Skygen USA Dental user ID and password. The portal is accessible 24/7/365 from

any computer with internet connectivity. Providers and authorized office staff can log in for secured access to the system and handle a variety of day-to-day tasks, including the ability to:

- Verify member eligibility.
- Set up office appointment schedules, which can automatically verify eligibility and pre- populate claim forms for online submission.
- Submit claims for services rendered by simply entering procedure codes.
- Submit authorization requests, using interactive clinical algorithms when appropriate.
- Check the status of submitted claims and authorizations.
- Review provider clinical profiling data relative to peers.
- Download and print Office Reference Manuals.
- Send electronic attachments, such as digital x-rays, EOBs, and treatment plans.
- Check patient treatment history for specific services.
- Upload and download documents using a secure encryption protocol.
- Participate in provider surveys to rate satisfaction with Skygen USA Dental services.
- View personal "Rate a Provider" results from member surveys.

Check Member Eligibility

Log into the Skygen USA Provider Web Portal and select the Check Eligibility Tab for a particular patient. Fill in the below information:

Member Information

- Must enter either a subscriber number or a last and first name.
- The person's date of birth

Provider Information

- Use the Location dropdown menu to select the desired location associated with this payee.
- Use the Provider dropdown menu to select the desired provider associated with this payee.

You also have the option to generate an eligibility report to check a patient's eligibility prior to scheduling and rendering services and to ensure the patient is eligible to receive benefits from the provider at that location. The information provided on the Eligibility Report does not guarantee or imply payment and is contingent upon other factors including, but not limits to, eligibility changes, covered services and benefit limitations.

When the report opens, the selected provider and location will be on top of the report. **Important to have the correct provider and location selected.**

The report is separated into three groupings:

- Eligible Members
  - Individuals in this category currently have valid coverage under the insurance product or benefit plan listed on the report, and they qualify for benefits if they receive services from the provider at the location within the service date designated on the report.
  - Information that will be provided about the patient:
    - Subscriber ID
    - Name
    - DOB
    - Address
    - Insurer
    - Product
    - Potential DOS
    - Dental Service History
  - Information that will be provided about the patient's service history:
    - The dates when certain services were performed for eligible members are included as a Service History subsection on the Eligibility Report.
    - The Dental Service History will contain code, tooth, DOS and description.

- Non-Eligible Members
- Members Not Found

If you are having an issue with eligibility, change the provider and the location on the location and provider tabs rather than the dropdown menu.

Enter the expected date of service, limited to 3 days before and 10 days after today's date.

Dentist Education/ Outreach

The Connection Newsletter

One of the most important ways we communicate with dentists and their office staff is through our newsletter, the Connection. This newsletter is designed to:

- Advise dental offices of new dental policies and procedures or changes to existing policies.
- Present guidelines for accurate and timely claim submission
- Inform dentists and their staff of new benefits and guidelines or product offerings.
- Provide corporate updates.

The Connection newsletter is emailed quarterly to all offices that have an email address on file and is also available on our website. The Connection is considered official notification for policies and procedure changes.

Communications

In addition to the Connection newsletter, United Concordia uses mailings, facsimiles and/or emails to inform dental offices of significant changes in coverage, claim payments, website updates, policies or procedures, product offerings, and other important information. Network dentists agree to accept communications from United Concordia via mail, facsimile or email at the address/numbers shown on their Credentialing Application and/or at other addresses/numbers provided by a dentist. Special mailings are used when we receive several provider calls regarding the same topic, when we want to send information quickly, when the information is too complicated or lengthy to include in *The Connection Newsletter*.

Special Mailings

In addition to the Connection and the quarterly *Medicaid and Medicare Edition Connections Newsletter*, United Concordia uses special mailings to inform dental offices of significant changes in coverage, claim payment policies or procedures. Special mailings are used when we receive several provider calls regarding the same topic, when we want to send information quickly, when the information is too complicated or lengthy to include in *The Connection Newsletter* or *Medicaid and Medicare Edition Connections Newsletter*.

Website

United Concordia's website, www.UnitedConcordia.com provides detailed information on certain commercial programs, government programs, electronic claims, corporate information, automated services, press releases and much more.

Virtual Hold Technology

Virtual Hold, designed to improve how we handle customer service inquiries. During regular business hours, if call volumes increase and estimated wait times reach a higher level, callers will be offered three options:

- Remain on hold.
- Request a call back within an estimated amount of time.
- Schedule a different time and day (up to 7 days) to receive a call back.

Callers who choose the callback option will be asked to speak their name and enter the phone number at which they would like to receive a callback. The caller can then hang up while Virtual Hold maintains their place in line.
When a representative is available, the system calls the phone number provided by the caller, verifies that the correct person is on the line and then connects them with a representative. There is no difference in wait time between remaining on hold and the callback option.

Appeals, Complaints, Disputes and Grievances

Section 11

Highmark Wholecare Medicaid

First Level Provider Appeal

First Level Provider Appeal process, the appeal must be initiated by the provider. The provider must submit a written request for an appeal. The written request for an Appeal must be received by United Concordia within thirty (30) calendar days of the date of the initial decision letter and/or claim denial.

Written appeals should be submitted to the below address or faxed to the below number:
Dental Advisor Review
United Concordia
PO Box 69420
Harrisburg, PA 17106-9420

Fax: 717-260-7029

Note: Provider Appeals must be submitted separately from dental claims. If submitted together in the same envelope, the Provider Appeal may be processed as a claim and will be denied.

Upon submission of the written request for an appeal, the provider is required to submit all documentation supporting the provider's contention that the decision to deny the payment of the claim, is in error. The review will be completed within thirty (30) days of the date that the written Appeal request was received by United Concordia by United Concordia staff members who were not involved in the initial review. The provider will be notified of the first level provider appeal committee decision, which will be mailed to the provider within five (5) business days of the first level appeal decision.

Second Level Provider Appeal

If the provider is dissatisfied with the first level appeal decision, the provider may seek a second level provider appeal review with the second level provider appeal committee. The second level provider appeal must be submitted to United Concordia in writing within thirty (30) days of the date on the first level appeal committee decision letter. The second level provider appeal will be reviewed by United Concordia staff members who were not involved in the previous levels of review. All second level provider appeal requests must set forth specific reasons why the provider feels that United Concordia's first level appeal review decision is in error.

The provider may participate in the second level provider appeal committee via telephone and may present any additional relevant information that the provider feels the second level provider appeal committee should know prior to rendering a decision.

All Second Level Provider Appeals will be completed within forty-five (45) calendar days of the date that the written appeal request was received by United Concordia. Notwithstanding the forty-five (45) day time frame to render a second level provider appeal decision, the second level provider appeal committee will have five (5) business days following the receipt of any additional information to render a decision. The provider will be notified of the second level provider appeal decision through a second level provider appeal committee decision letter, which will be mailed to the provider within five (5) business days of the second level provider appeal decision. The decision issued by the second level provider appeal committee is final.

Member Complaints, Appeals and Grievance Process

Below is an excerpt from the member manual, provided only as a reference for providers on the member complaints, appeals and grievance process.

Complaints, Grievances and Fair Hearings

If a provider or Highmark Wholecare does something that you are unhappy about or do not agree with, you can tell Highmark Wholecare or the Department of Human Services what you are unhappy about or that you disagree with what the provider or Highmark Wholecare has done. This section describes what you can do and what will happen.

Complaints

What is a Complaint?

A Complaint is when you tell Highmark Wholecare you are unhappy with Highmark Wholecare or your provider or do not agree with a decision by Highmark Wholecare.

Some things you may complain about:

- You are unhappy with the care you are getting.
- You cannot get the service or item you want because it is not a covered service or item.
- You have not gotten services that Highmark Wholecare has approved.

- You were denied a request to disagree with a decision that you have to pay your provider.

First Level Complaint

What Should I Do if I Have a Complaint?

To file a first level Complaint:

- Call Highmark Wholecare at 1-800-392-1147 (TTY users call 711 or 1-800-654-5984) and tell Highmark Wholecare your Complaint, or
- Write down your Complaint and send it to Highmark Wholecare by mail or fax, or
- If you received a notice from Highmark Wholecare telling you Highmark Wholecare's decision and the notice included a Complaint/Grievance Request Form, fill out the form and send it to Highmark Wholecare by mail or fax.

Highmark Wholecare's address and fax number for Complaints:

Highmark Wholecare
Attn: Complaints and Grievance Department
P.O. Box 22278
Pittsburgh, PA 15222-1222
Fax: 412-255-4503

Your provider can file a Complaint for you if you give the provider your consent in writing to do so.

When Should I File a First Level Complaint?

Some Complaints have a time limit on filing. You must file a Complaint within **60 days of getting a notice** telling you that.

- Highmark Wholecare has decided that you cannot get a service or item you want because it is not a covered service or item.
- Highmark Wholecare will not pay a provider for a service or item you got.
- Highmark Wholecare did not tell you it's decision about a Complaint or Grievance you told Highmark Wholecare about within 30 days from when Highmark Wholecare got your Complaint or Grievance.
- Highmark Wholecare has denied your request to disagree with Highmark Wholecare's decision that you have to pay your provider.

You must file a Complaint **within 60 days of the date you should have gotten a service or item** if you did not get a service or item. The time by which you should have received a service or item is listed below:

New member appointment for your first examination…	**We will make an appointment for you…**
members with HIV/AIDS	with PCP or specialist no later than 7 days after you become a member in Highmark Wholecare unless you are already being treated by a PCP or specialist.
members who receive Supplemental Security Income (SSI)	with PCP or specialist no later than 45 days after you become a member in Highmark Wholecare, unless you are already being treated by a PCP or specialist.
members under the age of 21	with PCP for an EPSDT exam no later than 45 days after you become a member in Highmark Wholecare, unless you are already being treated by a PCP or specialist.
all other members	with PCP no later than 3 weeks after you become a member in Highmark Wholecare
Members who are pregnant:	**We will make an appointment for you ...**
pregnant women in their first trimester	with OB/GYN provider within 10 business days of Highmark Wholecare learning you are pregnant.
pregnant women in their second trimester	with OB/GYN provider within 5 business days of Highmark Wholecare learning you are pregnant.
pregnant women in their third trimester	with OB/GYN provider within 4 business days of Highmark Wholecare learning you are pregnant.
pregnant women with high-risk pregnancies	with OB/GYN provider within 24 hours of Highmark Wholecare learning you are pregnant
Appointment with…	**An appointment must be scheduled . . . .**
PCP	

urgent medical condition	within 24 hours.
routine appointment	within 10 business days.
health assessment/general physical examination	within 3 weeks.
Specialists (when referred by PCP)	
urgent medical condition	within 24 hours of referral.
routine appointment with one of the following specialists: • Otolaryngology • Dermatology • Pediatric Endocrinology • Pediatric General Surgery • Pediatric Infectious Disease • Pediatric Neurology • Pediatric Pulmonology • Pediatric Rheumatology • Dentist • Orthopedic Surgery • Pediatric Allergy & Immunology • Pediatric Gastroenterology • Pediatric Hematology • Pediatric Nephrology • Pediatric Oncology • Pediatric Rehab Medicine • Pediatric Urology	within 15 business days of referral within 10 business days of referral
routine appointment with all other specialists	

You may file **all other Complaints at any time.**

What Happens After I File a First Level Complaint?

After you file your Complaint, you will get a letter from Highmark Wholecare telling you that Highmark Wholecare has received your Complaint, and about the First Level Complaint review process.

You may ask Highmark Wholecare to see any information Highmark Wholecare has about the issue you filed your Complaint about at no cost to you. You may also send information that you have about your Complaint to Highmark Wholecare.

You may attend the Complaint review if you want to attend it. Highmark Wholecare will tell you the location, date, and time of the Complaint review at least 10 days before the day of the Complaint review. You may appear at the Complaint review in person, by phone, or by videoconference**.** If you decide that you do not want to attend the Complaint review, it will not affect the decision.

A committee of 1 or more Highmark Wholecare staff who were not involved in and do not work for someone who was involved in the issue you filed your Complaint about will meet to make a decision about your Complaint. If the Complaint is about a clinical issue, a licensed doctor will be on the committee. Highmark Wholecare will mail you a notice within 30 days from the date you filed your First Level Complaint to tell you the decision on your First Level Complaint. The notice will also tell you what you can do if you do not like the decision.

If you need more information about help during the Complaint process, see page 89.

What to do to continue getting services:

If you have been getting the services or items that are being reduced, changed or denied and you file a Complaint verbally, or that is faxed, postmarked, or hand-delivered within 15 days of the date on the notice telling you that the services or items you have been receiving are not covered services or items for you, the services or items will continue until a decision is made.

What if I Do Not Like Highmark Wholecare's Decision?

You may ask for an external Complaint review, a Fair Hearing, or an external Complaint review and a Fair Hearing if the Complaint is about one of the following:

- Highmark Wholecare's decision that you cannot get a service or item you want because it is not a covered service or item.
- Highmark Wholecare's decision to not pay a provider for a service or item you got.
- Highmark Wholecare's failure to decide a Complaint or Grievance you told Highmark Wholecare about within 30 days from when Highmark Wholecare got your Complaint or Grievance.
- You did not get a service or item within the time by which you should have received it.
- Highmark Wholecare's decision to deny your request to disagree with Highmark Wholecare's decision that you have to pay your provider.

You must ask for an external Complaint review within **15 days of the date you got the First Level Complaint decision notice.**

To ask for an external review of your Complaint, send your request to the following:

Pennsylvania Insurance Department
Bureau of Consumer Services
Room 1209, Strawberry Square
Harrisburg, PA 17120
Fax: 717-787-8585

or

Go to the "File a Complaint Page" at
https://www.insurance.pa.gov/Consumers/Pages/default.aspx

You must ask for a Fair Hearing within **120 days from the date on the notice telling you the Complaint decision.**

For all other Complaints, you may file a Second Level Complaint within **45 days of the date you got the Complaint decision notice.**

For information about Fair Hearings, see page 104.
For information about external Complaint review, see page 96.
If you need more information about help during the Complaint process, see page 89.

Second Level Complaint

What Should I Do if I Want to File a Second Level Complaint?

To file a Second Level Complaint:

- Call Highmark Wholecare at 1-800-392-1147 (TTY users call 711 or 1-800-654-5984) and tell Highmark Wholecare your Second Level Complaint, or
- Write down your Second Level Complaint and send it to Highmark Wholecare by mail or fax, or
- Fill out the Complaint Request Form included in your Complaint decision notice and send it to Highmark Wholecare by mail or fax.

Highmark Wholecare's address and fax number for Second Level Complaints
Highmark Wholecare
Attn: Complaint and Grievance Department
P.O. Box 22278
Pittsburgh, PA 15222
Fax: 412-255-4503

What Happens After I File a Second Level Complaint?

After you file your Second Level Complaint, you will get a letter from Highmark Wholecare telling you that Highmark Wholecare has received your Complaint, and about the Second Level Complaint review process.

You may ask Highmark Wholecare to see any information Highmark Wholecare has about the issue you filed your Complaint about at no cost to you. You may also send information that you have about your Complaint to Highmark Wholecare.

You may attend the Complaint review if you want to attend it. Highmark Wholecare will tell you the location, date, and time of the Complaint review at least 15 days before the Complaint review. You may appear at the Complaint review in person, by phone, or by videoconference. If you decide that you do not want to attend the Complaint review, it will not affect the decision.

A committee of 3 or more people, including at least 1 person who does not work for Highmark Wholecare, will meet to decide your Second Level Complaint. The Highmark Wholecare staff on the committee will not have been involved in and will not have worked for someone who was involved in the issue you filed your Complaint about. If the Complaint is about a clinical issue, a licensed doctor will be on the committee. Highmark Wholecare will mail you a notice within 45 days from the date you filed your Second Level Complaint to tell you the decision on your Second Level Complaint. The letter will also tell you what you can do if you do not like the decision.

If you need more information about help during the Complaint process, see page 89.

What if I Do Not Like Highmark Wholecare's Decision on My Second Level Complaint?

You may ask for an external review from the Pennsylvania Insurance Department's Bureau of Managed Care.

You must ask for an external review **within 15 days of the date you got the Second Level Complaint decision notice.**

External Complaint Review

How Do I Ask for an External Complaint Review?

Send your written request for external review of your Complaint to the following:

Pennsylvania Insurance Department
Bureau of Health Coverage Access, Administration, and Appeals
Room 1311, Strawberry Square
Harrisburg, Pennsylvania 17120
Telephone Number: 717-787-8585

You can also go to the "File a Complaint Page" at: https://www.pa.gov/agencies/insurance.html

If you need help filing your request for external review, call the Bureau of Consumer Services at 1-877-881-6388.

If you ask, the Bureau of Consumer Services will help you put your Complaint in writing.

What Happens After I Ask for an External Complaint Review?

The Pennsylvania Insurance Department will get your file from Highmark Wholecare. You may also send them any other information that may help with the external review of your Complaint.

You may be represented by an attorney or another person such as your representative during the external review.

A decision letter will be sent to you after the decision is made. This letter will tell you all the reason(s) for the decision and what you can do if you do not like the decision.

What to do to continue getting services:

If you have been getting the services or items that are being reduced, changed or denied and your request for an external Complaint review is postmarked or hand-delivered within 15 days of the date on the notice telling you Highmark Wholecare's First Level Complaint decision that you cannot get services or items you have been receiving because they are not covered services or items for you, the services or items will continue until a decision is made. If you will be asking for both an external Complaint review and a Fair Hearing, you must request both the external Complaint review and the Fair Hearing within 15 days of the date on the notice telling Highmark Wholecare's First Level Complaint decision. If you wait to request a Fair Hearing until after receiving a decision on your external Complaint, services will not continue.

Grievances

What is a Grievance?

When Highmark Wholecare denies, decreases, or approves a service or item different than the service or item you requested because it is not medically necessary, you will get a notice telling you Highmark Wholecare's decision.

A Grievance is when you tell Highmark Wholecare you disagree with Highmark Wholecare's decision.

What Should I Do if I Have a Grievance?

To file a Grievance:

- Call Highmark Wholecare at 1-800-392-1147 (TTY users call 711 or 1-800-654-5984) and tell Highmark Wholecare your Grievance, or
- Write down your Grievance and send it to Highmark Wholecare by mail or fax, or
- Fill out the Complaint/Grievance Request Form included in the denial notice you got from Highmark Wholecare and send it to Highmark Wholecare by mail or fax.

Highmark Wholecare's address and fax number for Grievances:
Highmark Wholecare
Attn: Complaint and Grievance Department
P.O. Box 22278
Pittsburgh, PA 15222-1222
Fax: 412-255-4503

* Because emails are not secure unless encrypted by the sender, you should not include personal identifying information such as your date of birth or personal medical information unless you encrypt the email.

Your provider can file a Grievance for you if you give the provider your consent in writing to do so. If your provider files a Grievance for you, you cannot file a separate Grievance on your own.

When Should I File a Grievance?

You must file a Grievance within **60 days from the date you get the notice** telling you about the denial, decrease, or approval of a different service or item for you.

What Happens After I File a Grievance?

After you file your Grievance, you will get a letter from Highmark Wholecare telling you that Highmark Wholecare has received your Grievance, and about the Grievance review process.

You may ask Highmark Wholecare to see any information that Highmark Wholecare used to make the decision you filed your Grievance about at no cost to you. You may also send information that you have about your Grievance to Highmark Wholecare.

You may attend the Grievance review if you want to attend it. Highmark Wholecare will tell you the location, date, and time of the Grievance review at least 10 days before the day of the Grievance review. You may appear at the Grievance review in person, by phone, or by videoconference. If you decide that you do not want to attend the Grievance review, it will not affect the decision.

A committee of 3 or more people, including a licensed doctor, will meet to decide your Grievance. If the Grievance is about dental services, the Grievance review committee will include a dentist. The Highmark Wholecare staff on the committee will not have been involved in and will not have worked for someone who was involved in the issue you filed your Grievance about. Highmark Wholecare will mail you a notice within 30 days from the date you filed your Grievance to tell you the decision on your Grievance. The notice will also tell you what you can do if you do not like the decision.

If you need more information about help during the Grievance process, see page 97.

What to do to continue getting services:

If you have been getting services or items that are being reduced, changed, or denied and you file a Grievance verbally, or that is faxed, postmarked, or hand-delivered within 15 days of the date on the notice telling you that the services or items you have been receiving are being reduced, changed, or denied, the services or items will continue until a decision is made.

What if I Do Not Like Highmark Wholecare's Decision?

You may ask for an external Grievance review or a Fair Hearing or you may ask for both an external Grievance review and a Fair Hearing. An external Grievance review is a review by a doctor who does not work for Highmark Wholecare.

You must ask for an external Grievance review within **15 days of the date you got the Grievance decision notice.**

You must ask for a Fair Hearing from the Department of Human Services **within 120 days from the date on the notice** telling you the Grievance decision.

For information about Fair Hearings, see page 104.
For information about external Grievance review, see below

If you need more information about help during the Grievance process, see page 97.

External Grievance Review

How Do I Ask for External Grievance Review?

To ask for an external Grievance review:

- Call Highmark Wholecare at 1-800-392-1147 (TTY users call 711 or 1-800-654-5984) and tell Highmark Wholecare your Grievance, or
- Write down your Grievance and send it to Highmark Wholecare by mail to:

Highmark Wholecare
Attn: Complaints and Grievance Department
P.O. Box 22278
Pittsburgh, PA 15222

Highmark Wholecare will send your request for external Grievance review to the Insurance Department.

What Happens After I Ask for an External Grievance Review?

Highmark Wholecare will notify you of the external Grievance reviewer's name, address and phone number. You will also be given information about the external Grievance review process.

Highmark Wholecare will send your Grievance file to the reviewer. You may provide additional information that may help with the external review of your Grievance to the reviewer within 15 days of filing the request for an external Grievance review.

You will receive a decision letter within 60 days of the date you asked for an external Grievance review. This letter will tell you all the reason(s) for the decision and what you can do if you do not like the decision.

What to do to continue getting services:

If you have been getting the services or items that are being reduced, changed, or denied and you ask for an external Grievance review verbally or in a letter that is postmarked or hand-delivered within 15 days of the date on the notice telling you Highmark Wholecare's Grievance decision, the services or items will continue until a decision is made. If you will be asking for both an external Grievance review and a Fair Hearing, you must request both the external Grievance review and the Fair Hearing within 15 days of the date on the notice telling you Highmark Wholecare's Grievance decision. If you wait to request a Fair Hearing until after receiving a decision on your external Grievance, services will not continue.

Expedited Complaints and Grievances

What Can I Do if My Health Is at Immediate Risk?

If your doctor or dentist believes that waiting **30** days to get a decision about your Complaint or Grievance could harm your health, you or your doctor or dentist may ask that your Complaint or Grievance be decided more quickly. For your Complaint or Grievance to be decided more quickly:

- You must ask Highmark Wholecare for an early decision by calling Highmark Wholecare at 1-800-392-1147 (TTY users call 711 or 1-800-654-5984), faxing a letter or the Complaint/Grievance Request Form to 412-255-4503, or sending an email to medicaidcommitteereviews@HighmarkWholecare.com.
- Your doctor or dentist should fax a signed letter to 412-255-4503 within 72 hours of your request for an early decision that explains why Highmark Wholecare taking 30 days to tell you the decision about your Complaint or Grievance could harm your health.

If Highmark Wholecare does not receive a letter from your doctor or dentist and the information provided does not show that taking the usual amount of time to decide your Complaint or Grievance could harm your health, Highmark Wholecare will decide your Complaint or Grievance in the usual time frame of **30** days from when Highmark Wholecare first got your Complaint or Grievance.

Expedited Complaint and Expedited External Complaint

A committee of 1 or more people, including a licensed doctor or dentist, will decide your Complaint. If the Complaint is about dental services, the expedited Complaint review committee will include a dentist. The Highmark Wholecare staff on the committee will not have been involved in and will not have worked for someone who was involved in the issue you filed your Complaint about.

You may attend the expedited Complaint review if you want to attend it. You can attend the Complaint review in person but may have to appear by phone or by videoconference because Highmark Wholecare has a short amount of time to decide an expedited Complaint. If you decide that you do not want to attend the Complaint review, it will not affect the decision.

Highmark Wholecare will tell you the decision about your Complaint within 48 hours of when Highmark Wholecare gets your doctor's or dentist's letter explaining why the usual time frame for deciding your Complaint will harm your health or within 72 hours from when Highmark Wholecare gets your request for an early decision, whichever is sooner, unless you ask Highmark Wholecare to take more

time to decide your Complaint. You can ask Highmark Wholecare to take up to 14 more days to decide your Complaint. You will also get a notice telling you the reason(s) for the decision and how to ask for expedited external Complaint review, if you do not like the decision.

If you did not like the expedited Complaint decision, you may ask for an expedited external Complaint review from the Insurance Department within **2 business days from the date you get the expedited Complaint decision notice**. To ask for expedited external review of a Complaint, send your request to the following:

Pennsylvania Insurance Department
Bureau of Health Coverage Access, Administration, and Appeals
Room 1311, Strawberry Square
Harrisburg, PA 17120
Fax: 717-787-8585

or

Go to the "File a Complaint Page" at
https://www.insurance.pa.gov/Consumers/Pages/default.aspx If you need help filing your request for external review, call the Bureau of Consumer Services at 1-877-881-6388.

Expedited Grievance and Expedited External Grievance

A committee of 1 or more people, including a licensed doctor or dentist, will decide your Complaint. The Highmark Wholecare staff on the committee will not have been involved in and will not have worked for someone who was involved in the issue you filed your Grievance about.

You may attend the expedited Grievance review if you want to attend it. You can attend the Grievance review in person but may have to appear by phone or by videoconference because Highmark Wholecare has a short amount of time to decide the expedited Grievance. If you decide that you do not want to attend the Grievance review, it will not affect our decision.

Highmark Wholecare will tell you the decision about your Grievance within 48 hours of when Highmark Wholecare gets your doctor's or dentist's letter explaining why the usual time frame for deciding your Grievance will harm your health or within 72 hours from when Highmark Wholecare gets your request for an early decision, whichever is sooner, unless you ask Highmark Wholecare to take more time to decide your Grievance. You can ask Highmark Wholecare to take up to 14 more days to decide your Grievance. You will also get a notice telling you the reason(s) for the decision and what to do if you do not like the decision.

If you do not like the expedited Grievance decision, you may ask for an expedited external Grievance review or an expedited Fair Hearing by the Department of Human Services or both an expedited external Grievance review and an expedited Fair Hearing.

You must ask for expedited external Grievance review within **2 business days from the date you get the expedited Grievance decision notice**. To ask for expedited external review of a Grievance:

- Call Highmark Wholecare at 1-800-392-1147 (TTY users call 711 or 1-800-654-5984) and tell Highmark Wholecare your Grievance, or
- Send an email to Highmark Wholecare at medicaidcommitteereviews@HighmarkWholecare.com, or
- Write down your Grievance and send it to Highmark Wholecare by mail or fax:

Highmark Wholecare Attention:
Complaint and Grievance Department
P.O. Box 22278
Pittsburgh, PA 15222
Fax: 412-255-4503

Highmark Wholecare will send your request to the Insurance Department within 24 hours after receiving it.

You must ask for a Fair Hearing within **120 days from the date on the notice** telling you the expedited Grievance decision.

What Kind of Help Can I Have with the Complaint and Grievance Processes?

If you need help filing your Complaint or Grievance, a staff member of Highmark Wholecare will help you. This person can also represent you during the Complaint or Grievance process. You do not have to pay for the help of a staff member. This staff member will not have been involved in any decision about your Complaint or Grievance.

You may also have a family member, friend, lawyer or other person help you file your Complaint or Grievance. This person can also help you if you decide you want to appear at the Complaint or Grievance review.

At any time during the Complaint or Grievance process, you can have someone you know represent you or act for you. If you decide to have someone represent or act for you, tell Highmark Wholecare, in writing, the name of that person and how Highmark Wholecare can reach him or her.

You or the person you choose to represent you may ask Highmark Wholecare to see any information Highmark Wholecare has about the issue you filed your Complaint or Grievance about at no cost to you.

You may call Highmark Wholecare's toll-free telephone number at 1-800-392-1147 (TTY users call 711 or 1-800-654-5984) if you need help or have questions about Complaints and Grievances, you can contact your local legal aid office at 1-800-322-7572 or call the Pennsylvania Health Law Project at 1-800-274-3258. You can also find self-help forms and other information at www.phlp.org.

Persons Whose Primary Language Is Not English

If you ask for language services, Highmark Wholecare will provide the services at no cost to you.

Persons with Disabilities

Highmark Wholecare will provide persons with disabilities with the following help in presenting Complaints or Grievances at no cost, if needed. This help includes:

- Providing sign language interpreters.
- Providing information submitted by Highmark Wholecare at the Complaint or Grievance review in an alternative format. The alternative format version will be given to you before the review; and
- Providing someone to help copy and present information.

DEPARTMENT OF HUMAN SERVICES FAIR HEARINGS

In some cases, you can ask the Department of Human Services to hold a hearing because you are unhappy about or do not agree with something Highmark Wholecare did or did not do. These hearings are called "Fair Hearings." You can ask for a Fair Hearing after Highmark Wholecare decides your First Level Complaint or decides your Grievance.

What Can I Request a Fair Hearing About and By When Do I Have to Ask for a Fair Hearing?

Your request for a Fair Hearing must be postmarked within **120 days from the date on the notice** telling you Highmark Wholecare's decision on your First Level Complaint or Grievance about the following:

- The denial of a service or item you want because it is not a covered service or item.
- The denial of payment to a provider for a service or item you got, and the provider can bill you for the service or item.
- Highmark Wholecare's failure to decide a First Level Complaint or Grievance you told Highmark Wholecare about within 30 days from when Highmark Wholecare got your Complaint or Grievance.
- The denial of your request to disagree with Highmark Wholecare's decision that you have to pay your provider.
- The denial of a service or item, decrease of a service or item, or approval of a service or item different from the service or item you requested because it was not medically necessary.
- You're not getting a service or item within the time by which you should have received a service or item.

You can also request a Fair Hearing within 120 days from the date on the notice telling you that Highmark Wholecare failed to decide a First Level Complaint or Grievance you told Highmark Wholecare about within 30 days from when Highmark Wholecare got your Complaint or Grievance.

How Do I Ask for a Fair Hearing?

Your request for a Fair Hearing must be in writing. You can either fill out and sign the Fair Hearing Request Form included in the Complaint or the Grievance decision notice or write a letter.

If you write a letter, it needs to include the following information:

- Your (the member's) name and date of birth.
- A telephone number where you can be reached during the day.
- Whether you want to have the Fair Hearing in person or by telephone.
- The reason(s) you are asking for a Fair Hearing; and
- A copy of any letter you received about the issue you are asking for a Fair Hearing about.

You must send your request for a Fair Hearing to the following address:

Department of Human Services

Office of Medical Assistance Programs – HealthChoices Program

Complaint, Grievance and Fair hearings
PO Box 2675, Harrisburg, PA 17105-2675
Fax: 1-717-772-6328
Email: RA-PWCGFHteam@pa.gov

*Because emails are not secure unless encrypted by the sender, you should not include personal identifying information such as your date of birth or personal medical information unless you encrypt the email. You may send a request for a Fair Hearing through email and provide your personal identifying information in a letter mailed to the above address.

What Happens After I Ask for a Fair Hearing?

You will get a letter from the Department of Human Services' Bureau of Hearings and Appeals telling you where the hearing will be held and the date and time for the hearing. You will receive this letter at least 10 days before the date of the hearing.

You may come to where the Fair Hearing will be held or be included by phone. A family member, friend, lawyer or other person may help you during the Fair Hearing. You **MUST** participate in the Fair Hearing.

Highmark Wholecare will also go to your Fair Hearing to explain why Highmark Wholecare made the decision or explain what happened.

You may ask Highmark Wholecare to give you any records, reports and other information about the issue you requested your Fair Hearing about at no cost to you.

When Will the Fair Hearing Be Decided?

The Fair Hearing will be decided within 90 days from when you filed your Complaint or Grievance with Highmark Wholecare, not including the number of days between the date on the written notice of the Highmark Wholecare's First Level Complaint decision or Grievance decision and the date you asked for a Fair Hearing.

If you requested a Fair Hearing because Highmark Wholecare did not tell you it's decision about a Complaint or Grievance you told Highmark Wholecare about within 30 days from when Highmark Wholecare got your Complaint or Grievance, your Fair Hearing will be decided within 90 days from when you filed your Complaint or Grievance with Highmark Wholecare, not including the number of days between the date on the notice telling you that Highmark Wholecare failed to timely decide your Complaint or Grievance and the date you asked for a Fair Hearing.

The Department of Human Services' Bureau of Hearings and Appeals will send you the decision in writing and tell you what to do if you do not like the decision.

If your Fair Hearing is not decided within 90 days from the date the Department of Human Services receives your request, you may be able to get your services until your Fair Hearing is decided. You can call the Department of Human Services at 1-800-798-2339 to ask for your services.

What to do to continue getting services:

If you have been getting the services or items that are being reduced, changed or denied and you ask for a Fair Hearing and your request is postmarked or hand-delivered within 15 days of the date on the notice telling you Highmark Wholecare's First Level Complaint or Grievance decision, the services or items will continue until a decision is made.

Expedited Fair Hearing

What Can I Do if My Health Is at Immediate Risk?

If your doctor or dentist believes that waiting the usual time frame for deciding a Fair Hearing could harm your health, you may ask that the Fair Hearing take place more quickly. This is called an expedited Fair Hearing. You can ask for an early decision by calling the Department at 1-800-798-2339 or by faxing a letter or the Fair Hearing Request Form to 717-772-6328. Your doctor or dentist must fax a signed letter to 717-772-6328 explaining why taking the usual amount of time to decide your Fair Hearing could harm your health. If your doctor or dentist does not send a letter, your doctor or dentist must testify at the Fair Hearing to explain why taking the usual amount of time to decide your Fair Hearing could harm your health.

The Bureau of Hearings and Appeals will schedule a telephone hearing and will tell you it's decision within 3 business days after you asked for a Fair Hearing.

If your doctor does not send a written statement and does not testify at the Fair Hearing, the Fair Hearing decision will not be expedited. Another hearing will be scheduled, and the Fair Hearing will be decided using the usual time frame for deciding a Fair Hearing.

You may call Highmark Wholecare's toll-free telephone number at 1-800-392-1147 (TTY users call 711 or 1-800-654-5984) if you need help or have questions about Fair Hearings, you can contact your local legal aid office at 1-800-322-7572 or call the Pennsylvania Health Law Project at 1-800-274-3258.

Highmark Health Options Delaware

Provider Complaint

Registering a formal complaint

Highmark Health Options has created a Provider Complaint system for participating and non-participating providers to raise issues with Highmark Health Options' policies, procedures and administrative functions. Providers can call (844) 789-1722 to discuss their issue with a Provider Representative. Complaints will be investigated, and the details of the findings and disposition will be communicated back in writing to the provider within 30 days of receipt. If additional time is needed to resolve Highmark Health Options will provide status updates to the provider as applicable.

In addition to calling, providers have the option of sending a written complaint within 45 days regarding any policy, procedure or administrative function using one of the following methods:

- Calling United Concordia Dental Provider Customer Service at (844) 789-1722
- Mailing a complaint to United Concordia Dental Provider Customer Service at the mailing address below

Highmark BCBSD Health Options
Attn: Provider Complaints
PO Box 69456
Harrisburg, PA 17106

Highmark Health Options will send a letter confirming that a written response should be expected within 30 calendar days. Any misdirected submissions, including but not limited to Administrative Reviews or Clinical Appeals, into the Provider Complaint system will be routed to the appropriate department. The provider will be advised of the redirection and educated on proper handling and contact details of the appropriate department for future reference.

Complaints about claims payment

Provider inquiries for administrative payment disputes/medical review should be faxed to 877-545-9045, complaints about claims payment administrative in nature are handled as a provider dispute. The provider may file a written complaint about claims payment by faxing a request to 877-545-9045. Complaints may also be sent to the address listed below within twelve (12) months of the date of service, or sixty (60) days of the date of payment, whichever is later.

Highmark Health Options
Attn: Claims Review
P.O. Box 69456
Harrisburg, PA 17106

Clinical Provider appeals, when a service has been denied due to lack of prior authorization or denied based on medical necessity and still provided to the member, the provider can appeal that decision after the service. You may fax these requests along with all supporting documentation to 877-545-9045 or mail to:

Highmark Health Options
Attn: Claims Review
P.O. Box 69456
Harrisburg, PA 17106

A physician not involved in the original decision will review the clinical information and render a decision. The provider will be notified of the status of this review within thirty (30) days of the request. **NOTE: If the services have not been provided to the member, please follow the Member Appeals process as documented below.**

First Level Provider Appeal

Any provider may file a provider appeal to request the review of any post- service denial. This process is intended to afford providers with the opportunity to address issues regarding payment only. Appeals for services that have not yet been provided must follow the Member Appeal process. The Provider Appeal Process must be initiated by the provider through a written request for an appeal. Providers request for appeal must be received by Highmark Health Options within:

- 60 calendar days of the date of the Notice of Adverse Benefit Determination denying an authorization, unless otherwise negotiated by contract. In this instance, there is a denied authorization, however, services have already been provided.
- 180 calendar days of the date of the denial notice denying a post- service claim, unless otherwise negotiated by contract. When an authorization has been denied, providers must adhere to the 90-day time frame above. You will not receive an additional 180 days once the claim has been denied.

When submitting a written request for an appeal, providers are required to submit any and all supporting documentation including, but not limited to, a copy of the denied claim, the reason for the appeal, and the member's medical records containing all pertinent information regarding the services rendered by the provider.

All first level provider appeal reviews will be completed within thirty (30) calendar days of the date the written request was received by Highmark Health Options.

Providers will be informed of the decision in writing by mailing notification within thirty (30) calendar days from receipt. This notification will include additional appeal rights as applicable (i.e. Second Level Provider Appeal) (see below). If the appeal is approved, payment will be issued within 60 calendar days of notification.

Second Level Provider Appeal

If the provider is not in agreement with the first level provider appeal committee's decision, the provider may seek a second level provider appeal. A request for a second level provider appeal must be submitted to Highmark Health Options in writing within sixty (60) calendar days of the date on the first level provider appeal decision letter, or as otherwise indicated via contract. All second level provider appeal requests must include specific reasons as to why the provider does not agree with Highmark Health Options' first level provider appeal committee's decision.

All second level provider appeal reviews will be completed within thirty (30) calendar days of the date the second level provider appeal request was received by Highmark Health Options.

The second level appeal committee will inform the provider of its decision in a written decision notice within thirty (30) calendar days. This is the final level of appeal, and the decision is binding, unless otherwise governed per contract.

Member Appeals and Grievances

Our members have a right to appoint a representative to act on their behalf. If a provider is acting on behalf of a member, we will need to obtain the member's consent in writing prior to reviewing a request for an appeal or grievance (except for an expedited request). A member or provider may contact a grievance coordinator at any time for help or any questions about the grievance and appeals process.

Members may also ask for help with their grievance or appeal by asking for a Member Advocate. A Member Advocate can be assigned by calling our Member Services at (844) 325-6251.

A Member Advocate can help:

- File a grievance or appeal.
- Help the member through the grievance or appeal process.
- Answer member questions about the grievance or appeal process.
- Help the member get additional information from a provider to help with their grievance or appeal review.

Appeals

An appeal is a request for a review of an adverse benefit determination. This could include any of the following:

- The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit.
- The reduction, suspension, or termination of a previously authorized service
- The denial, in whole or in part, of payment for a service
- Highmark Health Options' failure to provider services in a timely manner
- The failure of Highmark Health Options to act within 30 calendar days from the date the plan receives a grievance and/or appeal.
- The denial of a member's request to dispute a financial liability, including cost sharing, copayments, and other member financial liabilities.

The following guidance on how to file an appeal is given to members in the Member Handbook:

What should I do if I have an appeal?

To file an appeal on behalf of a member, you can call Member Services to help you file an appeal. However, we will need to get the member's consent in writing prior to processing the appeal. If a provider files an appeal on behalf of a member, the member cannot file a separate appeal.

If you file your appeal by phone, you must also put your appeal request in writing (with your signature) within ten (10) days of calling Member Services. An appeal review will not take place without your written signature. This does not apply to expedited appeal requests.

You can file an appeal in writing, by mail or fax by completing a *Member Appeal Form*. You can find this form on our website at www.highmarkhealthoptions.com.

When you file your appeal, here are the things you should include:

- Member's name
- Member ID number
- Your phone number
- Your address
- State what you are appealing.
- State why you are appealing.
- State what you want as the outcome of your appeal.

You may send or attach any additional information that will help us with the review of your appeal. You can contact us at:

Highmark Health Options
Member Correspondence
P.O. Box 22278
Pittsburgh, PA 15222-0188
Phone: 1-844-325-6251; Fax: 1-844-325-3435

When should I file an appeal?

An appeal must be filed within ninety (90) days from the date of the "Notice of Action" letter.

Can I continue to render services during the appeal process?

If the member was previously authorized and getting services, the member may ask to continue getting these services if:

- The member files the request for an appeal timely (within 10 calendar days of us sending the "Notice of Adverse Benefit Determination".
- The appeal involves the termination, suspension, or reduction of a previously authorized service.
- The services were ordered by an authorized provider.
- The period covered by the original authorization has not expired; and
- The member timely files for continuation of the benefits.

If we continue the member's services during the appeal process, we will cover these services until:

- The member or member's representative withdraws the appeal or request for a state fair hearing.
- The member or member's representative fails to request a state fair hearing and continuation of benefits within 10 calendar days after we send the notice of an adverse resolution.
- A decision from the State Fair Hearing Officer was not in the member's favor.

It is important to know that the member may have to pay for the services received during the appeal or state fair hearing process if the final decision is not in the member's favor. If the decision is in the member's favor, we will authorize services within 72 hours from the date we receive notice reversing the determination.

What happens after I file an appeal?

You will get a letter from us within five (5) working days after your appeal is received. This letter will tell you that we have received your appeal. It will also include information about the appeal review process. You may submit additional information to support the appeal, and you may ask to look over all documents for the appeal.

You may also request a copy of the information used to review your appeal free of charge. In addition, as a representative on behalf of the member, you have the right to present additional information in person or in writing by sending it to the address or fax number above.

After requesting additional information, the grievance coordinator will send the case to a health care professional who has the appropriate clinical expertise, as determined by the State, in treating the member's condition or disease for review. If your doctor would like to discuss your appeal with one of our medical directors, you may call us at 1-844-325-6254.

You may extend the time frame for making the appeal decision for up to fourteen (14) days. We may also extend the time frame for decision up to fourteen (14) days if additional information is necessary and the delay is in the member's best interest. If we extend the time frame, we will send you a written notice with the reason for the delay.

A decision letter will be mailed to you within thirty (30) days from the date you filed your appeal or within two (2) days of the decision, whichever is sooner. This letter will tell you the reason for our decision and further appeal rights including your right to ask for a State Fair Hearing.

What if I don't like Highmark BCBSD Health Options' decision about my appeal?

If you do not agree with our decision, you may ask for a State Fair Hearing. Please see the next section of this unit on State Fair Hearings.

Expedited "Fast" Appeals

The following guidance on how to file an expedited appeal is given to members in the Member Handbook:

What should I do if I need a decision faster than 30 days?

If you think the normal time frame to review your appeal could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function, you may ask for an expedited appeal.

You can request an expedited appeal orally or in writing. You will receive a decision within seventy-two (72) hours from the day you file your request.

When you file an expedited appeal, please include the following:

- Member's name
- Member ID number
- Your phone number
- Your address
- State the service/item you are appealing.
- **State why you feel the member's life or health or ability to attain, maintain, or regain maximum function is in jeopardy.**
- State what you want as a result of your appeal.

What happens after I file an expedited appeal?

You may submit additional information to support the appeal, and you may ask to look over all documents for the appeal. You may also request a copy of the information used to review your appeal free of charge. In addition, as a representative on behalf of the member, you have a right to present additional information by fax using the fax number above. **Please Note:** The time frame for an expedited appeal is very short. Immediate action is required.

After requesting additional information, the grievance coordinator will send the case to a health care professional who has the appropriate clinical expertise, as determined by the State, in treating the member' condition or disease for review. If your doctor would like to discuss your appeal with one of our medical directors, you may call us at 1-844-325-6254.

You may extend the time frame for making the appeal decision for up to fourteen (14) days. We may also extend the time frame for decision up to fourteen (14) days if additional information is necessary and the delay is in the member's best interest. If we extend the time frame, we will send you a written notice with the reason for the delay.

After a decision is made, the grievance coordinator will promptly contact you with the outcome of the expedited appeal. A decision letter will also be mailed to you within seventy-two (72) hours or three (3) working days, whichever is sooner, from the date you filed your appeal. This letter will tell you the reason for our decision and further appeal rights including your right to ask for a State Fair Hearing.

What if I don't like Highmark BCBSD Health Options' decision about my appeal?

If you do not agree with our decision, you may ask for a State Fair Hearing.

For more information about State Fair Hearings, please see the next section of this unit beginning on the next page.

State Fair Hearings

A State Fair Hearing is an appeal process provided by the State of Delaware. If you are acting on behalf of a member, you may request a State Fair Hearing instead of or in addition to filing an appeal with us.

What should I do to get a State Fair Hearing?

You may ask for a State Fair Hearing if:

- We have denied, suspended, terminated, or reduced a service.
- We have delayed service.
- We have failed to give you timely service.

You can ask for a State Fair Hearing by calling or writing to the State's Division of Medicaid and Medical Assistance (DMMA) office at:

Division of Medicaid & Medical Assistance DMMA Fair Hearing Officer
1901 North DuPont Highway
P.O. Box 906, Lewis Building New Castle, DE 19720
Phone: 1-302-255-9500; or 1-800-372-2022 (toll free)

When should I file a State Fair Hearing?

If you are not happy with a denial of an appeal decision, you may request a State Fair Hearing within 120 calendar days of the date on the notice of resolution upholding the adverse benefit determination.

What happens after I file a State Fair Hearing?

You will receive a letter from the State Fair Hearing Officer that will tell you the date, time, and location of the hearing. The hearing can be held in person or by telephone. The letter will also tell you what you need to know to get ready for the hearing. You may ask to review and copy all documentation regarding the State Fair Hearing. Highmark Health Options will also have a representative at a State Fair Hearing.

The DMMA State Fair Hearing Officer will send you a letter with their decision within thirty (30) days from the date of the hearing.

How do I continue getting services during the State Fair Hearing process?

If the member was previously authorized and getting services, the member may ask to continue getting these services if:

- The member files the State Fair Hearing request timely (within 10 calendar days of us sending the denial of appeal.
- The State Fair Hearing involves the termination, suspension, or reduction of a previously authorized service.
- The services were ordered by an authorized provider.
- The period covered by the original authorization has not expired; and
- The member timely files for continuation of the benefits.

If we continue the member's services during the State Fair Hearing process, we will cover these services until:

- The member or member's representative withdraws the appeal or request for a State Fair Hearing
- The member or member's representative fails to request a State Fair Hearing and continuation of benefits within 10 calendar days after we send the notice of an adverse resolution.
- A decision from the State Fair Hearing Officer was not in the member's favor.

It is important to know that the member might have to pay for the services they received while the State Fair Hearing was pending if the final decision is not in the member's favor. If the decision is in the member's favor, we will authorize services immediately.

What if I do not like the State Fair Hearing decision?

If the member or member's representative is unhappy with the State Fair Hearing decision, they can ask for a judicial review in Superior Court. To do this, they must file an appeal with the clerk (Prothonotary) of the Superior Court within thirty (30) days of the date of the State Fair Hearing decision.

Alternate forms

All notices can be provided in a language other than English or in another format (i.e., Braille) for those who are unable to see or read written materials. We also have oral interpretation services available in non-English languages free of charge. If you need services, please call Member Services at 1-844- 325-6251.

Grievances

A grievance is a statement of unhappiness, like a complaint, and can either be filed in writing or verbally. A grievance can be about any service that a member received from a provider or by Highmark Health Options. A grievance does not include a denial of benefits for health care services. Those matters are handled as appeals (see the next section of this unit on appeals).

Some examples of a non-medical grievance are:

- If we did not grant a "fast decision" for an appeal
- If a provider or our employee was rude
- Is the member feels a provider or the plan did not respect their rights as a member

Some examples of medical grievances are:

- If member has a concern with the quality of care or services they have received
- If the member has trouble finding or getting services from a provider
- If a provider or our employee was verbally abusive to the member

The following guidance on how to file a grievance is given to members in the Member Handbook:

What should I do if I have a grievance?
To file a grievance, on behalf of a member, you can call Member Services to help you file a grievance. However, we will need to get the member's consent in writing prior to processing the grievance. If a provider files a grievance on behalf of a member, the member cannot file a separate grievance.

A grievance can also be filed in writing or by filling out a *Member Grievance Form*. You can find this form on our website at www.highmarkhealthoptions.com.

When you file your grievance, here are the things you should include:

- Member name
- Member's ID number
- Your phone number
- Your address
- Who is involved in the grievance
- Details of the occurrence
- Date of the occurrence
- Where did the occurrence happen
- What you want as the outcome of the grievance

You may send or attach any additional documents to support your grievance to the *Member Grievance Form*. You can contact us with this information at:

Highmark Health Options Member Appeals
P.O. Box 22278
Pittsburgh, PA 15222-0188
Phone: 1-844-325-6251; Fax: 1-844-325-3435

When should I file a grievance?
A grievance must be filed within ninety (90) days of the date of the occurrence.

What happens after I file a grievance?
After you file a grievance, you will get a letter from us within five (5) working days. This letter will tell you that we have received your grievance. It will include information about the grievance review process and your rights as a member representative, including your right to submit additional information and your right to review or request a copy of all documentation regarding the grievance upon request free of charge.

After requesting additional information, the grievance coordinator will send the case to a subject matter expert or a health care professional. If your grievance does not involve a medical issue, one of our staff members, who has not been involved with your grievance but is a subject matter expert, will review your request. If your grievance is medical in nature, a health care professional that has the appropriate clinical expertise, as determined by the State, in treating the member's condition or disease will review. A decision will be made within thirty (30) days after we receive your grievance.

You may extend the time frame for decision of the grievance up to fourteen (14) days. We may also extend the time frame for decision of the grievance up to fourteen (14) days if additional information is necessary and the delay is in the member's best interest. If we extend the time frame, we will send you a written notice of the reason for the delay. After a decision is made, a decision letter will be mailed to you. This letter will tell you the reason(s) for the decision.

Highmark Health Options West Virginia

Provider Complaint

Highmark Health Options has created a Provider Complaint system for participating and non-participating providers to raise issues with Highmark Health Options' policies, procedures and administrative functions. Providers can call (844) 789-1722 to discuss their issue with a Provider Representative. Complaints will be investigated, and the details of the findings and disposition will be communicated

back in writing to the provider within 30 days of receipt. If additional time is needed to resolve Highmark Health Options will provide status updates to the provider as applicable.

In addition to calling, providers have the option of sending a written complaint within 45 days regarding any policy, procedure or administrative function using one of the following methods:

- Calling United Concordia Dental Provider Customer Service at (844) 789-1722
- Mailing a complaint to United Concordia Dental Provider Customer Service at the mailing address below

WV Medicaid Customer Service Complaints
PO Box 69456
Harrisburg, PA 17106

Highmark Health Options will send a letter confirming that a written response should be expected within 30 calendar days. Any misdirected submissions, including but not limited to Administrative Reviews or Clinical Appeals, into the Provider Complaint system will be routed to the appropriate department. The provider will be advised of the redirection and educated on proper handling and contact details of the appropriate department for future reference.

Provider Dispute

Provider inquiries for administrative payment disputes/medical review should be sent to the PO box listed below, complaints about claims payment administrative in nature are handled as a provider dispute. The provider may file a written complaint about claims payment by faxing a request to 888-297-0966. Complaints may also be sent to the address listed below within twelve (12) months of the date of service, or sixty (60) days of the date of payment, whichever is later.

WV Medicaid Customer Service Disputes
PO Box 69456
Harrisburg, PA 17106

Provider Appeal

Clinical Provider appeals, when a service has been denied due to lack of prior authorization or denied based on medical necessity and still provided to the member, the provider can appeal that decision after the service. You may mail these requests along with all supporting documentation to:

WV Medicaid Customer Service Appeals
PO Box 69456
Harrisburg, PA 17106

A physician not involved in the original decision will review the clinical information and render a decision. The provider will be notified of the status of this review within thirty (30) days of the request. **NOTE: If the services have not been provided to the member, please follow the Member Appeals process as documented below.**

Member Appeals and Grievances

Appeals

Our members have a right to appoint a representative to act on their behalf. If a provider is acting on behalf of a member, we will need to obtain the member's consent in writing prior to reviewing a request for an appeal or grievance (*except* for an expedited request). A member or provider may contact a grievance coordinator at any time for help or any questions about the grievance and appeals process.

Members may also ask for help with their grievance or appeal by asking for a Member Advocate. A Member Advocate can be assigned by calling our Member Services at (844)-789-1722.

Grievances

A grievance is a statement of unhappiness, like a complaint, and can either be filed in writing or verbally. A grievance can be about any service that a member received from a provider or by Highmark Health Options. A grievance does not include a denial of benefits for health care services. Those matters are handled as appeals (see the next section of this unit on appeals).

To file a grievance by mail, send it to:

Highmark Health Options West Virginia
Attn: Grievance and Appeals
P.O. Box 1709
Parkersburg, WV 26102
Phone: 1-833-957-0020; Fax: 1-833-547-2022

You may send or attach any additional information that will help us with the review of your appeal. You can contact us at:

Highmark Health Options West Virginia
Attn: Grievance and Appeals
P.O. Box 1709
Parkersburg, WV 26102
Phone: 1-833-957-0020; Fax: 1-833-547-2022

Benefit Safeguards

Section 12

Health Insurance Portability and Accountability Act (HIPAA)

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) mandates standards for electronic data interchange (EDI) and code sets, establishes uniform health care identifiers and seeks protection for the privacy and security of patient data.

The overall objectives of HIPAA are to reduce paperwork, improve efficiency of health systems, and protect the security and confidentiality of electronic information. National Standards for electronic transactions are intended to encourage electronic commerce as health care providers will be able to submit the same HIPAA compliant transaction to any health plan in the United States and the health plan must accept it. There will no longer be hundreds of different formats.

TITLE VI of the Civil Rights Act of 1964

Practitioners are expected to comply with the Civil Rights Act of 1964. Title V of the Act pertains to discrimination on the basis of national origin or limited English proficiency. Practitioners 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. 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 United Concordia at (866) 529-4827. If you need assistance with a member request for alternate methods of communication, contact Propio Language Services at (913) 381-3143. Providers may utilize this translation service for translations with members' who require communication in a different language.

Transactions and Code Sets

United Concordia is compliant with the current transactions and code sets defined by HIPAA.

HIPAA Privacy

The Department of Health and Human Services (HHS) issued the final HIPAA Privacy Rule in 2000 and it became effective in 2001. The intent of this law is to protect a person's health information from unwanted, unauthorized, and/or commercial uses without impeding the delivery of health care services or payment. The HIPAA Privacy Rule covers health plans, health care clearinghouses and those health care providers who conduct certain financial and administrative transactions electronically. United Concordia is committed to protecting our members' privacy in accordance with all applicable Federal and State laws and is compliant with the HIPAA Privacy Rule.

HIPAA Security

The final HIPAA Security Rule was published in February 2003 and most health plans, clearinghouses and health care providers that are covered by this rule were required to comply by April 20, 2005. The intent of this law is to protect the confidentiality, integrity, and availability of electronic protected health information.

For more information about HIPAA, visit the following websites:

- https://www.cms.gov/Regulations-and-Guidance/Administrative-Simplification/HIPAA-ACA/AdoptedStandardsandOperatingRules – provides implementation guides or the x12N transaction standards.
- http://www.hhs.gov/ocr/hipaa – Privacy Information from the Office of Civil Rights.

HITECH

The American Recovery and Reinvestment Act of 2009 (ARRA) also known as the "Stimulus bill" was enacted on February 17, 2009. ARRA contains extensive provisions that collectively are referred to as the "Health Information Technology for Economic and Clinical Health Act" or "HITECH Act". These provisions include important changes to the Health Insurance Portability and Accountability Act (HIPAA) Privacy and Security Rules. The Department of Health and Human Services (HHS) is in the process of issuing regulations and other guidance, which will continue for several years. United Concordia has achieved compliance with the September 23, 2009 "Breach Notification for Unsecured Protected health Information Interim Final Rule of the "HITECH Act" and will achieve compliance with all future HITECH provision for which United Concordia is considered a covered entity as defined by HIPAA

Utilization Review

United Concordia's Utilization Review (UR) program is designed to help ensure that procedures reported on behalf of our members are rendered consistent with the provisions of their benefit programs. Because this program can affect any dentist who treats a patient covered by Highmark Wholecare, it is important to understand its purpose and how it works.

The Utilization Review Process - Data Collection & Statistical Analysis

Post-payment utilization reviews generally begin with the identification of a potential concern. Most frequently, the concern is identified through statistical analyses and peer comparisons, but can occur as the result of an inquiry or complaint received from a patient or another dentist or as the result of discrepancies noted during normal claims processing.

Professional Consultant Reviews

It may be necessary to review a sample of patient records to evaluate a dentist's reporting pattern. The record review is always conducted by a Dental Director or Advisor, who is a licensed dentist. The Dental Director or Advisor is asked to review the available clinical records and diagnostic materials and render a professional opinion as to whether the records adequately document the services reported.

Follow-up Actions

Upon completion of the review, a resolution letter including the review findings are sent to the dental office. If problems were identified during the review that resulted in overpayments, an appropriate refund may be calculated.

If a refund is calculated, the dentist will be informed of the amount, the reason(s) for it, the options for repayment, and, as appropriate, his/her right to appeal.

Fraud and Abuse

In order to comply with the Deficit Reduction Act of 2005, Highmark Wholecare, Highmark Health Options Delaware, and Highmark Health Options West Virginia has developed policies and procedures designed to provide detailed information about the type of conduct prohibited under the Federal False Claims Act and all applicable state laws that forbid the same type of conduct. These policies also detail the penalties for prohibited conduct under the various pieces of legislation that address false claims as well as Highmark Wholecare's own procedures for deterring fraud and abuse. Finally, Highmark Wholecare's policies also discuss whistleblower protections for individuals who report in good faith suspected fraudulent activity within the Medicaid system.

United Concordia providers, as well as staff members, contractors or agents of United Concordia providers are expected to abide by Highmark Wholecare, Highmark Health Options Delaware, and Highmark Health Options West Virginia's policies concerning fraud and abuse. Highmark Wholecare's and Highmark Health Options's fraud and abuse policies are available electronically to United Concordia providers through Highmark Wholecare's internet website, http://www.highmark.com/wholecare Highmark Health Options's internet website, www.highmarkhealthoptions.com (DE), or https://www.highmark.com/health-options-wv (WV). United Concordia providers can also obtain a paper copy of Highmark Wholecare's fraud and abuse policy by calling United Concordia's Highmark Wholecare Customer Service Department at (866) 568-5467, Highmark Health Options Delaware Customer Service Department at (866) 568-5933, or Highmark Health Options West Virginia's Customer Service Department at (844) 789-1722.

Highmark Wholecare, Highmark Health Options and United Concordia incorporate comprehensive policies for the detection and reporting of alleged fraud and abuse. It is Highmark Wholecare, Highmark Health Options and United Concordia's policy to investigate potential fraudulent activity by an employee, member, recipient, and/or dental practitioner which affects the integrity of the Medical Assistance Program.

As a participating dentist with Highmark Wholecare, Highmark Health Options Delaware, Highmark Health Options West Virginia and United Concordia the contract you signed requires compliance with all policies and procedures set forth, to include the prevention and detection of alleged fraud and abuse. Compliance may include the referral of information regarding suspected or confirmed allegations of fraud and/abuse to Highmark Wholecare, Highmark Health Options Delaware, Highmark Health Options West Virginia, and United Concordia.

It is your responsibility to notify the following if fraud or abuse is suspected:

- United Concordia Special Investigations Unit:
  (877) 968-7455 (Toll-Free Fraud Hotline or visit our website at www.unitedconcordia.com)
- Highmark Wholecare Special Investigations Unit:
  Tip line: 1-844-718-6400 (Toll-Free Fraud Hotline) (TTY Users can call 711 or 1-800-654-5984)
- Highmark Health Options Fraud and Abuse for Delaware
  Tip line: (844) 325-6256

- Highmark Health Options Fraud and Abuse for West Virginia
  Tip line: 1-844-718-6400

Special Investigations Unit (SIU)

The SIU is a department at United Concordia that is responsible for the investigation of potential fraudulent activity by an employee, member, recipient, and/or dental practitioner that affects the integrity of the Medical Assistance Program. It is your responsibility to immediately notify the SIU unit at (877) 968-7455 if fraudulent activity is suspected,

SIU Mailing Address

Special Investigations Unit
4401 Deer Path Road, DP-3B
Harrisburg, PA 17110

SIU Toll-Free Fraud Hotline

(877) 968-7455

SIU Fraud Complaint Form Online

www.unitedconcordia.com

Department of Human Services

The Department of Human Services established a Medical Assistance Provider Compliance Hotline to report suspected fraud or abuse by any entity rendering services to Medical Assistance Program recipients:

Telephone (includes TTY service): 1-866-379-8477

The Toll-Free Hotline operates between the hours of 8:30 am to 3:30 pm (EST), Monday through Friday. Voice messaging is available outside of these hours. Callers may remain anonymous if they prefer.

Suspected fraud or abuse may also be reported via the Department of Human Services Medical Assistance Compliance Hotline "Response Form" online at:

- http://www.dhs.pa.gov/learnaboutdhs/fraudandabuse/maprovidercompliancehotlineresponseform/index.htm

Or through the U.S. Postal Service at the following address:

Bureau of Program Integrity
MA Provider Compliance Hotline
P.O. Box 2675
Harrisburg, PA 17105-2675

Department of Human Services "Pennsylvania Medical Assistance (MA) Provider Self-Audit Protocol" encourages providers to voluntarily come forward and disclose overpayments or improper payments of Medical Assistance funds. There exists no formal mechanism or process for such voluntary disclosures. The protocol provides this formal mechanism.

Providers are reminded that this is a voluntary protocol and does not affect the requirements of the Single Audit Act. Further, the protocol suggests that managed care organizations under contract with Department of Human Services educate their network providers about the self- audit protocol and encourage the providers to use it.

Department of Human Services believes this protocol fosters a unique partnership between us and Medical Assistance providers, thereby serving our common interest to protect the financial integrity of the Program.

Regulatory Compliance

Dentists have a responsibility to ensure the claims they submit are truthful, accurate and comply with all federal and state contractual regulations. We realize ethical dentists and their staffs may make billing mistakes and errors through inadvertence or omission. When a billing error, honest mistake or omission has resulted in an inappropriate payment, we request that you return the payment. However, the dental practice will not be subject to civil or criminal penalties.

If a dentist submits a fraudulent claim, we will rely on Federal/State criminal and civil health care fraud laws. These laws cover offenses that are committed with actual knowledge of the falsity of the claim, reckless disregard or deliberate ignorance of the falsity of the claim.

Coding and Billing

The following risk areas associated with billing have been among the most frequent subjects of investigations and audits conducted by the SIU:

- Billing for items or services not rendered
- Submitting claims for services that are not reasonable or necessary
- Duplicate billings
- Billing for non-covered services as if covered
- Billing for unbundled services
- Upcoding the level of service provided
- Identity theft, and
- Routine waiver of co-payments or cost share

Documentation & Record Keeping

Timely, accurate and complete documentation is critical to nearly every aspect of a dental practice. Documentation is necessary to maintaining complete dental records for the patient and is the basis for coding and billing determinations. Most importantly, failure to document properly has the potential to compromise good patient care.

In addition to facilitating high quality patient care, a properly documented dental record accurately denotes what services were provided and why. The dental record may be used to validate:

- The site of service
- The appropriateness of the services provided, and
- The accuracy of the billing

Accurate dental record documentation should comply with, at the minimum, the following principles:

- The dental record should be complete and legible, and
- The documentation for each service performed should include the reason, any relevant history, physical examination findings, assessment, clinical impression, diagnosis, treatment plan, date and treating dentist, if applicable

The current version CDT codes reported on the insurance claims form should be supported by documentation in the dental record and chart.

Office Standards of Care

Quality Improvement and Utilization Program

United Concordia has established an ongoing program of quality improvement to improve member care and services. Your office is required to cooperate with all of United Concordia's Quality Management Policies and Procedures and Quality Improvement activities conducted by Highmark Wholecare, Highmark Health Options Delaware, or Highmark Health Options West Virginia. If the QI/UM Program discovers any particular issues, United Concordia will include all relevant information into a quarterly provider newsletter, a special fax notice or a webinar.

The policies and procedures include, but are not limited to, Utilization Review, Appeals and Participating with United Concordia sections of this manual. Please contact Government Business Operations at (866) 568-5467 for Highmark Wholecare, Delaware Customer Service Department at (866) 568-5933, or Highmark Health Options West Virginia's Customer Service Department at (844) 789-1722 to request a copy of United Concordia's Quality Management Policies and Procedures.

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

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 Highmark Wholecare or Highmark Health Options 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.

Accessibility

Highmark Wholecare

Emergency Care Coverage
Your office is required to provide twenty-four (24) hour emergency coverage to eligible members. Emergency patients must be seen immediately. Message retrieval systems or alternate coverage is required to ensure the patient timely access to your office or a participating designee.

Urgent Care Coverage
Your office is required to provide services to eligible members within twenty-four (24) hours of request for urgent services.

Routine Care Coverage
Your office is required to provide services to eligible members within fifteen (15) business days from the date of the member's request for an appointment.

Office Wait Time
Average office wait time should be no more than fifteen (15) minutes or no more than one (1) hour when the provider encounters an unanticipated urgent condition or need.

Highmark Health Options

Emergency Care Coverage
Your office is required to provide twenty-four (24) hour emergency coverage to eligible members. Emergency patients must be seen immediately. Message retrieval systems or alternate coverage is required to ensure the patient timely access to your office or a participating designee.

"Trauma-Informed Care" is a newly defined term meaning, "The delivery of care in a manner that understands and considers the pervasive nature of trauma and promotes environments of healing and recovery rather than practices and services that may inadvertently re-traumatize."

Urgent Care Coverage
Your office is required to provide services to eligible members within forty – eight (48) hours of request for urgent services.

Routine Care Coverage

Your office is required to provide services to eligible members within three (3) weeks from the date of the member's request for an appointment.

Office Wait Time
Average office wait time should be no longer than one hour. Office visits can be delayed when a provider "works in" urgent cases, when a serious problem is found, or when a patient had an unknown need that requires more services or education than was described at the time the appointment was made. If a provider is delayed, patients must be notified as soon as possible so they understand the delay. If the delay will result in more than an hour wait, then the patient must be offered a new appointment.

Continuity and Coordination of Care

United Concordia 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 Highmark Wholecare, Highmark Health Options Delaware, or Highmark Health Options West Virginia.

Highmark Wholecare, Highmark Health Options Delaware, and Highmark Health Options West Virginia physicians, dental providers 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.

"Store and Forward" is a newly defined term meaning, "The asynchronous, secure electronic transmission of a patient's health information provided through the transference of digital images, sounds, or previously recorded video from one location to another to allow a consulting provider the ability to obtain the information, analyze it, and report back to the referring provider. The referring provider is located at the Originating Site and consults with the provider at the Distant Site."

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. Pertinent clinical information may be sent to the PCP. The member's PCP name is listed on the front of the Highmark Wholecare ID card. Should you need assistance from Highmark Wholecare's Member Service Department in identifying the member's PCP or contact information, please call (800) 392-1147, (844) 325-6251 for Highmark Health Options Delaware, or (833)-957-0020 for Highmark Health Options West Virginia.

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 www.ada.gov.

Highmark Wholecare Enhanced Member Supports Unit (EMSU)/Care Management General Information

The goal of the Enhanced Member Supports Unit (EMSU) is to intervene in medically or socially complex cases that may benefit from increased coordination of services to optimize health and prevent disease. The EMSU is staffed by individuals with medical or social service backgrounds in the following areas: oncology, medically complex children, HIV/AIDS, substance abuse, mental health, physical rehabilitation and mental retardation.

For Highmark Wholecare, an Enhanced Member Supports Unit Case Manager is available at (800) 642-3550, option 1, Monday through Friday from 8:30 AM to 4:30 PM to assist with coordination of the member's healthcare needs. When calling after hours or on holidays, Member Services is available at (800) 392-1147.

Care Management is a creative and collaborative process involving skills such as assessment, planning, coordination and advocacy. Care Management facilitates optimal patient outcomes. Early intervention is essential to maximize treatment options while minimizing potential complications associated with catastrophic illnesses or injury and exacerbation of chronic conditions. The Care Management process includes:

- Assessment
- Planning
- Intervention
- Quality Monitoring
- Evaluation/Reassessment

The responsibilities of the EMSU include:

The Enhanced Member Supports Unit is responsible for providing support and Case Management Services to assist Members in addressing their Special Healthcare Needs and/or Health Related Social Needs (HRSNs) and supporting them with their overall Personal Well-being. The purpose of the EMSU is to ensure that all Members who have Special Healthcare Needs and/or HRSNs are able to receive all necessary services and supports in a timely manner. EMSU case managers must be Licensed Registered Nurses (RNs), Licensed

Practical Nurses (LPNs), Licensed Social Workers, Licensed Clinical Social Workers, Licensed Professional Counselors, or Licensed Marriage and Family Therapists. EMSU case managers are Licensed Registered Nurses (RNs), Licensed Practical Nurses (LPNs), Licensed Social Workers, Licensed Clinical Social Workers, Licensed Professional Counselors, or Licensed Marriage and Family Therapists. Outreach navigators may provide referrals for members to community based services and answer questions about coordinating healthcare services.

Criteria for Referrals to the Highmark Wholecare Enhanced Member Supports Unit (EMSU)

Examples of referrals to the EMSU include, but are not limited to:

- Children with Special Healthcare Needs and/or HRSNs, including those requiring skilled or unskilled home shift care or children in substitute care
- Members with limited English proficiency or special communication needs due to sensory deficits
- Members with Physical and/or Intellectual/Developmental Disabilities
- Members with HIV/AIDS
- Members with behavioral health diagnoses
- Members who require transportation assistance
- Members who require care and/or services of a type or amount that is beyond what is typically required
- Members who require extensive rehabilitative, habilitative, or other therapeutic interventions to maintain or improve their level of functioning

Highmark Wholecare allows for a standing referral to a specialist for sixty (60) days or to serve as a primary care practitioner in certain pre-authorized situations. The specialist must be an existing Highmark Wholecare practitioner, must be agreeable to following Highmark Wholecare's requirements for acting as a primary care practitioner, and must receive prior authorization by Highmark Wholecare's Medical Director. Practitioners interested in obtaining more information regarding this process should contact Provider Servicing at (800) 392-1145.

Highmark Health Options DE & WV Medicaid Special Needs/Care Management General Information

Highmark Health Options Delaware Medicaid Care Management includes Service Coordination, Care Coordination, Maternity Care Coordination, and Complex Case Management. The purpose of Highmark Health Options Care Management is to identify and assess patients who need individualized, comprehensive, health care management due to their complex health care needs. This includes addressing chronic conditions, severity of illness, and cost factors to ensure optimal patient outcome through targeted interventions.

- For Highmark Health Options DE Medicaid, a Case Manager is available at (844) 325-6251 and ask for the Care Coordination Department, Monday through Friday from 8:00 AM to 5:00 PM.

Highmark Health Options West Virginia (HHO WV) Medicaid uses a multidisciplinary approach to improve patient health. Licensed Care Coordination staff proactively contact and engage patients through interactive care management (ICM), providing personalized education, medication adherence support, health status monitoring, and lifestyle guidance. This collaborative, interactive approach, involving HHO WV staff, patients, and providers, improves the management of chronic diseases, complex health issues, and maternity care.

- For Highmark Health Options WV, a Case Manager is available at (833) 957-0020 Monday through Friday from 8:30 AM to 4:30 PM.

Office Environment

Dental plan office equipment should be in good working condition. The office should be kept neat and clean. Dental plan providers' offices and treatment accessibility should comply with the Americans with Disabilities Act and Section 504 of the Rehabilitation Act of 1973 and the following guidelines:

- A portable oxygen unit or ambu bag should be readily available.
- Patients shall wear protective lead aprons with thyroid collars during all radiographic procedures. Aprons shall be hung after use, not folded. Radiographic images shall be of diagnostic quality, labeled with date and patient's name and stored in the patient's chart.
- A comprehensive oral evaluation is a thorough evaluation and recording of the extraoral and intraoral hard and soft tissues. This evaluation shall include the following:
- Comprehensive examination by a dentist
    - Tooth charting (existing fillings, missing teeth, etc.)

- Periodontal charting of pocket depth
- Recording of a patient's medical and dental history, including known allergies
- Review of x-rays necessary for diagnosis
- Oral 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 shall include the following:
  - Examination by a dentist
  - Documentation of changes in medical history, including known allergies
  - Documentation of changes in oral health o Diagnosis of dental problems / diseases o Oral cancer screening
  - Review of x-rays and treatment plan when necessary
  - 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 in the permanent/primary and transitional dentition.
  - Fluoride status should be reviewed for children starting at age one (1). Fluoride should be provided every six months as indicated and based on caries risk and exposure to other sources of fluoride.
  - Endodontic treatment should not be performed on teeth with a poor restorative or periodontal prognosis. Apical therapies and endodontic surgeries require pre and post- operative radiographic images and date of initial root canal treatment as appropriate documentation.
  - In cases of periodontal disease, a baseline periodontal evaluation should be recorded in the patient's chart, including the recording or 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.
  - 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 Pennsylvania dental board permit holder.

Sterilization and Asepsis Control

Dental office sterilization protocol should meet OSHA requirements. All instruments should be heat sterilized where possible. Masks and eye protection should be worn by clinical staff where indicated; gloves should be worn during every clinical procedure. The dental office should have a sharps container for proper disposal of sharps. Disposal of medical waste should be handled per OSHA guidelines.

55 PA Code, Chapter 1101, General Provisions

Please visit the following site to access 55 PA Code, Chapter 1101, General Provisions:

https://www.pacode.com/secure/data/055/chapter1101/chap1101toc.html

Advanced Directives

The Omnibus Budget Reconciliation Act (OBRA) of 1990 included substantive new law that has come to be known as the Patient Self-Determination Act and which largely became effective December 1, 1991.

The Patient Self-Determination Act applies to hospitals, nursing facilities, providers of home health care or personal care services, hospice programs and health maintenance organizations that receive Medicare or Medicaid funds. The primary purpose of the act is to ensure that the beneficiaries of such care are made aware of advance directives and are given the opportunity to execute them if they so desire. It is also to prevent discrimination in care if the member chooses not to execute advance directives.

As a participating provider within United Concordia's network, you are responsible for determining if the member has executed an advance directive and for providing education when it is requested. You can also request a copy of a "Living Will" form from Customer Service Department by calling (866) 568-5467. There is no governmentally mandated form. A copy of the "Living Will" form should be maintained in the medical record. United Concordia's Medical Records Review Standards state that providers ask members age 21 and older whether they have executed advance directives and will document the response.

Member outreach or advance directive forms are made available through Highmark Wholecare's Member Handbook and Member Newsletter, or by visiting Highmark Wholecare's website at http://www.highmark.com/wholecare.

Recipient Restriction Program

If fraud or abuse is suspected, whether it is by a member, employee or practitioner, it is your responsibility to immediately notify United Concordia's Customer Service Department at (866) 568-5467. In cooperation with the Department of Human Services Highmark Wholecare maintains a Recipient Restriction Program, which restricts members who misutilize medical services or pharmacy benefits. Highmark Wholecare enforces and monitors these restrictions. If the recipient has been restricted to certain practitioners, EVS alerts the practitioner to whom the recipient is restricted.

55 PA Code, § 1101.9.Recipient misutilization and abuse:

- Identification of recipient misutilization and abuse. It is a function of the CAO to identify recipient misutilization; abuse or possible fraud in relation to the MA Program. Therefore, providers should notify the CAO if they have reason to believe that a recipient is misutilizing or abusing MA services or may be defrauding the MA Program. In addition, the Department has established procedures for reviewing recipient utilization of MA services. The review procedures identify recipients or families that are receiving excessive or unnecessary treatment, diagnostic services, drugs, medical supplies, or other services by visiting numerous practitioners. If the results of the Department's review warrant it, the recipient will be placed on the restricted recipient program, which means that he will be restricted to obtaining certain services from a single provider of his choice.

Restricted recipient program. A recipient who has been placed on the restricted recipient program will be notified in writing at least 10 days prior to the effective date of the restriction. The notice will include the name of the proposed provider which will become the one the recipient shall use if he does not notify the Department, in writing, prior to the effective date of the restriction that he wishes to choose a different provider. If, during a period of restriction, a recipient wishes to change a designated provider, a 30-day written notice shall be given in writing to the Office of Medical Assistance.

Contact Information

Telephone Numbers:

Customer Service
DE: (866) 568-5933
WV: (844) 789-1722
PA: (866) 568-5467

Website:

www.UnitedConcordia.com

Mailing Address for Claim Submission

In Pennsylvania:

Highmark Wholecare Claims
PO Box 2190
Milwaukee, WI 53201

All other states:

Highmark Health Options Claims
PO Box 69455
Harrisburg, PA 17106-9455

United Concordia dental℠