Dental Provider Manual

UnitedHealthcare KanCare

Provider Services: 1-855-878-5372

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5/27/2025

United Healthcare® | Dental Benefit Providers® | KanCare

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Section 1: Introduction — who we are

Welcome to UnitedHealthcare®

UnitedHealthcare welcomes your participation with the UnitedHealthcare Community Plan KanCare dental provider network.

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

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

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

Our Commercial program plan requirements are contained in a separate Provider Manual. If you support one of our Commercial plans and need that Manual, please contact Provider Services at **1-800-822-5353**.

If you have any questions or concerns about the information contained within this Manual, please contact the UnitedHealthcare Community Plan Provider Services team at the telephone number listed on the cover of this document.

Unless otherwise specified herein, this Manual is effective the date found on the cover of this document for dental providers currently participating in the UnitedHealthcare Community Plan's network, and effective immediately for newly contracted dental providers.

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

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

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

Provider Online Academy

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

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

To access Provider Online Academy, visit **UHCdental.com/medicaid** and go to Resources > Dental Provider Online Academy.

Section 2: Patient eligibility verification procedures

2.1 Member eligibility

Member eligibility or dental benefits may be verified online or via phone.

We receive daily updates on member eligibility and can provide the most up-to-date information available.

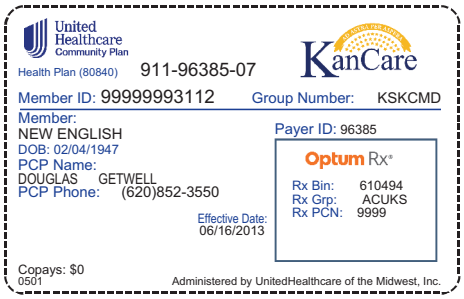
Important note: Eligibility should be verified on the date of service. Verification of eligibility is not a guarantee of payment. Payment can only be made after the claim has been received and reviewed in light of eligibility, dental necessity and other limitations and/or exclusions. **Additional rules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

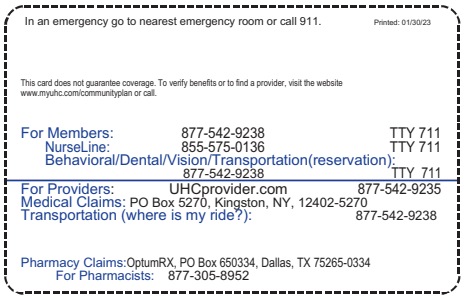
2.2 Member identification card

Members are issued an identification (ID) card by UnitedHealthcare Community Plan. There will not be separate dental cards for UnitedHealthcare Community Plan members. The ID cards are customized with the UnitedHealthcare Community Plan logo and include the toll-free customer service number for the health plan.

A member ID card is not a guarantee of payment. It is the responsibility of the provider to verify eligibility at the time of service.

To verify a member's dental coverage, go to **UHCdental.com/medicaid** or contact the dental Provider Services line at the telephone number listed on the cover of this document. A sample ID card is provided below. The member's actual ID card may look slightly different.





2.3 Eligibility verification

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

The username and password that are established during the registration process will be used to access the website. One username and password are granted for each payee ID number.

UnitedHealthcare Community Plan also offers an Interactive Voice Response (IVR) system for eligibility verification. The IVR is available 24 hours a day, 7 days a week.

2.4 Quick reference guide

UnitedHealthcare Community Plan is committed to providing your office accurate and timely information about our programs, products and policies.

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

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

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

2.5 Provider Portal / Dental Hub

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

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

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

2.6 Integrated Voice Response (IVR) system

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

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

Section 3: Office administration

3.1 Office site quality

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

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

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

3.2 Office conditions

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

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

3.3 Sterilization and infection control fees

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

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

3.4 Recall system

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

3.5 Transfer of dental records

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

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

3.6 Office hours

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

3.7 Protect confidentiality of member data

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

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

3.8 Provide access to your records

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

3.9 Inform members of advance directives

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

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

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

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

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

3.10 Participate in quality initiatives

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

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

3.11 New associates

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

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

If you have any questions or need to receive a copy of our provider application packet, please contact Provider Services at the telephone number listed on the cover of this document.

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

When there are demographic changes within your office, you must notify us at least 10 calendar days prior to the effective date of the change. This supports accurate claims processing as well as helps to make sure that member directories are up-to-date.

Changes should be submitted to:

UnitedHealthcare – RMO
ATTN: 400-Provider Services
PO BOX 30567
SALT LAKE CITY, UT 84130

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

Credentialing updates should be sent to:

2300 Clayton Road
Suite 1000
Concord, CA 94520

Requests must be made in writing with corresponding and/or backup documentation. For example, a tax identification number (TIN) change would require submission of a copy of the new W9, versus an office closing notice where we'd need the notice submitted in writing on office letterhead.

When changes need to be made to your practice, we will need an outline of the old information as well as the changes that are being requested. This should include the name(s), TIN(s) and/or Practitioner ID(s) for all associates to whom that the changes apply.

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

If you have any questions, don't hesitate to contact Provider Services at the telephone number listed on the cover of this document for guidance.

Section 4: Patient access

4.1 Appointment scheduling standards

The state of Kansas has established appointment time requirements for all situations to ensure that Members receive dental services in a time period that is appropriate to their health condition. Providers are required to adhere to the appointment standards are adhered to in an effort to ensure accessibility of needed services, maintain Member satisfaction and reduce unnecessary use of alternative services such as an emergency room.

- Routine dental care must be scheduled within 21 calendar days*
- Urgent care must be scheduled within 48 hours.
- Emergent care must be scheduled immediately.

Appointment standards will be monitored and corrective action will be taken if required.*

* UnitedHealthcare understands that there may be extenuating circumstances such as limited provider availability in a county which could prohibit a practitioner from meeting the 21 day period for routine appointments. Corrective action will not be taken when extenuating circumstances exist.

4.2 Emergency coverage

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

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

4.3 Specialist referral process

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

To obtain a list of participating dental network specialists, go to our website at **UHCdental.com/medicaid**. Click "Find a Dentist" on the top right and then choose "Medicaid Plans" to search by location. You may also contact Provider Services on the telephone number listed on the cover of this document.

4.4 Missed appointments

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

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

- "We missed you when you did not come for your dental appointment on month/date. Regular check-ups are needed to keep your teeth healthy."

- "Please call to reschedule another appointment. Call us ahead of time if you cannot keep the appointment. Missed appointments are very costly to us. Thank you for your help."

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

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

4.5 Nondiscrimination

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

Section 5: Utilization Management program

5.1 Utilization Management

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

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

5.2 Community practice patterns

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

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

5.3 Evaluation of utilization management data

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

5.4 Utilization Management analysis results

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

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

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

5.5 Utilization review

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

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

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

Utilization review is completed based on the following:

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

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

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

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

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

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

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

- Electronic database searches such as Medline®, PubMed®, and the Cochrane Library.

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

The Dental Clinical Policy and Technology Committee (DCPTC) is responsible for developing and evaluating the inclusion of evidence-based practice guidelines, new technology and the new application of existing technology in the UnitedHealthcare Community Plan dental policies, benefits, clinical programs, and business functions; to include, but not limited to dental procedures, pharmaceuticals as utilized in the practice of dentistry, equipment, and dental services. The DCPTC convenes every other month and no less frequently than four times per year. The DCPTC is comprised of Dental Policy Development and Implementation Staff Members, Non-Voting Members, and Voting Members. Voting Members are UnitedHealth Group Dentists with diverse dental experience and business background including but not limited to members from Utilization Management and Quality Management.

Section 6: Quality management

6.1 Quality Improvement Program (QIP) description

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

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

The QIP description is reviewed and updated annually:

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

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

6.2 Credentialing

In compliance with the Centers for Medicare & Medicaid Services (CMS) Medicaid Managed Care Final Rule 2390F and 42 CFR 438.602(b)(1), all participating providers who receive payment for KanCare members are required to be screened and enrolled in the Kansas Medical Assistance Program (KMAP).

This federal requirement applies to all provider types and specialties and is inclusive of all network billing, rendering, ordering, prescribing, referring, sponsoring, and attending providers. All MCO network providers must be enrolled with KMAP and screened prior to receiving payments from an MCO.

Providers may access the Provider Enrollment Portal at: https://portal.kmap-state-ks.us/providerenrollment/enrollmentcreate, or they may visit the KMAP main site, at https://www.kmap-state-ks.us.

Once providers have been enrolled as a KMAP provider, UnitedHealthcare will retrieve all credentialing documents from KMAP, and will proceed with the credentialing and contracting process.

6.3 Site visits

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

The site visit focuses primarily on: dental record keeping, patient accessibility, infection control, and emergency preparedness and radiation safety. Results of site reviews will be shared with the dental office. Any significant failures may result in a review by the Peer Review Committee, leading to a corrective action plan or possible termination. If terminated, the dentist can reapply for network participation once a second review has been completed and a passing score has been achieved.

UnitedHealthcare Dental, Dental Benefit Providers, reserves the right to conduct an on-site inspection prior to and any time during the effectuation of the contract of any Mobile Dental Facility or Portable Dental Operation bound by the "Mobile Dental Facilities Standard of Care Addendum."

6.4 Preventive health guideline

The UnitedHealthcare Community Plan approach to preventive health is a multi-focused strategy which includes several integrated areas. The following guidelines are for informational purposes for the dental provider, and will be referred to in a general way, in judging clinical appropriateness and competence.

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

Caries Management – Begins with a complete evaluation including an assessment for risk.

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

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

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

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

Additional areas for prevention evaluation and intervention include malocclusion, prevention of sports injuries and harmful habits (including, but not limited to, digit- and pacifier-sucking, tongue thrusting, mouth breathing, intraoral and perioral piercing, and the use of tobacco products). Other preventive concerns may include preservation of primary teeth, space maintenance and eruption of permanent dentition. UnitedHealthcare Community Plan may perform clinical studies and conduct interventions in the following target areas:

- Access
- Preventive services, including topical fluoride and sealant application
- Procedure utilization patterns

Multiple channels of communication will be used to share information with providers and members via manuals, websites, newsletters, training sessions, individual contact, health fairs, in-service programs and educational materials. It is the mission of UnitedHealthcare Community Plan to educate providers and members on maintaining oral health, specifically in the areas of prevention, caries, periodontal disease and oral cancer screening.

6.5 Addressing the opioid epidemic

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

Brief summary of framework

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

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

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

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

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

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

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

Increasing education & awareness of opioids

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

Access these resources at **UHCprovider.com** > Tools and resources > Resource library > Pharmacy resources > Drug lists and pharmacy > Opioid Programs and Resources - Community Plan (Medicaid).

Prevention

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

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

Section 7: Fraud, waste and abuse training

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

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

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

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

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

Section 8: Governance

8.1 Provider rights bulletin

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

To review your information

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

To correct erroneous information

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

To be informed of status of your application

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

To appeal adverse committee decisions

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

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

8.2 Provider responsibilities

Enrolled Participating Providers have the following responsibilities:

- If a recommended treatment plan is not covered, the participating dentist, if intending to charge the Member for the non-covered services, must notify the Member in writing that the service will not be covered. The notice must contain language explaining that the member will be liable for the services if rendered and must be signed by the member.
- A Provider wishing to terminate from participation with the UnitedHealthcare KanCare provider network due to retirement, relocation, or voluntary termination must supply written notification of termination at least 60 days prior to expected final date of participation. All patients should be referred to the toll-free Member number **1-877-542-9238 (TTY: 711)** to find another dentist in their area.
- A Provider may not bill both medical and dental codes for the same procedure.

8.3 Quality of care issues

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

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

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

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

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

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

8.4 Appeals process

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

- Providers are notified in writing of their appeal rights within fifteen (15) calendar days of the Committee's determination. The letter will include the reason for denial/termination; notice that the provider has the right to request a hearing or review, at the provider's discretion, before a panel appointed by UnitedHealthcare; notice of a thirty (30)-day time frame for the request; and, a time limit for the hearing date, which must be held within thirty (30) days after the receipt of a request for a hearing.
- The Hearing will be scheduled within thirty (30) days of the request for a hearing.

- The Hearing Committee includes at least three members appointed by UnitedHealthcare, who are not in direct economic competition with the provider, and who have not acted as accuser, investigator, fact-finder, or initial decision-maker in the matter. At least one person on the panel will be the same discipline or same specialty as the person under review. The panel can consist of more than three members, provided the number of clinical peers constitute one-third or more of the total membership.
- The Hearing Committee may uphold, overturn, or modify the original determination. Modifications may include, but are not limited to, placing the provider on probation, requiring completion of specific continuing education courses, requiring site or chart audits, or other corrective actions.
- The decision of the Hearing Committee is sent to the provider by certified letter within thirty (30) calendar days.
- Decisions of terminations shall be effective not less than thirty (30) days after the receipt by the provider of the Hearing Panel's decision.
- In no event shall determination be effective earlier than sixty (60) days from receipt of the notice of termination.

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

8.5 Cultural competency

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

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

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

Section 9: Claim submission procedures

9.1 Claim submission options

9.1.a Paper claims

To receive payment for services, practices must submit claims via paper or electronically. When submitting a paper claim, dentists are required to submit an American Dental Association (ADA) Dental Claim Form (2024 version).If an incorrect claim form is used, the claim cannot be processed and will be returned.

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

Refer to Section 9.4 for more information on claims submission best practices and required information. Appendix A will provide you with the appropriate claims address information to ensure your claims are routed to the correct resource for payment.

9.1.b Electronic claims

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

Dentists may continue to submit their claims via the State of Kansas.

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

9.1.c Electronic payments

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

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

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

ePayment Center allows you to:

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

- Streamline reconciliation with automated payment posting capabilities
- Download remittances in various formats (835, CSV, XLS, PDF)
- Search payments history up to 7 years

To register:

1. Visit **UHCdental.epayment.center/register**
2. Follow the instructions to obtain a registration code
3. Your registration will be reviewed by a customer service representative and a link will be sent to your email once confirmed
4. Follow the link to complete your registration and setup your account
5. Log into **UHCdental.epayment.center**
6. Enter your bank account information
7. Select remittance data delivery options
8. Review and accept ACH Agreement
9. Click "Submit"
10. Upon completion of the registration process, your bank account will undergo a prenotification process to validate the account prior to commencing the electronic fund transfer delivery. This process may take up to 6 business days to complete

Need additional help? Call **1-855-774-4392** or email **help@epayment.center**.

In addition to a no-fee ACH option, other electronic payment methods are available through Zelis Payments.

The Zelis Payments advantage:

- Access all payers in the Zelis Payments network through one single portal
- Experience award winning customer service
- Receive funds weeks faster than mailed checks and improve the accuracy of your claim payments
- Streamline your operations and improve revenue stability with virtual card and ACH
- Protect your account with 24/7 Office of Foreign Assets Control (OFAC) fraud monitoring
- Reduce costs and boost efficiency by simplifying administrative work from processing payments
- Gain visibility and insights from your payment data with a secure provider portal. Download files (10 years of storage)
  in various formats (XLS, PDF, CSV or 835)

Each Zelis Payments product gives you multiple options to access data and customize notifications. You will have access to several features via the secure web portal.

All remittance information is available 24/7 via **provider.zelispayments.com** and can be downloaded into a PDF, CSV, or standard 835 file format. For any additional information or questions, please contact Zelis Payments Client Service Department at **1-877-828-8770**.

9.2 Facilities with encounter payments (FQHCs, etc.)

All dental services performed by facilities that are reimbursed through encounter payments need to submit an encounter claim for each unique member visit. The encounter claim is processed to track utilization of HEDIS/EPSDT services. It is mandatory to submit encounter data per state and federal guidelines. Claims should be submitted with each individual service rendered. The services will be entered

into Skygen USA's claims payment system for utilization tracking. The actual encounter (PPS) rate will be paid for the claim.

9.3 Receipt and audit of claims

In order to ensure timely, accurate remittances to each dentist, an edit of all claims is performed upon receipt. This edit validates Member eligibility, procedure codes, and Provider identifying information. A Dental Reimbursement Analyst dedicated to Kansas dental offices analyzes any claim conditions that would result in non-payment. When potential problems are identified, your office may be contacted and asked to assist in resolving this problem. Please feel free to contact Provider Services at 1-855-878-5372 with any questions you may have regarding claim submission or your remittance.

Each Enrolled Participating Provider office receives an "explanation of benefit" report with their remittance. This report includes Member information and an allowable fee by date of service for each service rendered during the period.

If a dentist wishes to appeal any reimbursement decision, they need to submit an appeal in writing, along with any necessary additional documentation within 60 calendar days of the date on the provider remittance to:

UnitedHealthcare of Kansas – Corrected Claims
P.O. Box 481
Milwaukee, WI 53201

Provider will receive a response to the appeal within 30 BUSINESS days,

9.4 Claim submission requirements and best practices

9.4.a Dental claim form required information

The Dental ADA claim form 2024 version must be submitted for payment of services rendered.

One claim form should be used for each patient and the claim should reflect only 1 treating dentist for services rendered. The claims must also have all necessary fields populated as outlined in the following:

Header information

Indicate the type of transaction by checking the appropriate box: Statement of Actual Services.

Subscriber information

- Name (last, first and middle initial)
- Address (street, city, state, ZIP code)
- Date of birth
- Gender
- Subscriber ID number

Patient information

- Name (last, first and middle initial)
- Address (street, city, state, ZIP code)
- Date of birth
- Gender
- Patient ID number

Primary payer information

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

Other coverage

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

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

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

- Name of subscriber/policy holder (last, first and middle initial)
- Date of birth
- Gender
- Subscriber ID number
- Relationship to the member

Billing dentist or dental entity

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

- Name
- Address (street, city, state, ZIP code)
- License number
- Social Security number (SSN) or tax identification number (TIN)
- Phone number
- National provider identifier (NPI)

Treating dentist and treatment location

List the following information regarding the dentist that provided treatment:

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

Record of services provided

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

Missing teeth information

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

Remarks section

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

ICD-10 instructions

RECORD OF SERVICES PROVIDED

	24. Procedure Date (MM/DD/CCYY)	25. Area of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Letter(s)	28. Tooth Surface	29. Procedure Code	29a. Diag. Pointer	29b. Qty.	30. Description	31. Fee
1										
2										
3										
4										
5										
6										
7										
8										
9										
10										

33. Missing Teeth Information (Place an "X" on each missing tooth.) 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17	34. Diagnosis Code List Qualifier ☐☐ (ICD-10 = AB) 34a. Diagnosis Code(s) A _____ C _____ (Primary diagnosis in "A") B _____ D _____	31a. Other Fee(s) 32. Total Fee
35. Remarks		

29a **Diagnosis Code Pointer:** Enter the letter(s) from Item 34 that identifies the diagnosis code(s) applicable to the dental procedure. List the primary diagnosis pointer first.

29b **Quantity:** Enter the number of times (01-99) the procedure identified in Item 29 is delivered to the patient on the date of service shown in Item 24. The default value is "01".

34 **Diagnosis Code List Qualifier:** Enter the appropriate code to identify the diagnosis code source:
B = ICD-9-CM **AB** = ICD-10-CM (as of Oct. 1, 2013)

This information is required when the diagnosis may have an impact on the adjudication of the claim in cases where specific dental procedures may minimize the risks associated with the connection between the patient's oral and systemic health conditions.

34a **Diagnosis Code(s):** Enter up to 4 applicable diagnosis codes after each letter (A.-D.). The primary diagnosis code is entered adjacent to the letter "A."

This information is required when the diagnosis may have an impact on the adjudication of the claim in cases where specific dental procedures may minimize the risks associated with the connection between the patient's oral and systemic health conditions.

By Report procedures

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

Using current ADA codes

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

Supernumerary teeth

UnitedHealthcare recognizes tooth letters "A" through "T" for primary teeth and tooth numbers "1" to "32" for permanent teeth. Supernumerary teeth should be designated by using codes AS through TS or

51 through 82. Designation of the tooth can be determined by using the nearest erupted tooth. If the tooth closest to the supernumerary tooth is # 1 then the supernumerary tooth should be charted as #51, likewise if the nearest tooth is A the supernumerary tooth should be charted as. These procedure codes must be referenced in the patient's file for record retention and review. Patient records must be kept for a minimum of 7 years.

Insurance fraud

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

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

Invalid or incomplete claims:

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

9.4.b Coordination of Benefits (COB)

Our benefits contracts are subject to coordination of benefits (COB) rules. We coordinate benefits based on the member's benefit contract and applicable regulations.

UnitedHealthcare Community Plan is the payer of last resort. Other coverage should be billed as the primary carrier. When billing UnitedHealthcare Community Plan as a secondary payer, submit the primary payer's Explanation of Benefits or remittance advice with the claim.

NOTE: UnitedHealthcare follows KMAP TPL policy. All KMAP TPL billing requirements still apply. Please refer to KMAP General TPL Payment provider manual. Clarification to this provider manual will be added at a later date.

9.4.c Timely submission (Timely filing)

All claims should be submitted within 180 calendar days from the date of service.

All adjustments or requests for reprocessing must be made within 365 days from date of service, or date of eligibility posting, only if the initial submission time period has been met. An adjustment can be requested in writing or telephonically.

Secondary claims must be received within 180 calendar days of the primary payer's determination (see section 9.4.b).

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

9.5 Timely payment

- 90% of all clean claims will be paid or denied within 30 calendar days of receipt.
- 99% of all clean claims will be paid or denied within 45 calendar days of receipt.

Quality Assurance (QA) audits are performed to ensure the accuracy and effectiveness of our claim adjudication procedures. Any identified discrepancies are resolved within established timelines. The QA process is based on an established methodology but as a general overview, on a daily basis various samples of claims are selected for quality assurance reviews. QA samples include center-specific claims, adjustments, claims adjudicated by newly hired claims processors, and high-dollar claims. In addition, management selects other areas for review, including customer-specific and processor-specific audits. Management reviews the summarized results and correction is implemented, if necessary.

9.6 Provider remittance advice

9.6.a Explanation of dental plan reimbursement (remittance advice)

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

Below is a list and description of each field:

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

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

AMOUNT BILLED - Amount submitted by provider

AMOUNT PAYABLE - Amount payable after benefits have been applied

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

OTHER INSURANCE - Amount payable by another carrier

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

NET AMOUNT (Summary Page) - Total amount paid

PATIENT NAME

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

PATIENT DOB

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

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

ENCOUNTER NUMBER - Claim reference number

BENEFIT LEVEL - In or out-of-network coverage

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

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

CDTCODE - Current Dental Terminology - Procedure code of service performed

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

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

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

QTY OR NO. OF UNITS

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

PAYABLE AMOUNT - Contracted amount

COPAY AMOUNT - Member responsibility

COINSURANCE AMOUNT - Member responsibility of total payment amount

DEDUCTIBLE AMOUNT - Member responsibility before benefits begin

PATIENT PAY - Amount to be paid by the member

OTHER INSURANCE AMOUNT - Amount paid by other carriers

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

EXCEPTION CODES - Codes that explain how the claim was adjudicated

9.6.b Provider Remittance Advice sample (page 1)

UnitedHealthcare KS Medicaid

Payee ID: 55555 Payee Name: Dental Office Name Remittance Date: 10/20/2017

UnitedHealthcare

Please address questions to:

UnitedHealthcare KS Medicaid
PO Box 1427
Milwaukee, WI 53201

Contact: UnitedHealthcare Community Plan - Provider Services
Phone: (855)934-9818
Fax:

Dental Office Name
Street Address
City, State ZIP

Current Period:	**10/20/2017**
Payee ID:	55555
Phone:	(555)555-5555
Fax:	(555)555-5555
Tax ID:	555555555

Remittance Summary

Fee For Service:	**$2,164.33**
Budget Allocation:	**$0.00**
Capitation:	**$0.00**
Case Fees:	**$0.00**
Additional Compensation:	**$0.00**
Prior Period Recovery and other Payee Adjustments:	**$0.00**
Total:	**$2,164.33**

What if I do not agree with this decision?
If you do not agree with the denial, you may appeal. You may appeal within 90 calendar days after the payment, denial or recoupment of a timely claim submission. Administrative appeals should be sent to the address below.
UnitedHealthcare Community Plan
P.O. Box 1427
Milwaukee, WI 53201
If you have any questions, please call Provider Customer Services at 855-934-9818

Ref #: 34143 / 169 Page 1

9.6.c Provider Remittance Advice sample (page 2)

UnitedHealthcare KS Medicaid

Payee ID: 55555 Payee Name: Dental Office Name Remittance Date: 10/20/2017

Fee For Service Summary

Dental Office Name
Street Address
City, State ZIP

Provider / ID	Location / ID	Amount Billed	Amount Payable	Patient Pay	Other Insurance	Prior Mo. Adj	Net Amount
Provider Name/ 55555	Dental Office Name / 55555	$4,785.00	$1,870.84	$0.00	$0.00	$0.00	$1,870.84
Provider Name / 55555	Dental Office Name / 55555	$1,110.00	$109.37	$0.00	$0.00	$0.00	$109.37
Provider Name / 55555	Dental Office Name / 55555	$450.00	$184.12	$0.00	$0.00	$0.00	$184.12
	Totals:	**$6,345.00**	**$2,164.33**	**$0.00**	**$0.00**	**$0.00**	**$2,164.33**

Ref #: 34143 / 170 Page 2

9.6.d Provider Remittance Advice sample (page 3)

UnitedHealthcare KS Medicaid

Payee ID: 55555 Payee Name: Dental Office Name Remittance Date: 10/20/2017

Services Detail

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

Patient Name: Last, First Name
Subscriber/Member: 555555555 / 00
DOB: 00/00/0000
Office Reference No: 555555555
Provider Name: Last, First Name
Provider NPI: 5555555555
Plan: UnitedHealthcare Missouri
Product: UHC KS Medicaid
Encounter #: **55555555555555**
Referral #:
Referral Date:
Benefit Level: In Network

ITM	DOS	CODE	POS	BILLED QTY	BILLED AMOUNT	ALLOWED QTY	ALLOWED AMOUNT	PAY %	PAYABLE AMOUNT	COPAY AMOUNT	COINS AMOUNT	DEDUCT AMOUNT	PATIENT PAY	OTHER INSUR	NET AMOUNT	PAY CODE
1	10/16/17	D2740 4	11	1	$885.00	0	$0.00	100.00 %	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	FFS
2	10/16/17	D2954 4	11	1	$225.00	1	$109.37	100.00 %	$109.37	$0.00	$0.00	$0.00	$0.00	$0.00	$109.37	FFS
					$1,110.00		**$109.37**		**$109.37**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$109.37**	

ITEM: 1 Exception Code: 1096 Service Authorization not Found.

Patient Name: Last, First Name
Subscriber/Member: 555555555 / 00
DOB: 00/00/0000
Office Reference No: 555555555
Provider Name: Last, First Name
Provider NPI: 5555555555
Plan: UnitedHealthcare Missouri
Product: UHC KS Medicaid Adult
Encounter #: **55555555555555**
Referral #:
Referral Date:
Benefit Level: In Network

ITM	DOS	CODE	POS	BILLED QTY	BILLED AMOUNT	ALLOWED QTY	ALLOWED AMOUNT	PAY %	PAYABLE AMOUNT	COPAY AMOUNT	COINS AMOUNT	DEDUCT AMOUNT	PATIENT PAY	OTHER INSUR	NET AMOUNT	PAY CODE
1	10/12/17	D2392 29 DO	11	1	$135.00	1	$71.84	100.00 %	$71.84	$0.00	$0.00	$0.00	$0.00	$0.00	$71.84	FFS
2	10/12/17	D7140 30	11	1	$160.00	1	$52.28	100.00 %	$52.28	$0.00	$0.00	$0.00	$0.00	$0.00	$52.28	FFS
					$295.00		**$124.12**		**$124.12**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$124.12**	

Patient Name: Last, First Name
Subscriber/Member: 555555555 / 00
DOB: 00/00/0000
Office Reference No: 555555555
Provider Name: Last, First Name
Provider NPI: 5555555555
Plan: UnitedHealthcare Missouri
Product: UHC KS Medicaid Adult
Encounter #: **55555555555555**
Referral #:
Referral Date:
Benefit Level: In Network

ITM	DOS	CODE	POS	BILLED QTY	BILLED AMOUNT	ALLOWED QTY	ALLOWED AMOUNT	PAY %	PAYABLE AMOUNT	COPAY AMOUNT	COINS AMOUNT	DEDUCT AMOUNT	PATIENT PAY	OTHER INSUR	NET AMOUNT	PAY CODE
1	10/12/17	D0120 00	11	1	$50.00	1	$0.00	100.00 %	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	FFS
2	10/12/17	D0220 00	11	1	$25.00	1	$9.58	100.00 %	$9.58	$0.00	$0.00	$0.00	$0.00	$0.00	$9.58	FFS
3	10/12/17	D0230 00	11	1	$20.00	1	$7.98	100.00 %	$7.98	$0.00	$0.00	$0.00	$0.00	$0.00	$7.98	FFS
4	10/12/17	D0274 00	11	1	$50.00	1	$21.63	100.00 %	$21.63	$0.00	$0.00	$0.00	$0.00	$0.00	$21.63	FFS
5	10/12/17	D2392 13 DO	11	1	$135.00	1	$71.84	100.00 %	$71.84	$0.00	$0.00	$0.00	$0.00	$0.00	$71.84	FFS
					$280.00		**$111.03**		**$111.03**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$111.03**	

ITEM: 1 Exception Code: 1039 This service is not covered under the plan.

Patient Name: Last, First Name
Subscriber/Member: 555555555 / 00
DOB: 00/00/0000
Office Reference No: 555555555
Provider Name: Last, First Name
Provider NPI: 5555555555
Plan: UnitedHealthcare Missouri
Product: UHC KS Medicaid
Encounter #: **55555555555555**
Referral #:
Referral Date:
Benefit Level: In Network

ITM	DOS	CODE	POS	BILLED QTY	BILLED AMOUNT	ALLOWED QTY	ALLOWED AMOUNT	PAY %	PAYABLE AMOUNT	COPAY AMOUNT	COINS AMOUNT	DEDUCT AMOUNT	PATIENT PAY	OTHER INSUR	NET AMOUNT	PAY CODE
1	10/12/17	D0150 00	11	1	$55.00	1	$39.66	100.00 %	$39.66	$0.00	$0.00	$0.00	$0.00	$0.00	$39.66	FFS
2	10/12/17	D0210 00	11	1	$125.00	1	$40.72	100.00 %	$40.72	$0.00	$0.00	$0.00	$0.00	$0.00	$40.72	FFS
3	10/12/17	D1120 00	11	1	$60.00	1	$21.95	100.00 %	$21.95	$0.00	$0.00	$0.00	$0.00	$0.00	$21.95	FFS
4	10/12/17	D1208 00	11	1	$25.00	1	$11.98	100.00 %	$11.98	$0.00	$0.00	$0.00	$0.00	$0.00	$11.98	FFS
					$265.00		**$114.31**		**$114.31**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$114.31**	

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9.7 Overpayment

If you find an overpaid claim, notify us of the overpayment immediately. Send us the overpayment within the time specified in your Agreement. If your payment is not received by that time, we may apply the overpayment against future claim payments in accordance with our Agreement and applicable law.

If you prefer us to recoup the funds from your next payment, call Provider Services.

If you prefer to mail a refund, send an Overpayment Return Check oto:

Overpayment
P.O. Box 481
Milwaukee, WI 53201

Include the following information with the Overpayment Return Check:

- Name and contact information for the person authorized to sign checks or approve financial decisions.
- Member identification number.
- Date of service.
- Original claim number (if known).
- Date of payment.
- Amount paid.
- Amount of overpayment.
- Overpayment reason.
- Check number

9.8 Tips for successful claims resolution

- Do not let claim issues grow or go unresolved.
- Call Provider Services if you can't verify a claim is on file.
- Do not resubmit validated claims on file unless submitting a corrected claim with the required indicators.
- File adjustment requests and claims disputes within contractual time requirements.
- If you must exceed the maximum daily frequency for a procedure, submit the medical records justifying medical necessity.
  If you have questions, call Provider Services.
- UnitedHealthcare Community Plan is the payer of last resort. This means you must bill and get an EOB from other insurance or source of health care coverage before billing UnitedHealthcare Community Plan. Secondary claims must be received within 180 calendar days from the date of service, even if the primary carrier has not made payment.
- When submitting appeal or reconsiderations requests, provide the same information required for a clean claim. Explain the discrepancy, what should have been paid and why.

9.9 Payment for non-covered services

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

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

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

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

9.8 Radiology requirements

Guidelines for providing radiographs are as follows:

- Send a copy or duplicate radiograph instead of the original.
- Radiograph must be diagnostic for the condition or site.
- Radiographs should be mounted and labeled with the practice name, patient name and exposure date (not the duplication date).
- When a radiograph does not demonstrate a clinical condition well, an intra-oral photo and/or narrative are suggested as additional diagnostic aides.

X-rays submitted with Authorizations or Claims will not be returned. This includes original film radiographs, duplicate films, paper copies of x-rays and photographs.

Electronic submission, rather than paper copies of digital x-rays is preferred. Film copies are only accepted if labeled, mounted and paper clipped to the authorization. Please do not utilize staples.

Orthodontic and other models are not accepted forms of supporting documentation and will not be reviewed. Orthodontic models will be returned to you along with a copy of the paperwork submitted.

Please note: Authorizations, including attachments, can be submitted online at no additional cost by visiting our website: **UHCdental.com/medicaid**.

9.9 Corrected Claim submission guidelines

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

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

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

A corrected claim may be submitted using the methods below:

- Electronically through Clearing House
- Electronically through the Dental Hub if original claim was submitted on the Dental Hub. If original claim was not submitted on the Dental Hub, another method should be utilized.

- Paper to the mailing address below

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

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

- Must be submitted to the Corrected Claims P.O. Box for proper processing and include the following:
  - 2024 version of the ADA claim form and all required information
  - The ADA form must be clearly noted "Corrected Claim"
  - In the remarks field (Box 35) on the ADA claim form indicate the original paid encounter number and record all corrections you are requesting to be made.

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

If a claim or service originally DENIED due to incorrect or missing information/authorization, or was not previously processed for payment, DO NOT submit a corrected claim. Denied services have no impact on member tooth history or service accumulators, and, as such, do not require reprocessing. Submit a new claim with the updated information per your normal claim submission channels. Timely filing limitations apply when a denied claim is being resubmitted with additional information for processing.

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

Appendices for the State of Kansas

Appendix A: Resources and services – how we help you

Addresses and phone numbers

Need:	Address:	Phone Number:	Payer I.D.:	Submission Guidelines:	Form(s) Required:
Claim Submission (initial)	Claims: UnitedHealthcare KS Claims P.O. Box 1158 Milwaukee, WI 53201	**1-855-878-5372**	GP133	Within 180 calendar days from the date of service For secondary claims, within 180 calendar days from the primary payer determination	ADA Claim Form, 2024 version
Corrected Claims	Corrected Claims: UnitedHealthcare KS Claims P.O. Box 481 Milwaukee, WI 53201	**1-855-878-5372**	N/A	Within 365 days plus 3 calendar days of the date the denial letter was mailed or the date on the Provider Remittance.	ADA Claim Form Reason for requesting adjustment or resubmission
Claim Appeals (Appeal of a denied or reduced payment)	Claim Appeals: UnitedHealthcare Appeals P.O. Box 1244 Milwaukee, WI 53201	**1-855-878-5372**	N/A	Within 60 days after the claim determination	Supporting documentation, including claim number is required for processing.
Prior Authorization Requests	Pre-authorizations: UnitedHealthcare Authorizations P.O. Box 2135 Milwaukee, WI 53201	**1-855-878-5372**	GP133	N/A	ADA Claim Form – check the box titled: Request for Predetermination / Preauthorization section of the ADA Dental Claim Form
Member Benefit Appeal for Service Authorization (Appeal of a denied or reduced service)	UnitedHealthcare Community Attn: Appeals and Grievances Unit P.O. Box 31364 Salt Lake City, UT 84131-0364	**1-866-293-1796**	N/A	Within 60 calendar days from the date of the adverse benefit determination	N/A

Appendix B: Member benefits/exclusions and limitations

B.1 Exclusions & limitations

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

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

Please call Provider Services if you have any questions regarding frequency limitations.

General exclusions

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

B.2 Benefit grid

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

UHC KanCare CHIP (Ages 0-18) and Medicaid (Ages 0-20)

Code	Code description	Teeth or area covered	Review required	CHIP Age Range	Medicaid Age Range	Benefit limitations
D0120	Periodic Oral Evaluation - Established Patient		No	0-18	0-20	Only one exam every 6 months per provider or provider billing group. Only one exam (D0120, D0140, D0145, Do150, D0170) per date of service, per beneficiary, per provider or provider billing group.
D0140	Limited Oral Evaluation - Problem Focused		No	0-18	0-20	Only one exam (D0120, D0140, D0145, Do150, D0170) per date of service, per beneficiary, per provider or provider billing group. Limited oral evaluation is only covered when performed in conjunction with treatment to address an emergency situation. An emergency is defined as treatment medically necessary to treat pain, infection, swelling, uncontrolled bleeding, or traumatic injury.
D0145	Oral Evaluation, Patient Under Three		No	0-2	0-2	Only one exam (D0120, D0140, D0145, Do150, D0170) per date of service, per beneficiary, per provider or provider billing group.
D0150	Comprehensive Oral Evaluation - New or Established Patient		No	0-18	0-20	One comprehensive exam per beneficiary, per provider or provider billing group per lifetime. Only one exam (D0120, D0140, D0145, or D0150) every six months per beneficiary, per provider or provider billing group.
D0170	Reevaluation - limited, problem focused		No	0-18	0-20	One per 12 months. Established beneficiary to assess the status of a previously existing condition (not post- operative visit). Not covered with any other procedure other than radiographs.
D0210	Intraoral - Complete Series (Including Bitewings)		No	0-18	0-20	One per 36 months. The following are also considered an Intraoral Complete Series (D0210) D0330 and D0272 D0330 and D0273 D0330 and D0274 D0330 and D0277
D0220	Intraoral - Periapical First Film		No	0-18	0-20	One per day. Any additional films (D0220 - D0340) performed on the same date of service as a complete intraoral series, or its equivalent, are considered content of service of the complete series and will not be reimbursed.
D0230	Intraoral - Periapical Each Additional Film		No	0-18	0-20	Any additional films (D0220 - D0340) performed on the same date of service as a complete intraoral series, or its equivalent, are considered content of service of the complete series and will not be reimbursed.
D0240	Intraoral - Occlusal Film		No	0-18	0-20	Any additional films (D0220 - D0340) performed on the same date of service as a complete intraoral series, or its equivalent, are considered content of service of the complete series and are not reimbursed.

UHC KanCare CHIP (Ages 0-18) and Medicaid (Ages 0-20)

Code	Code description	Teeth or area covered	Review required	CHIP Age Range	Medicaid Age Range	Benefit limitations
D0250	Extraoral - 2d projection radiographic image created using a stationary radiation source, and detector		No	0-18	0-20	Any additional films (D0220 - D0340) performed on the same date of service as a complete intraoral series, or its equivalent, are considered content of service of the complete series and are not reimbursed.
D0251	Extraoral - First Radiographic Image		No	0-18	0-20	Any additional films (D0220 - D0340) performed on the same date of service as a complete intraoral series, or its equivalent, are considered content of service of the complete series and are not reimbursed.
D0270	Bitewing - Single Film		No	0-18	0-20	Any additional films (D0220 - D0340) performed on the same date of service as a complete intraoral series, or its equivalent, are considered content of service of the complete series and are not reimbursed. Only one bitewing code (D0270, D0272, D0273, D0274, D0277) per date of service, per beneficiary, per provider or provider billing group.
D0272	Bitewings - Two Films		No	0-18	0-20	Any additional films (D0220 - D0340) performed on the same date of service as a complete intraoral series, or its equivalent, are considered content of service of the complete series and are not reimbursed. Only one bitewing code (D0270, D0272, D0273, D0274, D0277) per date of service, per beneficiary, per provider or provider billing group.
D0273	Bitewings - Three Films		No	0-18	0-20	Any additional films (D0220 - D0340) performed on the same date of service as a complete intraoral series, or its equivalent, are considered content of service of the complete series and are not reimbursed. Only one bitewing code (D0270, D0272, D0273, D0274, D0277) per date of service, per beneficiary, per provider or provider billing group.
D0274	Bitewings - Four Films		No	0-18	0-20	Any additional films (D0220 - D0340) performed on the same date of service as a complete intraoral series, or its equivalent, are considered content of service of the complete series and are not reimbursed. Only one bitewing code (D0270, D0272, D0273, D0274, D0277) per date of service, per beneficiary, per provider or provider billing group.
D0277	Vertical Bitewings - 7-8 Films		No	0-18	0-20	Any additional films (D0220 - D0340) performed on the same date of service as a complete intraoral series, or its equivalent, are considered content of service of the complete series and are not reimbursed. Only one bitewing code (D0270, D0272, D0273, D0274, D0277) per date of service, per beneficiary, per provider or provider billing group.

UHC KanCare CHIP (Ages 0-18) and Medicaid (Ages 0-20)

Code	Code description	Teeth or area covered	Review required	CHIP Age Range	Medicaid Age Range	Benefit limitations
D0321	Other Temporomandibular Joint Films, By Report		No	0-18	0-20	Any additional films (D0220 - D0340) performed on the same date of service as a complete intraoral series, or its equivalent, are considered content of service of the complete series and are not reimbursed.
D0322	Tomographic Survey		No	0-18	0-20	Any additional films (D0220 - D0340) performed on the same date of service as a complete intraoral series, or its equivalent, are considered content of service of the complete series and are not reimbursed.
D0330	Panoramic Film		No	0-18	0-20	One per 36 months. The following are also considered an Intraoral Complete Series (D0210) D0330 and D0272 D0330 and D0273 D0330 and D0274 D0330 and D0277
D0460	Pulp Vitality Test	1 - 32 51 - 82 (SN) A - T AS - TS (SN)	No	0-18	0-20	Maximum of three teeth per visit.
D0999	Unspecified Diagnostic Procedures, By Report		Yes	0-18	0-20	
D1110	Prophylaxis - Adult		No	13-18	13-20	Twice per calendar year. Title 21 Children Ages 13-18 Title 19 Children Ages 13-20 Includes scaling and polishing procedures to remove coronal plaque, calculus, and stains.
D1120	Prophylaxis - Child		No	0-12	0-12	Twice per calendar year. Title 21 Children Ages 0-12 Title 19 Children Ages 0-12 Includes scaling and polishing procedures to remove coronal plaque, calculus, and stains.
D1206	Topical Application Of Fluoride		No	0-18	0-20	1 application every 120 days
D1208	Topical Application Of Fluoride (excluding varnish)		No	0-18	0-20	1 application every 120 days
D1351	Sealant - Per Tooth		No	0-18	0-20	Once per 12 months. Occlusal surfaces only. Teeth must be caries free. Sealant is not covered when placed over restorations.
D1354	Application of caries arresting medicament - per tooth	1-32 51 - 82 (SN) A - T AS - TS (SN)	No	0-18	0-20	(Silver Diamine Fluoride Treatments) 2 applications per year per tooth and 6 applications per tooth per lifetime benefit limits
D1510	Space Maintainer - Fixed - Unilateral per quadrant/arch	Per quadrant 10 (UR) 20 (UL) 30 (LL) 40 (LR)	No	0-18	0-20	Once per 12 months per quadrant.
D1516	Space maintainer - fixed - bilateral, maxillary	01 (UA) 02 (LA)	No	0-18	0-20	One per 12 months per arch.
D1517	Space maintainer - fixed - bilateral, mandibular	01 (UA) 02 (LA)	No	0-18	0-20	One per 12 months per arch.
D1526	Space maintainer - removable - bilateral, maxillary	01 (UA) 02 (LA)	No	0-18	0-20	One per 12 months per arch.

UHC KanCare CHIP (Ages 0-18) and Medicaid (Ages 0-20)

Code	Code description	Teeth or area covered	Review required	CHIP Age Range	Medicaid Age Range	Benefit limitations
D1527	Space maintainer - removable - bilateral, mandibular	01 (UA) 02 (LA)	No	0-18	0-20	One per 12 months per arch.
D1551	Re-cement or re-bond space maintainer - maxillary		No	0-18	0-20	Not covered within 6 months of initial placement
D1552	Re-cement or re-bond space maintainer - mandibular		No	0-18	0-20	Not covered within 6 months of initial placement
D1553	Re-cement or re-bond unilateral space maintainer - per quadrant		No	0-18	0-20	Not covered within 6 months of initial placement
D1575	Distal shoe space maintainer-fixed, unilateral	Per quadrant 10 (UR), 20 (UL), 30 (LL), 40 (LR)	No	0-18	0-20	Once per 12 months per quadrant
D2140	Amalgam - One Surface, Primary Or Permanent	1 - 32 51 - 82 (SN) A - T AS - TS (SN)	No	0-18	0-20	1 in 12 months
D2150	Amalgam - Two Surfaces, Primary Or Permanent	1 - 32 51 - 82 (SN) A - T AS - TS (SN)	No	0-18	0-20	1 in 12 months
D2160	Amalgam - Three Surfaces, Primary Or Permanent	1 - 32 51 - 82 (SN) A - T AS - TS (SN)	No	0-18	0-20	1 in 12 months
D2161	Amalgam - Four Or More Surfaces, Primary Or Permanent	1 - 32 51 - 82 (SN) A - T AS - TS (SN)	No	0-18	0-20	1 in 12 months
D2330	Resin-Based Composite - One Surface, Anterior	6 - 11, 22 - 27 56 - 61 (SN) 72 - 77 (SN) C - H, M - R CS - HS (SN) MS - RS (SN)	No	0-18	0-20	1 in 12 months
D2331	Resin-Based Composite - Two Surfaces, Anterior	6 - 11, 22 - 27 56 - 61 (SN) 72 - 77 (SN) C - H, M - R CS - HS (SN) MS - RS (SN)	No	0-18	0-20	1 in 12 months
D2332	Resin-Based Composite - Three Surfaces, Anterior	6 - 11, 22 - 27 56 - 61 (SN) 72 - 77 (SN) C - H, M - R CS - HS (SN) MS - RS (SN)	No	0-18	0-20	1 in 12 months

UHC KanCare CHIP (Ages 0-18) and Medicaid (Ages 0-20)

Code	Code description	Teeth or area covered	Review required	CHIP Age Range	Medicaid Age Range	Benefit limitations
D2335	Resin-Based Composite - Four Or More Surfaces Or Involving Incisal Angle	6 - 11, 22 - 27 56 - 61 (SN) 72 - 77 (SN) C - H, M - R CS - HS (SN) MS - RS (SN)	No	0-18	0-20	1 in 12 months
D2390	Resin-Based Composite Crown, Anterior	6 - 11, 22 - 27 56 - 61 (SN) 72 - 77 (SN) C - H, M - R CS - HS (SN) MS - RS (SN)	No	0-18	0-20	1 in 12 months
D2391	Resin-Based Composite - One Surface, Posterior	1 - 5, 12 - 21, 28 - 32 51 - 55 (SN) 62 - 71 (SN) 78 - 82 (SN) A, B, I - L, S, T, AS (SN), BS (SN) IS - LS (SN), SS (SN),TS (SN)	No	0-18	0-20	1 in 12 months
D2392	Resin-Based Composite - Two Surfaces, Posterior	1 - 5, 12 - 21, 28 - 32 51 - 55 (SN) 62 - 71 (SN) 78 - 82 (SN) A, B, I - L, S, T, AS (SN), BS (SN) IS - LS (SN), SS (SN),TS (SN)	No	0-18	0-20	1 in 12 months
D2393	Resin-Based Composite - Three Surfaces, Posterior	1 - 5, 12 - 21, 28 - 32 51 - 55 (SN) 62 - 71 (SN) 78 - 82 (SN) A, B, I - L, S, T, AS (SN), BS (SN) IS - LS (SN), SS (SN),TS (SN)	No	0-18	0-20	1 in 12 months
D2394	Resin-Based Composite - Four Or More Surfaces, Posterior	1 - 5, 12 - 21, 28 - 32 51 - 55 (SN) 62 - 71 (SN) 78 - 82 (SN) A, B, I - L, S, T, AS (SN), BS (SN) IS - LS (SN), SS (SN),TS (SN)	No	0-18	0-20	1 in 12 months
D2710	Crown - Resin-Based Composite (Indirect)	6 - 11 22 - 27 56 - 61 (SN) 72 - 77 (SN)	Yes	0-18	0-20	Once per 60 months

UHC KanCare CHIP (Ages 0-18) and Medicaid (Ages 0-20)

Code	Code description	Teeth or area covered	Review required	CHIP Age Range	Medicaid Age Range	Benefit limitations
D2740	Crown - Porcelain/Ceramic Substrate	1 - 32 51 - 82 (SN)	Yes	0-18	0-20	Once per 60 months
D2751	Crown - Porcelain Fused To Predominantly Base Metal	1 - 32 51 - 82 (SN)	Yes	0-18	0-20	Once per 60 months
D2752	Crown - Porcelain Fused To Noble Metal	1 - 32 51 - 82 (SN)	Yes	0-18	0-20	Once per 60 months
D2753	Crown - Porcelain fused to titanium and titanium allows	1 - 32 51 - 82 (SN)	Yes	0-18	0-20	Once per 60 months
D2783	Crown - Full Cast High Noble Metal	1 - 32 51 - 82 (SN)	Yes	0-18	0-20	Once per 60 months
D2791	Crown - 3/4 porcelain/ceramic	1 - 32 51 - 82 (SN)	Yes	0-18	0-20	Once per 60 months
D2792	Crown - Full Cast Noble Metal	1 - 32 51 - 82 (SN)	Yes	0-18	0-20	Once per 60 months
D2910	Recement Inlay, Onlay, Or Partial Coverage Restoration	1 - 32 51 - 82 (SN)	No	0-18	0-20	
D2920	Recement Crown	1 - 32, 51-82 (SN)	No	0-18	0-20	
D2921	Reattachment of tooth fragment, incisal edge or cusp	1 - 32 51 - 82 (SN)	No	0-18	0-20	Not allowed same tooth, same surface(s), same DOS as D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394
D2928	Prefabricated Porcelain/Ceramic Crown Permanent Tooth	1- 32 51 - 82 (SN)	No	0-18	0-20	
D2929	Prefabricated Porcelain / Ceramic Crown - Primary Tooth	A-T	No	0-20	0-20	Once per 24 months
D2930	Prefabricated Stainless Steel Crown - Primary Tooth	A - T AS - TS (SN)	No	0-18	0-20	Once per 24 months.D2930 and D2934 cannot be placed on the same tooth during a 24-month period.
D2931	Prefabricated Stainless Steel Crown - Permanent Tooth	1 - 32 51 - 82 (SN)	No	0-18	0-20	Once per 24 months.
D2934	Prefabricated Esthetic coated Stainless Steel Crown - Primary Tooth	C - H, M - R CS - HS (SN) MS - RS (SN)	No	0-18	0-20	Once per 24 months. D2930 and D2934 cannot be placed on the same tooth during a 24-month period.
D2940	Sedative Filling	1 - 32 51 - 82 (SN)	No	0-18	0-20	Temporary restoration intended to relieve pain. Not to be used as a base or liner under a restoration.
D2951	Pin Retention - Per Tooth, In Addition To Restoration	1 - 32 51 - 82 (SN)	No	0-18	0-20	
D2954	Prefabricated Post And Core In Addition To Crown	1 - 32 51 - 82 (SN)	Yes	0-18	0-20	Once per 60 months
D2957	Each additional Prefabricated post - same tooth	1 - 3, 14 - 19, 30 - 32 51- 53 (SN) 64 - 69 (SN) 80 - 82 (SN)	No	0-18	0-20	Once per 60 months
D3110	Pulp Cap Indirect (excluding restoration)	1 - 32 51 - 82(SN)	No	0-18	0-20	

UHC KanCare CHIP (Ages 0-18) and Medicaid (Ages 0-20)

Code	Code description	Teeth or area covered	Review required	CHIP Age Range	Medicaid Age Range	Benefit limitations
D3220	Therapeutic Pulpotomy	1 - 32 51 - 82(SN) A - T AS - TS	No	0-18	0-20	One per tooth, per lifetime. Not covered within 30 days of D3310 - D3331 on same tooth.
D3221	Pulpal Debridement	1 - 32 51 - 82(SN) A - T AS - TS	No	0-18	0-20	One per tooth, per lifetime. Not covered within 30 days ofD3310 - D3331 on same tooth.
D3222	Partial Pulpotomy For Apexogenesis - Permanent Tooth	1 - 32 51 - 82(SN)	Yes	0-18	0-20	One per tooth, per lifetime. Should only be performed as preparation for endodontic treatment.
D3310	Endodontic Therapy, Anterior Tooth (Excluding Final Restoration)	6 - 11 22 - 27 56 - 61(SN) 72 - 77(SN)	No	0-18	0-20	One per tooth, per lifetime.
D3320	Endodontic Therapy, Bicuspid Tooth (Excluding Final Restoration)	4, 5, 12, 13, 20, 21, 28, 29, 54(SN), 55(SN), 62(SN), 63(SN), 70(SN), 71(SN), 78(SN), 79(SN)	No	0-18	0-20	One per tooth, per lifetime.
D3330	Endodontic Therapy, Molar (Excluding Final Restoration)	1 - 3, 14 - 19 30 - 32 51 - 53(SN) 64 - 69(SN) 80 - 82(SN)	No	0-18	0-20	One per tooth, per lifetime.
D3331	Treatment of root canal obstruction - non surgical	1 - 32 51 - 82 (SN)	Yes	0-18	0-20	
D3351	Apexification / Recalcification / Pulpal Regeneration - Initial Visit	1 - 32 51 - 82 (SN)	No	0-18	0-20	
D3352	Apexification / Recalcification / Pulpal Regeneration - Interim	1 - 32 51 - 82 (SN)	No	0-18	0-20	
D3353	Apexification / Recalcification / Pulpal Regeneration - Final Visit	1 - 32 51 - 82 (SN)	No	0-18	0-20	
D3410	Apicoectomy / Periradicular Surgery - Anterior	6 - 11, 22 - 27 56 - 61(SN) 72 - 77(SN)	No	0-18	0-20	
D3421	Apicoectomy / Periradicular Surgery - Bicuspid (First Root)	4, 5, 12, 13, 20, 21, 28, 29, 54(SN), 55(SN), 62(SN), 63(SN), 70(SN), 71(SN), 78(SN), 79(SN)	No	0-18	0-20	
D3425	Apicoectomy / Periradicular Surgery - Molar (First Root)	1 - 3, 14 - 19 30 - 32 51 - 53(SN) 64-69(SN) 80 - 82(SN)	No	0-18	0-20	

UHC KanCare CHIP (Ages 0-18) and Medicaid (Ages 0-20)

Code	Code description	Teeth or area covered	Review required	CHIP Age Range	Medicaid Age Range	Benefit limitations
D3426	Apicoectomy / Periradicular Surgery - Each Additional Root)	1 - 5, 12 - 21 28 - 32 51 - 55(SN) 62 - 71(SN) 78 - 82(SN)	No	0-18	0-20	
D3427	Periradicular surgery without apicoectomy	1 - 32 51 - 82 (SN)	No	0-18	0-20	Not allowed same tooth, same DOS as D3410, D3421, D3425, D3426
D3430	Retrograde Filling, per root	1 - 32 51 - 82 (SN)	No	0-18	0-20	
D4210	Gingivectomy Or Gingivoplasty - Four Or More Contiguous Teeth	Per quadrant - 10 (UR) 20 (UL) 30 (LL) 40 (LR)	Yes	0-18	0-20	A minimum of four affected teeth in the quadrant.
D4211	Gingivectomy Or Gingivoplasty - One To Three Contiguous Teeth	Per quadrant - 10 (UR) 20 (UL) 30 (LL) 40 (LR)	Yes	0-18	0-20	One to three affected teeth in the quadrant.
D4230	Anatomical Crown Exposure - 4 or more contiguous teeth per quadrant	Per quadrant - 10 (UR) 20 (UL) 30 (LL) 40 (LR)	Yes	0-18	0-20	Must be billed same date same tooth in conjunction with the restorative codes (D2140 - D2957).
D4231	Anatomical Crown Exposure - 1- 3 contiguous teeth per quadrant	Per quadrant - 10 (UR) 20 (UL) 30 (LL) 40 (LR)	Yes	0-18	0-20	Same date and same tooth in conjunction with the restorative code.
D4268	Surgical Revision Procedure per tooth	1 - 32 51 - 82 (SN)	Yes	0-18	0-20	Only covered after D4210.
D4341	Periodontal Scaling And Root Planing - Four Or More Teeth Per Quadrant	Per quadrant - 10 (UR) 20 (UL) 30 (LL) 40 (LR)	Yes	0-18	0-20	Four per 12 months. A minimum of four affected teeth in the quadrant.
D4342	Periodontal Scaling And Root Planing - One To Three Teeth Per Quadrant	Per quadrant - 10 (UR) 20 (UL) 30 (LL) 40 (LR)	Yes	0-18	0-20	Four per 12 months. One to three affected teeth in the quadrant.
D4346	Scaling in presence of generalized moderate or severe gingival inflammation- full mouth, after oral evaluation		Yes	0-18	0-20	Once per 12 months. Not covered on the same DOS as D1110, D1120, D4341, D4342, D4355, or D4910
D4355	Full Mouth Debridement		No	0-18	0-20	One per 12 months.
D4910	Periodontal Maintenance, office visit non-covered on the date of service		No	0-18	0-20	2 per code every accum year per patient
D5110	Complete Denture - Maxillary		Yes	0-18	0-20	One per 60 months.

UHC KanCare CHIP (Ages 0-18) and Medicaid (Ages 0-20)

Code	Code description	Teeth or area covered	Review required	CHIP Age Range	Medicaid Age Range	Benefit limitations
D5120	Complete Denture - Mandibular		Yes	0-18	0-20	One per 60 months.
D5211	Maxillary Partial Denture - Resin Base		Yes	0-18	0-20	One per 60 months.
D5212	Mandibular Partial Denture - Resin Base		Yes	0-18	0-20	One per 60 months.
D5213	Maxillary Partial Denture - Cast Metal Framework With Resin Denture Bases		Yes	0-18	0-20	One per 60 months.
D5214	Mandibular Partial Denture - Cast Metal Framework With Resin Denture Bases		Yes	0-18	0-20	One per 60 months.
D5225	Maxillary Partial Denture - Flexible Base		Yes	0-18	0-20	One per 60 months.
D5226	Mandibular Partial Denture - Flexible Base		Yes	0-18	0-20	One per 60 months.
D5282	Removable unilateral partial denture - one piece cast metal (including clasps and teeth), maxillary	Per quadrant - 10 (UR) 20 (UL) 30 (LL) 40 (LR)	Yes	0-18	0-20	One per 60 months
D5284	Removable unilateral partial denture - one piece flexible base (including clasps and teeth) - per quadrant	Per quadrant - 10 (UR) 20 (UL) 30 (LL) 40 (LR)	Yes	0-18	0-20	One per 60 months
D5286	Removable unilateral partial denture - one piece resin (including clasps and teeth) - per quadrant	Per quadrant - 10 (UR) 20 (UL) 30 (LL) 40 (LR)	Yes	0-18	0-20	Once per 60 months
D5410	Adjust Complete Denture - Maxillary		No	0-18	0-20	Not covered within 6 months of placement
D5411	Adjust Complete Denture - Mandibular		No	0-18	0-20	Not covered within 6 months of placement
D5421	Adjust Partial Denture - Maxillary		No	0-18	0-20	Not covered within 6 months of placement
D5422	Adjust Partial Denture - Mandibular		No	0-18	0-20	Not covered within 6 months of placement
D5511	Repair broken complete denture base, mandibular		No	0-18	0-20	
D5512	Repair broken complete denture base, maxillary		No	0-18	0-20	
D5520	Replace Missing Or Broken Teeth - Complete Denture (Each Tooth)	1 - 32	No	0-18	0-20	
D5611	Repair resin partial denture base, mandibular	02 (LA) 30 (LL) 40 (LR)	No	0-18	0-20	

UHC KanCare CHIP (Ages 0-18) and Medicaid (Ages 0-20)

Code	Code description	Teeth or area covered	Review required	CHIP Age Range	Medicaid Age Range	Benefit limitations
D5612	Repair resin partial denture base, maxillary	01 (UA) 10 (UR) 20 (UL)	No	0-18	0-20	
D5621	Repair cast partial framework, mandibular	02 (LA) 30 (LL) 40 (LR)	No	0-18	0-20	
D5622	Repair cast partial framework, maxillary	01 (UA) 10 (UR) 20 (UL)	No	0-18	0-20	
D5630	Repair Or Replace Broken Clasp	1 (UA) 2 (LA) 10 (UR) 20 (UL) 30 (LL) 40 (LR)	No	0-18	0-20	
D5640	Replace Broken Teeth - Per Tooth	1 - 32	No	0-18	0-20	
D5650	Add Tooth To Existing Partial Denture	1 - 32	No	0-18	0-20	
D5660	Add Clasp To Existing Partial Denture	1 (UA) 2 (LA) 10 (UR) 20 (UL) 30 (LL) 40 (LR)	No	0-18	0-20	
D5670	Replace all teeth and acrylic on cast metal framework (maxillary)		No	0-18	0-20	
D5671	Replace all teeth and acrylic on cast metal framework (maxillary)		No	0-18	0-20	
D5750	Reline Complete Maxillary Denture (Laboratory)		No	0-18	0-20	One per 24 months. Not covered within 24 months of placement.
D5751	Reline Complete Mandibular Denture (Laboratory)		No	0-18	0-20	One per 24 months. Not covered within 24 months of placement.
D5760	Reline Maxillary Partial Denture (Laboratory)		No	0-18	0-20	One per 24 months. Not covered within 24 months of placement.
D5761	Reline Mandibular Partial Denture (Laboratory)		No	0-18	0-20	One per 24 months. Not covered within 24 months of placement.
D5850	Tissue Conditioning, Maxillary		No	0-18	0-20	
D5851	Tissue Conditioning, Mandibular		No	0-18	0-20	
D6081	Scaling and debridement in the presence of inflammation or mucositis of a single implant, including cleaning of the implant surfaces, without flap entry and closure		Yes	0-18	0-20	Once per 12 months
D6198	Remove interim implant component	1-32 51-82 (SN)	No	15-18	15-20	

UHC KanCare CHIP (Ages 0-18) and Medicaid (Ages 0-20)

Code	Code description	Teeth or area covered	Review required	CHIP Age Range	Medicaid Age Range	Benefit limitations
D6930	Recement Fixed Partial Denture	1 (UA) 2 (LA) 10 (UR) 20 (UL) 30 (LL) 40 (LR)	No	0-18	0-20	
D7140	Extraction, Erupted Tooth Or Exposed Root	1 - 32 51- 82 (SN) A - T AS - TS (SN)	No	0-18	0-20	
D7210	Surgical Removal Or Erupted Tooth	1 - 32 51- 82 (SN) A - T AS - TS (SN)	No	0-18	0-20	Includes cutting of gingiva and bone, removal of tooth structure, and closure.
D7220	Removal Of Impacted Tooth - Soft Tissue	1-32 51-82 (SN)	Yes	0-18	0-20	Includes cutting of gingiva and bone, removal of tooth structure, and closure.
D7230	Removal Of Impacted Tooth - Partially Bony	1-32 51-82 (SN)	Yes	0-18	0-20	Includes cutting of gingiva and bone, removal of tooth structure, and closure.
D7240	Removal Of Impacted Tooth - Completely Bony	1-32 51-82 (SN)	Yes	0-18	0-20	Includes cutting of gingiva and bone, removal of tooth structure, and closure.
D7241	Removal Of Impacted Tooth - Completely Bony, Unusual Surgical Complications	1-32 51-82 (SN)	Yes	0-18	0-20	Includes cutting of gingiva and bone, removal of tooth structure, and closure. Unusual complications such as nerve dissection, separate closure of the maxillary sinus, or aberrant tooth position.
D7250	Surgical Removal Of Residual Tooth (Cutting Procedure)	1 - 32 51- 82 (SN) A - T AS - TS (SN)	No	0-18	0-20	Includes cutting of gingiva and bone, removal of tooth structure, and closure. Will not be paid to the providers or group that originally removed the tooth.
D7260	Oroantral Fistula Closure		No	0-18	0-20	
D7270	Reimplantation And/Or Stabilization Of Accidentally Evulsed / Displaced Tooth	1 - 32 51- 82 (SN) A - T AS - TS (SN)	No	0-18	0-20	Includes splinting and/or stabilization.
D7280	Surgical Access Of An Unerupted Tooth	1-32 51-82 (SN)	Yes	0-18	0-20	Will not be payable unless the orthodontic treatment has been authorized as a covered benefit.
D7285	Biopsy of Oral Tissue, Hard		No	0-18	0-20	
D7286	Biopsy of Oral Tissue, Soft		No	0-18	0-20	
D7320	Alveoloplasty Not In Conjunction With Extractions - Four Or More Teeth	Per quadrant - 10 (UR) 20 (UL) 30 (LL) 40 (LR)	Yes	0-18	0-20	No extractions performed in an edentulous area.
D7350	Vesibuloplasty - Ridge Extension (Including Soft Tissue Grafts)	Per quadrant - 10 (UR) 20 (UL) 30 (LL) 40 (LR)	Yes	0-18	0-20	
D7410	Excision Of Pericoronal Gingiva		No	0-18	0-20	

UHC KanCare CHIP (Ages 0-18) and Medicaid (Ages 0-20)

Code	Code description	Teeth or area covered	Review required	CHIP Age Range	Medicaid Age Range	Benefit limitations
D7411	Excision Of Benign Lesion Greater Than 1.25 Cm		No	0-18	0-20	
D7412	Excision Of Benign Lesion, Complicated		No	0-18	0-20	
D7413	Excision Of Malignant Lesion Up To 1.25 Cm		No	0-18	0-20	
D7414	Excision Of Malignant Lesion Greater Than 1.25 Cm		No	0-18	0-20	
D7415	Excision Of Malignant Lesion, Complicated		No	0-18	0-20	
D7440	Excision Of Malignant Tumor - Lesion Diameter Up To 1.25 Cm		No	0-18	0-20	
D7441	Excision Of Malignant Tumor - Lesion Diameter Greater Than 1.25 Cm		No	0-18	0-20	
D7450	Removal Of Benign Odontogenic Cyst Or Tumor - Dia Up To 1.25 Cm		No	0-18	0-20	
D7451	Removal Of Benign Odontogenic Cyst Or Tumor - Dia Greater Than 1.25 Cm		No	0-18	0-20	
D7460	Removal Of Benign Nonodontogenic Cyst Or Tumor - Dia Up To 1.25 Cm		No	0-18	0-20	
D7461	Removal Of Benign Nonodontogenic Cyst Or Tumor - Dia Greater Than 1.25 Cm		No	0-18	0-20	
D7471	Removal Of Lateral Exostosis (Maxilla Or Mandible)	1 (UA) 2 (LA)	Yes	0-18	0-20	Once per lifetime.
D7472	Removal Of Torus Palatinus		Yes	0-18	0-20	Once per lifetime.
D7473	Removal Of Torus Mandibularis		Yes	0-18	0-20	Once per lifetime.
D7490	Radical Resection Of Maxilla Or Mandible	1 (UA) 2 (LA)	No	0-18	0-20	
D7510	Incision And Drainage Of Abscess - Intraoral Soft Tissue		No	0-18	0-20	Not covered same date of service as D7511.
D7511	Incision And Drainage Of Abscess - Intraoral Soft Tissue - Complicated		No	0-18	0-20	
D7520	Incision And Drainage Of Abscess - Extraoral Soft Tissue		No	0-18	0-20	Not covered same date of service as D7521.
D7521	Incision And Drainage Of Abscess - Extraoral Soft Tissue - Complicated		No	0-18	0-20	
D7530	Removal Of Foreign Body From Mucosa		No	0-18	0-20	
D7540	Removal Of Reaction Producing Foreign Bodies		No	0-18	0-20	

UHC KanCare CHIP (Ages 0-18) and Medicaid (Ages 0-20)

Code	Code description	Teeth or area covered	Review required	CHIP Age Range	Medicaid Age Range	Benefit limitations
D7550	partial ostectomy/ sequestrectomy for removal of non-vital bone		No	0-18	0-20	
D7560	maxillary sinusotomy for removal of tooth fragment or foreign body		No	0-18	0-20	
D7610	maxilla - open reduction (teeth immobilized, if present)		No	0-18	0-20	
D7620	maxilla - closed reduction (teeth immobilized, if present)		No	0-18	0-20	
D7630	mandible - open reduction (teeth immobilized, if present)		No	0-18	0-20	
D7640	mandible - closed reduction (teeth immobilized, if present)		No	0-18	0-20	
D7650	malar and/or zygomatic arch - open reduction		No	0-18	0-20	
D7660	malar and/or zygomatic arch - closed reduction		No	0-18	0-20	
D7670	alveolus - closed reduction, may include stabilization of teeth	1 - 32	No	0-18	0-20	May include stabilization.
D7680	facial bones - complicated reduction with fixation and multiple surgical approaches		Yes	0-18	0-20	
D7710	maxilla - open reduction		No	0-18	0-20	
D7720	maxilla - closed reduction		No	0-18	0-20	
D7730	mandible - open reduction		No	0-18	0-20	
D7740	mandible - closed reduction		No	0-18	0-20	
D7750	malar and/or zygomatic arch - open reduction		No	0-18	0-20	
D7760	malar and/or zygomatic arch - closed reduction		No	0-18	0-20	
D7770	alveolus, open reduction stabilization of teeth		No	0-18	0-20	
D7780	facial bones - complicated reduction with fixation and multiple surgical approaches		No	0-18	0-20	
D7820	Closed Reduction Of Dislocation		No	0-18	0-20	
D7860	Arthrotomy		Yes	0-18	0-20	
D7865	Arthroplasty		Yes	0-18	0-20	
D7910	Suture Of Recent Small Wounds Up To 5 Cm		No	0-18	0-20	Not covered on same day as D7140, D7210, D7220, D7230, D7240, D7241, or D7250.
D7911	Complicated Suture - Up To 5 Cm		No	0-18	0-20	Not covered on same day as D7140, D7210, D7220, D7230, D7240, D7241, or D7250.
D7912	Complicated Suture - Greater Than 5 Cm		No	0-18	0-20	Not covered on same day as D7140, D7210, D7220, D7230, D7240, D7241, or D7250.

UHC KanCare CHIP (Ages 0-18) and Medicaid (Ages 0-20)

Code	Code description	Teeth or area covered	Review required	CHIP Age Range	Medicaid Age Range	Benefit limitations
D7920	Skin Graft	1 (UA) 2 (LA) 10 (UR) 20 (UL) 30 (LL) 40 (LR)	Yes	0-18	0-20	
D7955	Repair of Maxillofacial soft or hard tissue		Yes	0-18	0-20	
D7961	Buccal / Labial Frenectomy (Frenulectomy)	1 (UA) 2 (LA)	No	0-18	0-20	
D7962	Lingual Frenectomy (Frenulectomy)	2 (LA)	No	0-18	0-20	
D7963	Frenuloplasty		No	0-18	0-20	Excision of frenum with excision or repositioning of abervant muscle and z- plasty or other local flap closure.
D7971	Excision Of Pericoronal Gingiva	1 - 32	No	0-18	0-20	
D7979	Non-surgical sialolithotomy		No	0-18	0-20	
D7980	Sialolithotomy		No	0-18	0-20	
D7981	excision of salivary gland, by report		No	0-18	0-20	
D7982	Sialodochoplasty		No	0-18	0-20	
D7983	Closure of Salivary Fistula		No	0-18	0-20	
D7990	Emergency Tracheotomy		No	0-18	0-20	
D8010	Limited Orthodontic Treatment Of The Primary Dentition		Yes - Prior Auth required	0-18	0-20	Limited to one replacement. Limited orthodontic treatment requires prior authorization and is only covered for eligible children with documented medical necessity.
D8020	Limited Orthodontic Treatment Of The Transitional Dentition		Yes - Prior Auth required	0-18	0-20	Limited to one replacement. Limited orthodontic treatment requires prior authorization and is only covered for eligible children with documented medical necessity.
D8070	Comprehensive Orthodontic Treatment Of The Transitional Dentition		Yes - Prior Auth required	0-18	0-20	Comprehensive orthodontic treatment requires prior authorization and is only covered for eligible children with documented medical necessity.
D8080	Comprehensive Orthodontic Treatment Of The Adolescent Dentition		Yes - Prior Auth required	0-18	0-20	Comprehensive orthodontic treatment requires prior authorization and is only covered for eligible children with documented medical necessity.
D8220	Fixed Appliance Therapy		Yes - Prior Auth required	0-18	0-20	Limited to one replacement. Removable appliance therapy requires prior authorization and is only covered for eligible children with documented medical necessity.
D8999	Unspecified Orthodontic Procedure, By Report		Yes - Prior Auth required	0-18	0-20	All orthodontic treatment requires prior authorization and is only covered for eligible children with documented medical necessity.

UHC KanCare CHIP (Ages 0-18) and Medicaid (Ages 0-20)

Code	Code description	Teeth or area covered	Review required	CHIP Age Range	Medicaid Age Range	Benefit limitations
D9130	Temporomandibular joint dysfunction - non-invasive physical therapies		Yes	0-18	0-20	
D9212	Trigeminal Division Block		Yes	0-18	0-20	
D9219	Evaluation for deep sedation or general anesthesia		No	0-18	0-20	1 per patient per 12 months and limited to 1 per patient per provider in a lifetime.
D9222	Deep sedation/general anesthesia - first 15 minutes		Yes	0-18	0-20	
D9223	Deep sedation/general anesthesia - each subsequent 15 minute increment		Yes	0-18	0-20	
D9230	Inhalation Of Nitrous/Analgesia, Anxiolysis		No	0-18	0-20	Not covered when billed with only diagnostic and/ or preventative services (D0120 through D1203, D1515 through D1550, D9410, D9420).
D9239	Intravenous moderate (conscious) sedation/ analgesia - first 15 minutes		Yes	0-18	0-20	Narrative of medical necessity/treatment plan must be submitted with claim.
D9243	Intravenous moderate (conscious) sedation/anesthesia - each 15 minute increment		Yes	0-18	0-20	
D9310	Consultation - Diagnostic Service Provided By Dentist Or Physician		No	0-18	0-20	One per 12 months by same provider. One inpatient follow-up per beneficiary within a 10 day period by same provider. Not covered on same date of service as D0120 -D0170, D9410, D9420.
D9311	Consultation with a medical health care professional		No	0-18	0-20	Once per 12 months by same provider. One inpatient follow- up per beneficiary within a 10 day period by same provider. Not covered on same DOS as D0120, D0170, D9410, or D9420
D9410	House/Extended Care Facility Call		No	0-18	0-20	Extended Care Facilities only.
D9420	Hospital Or Ambulatory Surgical Center Call		No	0-18	0-20	Hospital Facilities only
D9610	Therapeutic Drug Injection, By report		Yes	0-18	0-20	
D9613	Infiltration of sustained release therapeutic drug - single or multiple sites		No	0-18	0-20	
D9920	Behavior Management, By Report		Yes	0-18	0-20	
D9947	Custom sleep apnea appliance fabrication and placement		Yes	0-18	0-999	Limited to one replacement. Removable appliance therapy requires prior authorization and is only covered for eligible children with documented medical necessity.
D9948	Adjustment of custom sleep apnea appliance		Yes	0-18	0-999	Limited to one replacement. Removable appliance therapy requires prior authorization and is only covered for eligible children with documented medical necessity.

UHC KanCare CHIP (Ages 0-18) and Medicaid (Ages 0-20)

Code	Code description	Teeth or area covered	Review required	CHIP Age Range	Medicaid Age Range	Benefit limitations
D9949	Repair of custom sleep apnea appliance		Yes	0-18	0-999	Limited to one replacement. Removable appliance therapy requires prior authorization and is only covered for eligible children with documented medical necessity.
D9999	Unspecified Adjunctive Procedure, By Report		Yes	0-18	0-20	

Health guidelines – ages 0-18 years

Recommendations for Pediatric Oral Health Assessment, Preventive Services, and Anticipatory Guidance/ Counseling

Since each child is unique, these recommendations are designed for the care of children who have no contributing medical conditions and are developing normally. These recommendations will need to be modified for children with special health care needs or if disease or trauma manifests variations from normal. The American Academy of Pediatric Dentistry (AAPD) emphasizes the importance of very early professional intervention and the continuity of care based on the individualized needs of the child.

Refer to the text of guideline on the following page for supporting information and references.

American Academy of Pediatric Dentistry

	AGE				
	6 TO 12 MONTHS	12 TO 24 MONTHS	2 TO 6 YEARS	6 TO 12 YEARS	12 YEARS AND OLDER
Clinical oral examination [1]	•	•	•	•	•
Assess oral growth and development [2]	•	•	•	•	•
Caries-risk assessment [3]	•	•	•	•	•
Radiographic assessment [4]	•	•	•	•	•
Prophylaxis and topical fluoride [3,4]	•	•	•	•	•
Fluoride supplementation [5]	•	•	•	•	•
Anticipatory guidance/counseling [6]	•	•	•	•	•
Oral hygiene counseling [7]	Parent	Parent	Patient/parent	Patient/parent	Patient
Dietary counseling [8]	•	•	•	•	•
Injury prevention counseling [9]	•	•	•	•	•
Counseling for nonnutritive habits [10]	•	•	•	•	•
Counseling for speech/language development	•	•	•		
Substance abuse counseling				•	•
Counseling for intraoral/perioral piercing				•	•
Assessment and treatment of developing malocclusion			•	•	•
Assessment for pit and fissure sealants [11]			•	•	•
Assessment and/or removal of third molars					•
Transition to adult dental care					•

1 First examination at the eruption of the first tooth and no later than 12 months. Repeat every 6 months or as indicated by child's risk status/susceptibility to disease. Includes assessment of pathology and injuries.

2 By clinical examination.

3 Must be repeated regularly and frequently to maximize effectiveness.

4 Timing, selection, and frequency determined by child's history, clinical findings, and susceptibility to oral disease.

5 Consider when systemic fluoride exposure is suboptimal. Up to at least 16 years.

6 Appropriate discussion and counseling should be an integral part of each visit for care.

7 Initially, responsibility of parent; as child matures, jointly with parent; then, when indicated, only child.

8 At every appointment; initially discuss appropriate feeding practices, then the role of refined carbohydrates and frequency of snacking in caries development and childhood obesity.

9 Initially play objects, pacifiers, car seats; when learning to walk; then with sports and routine playing, including the importance of mouthguards.

10 At first, discuss the need for additional sucking: digits vs pacifiers; then the need to wean from the habit before malocclusion or skeletal dysplasia occurs. For school-aged children and adolescent patients, counsel regarding any existing habits such as fingernail biting, clenching, or bruxism.

11 For caries-susceptible primary molars, permanent molars, premolars, and anterior teeth with deep pits and fissures; placed as soon as possible after eruption.

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Code	Description	Teeth or area covered	Review required	FE waiver eligible	Benefit limitations
D0120	Periodic Oral Evaluation - Established Patient		No		Only one exam per 36 months per provider or provider billing group. Only one exam (D0120, D0140, D0145, D0150, D0170) per date of service, per beneficiary, per provider or provider billing group.
D0140	Limited Oral Evaluation - Problem Focused		No		Only one exam (D0120, D0140, D0145, D0150, D0170) per date of service, per beneficiary, per provider or provider billing group. Limited oral evaluation is only covered when performed in conjunction with treatment to address an emergency situation. An emergency is defined as treatment medically necessary to treat pain, infection, swelling, uncontrolled bleeding, or traumatic injury.
D0150	Comprehensive Oral Evaluation - New Or Established Patient		No		1 comprehensive exam per beneficiary, per provider or provider billing group per lifetime. Only one exam (D0120, D0145, or D0150) every six months per beneficiary per provider or provider billing group.
D0170	Re-Evaluation - Limited, Problem Focused		No		1 per 12 months Established beneficiary to assess the status of a previously existing condition (not post-operative visit). Not covered with any other procedure other than radiographs.
D0210	Intraoral - Complete Series of Radiographic Images		No		1 per 36 months. The following are also considered an Intraoral Complete Series (D0210) D0330 and D0272 D0330 and D0273 D0330 and D0274 D0330 and D0277
D0220	Intraoral - Periapical First Radiographic Image		No		1 per day. Any additional films (D0220 - D0340) performed on the same date of service as a complete intraoral series, or its equivalent, are considered content of service of the complete series and are not reimbursed.
D0230	Intraoral - Periapical Each Additional Image		No		8 per day. Any additional films (D0220 - D0340) performed on the same date of service as a complete intraoral series, or its equivalent, are considered content of service of the complete series and are not reimbursed.
D0240	Intraoral - Occlusal Radiographic Image		No		2 per year. Any additional films (D0220 - D0340) performed on the same date of service as a complete intraoral series, or its equivalent, are considered content of service of the complete series and are not reimbursed.
D0250	Extraoral - 2D Projection Radiographic image		No		2 per day. Any additional films (D0220 - D0340) performed on the same date of service as a complete intraoral series, or its equivalent, are considered content of service of the complete series and are not reimbursed.
D0251	Extra-Oral Posterior Dental Radiographic Image		No		2 per day. Any additional films (D0220 - D0340) performed on the same date of service as a complete intraoral series, or its equivalent, are considered content of service of the complete series and are not reimbursed.

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Code	Description	Teeth or area covered	Review required	FE waiver eligible	Benefit limitations
D0270	Bitewing - Single Radiographic Image		No		4 per 6 months. Any additional films (D0220 - D0340) performed on the same date of service as a complete intraoral series, or its equivalent, are considered content of service of the complete series and are not reimbursed. Only one bitewing code (D0270, D0272, D0273, D0274, D0277) per date of service, per beneficiary, per provider or provider billing group.
D0272	Bitewings - Two Radiographic Images		No		2 per 6 months. Any additional films (D0220 - D0340) performed on the same date of service as a complete intraoral series, or its equivalent, are considered content of service of the complete series and are not reimbursed. Only one bitewing code (D0270, D0272, D0273, D0274, D0277) per date of service, per beneficiary, per provider or provider billing group.
D0273	Bitewings - Three Radiographic Images		No		1 per 6 months. Any additional films (D0220 - D0340) performed on the same date of service as a complete intraoral series, or its equivalent, are considered content of service of the complete series and are not reimbursed. Only one bitewing code (D0270, D0272, D0273, D0274, D0277) per date of service, per beneficiary, per provider or provider billing group.
D0274	Bitewings - Four Radiographic Images		No		1 per 36 months. Any additional films (D0220 - D0340) performed on the same date of service as a complete intraoral series, or its equivalent, are considered content of service of the complete series and are not reimbursed. Only one bitewing code (D0270, D0272, D0273, D0274, D0277) per date of service, per beneficiary, per provider or provider billing group.
D0277*	Vertical Bitewings - 7 To 8 Radiographic Images		No	✔	1 per 36 months. Any additional films (D0220 - D0340) performed on the same date of service as a complete intraoral series, or its equivalent, are considered content of service of the complete series and are not reimbursed. Only one bitewing code (D0270, D0272, D0273, D0274, D0277) per date of service, per beneficiary, per provider or provider billing group.
D0321*	Other Temporomandibular Joint Radiographic Images, By Report		No	✔	1 per 36 months. Any additional films (D0220 - D0340) performed on the same date of service as a complete intraoral series, or its equivalent, are considered content of service of the complete series and are not reimbursed.
D0322*	Tomographic survey		No		1 per 36 months
D0330	Panoramic Radiographic Image		No		1 per 36 months. The following are also considered an Intraoral Complete Series (D0210) D0330 and D0272 D0330 and D0273 D0330 and D0274 D0330 and D0277
D0372	intraoral tomosynthesis - comprehensive series of radiographic images		No	✔	1 per 36 months
D0373	intraoral tomosynthesis - bitewing radiographic image		No	✔	1 per 36 months

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Code	Description	Teeth or area covered	Review required	FE waiver eligible	Benefit limitations
D0374	intraoral tomosynthesis - periapical radiographic image		No	✔	1 per 36 months
D0387	intraoral tomosynthesis - comprehensive series of radiographic images - image capture only		No	✔	1 per 36 months
D0388	intraoral tomosynthesis - bitewing radiographic image - image capture only		No	✔	1 per 36 months
D0389	intraoral tomosynthesis - periapical radiographic image - image capture only		No	✔	1 per 36 months
D0460	Pulp Vitality Tests		No	✔	Maximum of three teeth per visit.
D1110*	Prophylaxis - Adult		No	✔	2 per year. Includes scaling and polishing procedures to remove coronal plaque, calculus, and stains.
D1206	Topical Application Of Fluoride		No		1 application every 120 days
D1208	Topical Application Of Fluoride (Excluding Varnish)		No		1 application every 120 days
D1310	Nutritional Counseling		No		Once per year with other covered service.
D1320	Tobacco Counseling		No		Limit of twice per year with other covered service. Documentation of counseling activities and/or referral to remain in the member's dental chart
D1330	Oral Hygiene Instruction		No		One per year with covered service
D1351	Sealant - Per Tooth		No		1 per 12 months. Occlusal surfaces only. Teeth must be caries free. Sealant is not covered when placed over restorations.
D1353	Sealant Repair per tooth		No		Once per 12 months. Occlusal surface only. Teeth must be caries free. Sealant is not covered when placed over restorations
D1354	Application of caries arresting medicament - per tooth	1-32 51 - 82 (SN) A - T AS - TS (SN)	No	✔	(Silver Diamine Fluoride Treatments) 2 applications per year per tooth and 6 applications per tooth per lifetime benefit limits
D2140	Amalgam - One Surface, Primary Or Permanent	All Teeth (Teeth 1 through 32, A through T)	No		1 per 12 months
D2150	Amalgam - Two Surfaces, Primary Or Permanent	All Teeth (Teeth 1 through 32, A through T)	No		1 per 12 months
D2160	Amalgam - Three Surfaces, Primary Or Permanent	All Teeth (Teeth 1 through 32, A through T)	No		1 per 12 months

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Code	Description	Teeth or area covered	Review required	FE waiver eligible	Benefit limitations
D2161	Amalgam - Four Or More Surfaces, Primary Or Permanent	All Teeth (Teeth 1 through 32, A through T)	No		1 per 12 months
D2330	Resin-Based Composite - One Surface, Anterior	Anterior Teeth (Teeth 6 - 11, 22 - 27, C - H, M - R)	No		1 per 12 months
D2331	Resin-Based Composite - Two Surfaces, Anterior	Anterior Teeth (Teeth 6 - 11, 22 - 27, C - H, M - R)	No		1 per 12 months
D2332	Resin-Based Composite - Three Surfaces, Anterior	Anterior Teeth (Teeth 6 - 11, 22 - 27, C - H, M - R)	No		1 per 12 months
D2335	Resin-Based Composite - Four Or More Surfaces Or Involving Incisal Angle	Anterior Teeth (Teeth 6 - 11, 22 - 27, C - H, M - R)	No		1 per 12 months
D2390	Resin-Based Composite Crown, Anterior	Anterior Teeth (Teeth 6 - 11, 22 - 27, C - H, M - R)	No		1 per 12 months
D2391	Resin-Based Composite - One Surface, Posterior	Posterior Teeth (1-5, 12-21, 28-32, A, B, I, J, K, L, S, T)	No		1 per 12 months
D2392	Resin-Based Composite - Two Surfaces, Posterior	Posterior Teeth (1-5, 12-21, 28-32, A, B, I, J, K, L, S, T)	No		1 per 12 months
D2393	Resin-Based Composite - Three Surfaces, Posterior	Posterior Teeth (1-5, 12-21, 28-32, A, B, I, J, K, L, S, T)	No		1 per 12 months
D2394	Resin-Based Composite - Four Or More Surfaces, Posterior	Posterior Teeth (1-5, 12-21, 28-32, A, B, I, J, K, L, S, T)	No		1 per 12 months
D2710	Crown - Resin-Based Composite (Indirect)	All Permanent Teeth (Teeth 1 through 32)	Yes		1 per 60 months
D2740	Crown - Porcelain/Ceramic	All Permanent Teeth (Teeth 1 through 32)	Yes		1 per 60 months

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D2751	Crown - Porcelain Fused To Predominantly Base Metal	All Permanent Teeth (Teeth 1 through 32)	Yes		1 per 60 months
D2752	Crown - Porcelain Fused To Noble Metal	All Permanent Teeth (Teeth 1 through 32)	Yes		1 per 60 months
D2753	Crown - Porcelain Fused To Titanium And Titanium Alloys	All Permanent Teeth (Teeth 1 through 32)	Yes		1 per 60 months
D2783	Crown - 3/4 Porcelain/Ceramic	All Permanent Teeth (Teeth 1 through 32)	Yes		1 per 60 months
D2791	Crown - Full Cast Predominantly Base Metal	All Permanent Teeth (Teeth 1 through 32)	Yes		1 per 60 months
D2792	Crown - Full Cast Noble Metal	All Permanent Teeth (Teeth 1 through 32)	Yes		1 per 60 months
D2910	Re-Cement Or Re-Bond Inlay, Onlay, Veneer Or Partial Coverage Restoration	All Permanent Teeth (Teeth 1 through 32)	No		
D2920	Re-Cement or Re-Bond Crown	All Teeth (Teeth 1 through 32, A through T)	No		
D2921	Reattachment Of Tooth Fragment, Incisal Edge Or Cusp	All Permanent Teeth (Teeth 1 through 32)	No		Not allowed same tooth, same surface(s), same DOS as D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394
D2928	Prefabricated Porcelain/Ceramic Crown Permanent Tooth	1- 32 51 - 82 (SN)	No	✔	
D2930	Prefabricated Stainless Steel Crown - Primary Tooth	Primary Teeth (Teeth A through T)	No		1 per 24 months
D2931	Prefabricated Stainless Steel Crown - Permanent Tooth	All Permanent Teeth (Teeth 1 through 32)	No		1 per 24 months
D2940	Protective Restoration	All Teeth (Teeth 1 through 32, A through T)	No		1 per day per patient per tooth. Temporary restoration intended to relieve pain. Not to be used as a base or liner under a restoration.
D2951	Pin Retention - Per Tooth, In Addition To Restoration	All Permanent Teeth (Teeth 1 through 32)	No		

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Code	Description	Teeth or area covered	Review required	FE waiver eligible	Benefit limitations
D2954	Prefabricated Post And Core In Addition To Crown	All Teeth (Teeth 1 through 32, A through T)	Yes		1 per 60 months
D2957	Each Additional Prefabricated Post - Same Tooth	All Permanent Teeth (Teeth 1 through 32)	Yes		1 per 60 months
D3110	Pulp Cap - Direct (Excluding Final Restoration)	All Permanent Teeth (Teeth 1 through 32)	No	✔	
D3220	Therapeutic Pulpotomy	All Teeth (Teeth 1 through 32, A through T)	No	✔	1 per tooth, per lifetime. Not covered within 30 days of D3310 - D3331 on same tooth.
D3221	Pulpal Debridement - Primary And Permanent Teeth	All Teeth (Teeth 1 through 32, A through T)	No	✔	1 per tooth, per lifetime. Not covered within 30 days of D3310 - D3331 on same tooth.
D3222	Partial Pulpotomy For Apexogenesis - Permanent Tooth	All Permanent Teeth (Teeth 1 through 32)	Yes	✔	1 per tooth, per lifetime. Should only be performed as preparation for endodontic treatment.
D3310*	Endodontic Therapy, Anterior Tooth (Excluding Final Restoration)	Permanent Anterior (Teeth 6 - 11, 22 - 27)	No	✔	1 per tooth, per lifetime.
D3320*	Endodontic Therapy Premolar Tooth (Excluding Final Restoration)	Bicuspids (Teeth 4, 5, 12, 13, 20, 21, 28, 29)	No	✔	1 per tooth, per lifetime.
D3330*	Endodontic Therapy, Molar tooth (Excluding Final Restoration)	Permanent Molars (Teeth 1 - 3, 14 - 19, 30 - 32)	No	✔	1 per tooth, per lifetime.
D3331*	Treatment Of Root Canal Obstruction; Non-Surgical Access	All Permanent Teeth (Teeth 1 through 32)	Yes	✔	
D3351	Apexification / Recalcification - Initial Visit	All Permanent Teeth (Teeth 1 through 32)	No	✔	
D3352	Apexification / Recalcification - Interim	All Permanent Teeth (Teeth 1 through 32)	No	✔	
D3353	Apexification / Recalcification - Final Visit	All Permanent Teeth (Teeth 1 through 32)	No	✔	

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Code	Description	Teeth or area covered	Review required	FE waiver eligible	Benefit limitations
D3410	Apicoectomy - Anterior	Permanent Anterior (Teeth 6 - 11, 22 - 27)	No	✔	
D3421	Apicoectomy - Premolar (First Root)	Bicuspids (Teeth 4, 5, 12, 13, 20, 21, 28, 29)	No	✔	
D3425	Apicoectomy - Molar (First Root)	Permanent Molars (Teeth 1 - 3, 14 - 19, 30 - 32)	No	✔	
D3426	Apicoectomy - Each Additional Root)	Permanent Posterior (Teeth 1 - 5, 12 - 21, 28 - 32)	No	✔	
D3427	Periradicular Surgery Without Apicoectomy	All Permanent Teeth (Teeth 1 through 32)	No		Not allowed same tooth, same DOS as D3410, D3421, D3425, D3426
D3430	Retrograde Filling - Per Root	All Permanent Teeth (Teeth 1 through 32)	No	✔	
D3471	surgical repair of root resorption - anterior	Permanent Anterior (Teeth 6 - 11, 22 - 27)	No	✔	1 per lifetime.
D3472	surgical repair of root resorption - molar	Bicuspids (Teeth 4, 5, 12, 13, 20, 21, 28, 29)	No	✔	1 per lifetime.
D3473	surgical repair of root resorption - molar	Permanent Molars (Teeth 1 - 3, 14 - 19, 30 - 32)	No	✔	
D3501	surgical exposure of root surface without apicoectomy or repair of root resorption	All Permanent Teeth (Teeth 1 through 32)	No	✔	
D3502	surgical repair of root resorption - molar	All Permanent Teeth (Teeth 1 through 32)	No	✔	
D3503	surgical exposure of root surface without apicoectomy or repair of root resorption	All Permanent Teeth (Teeth 1 through 32)	No	✔	
D4210	Gingivectomy Or Gingivoplasty - Four Or More Contiguous Teeth	Quadrants (LL, LR, UR, UL)	Yes		1 per 12 months. A minimum of four affected teeth in the quadrant.

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Code	Description	Teeth or area covered	Review required	FE waiver eligible	Benefit limitations
D4211	Gingivectomy Or Gingivoplasty - One To Three Contiguous Teeth	Quadrants (LL, LR, UR, UL)	Yes		1 per 12 months. One to three affected teeth in the quadrant.
D4230	Anatomical Crown Exposure - Four Or More Contiguous Teeth Per Quadrant	Quadrants (LL, LR, UR, UL)	Yes		1 per lifetime. Must be billed same date same tooth in conjunction with the restorative codes (D2140 - D2957).
D4231	Anatomical Crown Exposure - One To Three Teeth Per Quadrant	Quadrants (LL, LR, UR, UL)	Yes		1 per lifetime. Must be billed same date same tooth in conjunction with the restorative codes (D2140 - D2957).
D4268	Surgical Revision Procedure, Per Tooth	All Permanent Teeth (Teeth 1 through 32)	Yes		Only covered after D4210.
D4341	Periodontal Scaling And Root Planing - Four Or More Teeth Per Quadrant	Quadrants (LL, LR, UR, UL)	Yes		1 per 12 months. A minimum of four affected teeth in the quadrant.
D4342	Periodontal Scaling And Root Planing - One To Three Teeth Per Quadrant	Quadrants (LL, LR, UR, UL)	Yes		1 per 12 months. One to three affected teeth in the quadrant.
D4346	Scaling in moderate or severe gingival inflammation		Yes		1 per 12 months. Not covered on the same DOS as D1110, D1120, D4341, D4342, D4355, D4910.
D4355	Full Mouth Debridement		No		1 per 12 months.
D4910	Description: Periodontal Maintenance, office visit non-covered on the date of service		No	✔	2 per code every accum year per patien
D5110	Complete Denture - Maxillary		Yes		1 per 60 months.
D5120	Complete Denture - Mandibular		Yes		1 per 60 months.
D5211	Maxillary Partial Denture - Resin Base		Yes		1 per 60 months.
D5212	Mandibular Partial Denture - Resin Base		Yes		1 per 60 months.
D5213	maxillary partial denture - cast metal framework with resin denture bases		Yes		1 per 60 months.
D5214	mandibular partial denture - cast metal framework with resin denture bases		Yes		1 per 60 months.
D5225	Maxillary Partial Denture - Flexible Base		Yes		1 per 60 months.
D5226	Mandibular Partial Denture - Flexible Base		Yes		1 per 60 months.
D5282	Removable Unilateral Partial Denture - One Piece Cast Metal - Maxillary		Yes		1 per 60 months.
D5283	Removable Unilateral Partial Denture - One Piece Cast Metal - Mandibular		Yes		1 per 60 months.

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Code	Description	Teeth or area covered	Review required	FE waiver eligible	Benefit limitations
D5284	Removable Unilateral Partial Denture - One Piece Flexible Base	Quadrants (LL, LR, UR, UL)	Yes		1 per 60 months.
D5286	Removable Unilateral Partial Denture - One Piece Resin	Quadrants (LL, LR, UR, UL)	Yes		1 per 60 months.
D5410	Adjust Complete Denture - Maxillary		No		1 per year. Not covered within 6 months of placement.
D5411	Adjust Complete Denture - Mandibular		No		1 per year. Not covered within 6 months of placement.
D5421	Adjust Partial Denture - Maxillary		No		1 per year. Not covered within 6 months of placement.
D5422	Adjust Partial Denture - Mandibular		No		1 per year. Not covered within 6 months of placement.
D5511	Repair Broken Complete Denture Base - Mandibular		Yes		
D5512	Repair Broken Complete Denture Base - Maxillary		Yes		
D5520	Replace Missing Or Broken Teeth - Complete Denture (Each Tooth)	All Permanent Teeth (Teeth 1 through 32)	No		
D5611	Repair Resin Partial Denture Base - Mandibular		Yes		
D5621	Repair Cast Partial Framework - Mandibular		Yes		
D5622	Repair Cast Partial Framework - Maxillary		Yes		
D5630	Repair Or Replace Broken Retentive / Clasping Materials - Per Tooth	All Permanent Teeth (Teeth 1 through 32)	No		
D5640	Replace Broken Teeth - Per Tooth	All Permanent Teeth (Teeth 1 through 32)	No		
D5650	Add Tooth To Existing Partial Denture	All Permanent Teeth (Teeth 1 through 32)	No		
D5660	Add Clasp To Existing Partial Denture - Per Tooth	All Permanent Teeth (Teeth 1 through 32)	No		
D5670	Replace All Teeth And Acrylic On Cast Metal Framework (Maxillary)		No		
D5671	Replace All Teeth And Acrylic On Cast Metal Framework (Mandibular)		No		
D5730	Reline Complete Maxillary Denture (Chairside)		No		1 per 24 months. Not covered within 24 months of placement. Covered for Frail Elderly benefit plan only.
D5731	Reline Complete Mandibular Denture (Chairside)		No		1 per 24 months. Not covered within 24 months of placement. Covered for Frail Elderly benefit plan only.

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Code	Description	Teeth or area covered	Review required	FE waiver eligible	Benefit limitations
D5750	Reline Complete Maxillary Denture (Laboratory)		No		1 per 24 months. Not covered within 24 months of placement.
D5751	Reline Complete Mandibular Denture (Laboratory)		No		1 per 24 months. Not covered within 24 months of placement.
D5760	Reline Maxillary Partial Denture (Laboratory)		No		1 per 24 months. Not covered within 24 months of placement.
D5761	Reline Mandibular Partial Denture (Laboratory)		No		1 per 24 months. Not covered within 24 months of placement.
D5850	Tissue Conditioning, Maxillary		No		
D5851	Tissue Conditioning, Mandibular		No		
D5912	Facial Moulage (Complete)		No		
D6081	Scaling and debridement	All Permanent Teeth (Teeth 1 through 32)	Yes	✔	1 per 12 months.
D6100	Implant Removal, By Report	All Permanent Teeth (Teeth 1 through 32)	Yes		1 per lifetime per patient per tooth
D6930	Re-Cement Or Re-Bond Fixed Partial Denture	All Permanent Teeth (Teeth 1 through 32)	No		
D7140	Extraction, Erupted Tooth Or Exposed Root	All Teeth (Teeth 1 through 32, A through T, SN)	No		1 per lifetime per patient per tooth
D7210	Extraction, Erupted Tooth	All Teeth (Teeth 1 through 32, A through T, SN)	No		1 per lifetime per patient per tooth. Includes cutting of gingiva and bone, removal of tooth structure and closure.
D7220	Removal Of Impacted Tooth - Soft Tissue	All Teeth (Teeth 1 through 32, A through T, SN)	Yes		1 per lifetime per patient per tooth. Removal of asymptotic tooth not covered. Includes cutting of gingiva and bone, removal of tooth structure, and closure.
D7230	Removal Of Impacted Tooth - Partially Bony	All Teeth (Teeth 1 through 32, A through T, SN)	Yes		1 per lifetime. Removal of asymptotic tooth not covered. Includes cutting of gingiva and bone, removal of tooth structure, and closure.
D7240	Removal Of Impacted Tooth - Completely Bony	All Teeth (Teeth 1 through 32, A through T, SN)	Yes		1 per lifetime per patient per tooth. Removal of asymptotic tooth not covered. Includes cutting of gingiva and bone, removal of tooth structure, and closure.
D7241	Removal Of Impacted Tooth - Completely Bony, Unusual Surgical Complications	All Teeth (Teeth 1 through 32, A through T, SN)	Yes		1 per lifetime per patient per tooth. Removal of asymptotic tooth not covered. Includes cutting of gingiva and bone, removal of tooth structure, and closure. Unusual complications such as nerve dissection, separate closure of the maxillary sinus, or aberrant tooth position.

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Code	Description	Teeth or area covered	Review required	FE waiver eligible	Benefit limitations
D7250	Removal Of Residual Tooth (Cutting Procedure)	All Teeth (Teeth 1 through 32, A through T, SN)	No		1 per lifetime per patient per tooth. Includes cutting of gingiva and bone, removal of tooth structure, and closure. Will not be paid to the providers or provider billing group that originally removed the tooth.
D7260	Oroantral Fistula Closure		Yes		
D7270	Reimplantation And/Or Stabilization Of Accidentally Evulsed / Displaced Tooth	All Permanent Teeth (Teeth 1 through 32)	No		Includes splinting and/or stabilization.
D7280	Exposure of an Unerupted Tooth	Teeth 2 - 15, 18 - 31	Yes		
D7285	Incisional Biopsy Of Oral Tissue - Hard (Bone, Tooth)		No		
D7286	Incisional Biopsy Of Oral Tissue - Soft		No		
D7310	Alveoloplasty In Conjunction With Extractions - Four Or More Teeth	Quadrants (LL, LR, UR, UL)	No		Covered for MFP Frail Elderly benefit plan only.
D7320	Alveoloplasty Not In Conjunction With Extractions - Four Or More Teeth	Quadrants (LL, LR, UR, UL)	Yes		No extractions performed in an edentulous area. Not covered when performed on the same day as an extraction for the same tooth.
D7350	Vesibuloplasty - Ridge Extension (Including Soft Tissue Grafts)	Quadrants (LL, LR, UR, UL)	Yes		
D7410	Excision Of Benign Lesion Up To 1.25 Cm		No		
D7411	Excision Of Benign Lesion Greater Than 1.25 Cm		No		
D7412	Excision Of Benign Lesion, Complicated		No		
D7413	Excision Of Malignant Lesion Up To 1.25 Cm		No		
D7414	Excision Of Malignant Lesion Greater Than 1.25 Cm		No		
D7415	Excision Of Malignant Lesion, Complicated		No		
D7440	Excision Of Malignant Tumor - Lesion Diameter Up To 1.25 Cm		No		
D7441	Excision Of Malignant Tumor - Lesion Diameter Greater Than 1.25 Cm		No		
D7450	Removal Of Benign Odontogenic Cyst Or Tumor - Dia Up To 1.25 Cm		No		
D7451	Removal Of Benign Odontogenic Cyst Or Tumor - Dia Greater Than 1.25 Cm		No		
D7460	Removal Of Benign Nonodontogenic Cyst Or Tumor - Dia Up To 1.25 Cm		No		

UHC KanCare Medicaid/Title 19 Adults 21 and over, UHC KanCare Medicaid Frail and Elderly

Limited preventative and restorative services for members age 21 and over are covered under this plan with an annual maximum of $500.00. These services are identified below by an asterisk (*).

Code	Description	Teeth or area covered	Review required	FE waiver eligible	Benefit limitations
D7461	Removal Of Benign Nonodontogenic Cyst Or Tumor - Dia Greater Than 1.25 Cm		No		
D7471	Removal Of Lateral Exostosis (Maxilla Or Mandible)	Arches (UA, LA)	Yes		1 per lifetime.
D7472	Removal Of Torus Palatinus		Yes		1 per lifetime.
D7473	Removal Of Torus Mandibularis		Yes		1 per lifetime.
D7490	Radical Resection Of Maxilla Or Mandible		Yes		
D7510	Incision And Drainage Of Abscess - Intraoral Soft Tissue		No		Not covered same date of service as D7511.
D7511	Incision And Drainage Of Abscess - Intraoral Soft Tissue - Complicated		No		
D7520	Incision And Drainage Of Abscess - Extraoral Soft Tissue		No		Not covered same date of service as D7521.
D7521	Incision And Drainage Of Abscess - Extraoral Soft Tissue - Complicated		No		
D7530	Removal Of Foreign Body From Mucosa		No		
D7540	Removal Of Reaction Producing Foreign Bodies		No		
D7550	Partial Ostectomy/Sequestrectomy For Removal Of Non-Vital Bone	Quadrants (LL, LR, UR, UL)	No		
D7560	Maxillary Sinusotomy For Removal Of Tooth Fragment Or Foreign Body		Yes		
D7610	Maxilla - Open Reduction (Teeth Immobilized, If Present)		No		
D7620	Maxilla - Closed Reduction (Teeth Immobilized, If Present)		No		
D7630	Mandible - Open Reduction (Teeth Immobilized, If Present)		No		
D7640	Mandible - Closed Reduction (Teeth Immobilized, If Present)		No		
D7650	Malar And/Or Zygomatic Arch - Open Reduction		No		
D7660	Malar And/Or Zygomatic Arch - Closed Reduction		No		
D7670	Alveolus - Closed Reduction, May Include Stabilization Of Teeth		No		May include stabilization.
D7680	Facial Bones - Complicated Reduction With Fixation And Multiple Surgical		Yes		
D7710	Maxilla - Open Reduction		No		

UHC KanCare Medicaid/Title 19 Adults 21 and over, UHC KanCare Medicaid Frail and Elderly

Limited preventative and restorative services for members age 21 and over are covered under this plan with an annual maximum of $500.00. These services are identified below by an asterisk (*).

Code	Description	Teeth or area covered	Review required	FE waiver eligible	Benefit limitations
D7720	Maxilla - Closed Reduction		No		
D7730	Mandible - Open Reduction		No		
D7740	Mandible - Closed Reduction		No		
D7750	Malar And/Or Zygomatic Arch - Open Reduction		No		
D7760	Malar And/Or Zygomatic Arch - Closed Reduction		No		
D7770	Alveolus - Open Reduction Stabilization Of Teeth		No		
D7780	Facial Bones - Complicated Reduction With Fixation And Multiple Approaches		No		
D7820	Closed Reduction Of Dislocation		No		
D7860	Arthrotomy		Yes		
D7865	Arthroplasty		Yes		
D7910	Suture Of Recent Small Wounds Up To 5 Cm		No		Not covered on same day as D7140, D7210, D7220, D7230, D7240, D7241 or D7250.
D7911	Complicated Suture - Up To 5 Cm		No		Not covered on same day as D7140, D7210, D7220, D7230, D7240, D7241 or D7250.
D7912	Complicated Suture - Greater Than 5 Cm		No		Not covered on same day as D7140, D7210, D7220, D7230, D7240, D7241 or D7250.
D7920	Skin Graft (Identify Defect Covered, Location And Type Of Graft)		Yes		
D7955	Repair Of Maxillofacial Soft And/Or Hard Tissue Defect		Yes	✔	
D7961	Buccal/Labial Frenectomy (Frenulectomy)	01 (UA) 02 (LA)	No	✔	
D7962	Lingual Frenectomy (Frenulectomy)	02 (LA)	No	✔	
D7963	Frenuloplasty		No		2 per lifetime. Excision of frenum with excision or repositioning of abervant muscle and z-plasty or other local flap closure.
D7971	Excision Of Pericoronal Gingiva	All Permanent Teeth (Teeth 1 through 32)	No		
D7979	Non-Surgical Sialolithotomy		Yes		
D7980	Surgical Sialolithotomy		No		
D7981	Excision Of Salivary Gland, By Report		No		
D7982	Sialodochoplasty		No		
D7983	Closure Of Salivary Fistula		Yes		
D7990	Emergency Tracheotomy		No		
D9212	Trigeminal Division Block Anesthesia		Yes		

UHC KanCare Medicaid/Title 19 Adults 21 and over, UHC KanCare Medicaid Frail and Elderly

Limited preventative and restorative services for members age 21 and over are covered under this plan with an annual maximum of $500.00. These services are identified below by an asterisk (*).

Code	Description	Teeth or area covered	Review required	FE waiver eligible	Benefit limitations
D9219	Evaluation For Moderate Sedation, Deep Sedation or General Anesthesia		No		One time per beneficiary per provider or provider billing group per lifetime. One time per beneficiary per 12 months.
D9222	Deep Sedation/General Anesthesia - First 15 Minutes		Yes		D9222/D9223 will not be considered for payment when ONLY diagnostic services are provided on the same date of service.
D9223	Deep Sedation / General Anesthesia - Each subsequent 15 Minute Increment		Yes		D9222/D9223 will not be considered for payment when ONLY diagnostic services are provided on the same date of service.
D9230	Inhalation Of Nitrous/Analgesia, Anxiolysis		No		Not covered when billed with diagnostic and/or preventive services (D0120 through D1208, D1516 through D1556, D9410, D9420).
D9239	Intravenous Moderate (Conscious) Sedation/Analgesia - First 15 Minutes		Yes		D9239/D9243 will not be considered for payment when ONLY diagnostic services are provided on the same date of service.
D9248	Non-Intravenous Conscious Sedation		No		D9239/D9243 will not be considered for payment when ONLY diagnostic services are provided on the same date of service.
D9310	Consultation - Diagnostic Service Provided By Dentist Or Physician		No		1 per 12 months by same provider. One inpatient follow-up per beneficiary within a 10-day period by same provider. Not covered on same date of service as D0120 -D0170, D9410, D9420.
D9311	Consultation with a medical health care professional		No		1 per 12 months by same provider. One inpatient follow-up per beneficiary within a 10 day period by same provider. Not covered on same date of service as D0120-D0170, D9410, D9420.
D9410	House/Extended Care Facility Call		No		1 per day per patient per (provider and location). Extended Care Facilities only.
D9420	Hospital Or Ambulatory Surgical Center Call		No		1 per day per patient per (provider and location) Hospital Facilities only.
D9610	Therapeutic Parenteral Drug, Single Administration		Yes		1 per day
D9613	Sustained Release Therapeutic Drug		Yes		1 per day
D9920	Behavior Management, By Report		Yes		
D9999	Unspecified Adjunctive Procedure, By Report		Yes		

For children receiving EPSDT services, any limits on services may be exceeded when medically necessary.

B.3.a Spenddown members-medically needy

In some cases, the income of a family or individual exceeds the income standard to receive public assistance monies. However, their income is not sufficient to meet all medical expenses. The family group/individual are considered Medically Needy (MN) must then incur a specified amount of medical expenses before they are eligible for Medicaid benefits. This process is referred to as spenddown.

Please refer to the KMAP website that identifies those beneficiaries with spenddown obligation.
https://www.kmap-state-ks.us/

B.3.b Claims processed against the spenddown

The spenddown amount will be reduced by expenses for medically necessary services of eligible beneficiaries but not allowed for in the state Medicaid plan in one of two ways. Providers will bill Skygen USA for these services and Skygen USA will deduct appropriately billed amounts from the appropriate spenddown.

The spenddown amount will be handled like a "deductible." Skygen USA will automatically credit the spenddown amount when participating providers bill claims for necessary services. Billed charges apply to spenddown in date-processed order. Providers should bill all services regardless of whether they believe they are Medicaid-covered services so that all charges can apply toward spenddown.

Providers will be reimbursed for claims submitted for Qualified Medicare Beneficiary (QMB)-covered services rendered to QMB/Medically Needy dual eligible members. These services are not affected by unmet spenddown.

B.3.c Beneficiaries responsibility

Each time a provider-billed or beneficiary-billed claim is used to reduce the spenddown, the members' managed care organization will identify the need for a notice to be sent to the beneficiary explaining which service(s) were used to credit the spenddown and what the new remaining spenddown amount is. These notices will be mailed to beneficiaries weekly. The beneficiary is responsible for the payment of all bills used to reduce their spenddown amount.

B.3.d Providers reimbursement maximized

Each claim used to reduce a beneficiary's spenddown amount will be flagged to identify whether the claim would have paid if spenddown had been met. In the event a claim is submitted which exceeds the amount of spenddown remaining, all claims for the beneficiary will be reviewed.

Claims that are for non-covered services or for services that would not otherwise have been paid by Medicaid will be applied to spenddown first. Processed claims that would have paid if spenddown were met will be applied to spenddown in reverse date order. Once the spenddown amount is met, the fiscal agent will adjust any remaining payable claims so that the provider may receive reimbursement from Skygen USA for the services rendered.

Appendix C: Authorization for treatment

Prior Authorization is only required for orthodontic and non-participating provider requests

C.1 Retrospective review

Services that require retrospective review are outlined in the exhibit section at the end of this manual.

Claims that require retrospective review need to be submitted with the appropriate documentation, below are examples of documentation that maybe required:

- Radiographs (Pre-op, post-op or opposing arch x-rays as indicated in the exhibits)
- Narrative of Medical Necessity
- Perio Charting

Any claim for retrospective review submitted without the required documents will be denied and must be resubmitted for reimbursement.

The Dental Consultant reviews the documentation to ensure the services rendered meet the clinical criteria requirements as outlined in this manual. Once the clinical review is completed, the claim is either paid or denied within 20 calendar days for clean claim and notification will be sent to the provider via the provider remittance statement.

C.2 Dental treatment requiring authorization

Orthodontic Services and Out of network services require Prior Approval. Prior authorizations will be honored for 180 days from the date they are issued. An approval does not guarantee payment. The Member must be eligible at the time the services are provided. The Provider should verify eligibility at the time of service.

With the exception of orthodontic services, participating providers have the option of submitting authorization requests for either Pre or Post review. Providers are encouraged to seek prior authorization in order to reduce the possibility of liability for their practice.

Requests for prior authorization should be sent with the appropriate documentation on a standard ADA Claim Form (2024 version) to:

UnitedHealthcare Community Plan – KS
PO Box 2135
Milwaukee, WI 53201

Prior Authorization decisions are made within fourteen (14) calendar days from the date the prior authorization request is received provided all information is complete. If UnitedHealthcare denies the approval for some or all of the services requested, a written notice of the reasons for the denial(s) will be sent to the member. The notice will tell the Member that he or she may appeal the decision and provide instructions for filing an appeal. Prior Authorization requests submitted without the required documentation will be denied and must be resubmitted for review. The basis for granting or denying approval shall be whether the item or service is medically necessary, whether a less expensive service would adequately meet the Member's needs, and whether the proposed item or service conforms to commonly accepted standards in the dental community. If you have questions regarding a prior authorization decision or would like a peer to peer consultation with the Dental Reviewer who determined the prior authorization request, you can contact Dental Provider Services at **1-800-955-7615**.

Note: UnitedHealthcare does not currently accept orthodontic models as supporting documentation for authorization or claim submissions. If an orthodontic model is received, UnitedHealthcare will create a copy of all accompanying paperwork, process the authorization and return the orthodontic model to the dentist per plan guidelines.

C.3 Authorization timelines

The following timelines will apply to requests for authorization:

- We will make a determination on standard authorizations within 2 days of receipt of the request. Written notification of denied determinations will be sent within 14 calendar days of receipt of the request.
- We will make a determination on expedited authorizations within 24 hours of receipt of the request. Written notification denied determinations will be sent within 2 business days of receipt of the request.
- Authorization approvals will expire 180 days from the date of determination.

C.4 Kansas clinical criteria for retro-review and prior authorization of treatment and emergency treatment

Some procedures require retrospective review or prior authorization before initiating treatment. When requesting these procedures, please note the documentation requirements when sending in the information to Skygen USA. The criteria that the Dental reviewers will look for in order to approve the request is listed below.

United Healthcare criteria utilized for this medical necessity determination were developed from information collected from American Dental Association's Code Manuals, clinical articles and guidelines, as well as dental schools, practicing dentists, insurance companies, other dental related organizations, and local state or health plan requirements.

If there is any question that a procedure that is subject to retro review may not meet criteria and may not be paid, you have the option of submitting the procedure for prior authorization first.

Code	Description	Submission Criteria	Approval Criteria
D0999	Diagnostics	Narrative of medical necessity with pre authorization	
D2710 D2740 D2751 D2752 D2753 D2783 D2791 D2792	Crowns	Periapical X-ray(s) that includes views of adjacent and opposing teeth, pre and post op X-rays required for teeth that have had root canal treatment.	• In general, criteria for crowns will be met only for permanent teeth needing multisurface restorations where other restorative materials have a poor prognosis. • Permanent molar teeth must have pathologic destruction to the tooth by caries or trauma and should involve four or more surfaces and two or more cusps. • Permanent bicuspid teeth must have pathologic destruction to the tooth by caries or trauma and should involve three or more surfaces and at least one cusp. • Permanent anterior teeth must have pathologic destruction to the tooth by caries or trauma and must involve four or more surfaces and at least 50 percent of the incisal edge. • To meet criteria, a crown must be opposed by a tooth or denture in the opposite arch or be an abutment for a partial denture. • The patient must be free from active and advanced periodontal disease. • The fee for crowns includes the temporary crown that is placed on the prepared tooth and worn while the permanent crown is being fabricated for permanent anterior teeth. • Cast crowns on permanent teeth are expected to last, at a minimum, five years. • A request for a crown following root canal therapy must meet the following criteria. • Request should include a dated postendodontic radiograph. • Tooth should be filled sufficiently close to the radiological apex to ensure that an apical seal is achieved, unless there is a curvature or calcification of the canal that limits the ability to fill the canal to the apex. • The filling must be properly condensed/obturated. Filling material does not extend excessively beyond the apex. Medical review for crowns will not meet criteria if a lesser means or restoration is possible Tooth has subosseous and/or furcation caries. • Tooth has advanced periodontal disease. • Tooth is a primary tooth. • Crowns are being planned to alter vertical dimension.
D2954	Prefabricated Post and Core	Pre-operative x-rays of adjacent teeth and opposing teeth.	Root canal fill should be sufficiently close to the radiological apex to ensure that an apical seal is achieved, unless there is a curvature or calcification of the canal that limits the dentist's ability to fill the canal to the apex.

Code	Description	Submission Criteria	Approval Criteria
D3222 D3310 D3320 D3330 D3331 D3426	Endodontics	Sufficient and appropriate preoperative radiographs showing clearly the adjacent and opposing teeth and a preoperative radiograph of the tooth to be treated; bitewings, periapicals or panorex. A dated postoperative radiograph must be submitted for review for payment showing the apex of each treated root	• Root canal therapy is performed in order to maintain teeth that have been damaged through trauma or carious exposure. Root canal therapy must meet the following criteria: • Fill should be sufficiently close to the radiological apex to ensure that an apical seal is achieved, unless there is a curvature or calcification of the canal that limits the dentist's ability to fill the canal to the apex. • Fill must be properly condensed/obturated. Filling material does not extend excessively beyond the apex. Medical review for root canal therapy will not meet criteria if: • Gross periapical or periodontal pathosis is demonstrated radiographically (caries subcrestal or to the furcation, deeming the tooth nonrestorable). • The general oral condition does not justify root canal therapy due to loss of arch integrity. • Root canal therapy is for third molars, unless they are an abutment for a partial denture. • Tooth does not demonstrate 50 percent bone support • Root canal therapy is in anticipation of placement of an overdenture. • A filling material not accepted by the Federal Food and Drug Administration (e.g. Sargenti filling material) is used.
D4210 D4211	Periodontics	Radiographs -pre-op periapicals or bitewings preferred. Narrative documenting medical necessity, photo (optional) • Complete periodontal charting with American Academy of Periodontology (AAP) Case Type • Treatment plan	• Shallow to moderate suprabony pockets after initial preparation • Suprabony pockets that require access after restorative therapy • Moderate gingival enlargements. • Not for infrabony pockets
D4230 D4231	Periodontics	Radiographs -pre-op periapicals or bitewings preferred. Narrative documenting medical necessity.	>75% crown coverage
D4268	Periodontics	Radiographs - periapicals or bitewings preferred. Narrative documenting medical necessity.	Narrative documenting medical necessity and past periodontal surgery.
D4341 D4342	Periodontics	Radiographs - periapicals or bitewings preferred • Complete periodontal charting with American Academy of Periodontology (AAP) Case Type • Treatment plan	• A minimum of three teeth affected in the quadrant • Periodontal charting indicating abnormal pocket depths in multiple sites • Additionally at least one of the following must be present: Radiographic evidence of root surface calculus • Radiographic evidence of noticeable loss of bone support
D5110 D5120	Complete Dentures	• Treatment plan. Appropriate radiographs showing clearly the adjacent and opposing teeth must be submitted for medical review: bitewings, periapicals or panorex.	If there is a pre-existing prosthesis, it must be at least five years old and unserviceable to qualify for replacement.
D5211 D5212 D5213 D5214 D5225	Partial Dentures	• Appropriate radiographs showing clearly the adjacent and opposing teeth must be submitted for medical review: bitewings, periapicals or panorex.	• Partial dentures are covered only for recipients with good oral health and hygiene, good periodontal health (AAP Type I or II), and a favorable prognosis where continuous deterioration is not expected.

Code	Description	Submission Criteria	Approval Criteria
D5226			• Radiographs must show no untreated cavities or active periodontal disease in the abutment teeth, and abutments must be at least 50 percent supported in bone. • In general, if there is a pre-existing removable prosthesis (includes partial and full dentures), it must be at least five years old and unserviceable to qualify for replacement. • In general, a partial denture will be approved for benefits if it replaces one or more anterior teeth, or replaces two or more posterior teeth unilaterally or replaces three or more posterior teeth bilaterally, excluding third molars, and it can be demonstrated that masticatory function has been severely impaired. The replacement teeth should be anatomically full-sized teeth.
D6100	Implant Removal by report	Preoperative radiographs and narrative of medical necessity submitted with claim.	Failure of implant
D7220 D7230 D7240 D7241	Oral Surgery	Preoperative radiographs and narrative of medical necessity submitted with claim.	Reimbursement for Oral and Maxillofacial Surgery Services includes local anesthesia, sutures, and routine postoperative care. The extraction of asymptomatic impacted teeth is not a covered benefit. Symptomatic conditions would include pain and/or infection or demonstrated malocclusion causing a shifting of existing dentition. Removal of impacted teeth (such as third molars) are reviewed by the dental consultant. If these impacted teeth are asymptomatic, the root of the tooth should be adequately developed to determine that the impacted tooth is so positioned that it cannot fully erupt into function and could also and medical consequences. Contribute to pathology with dental The radiographs and/or narrative submitted with the claim must support the CDT code submitted.
D7260	Oral Surgery	Pre- and postoperative radiographs and narrative of medical necessity submitted with claim.	Narrative of medical necessity submitted with claim.
D7280	Oral Surgery	Preoperative radiographs and narrative of medical necessity submitted with claim.	Will not be payable unless the orthodontic treatment has been authorized as a covered benefit.
D7320	Oral Surgery	Preoperative radiographs and narrative of medical necessity submitted with claim.	No extractions performed in an edentulous area.
D7350	Oral Surgery	Preoperative radiographs and narrative of medical necessity submitted with claim.	Narrative of medical necessity submitted with claim.
D7471 D7472 D7473	Oral Surgery	Appropriate radiographs and/or intraoral photographs/ bone scans which clearly identify the exostosis must be submitted for medical review; bitewings, periapicals or panorex. • Treatment plan – includes prosthetic plan. • Narrative of medical necessity, if appropriate. Photo(s) clearly identifying exostosis(es) to be removed	Medical Necessity. Once per lifetime.
D7490 D7680	Oral Surgery	Preoperative radiographs and narrative of medical necessity submitted with claim.	Postoperative radiographs must be available in the beneficiary records.
D7860 D7865 D7920 D7955	Oral Surgery	Preoperative radiographs, if appropriate and narrative of medical necessity submitted with claim.	Postoperative radiographs if appropriate must be available in the beneficiary records.

Code	Description	Submission Criteria	Approval Criteria
D8010 D8020 D8030 D8050 D8060 D8080 D8210 D8220	Orthodontics	Traced cephalometric radiograph. • Mounted full mouth radiograph (14 films) or panoramic view. • External face photographs (lateral and frontal). o Intraoral photographs or slides (upper and lower occlusal views: right, left, and anterior centric occlusion views). • Diagnosis for which treatment is requested • Treatment plan including type of treatment, type of retention, and estimate of treatment time. A case may be submitted only twice; once as an original submission and once as a resubmission for consideration of a denial.	Orthodontic services require prior authorization and are only covered for eligible children with cases of severe orthodontic abnormality caused by genetic deformity (such as cleft lip or cleft palate) or traumatic facial injury resulting in serious health impairment to the beneficiary at the present time. Limited orthodontic treatment is 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. Limited orthodontic treatment requires prior authorization and is only covered for eligible children with documented medical necessity
D8999	Orthodontics	Narrative of medical necessity, panorex of full mouth x-rays, photos	All orthodontic treatment requires prior authorization and is only covered for eligible children with documented medical necessity.
D9130		Narrative of medical necessity shall be submitted with claim	Medical necessity
D9223 D9243	Anesthesia	Narrative documenting: Medical condition(s) which require monitoring (e.g. cardiac problems, severe hypertension) Underlying hazardous medical condition (cerebral palsy, epilepsy, mental retardation, including Down's syndrome) which would render patient noncompliant • Documented failed sedation or a condition where severe periapical infection would render local anesthesia ineffective • Patients nine years of age and younger with extensive procedures to be accomplished. Procedures must be approved before anesthesia will be considered.	• Extensive or complex procedures for a member under the age of 9. Extensive or complex oral surgical procedures such as: • Impacted wisdom teeth • Surgical root recovery from maxillary antrum • Surgical exposure of impacted or unerupted cuspids • Radical excision of lesions in excess of 1.25 cm
D9947	Custom sleep apnea appliance fabrication and placement.	• Diagnosis from Physician • Copy of sleep study	Documentation from physician includes a diagnosis of sleep apnea and a copy of a completed sleep study.
D9999		Narrative of medical necessity shall be submitted with claim.	Medical necessity

The list of codes requiring medical review in the above grid applies to these benefit plans:

- UHC KanCare Medicaid Children (Ages 0-20)
- UHC KanCare CHIP (Ages 0-18)
- UHC KanCare Medicaid/Title 19 Adults 21 and over

While submission and approval criteria is the same for all codes, please note that the following benefit plans have fewer codes requiring medical review. See below for a complete list of codes requiring medical review for each plan.

Appendix D: Dental services in a hospital setting - authorization process

Dentists do not need to obtain prior approval for dental procedures performed in a hospital outpatient setting or an Ambulatory Surgical Treatment Center (ASTC) for children. All dental procedures performed in these outpatient settings may be subject to post payment review.

D.1 Dental billing procedures

Dentists must record a narrative of the dental procedure performed and the corresponding CDT/HCPCS dental codes in the patient's medical record at the outpatient setting. If the specific dental code is unknown, the code D9999 may be used.

Claims must be submitted for the covered professional services in the same format and manner as all standard dental procedures on a standard ADA Claim Form (2024 version) to the following:

Online: **UHCdental.com/medicaid**

EDI: **GP133**

Paper: **KanCare**
PO Box 3571
Topeka, KS 66601-3571

D.2 Hospital/ASTC billing procedures

The hospital or ASTC will bill UnitedHealthcare Community Plan on a UB-92 form for the all-inclusive rate for facility services using the assigned CDT/HCPCS dental code. The hospital must have this code in order to be paid for the facility services. The applicable dental codes will result in payment to hospital/ASTC for the Ambulatory Procedures Listing (APL) Group 1d – Surgical Procedures/Very Low Intensity.

D.3 Participating hospitals/ASCs

Dentists must administer the services at a hospital or ASC that is enrolled in the UnitedHealthcare medical benefits program.

Please note: Participating Hospitals may change. Please contact plan for current listing.

Appendix E: Member rights and responsibilities

For the most updated information regarding Member Rights and Responsibilities, please review the Member Handbook.

E.1 Member rights

Members of UnitedHealthcare Community Plan of Kansas have a right to:

- Respect, dignity, privacy, confidentiality, accessibility and nondiscrimination.
- A reasonable opportunity to choose a PCP and to change to another provider in a reasonable manner.
- Consent for or refusal of treatment and active participation in decision choices.
- Ask questions and receive complete information relating to your medical condition and treatment options, including specialty care.
- Voice grievances and receive access to the grievance process, receive assistance in filing an appeal, and request a State Fair Hearing from UnitedHealthcare Community Plan of Kansas and/or the Department.
- Timely access to care that does not have any communication or physical access barriers.
- Prepare Advance Medical Directives.
- Assistance with requesting and receiving a copy of your medical records.
- Timely referral and access to medically indicated specialty care.
- Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.
- Be furnished health care services in accordance with federal and state regulations.

E.2 Member responsibilities

Members of UnitedHealthcare Community Plan of Kansas agree to:

- Work with their PCP to protect and improve their health.
- Find out how their health plan coverage works.
- Listen to their PCP's advice and ask questions when in doubt.
- Call or go back to their PCP if they do not get better or ask to see another provider.
- Treat health care staff with the respect they expect themselves.
- Tell us if they have problems with any health care staff by calling Member Services at **1-877-542-9238**, TTY **711**.
- Keep their appointments, calling as soon as they can if they must cancel.
- Use the emergency department only for real emergencies.
- Call their PCP when you need medical care, even if it is after-hours.

Appendix F: Grievance reconsideration and appeal process

F.1 Member grievance, appeal, and state fair hearing process

Grievance process

A grievance is any expression of dissatisfaction about any matter other than an adverse benefit determination. You can file a grievance if you are not happy with the way you were treated, the quality of care or services you received or if you have problems getting culturally competent care. If you need help filing a grievance, UnitedHealthcare will provide designated Member advocates to assist you in understanding and using our grievance system. UnitedHealthcare has Member Advocates that will help you in writing or filing a grievance and help you through the grievance process until your issue is resolved. Call 1-877-542-9238, or if you have a machine for telephone calls because you do not hear well, please call TDD/TTY: 711.

To file a grievance:

In writing:

UnitedHealthcare Community Plan - Kansas
Attention: Appeals and Grievance
P.O. Box 31364
Salt Lake City, UT 84131-0364

By telephone (toll-free):

1-877-542-9238
(During business hours 8 a.m. – 6 p.m. CST)

Electronically:

https://www.personalhealthmessagecenter.com/public/forms/KS-Grievance

or In Person:

6860 W. 115th Street, Suite 500
Overland Park, KS 66211
(During business hours 8 a.m. – 5 p.m. CST by appointment only)

You may file a grievance at any time. UnitedHealthcare Community Plan will keep your grievance private. We will let you know we received your grievance within ten (10) calendar days. We will try to take care of your grievance right away. We will resolve your grievance within thirty (30) calendar days and tell you in writing how it was resolved.

Appeal process

An appeal is a request for a review of an action. You can appeal our decision if a service was denied, reduced, or ended early. You have sixty (60) calendar days from the date of the notice of adverse benefit determination (plus three (3) calendar days will be allowed for mailing time) to file an appeal. Below are your rights to proceed with the appeal process:

To file an appeal:

In writing:

UnitedHealthcare Community Plan - Kansas
Attention: Appeals and Grievance
P.O. Box 31364
Salt Lake City, UT 84131-0364

1-877-542-9238
(During business hours 8 a.m. – 6 p.m. CST)

Electronically:

https://www.personalhealthmessagecenter.com/public/forms/KS-Appeal

or In Person:

6860 W. 115th Street, Suite 500
Overland Park, KS 66211
(During business hours 8 a.m. – 5 p.m. CST)

You may also provide supporting appeal documents in person. If you need help filing an appeal, call Member Services at **1-877-542-9238**. Within five (5) calendar days, we will let you know in writing that we got your appeal. You may choose someone, including an attorney or provider, to represent you and act on your behalf. You must sign a consent form allowing this person to represent you. If you are a person with disabilities you may call Member Services at **1-877-542-9238 (TTY: 711)** to file the appeal. UnitedHealthcare Community Plan does not cover any fees or payments to your representatives. That is your responsibility.

If you want copies of your case file or the guidelines we used to make our decision, we can give them to you, free of charge. We will keep your appeal private. We will send you our decision in writing within thirty (30) calendar days.

Expedited (faster) decisions

If you or your doctor wants a fast decision because your health is at risk, call Member Services at 1-877-542-9238 for an expedited appeal. UnitedHealthcare Community Plan will call you with our decision within 72 hours of getting your request for an expedited appeal. This timeframe may be extended up to 14 calendar days if you ask for the extension or we show that there is need for additional information and the delay is in your best interest. If we ask for an extension, we will send you a letter to let you know the reason for the delay. If we decide your health is not at risk, we will send you a letter telling you we will follow the regular appeal process time to make our decision.

Continuation of services during the appeal process

If you want to keep getting previously approved services while we review your appeal, you must tell us within 10 calendar days from the date your notice is sent. If the final decision of the appeal review agrees with United Healthcare's action, you may need to pay for non-waiver services or benefits you received during the appeal process.

HCBS appeals

If you are a member receiving HCBS waiver services and benefits, the previously authorized waiver services and benefits will continue for sixty (60) calendar days from the date of the notice of adverse benefit determination that terminates, suspends or reduces the previously authorized waiver services and

benefits (plus three (3) calendar days will be allowed for mailing time). If an appeal is requested within sixty (60) calendar days (plus three (3) calendar days will be allowed for mailing time) calendar days from the date of the notice of adverse benefit determination, your current waiver services and benefits will continue while the appeal is being reviewed.

Benefits that are continued pending the outcome of the appeal will be continued for 120 calendar days from the date the notice of appeal resolution concerning the termination, suspension or reduction of previously authorized services (plus three (3) calendar days will be allowed for mailing). The notice of appeal resolution will advise you that the appeal decision may be reviewed through a request for a state fair hearing. If a State Fair Hearing request is submitted within one hundred twenty (120) calendar days (plus three (3) calendar days will be allowed for mailing time) from the date of appeal resolution notice, services and benefits will be continued through the date of the decision in the state fair hearing.

Deemed exhaustion

Failure of United Healthcare to adhere to the notice and timing requirements listed above, means that the Member is deemed to have exhausted the appeals process and the Member may initiate a State Fair Hearing. In these situations, the Member will be notified in writing of the deemed exhaustion and next steps. Receipt of this notice is not required before a member can submit a request for a State Fair Hearing.

State fair hearing:

If you disagree with the outcome of your appeal by UnitedHealthcare Community Plan, you or someone acting for you (provider, family member, etc.) can request a State Fair Hearing. You may only file for a State Fair Hearing after you have completed the formal appeal process with UnitedHealthcare Community Plan.

You must file for a State Fair Hearing within one hundred twenty (120) calendar days from the date of the appeal resolution notice (plus three (3) calendar days will be allowed for mailing time).

To file a State Fair Hearing:

In writing:

Office of Administrative Hearings
1020 S. Kansas Avenue
Topeka, KS 66612

By telephone (toll-free):

1-877-542-9238
(During business hours 8 a.m. – 6 p.m. CST)

Electronically via Office of Administrative Hearings fax:

(785) 296-4848

or In Person:

6860 W. 115th Street, Suite 500
Overland Park, KS 66211
(During business hours 8 a.m. – 5 p.m. CST)

Reconsideration process

Reconsideration is defined as a request by a provider for an MCO to review a claim decision. Reconsideration is an optional process available to providers prior to submitted an appeal.

Requests must be submitted within 120 calendar days from the remittance date, plus 3 calendar days from the date of the notice.

Reconsideration requests can be submitted through various means.

By Phone:

1-855-878-5372

By Mail:

UnitedHealthcare Community Plan - KS
Attention: Appeals and Grievances
P.O Box 1244
Milwaukee, WI 53201

Providers may terminate the reconsideration process and submit a formal appeal request within 60 calendar days of the original remittance notice of action, plus 3 calendar days from the date of the notice.

If you disagree with a claim reconsideration decision, you have the right to file a formal claim appeal within 60 calendar days of the reconsideration notice of action.

Providers have the right to represent him/herself or be represented by legal counsel or another spokesperson when requesting reconsideration or an appeal.

External independent third party review

UnitedHealthcare providers are entitled to an external independent third party review (EITPR) of the appeal determination. To request an EITPR, submit the External Independent Third Party Review Request Form found at https://www.uhcprovider.com/en/health-plans-by-state/kansas-health-plans/ks-comm-plan-home/ks-cp-forms-refs.html , in writing to:

By postal mail:
Attn: EITPR
6860 W. 115 Street, Suite 500
Overland Park, KS 66211

In person:
During regular business hours (8a-5p CST)
6860 W. 115 Street, Suite 500
Overland Park, KS 66211

By email:
KS_EITPR@uhc.com

Requests for EITPR must be received within 63 calendar days from the date on this notice of appeal resolution.

F.2 Provider grievance, reconsideration, appeal, and state fair hearing process

Grievance process

A grievance is any expression of dissatisfaction about any matter other than an Action. If you need help filing a grievance, call Provider Services at 1-877-542-9235 (TDD/TTY: 711).

To file a grievance

In writing:
UnitedHealthcare Community Plan - Kansas
Attention: Appeals and Grievance
P.O. Box 31364
Salt Lake City, UT 84131-0364

By telephone (toll-free):
1-877-542-9235
(During business hours 8am – 5pm CST)

Electronically:
UHCProvider.com > Provider Forms and References

Drop-off in person:
United Healthcare Community Plan of Kansas – Appeal, Mail Route: KS015-M400
6860 West 115th Street
Overland Park, KS 66211
(During business hours 8am-5pm CST*)

*Please contact the appeals team at **ks_sfh@uhc.com** to schedule an appointment prior to dropping off any requests or documentation in person.

Providers have one hundred eighty (180) calendar days from the date of the incident being grieved, to file a grievance. You may choose someone, including an attorney, to represent you and act on your behalf. UnitedHealthcare Community Plan does not cover any fees or payment to your representation. UnitedHealthcare Community Plan will keep your grievance private. We will let you know we received your grievance within ten (10) calendar days. We will resolve your grievance within thirty (30) calendar days and tell you in writing how it was resolved.

Appeal process

An appeal is a review of an action. You have sixty-three (63) calendar days from the date of the notice of action to file an appeal.

To file an appeal:

In writing:
UnitedHealthcare Community Plan - Kansas
Attention: Appeals and Grievance
P.O. Box 31364
Salt Lake City, UT 84131-0364

Electronically:
UHCProvider.com > Claims and Payments

Drop-off in person:
United Healthcare Community Plan of Kansas – Appeal, Mail Route: KS015-M400
6860 West 115th Street
Overland Park, KS 66211
(During business hours 8am-5pm CST*)

*Please contact the appeals team at **ks_sfh@uhc.com** to schedule an appointment prior to dropping off any requests or documentation in person.

You may submit additional documentation to support your appeal. You may do this via mail, the portal or in person. If you need help filing an appeal, call Provider Services at **1-877-542-9235, TTY 711**. Within 10 calendar days, we will let you know in writing that we got your appeal. You may choose someone, including an attorney, to represent you and act on your behalf. UnitedHealthcare Community Plan does not cover any fees or payments to your representatives. We will keep your appeal private and will send you our appeal decision in writing within 30 calendar days.

State fair hearing

If you disagree with the outcome of your appeal by UnitedHealthcare Community Plan, you can request a State Fair Hearing. You may only file for a State Fair Hearing after you have completed the formal appeal process with UnitedHealthcare Community Plan. You may choose someone, including an attorney, to represent you and act on your behalf. UnitedHealthcare Community Plan does not cover any fees or payment to your representation.

You must file for a State Fair Hearing within one hundred twenty-three (123) calendar days from the date of the appeal resolution notice. The request form can be found at https://www.kancare.ks.gov/providers/grievances-appeals-state-fair-hearings/provider-state-fair-hearing.

To file a State Fair Hearing-

In writing:
Office of Administrative Hearings
1020 S. Kansas Avenue
Topeka, KS 66612

By telephone (toll-free):
1-877-542-9238
(During business hours 8am-5pm CST)

Electronically via Office of Administrative Hearings fax:
1-785-296-4848

Drop-off in person:
United Healthcare Community Plan of Kansas – Appeal, Mail Route: KS015-M400
6860 West 115th Street
Overland Park, KS 66211
(During business hours 8am-5pm CST*)

*Please contact the appeals team at **ks_sfh@uhc.com** to schedule an appointment prior to dropping off any requests or documentation in person.

External independent third party review

Effective with denials dated January 01, 2020 and after, if you disagree with the outcome of your appeal by United HealthCare Community Plan, you can request an external independent third-party review (EITPR) of the appeal determination. EITPR is an optional process available to care providers only and the formal appeal must be completed prior to requesting an EITPR.

The EITPR will be available to KanCare providers who have received a denial of authorization of a new healthcare service to a United HealthCare member or a denial of a claim for reimbursement to the provider for a healthcare service to a United HealthCare member.

Documentation reviewed by the external reviewer will be limited to documentation submitted by the provider for the appeal process, along with the medical necessity criteria United HealthCare applied in the appeal decision (for denials of a healthcare service).

EITPR can be requested in writing, by submitting the EITPR request form found at https://www.uhcprovider.com/content/dam/provider/docs/public/commplan/ks/forms/EITPR-Request-Form.pdf.

By postal mail:
United Healthcare Community Plan of Kansas – EITPR
PO Box 31218
Salt Lake City, UT 84131

Drop off in person:
United Healthcare Community Plan of Kansas – EITPR, Mail Route: KS015-M400
6860 West 115th Street
Overland Park, KS 66211

(During business hours 8am-5pm CST*)

*Please contact the appeals team at **ks_sfh@uhc.com** to schedule an appointment prior to dropping off any requests or documentation in person.

Electronically by email:
KS_EITPR@uhc.com

Provider requests for an EITPR must be received by United HealthCare within sixty-three (63) calendar days from the date of the notice of appeal resolution. United HealthCare will acknowledge receipt of your request, in writing, within 5 business days of receipt. No additional documentation will be accepted with the EITPR request. Only the records and documentation reviewed during the appeal will be reviewed during the EITPR. Providers will receive a letter from the external reviewer that contains the external review decision. Following that, UnitedHealthcare Community Plan will issue a notice that includes your right to request a state fair hearing regarding the external reviewer's decision within thirty-three (33) calendar days of the date on the MCO's notice of external review decision.

Dental Benefit Providers®