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Welcome
Welcome to UPMC Dental Advantage. We are committed to providing quality coverage to our members. UPMC Health Plan,* a leading regional health insurer owned and led by providers, created UPMC Dental Advantage. We consider the dentists in our network to be leaders in providing quality care.

This manual is your main source of information about UPMC Dental Advantage’s products, services, and claims processes. We hope you find it helpful.

We value your participation and thank you for being a part of UPMC Dental Advantage.

UPMC Dental Advantage will update this manual and post revisions as needed. The back of this manual indicates the copyright date and the edition to show the timeliness of the information.

Advantages of Participating
UPMC Dental Advantage is dedicated to fostering a mutually beneficial relationship with participating dentists by offering the following business incentives:

- Rapid payment of claims and reimbursement
- Competitive fee schedule
- Live support from an organization known for excellent customer service
- With the exception of essential health benefits, there is no prior authorization of services**
- Simple, easy claims filing
- Only requires initial orthodontic claims submission: no additional claims required to receive subsequent payments – system automatically generates payments on a quarterly basis.
- Payments made directly to participating dentists; electronic funds transfer (EFT) payments also available
- Names, addresses, and phone numbers of participating dentists available to all members on the Plan’s website at www.upmchealthplan.com/providers
- UPMC Dental Advantage newsletter for participating dentists
- Dedicated Network Manager assigned to your practice to assist with operational issues and contractual questions

*The term UPMC Health Plan or “the plan” collectively refers to UPMC Health Plan Inc., UPMC Health Benefits Inc., and UPMC Dental Advantage.

**Prior approval is required for orthodontic treatment for eligible essential health benefit (EHB) members. Refer to page 8. The Plan may request additional clinical information for these members to determine eligibility for orthodontic services.

UPMC Dental Advantage Provider Portal
As a participating provider, you can access valuable information by visiting the UPMC Dental Advantage provider portal at www.upmchealthplan.com/providers. It’s easy to create an account. Log in and click on the Register box. Once you’re a registered user, you can:

- View up-to-date eligibility and covered benefits
- View real-time patient and claims data
- Receive 24-hour access to claims and coverage information
- Get an immediate response if mistakes are made submitting a claim (using HIPAA 837 forms)

Product at a Glance
UPMC Dental Advantage is a Preferred Provider Organization (PPO) plan that gives members the freedom to choose any dentist to provide care. Members have a combination of deductibles, coinsurance, and copayments for both in-network and out-of-network benefits. Members receive the highest level of benefits and lowest out-of-pocket costs when they use a UPMC Dental Advantage participating dentist.

There are many different cost-sharing structures based on the plan the employer selects. Benefit levels could vary by deductibles and coinsurance, benefit choices, and benefit maximums.

Some plans may change over time due to employer benefit changes, regulatory requirements, or policy requirements. For the latest updates, visit the UPMC Dental Advantage website at www.upmchealthplan.com/providers or call the Dental Benefits Advisory Team.

Under the Affordable Care Act (ACA), select UPMC Health Plan members will have access to pediatric dental essential health benefits (EHB). These benefits became effective January 1, 2014. Pediatric dental EHB for ACA compliant small group participants will be administered by UPMC Dental Advantage on behalf of UPMC Health Plan. Dependents through the age of 19 enrolled in an ACA compliant small group are eligible for the pediatric dental EHB administered by UPMC Dental Advantage.

You should process claims for these patients like any other UPMC Dental Advantage member. Check the “Verifying Eligibility,” “Processing Claims,” and “Benefit Limitations” sections in this manual for more information on these patients.
UPMC Dental Advantage does not issue identification cards to EHB eligible members. Members will receive medical ID cards with instructions that explain how to submit pediatric dental claims. However, the identification number presented on this card should not be used to submit claims to UPMC Dental Advantage. See below for a sample ID card.

You are only permitted to balance-bill a member for the difference between your charge and the UPMC Dental Advantage reimbursement under the following circumstances:

- If a member has completed the financial liability waiver and elects to have a non-covered service performed, or
- If the member exceeds the maximum benefit limit within the benefit year.

You may not balance-bill a member for preventive treatment. Please refer to page 8 for more information on non-covered services.

**Coordination of Benefits Information**

Coordination of benefits (COB) is a provision to prevent overpayment when a member is covered by more than one dental plan. If a member has coverage under two group dental plans, one as the employee and the other as the spouse of an employee, the group plan covering the member as a subscriber is primary. The plan covering the member as a dependent is secondary.

When UPMC Dental Advantage is the secondary payer, claims are accepted with the explanation of benefits (EOB) from the primary carrier. This secondary claim must be received within 90 days of the primary EOB remittance date or up to the new claim filing limit, whichever is greater. Claims submitted after these deadlines will be denied for untimely filing.

Members cannot be billed for the Plan’s portion of the claims submitted after these deadlines; however, they may be billed for copayments, coinsurance, and/or deductibles. For further assistance, contact the Dental Benefits Advisory Team.

To assist with timely and accurate processing of COB claims and to minimize adjustments and overpayment recoveries, the Plan requires the following information:

- Insured ID number
- Subscriber name
- Relationship to member
- Other insurance name
- Other insurance phone
- Other insurance address
- Effective date of coverage
- Termination date of coverage, if applicable
- Type of coverage (e.g., medical, dental, auto insurance, hospital only, vision, workers’ compensation, major medical, prescription, or supplemental)

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**Verifying Eligibility**

You can verify member eligibility online at the UPMC Dental Advantage provider portal. To view information about an eligible member, you will need the subscriber’s Social Security number or the member’s name and date of birth. Once you’ve entered this information, you will have access to the member’s plan information, including benefits, plan documents, and the date such benefits take effect. You can also verify eligibility by calling the Dental Benefits Advisory Team.

The process for verifying eligibility for patients who receive dental services under EHB is similar. The difference is that you will use the child’s Social Security number or name and date of birth. EHB-eligible dependents will have an 11-digit member ID with a suffix of 01.

Verifying eligibility does not guarantee claim payment, nor does it confirm benefits or exclusions. Members must acknowledge their financial responsibility in writing before you provide services.

**Fee Schedule**

UPMC Dental Advantage reimburses dental services on a fee-for-service basis. Network dentists agree to accept the network reimbursement, less deductibles and coinsurance, as payment in full for covered services provided to members. UPMC Dental Advantage annually updates all fee schedules with CPT-4, HCPCS, and CDT code additions and deletions. The Plan follows the American Dental Association (ADA) Current Dental Terminology (CDT) guidelines whenever appropriate. For a copy of the most current UPMC Dental Advantage fee schedule, contact your Network Manager.
If you see that a member’s COB or other dental insurance coverage information is missing or incorrect, please notify the Dental Benefits Advisory Team immediately.

COB determinations will not be made when a claim is submitted for predetermination. If you request a predetermination, we will only make a benefit determination as though no other insurance existed. Coordination of benefits will only occur when a claim is submitted for payment.

Determining Primary Insurance Coverage
These guidelines will help you determine primary dental insurance coverage:

• If a member is covered under two group dental plans, one as the employee and the other as the spouse of an employee, the group dental plan covering the member as a subscriber or a retiree is primary. The group dental plan covering the member as a dependent is secondary.

• If a member is a subscriber on more than one group dental plan, the plan that has been active the longest is the primary dental insurance carrier.

• If a child is adopted, the child is covered using the mother’s ID number for the first 31 days following placement.

• If a child has dual coverage from both parents who are not legally separated or divorced, the child’s primary dental insurance carrier is the parent or guardian whose birth date falls earlier in the calendar year. (This is known as the “birthday rule.”)

For questions about determining primary insurance coverage, call the Dental Benefits Advisory Team.

Predetermination
Predetermination is a process where a dentist submits a treatment plan before he or she begins treatment. Predetermination lets members know what their benefits are, the deductible and coinsurance that will apply, and what their out-of-pocket costs will be on a potential claim. Predeterminations are not a guarantee of payment. Payment is based on the member’s eligibility and plan enrollment at the time services are rendered. Predeterminations are not mandatory but are strongly recommended.

Radiographs are not required for predeterminations. With the exception of EHB,* UPMC Dental Advantage does not require prior authorization, so radiographs are not required in advance of a member’s treatment. However, UPMC Dental Advantage may request a post-chart review in which you will need to supply documentation, including radiographs.

It is important to note that when you submit a predetermination, planned services should never appear on the same form as actual services. You need to submit a predetermination as a separate transaction. When you submit a predetermination on a paper claim form, check the box in Block 1 that is labeled “Request for Predetermination/Preauthorization.” Do not include a service date.

*Prior approval is required for orthodontic treatment for members who are eligible for the pediatric dental essential health benefits (EHB). Refer to page 7. The Plan may request additional clinical information for these members to determine eligibility for orthodontic services.

Processing Claims
UPMC Dental Advantage accepts new claims for services up to 365 days after the date of service. Follow these guidelines to avoid the most common claims billing problems:

• If you are billing on a paper claim form, make sure that the values submitted fall within the correct block or field on the claim form.

• Include all required substantiating documentation.

• Make sure there is no missing or incomplete information.

• Make sure there are no invalid, incorrect, or expired codes (e.g., the use of single-digit instead of double-digit place-of-service codes).

• Include an explanation of benefits (EOB) for a member who has other coverage.

Electronic Filing Methods
UPMC Dental Advantage encourages you to submit claims for predetermination and for payment electronically. There are several options for electronic submission.

Individual Claim Entry
Individual claim entry is available to network dentists with a UPMC Dental Advantage provider portal account. If you don’t have an account, you can register as a new dentist or user. This feature allows you to submit dental claims and predeterminations from our website.

Electronic Data Interchange (EDI)
UPMC Dental Advantage accepts electronic claims in data file transmissions. Electronic claim files sent directly to the Plan are permitted only in the HIPAA standard formats.

Dentists who have existing relationships with clearinghouses such as WebMD® can continue to transmit claims in the format their billing software produces. The clearinghouses are then responsible for reformatting
these claims to meet HIPAA standards and forwarding the claims to UPMC Dental Advantage. Providers who submit claims through Emdeon should use Payer ID 23281.

For all EDI submissions, you must provide the National Provider Identifier (NPI) number. The NPI is an identification number that is a government-mandated requirement for electronic health care transactions and paper claims in some states. In addition, the member’s identification number is necessary, along with the patient’s name and demographic information. When care is coordinated, the referring dentist’s name and NPI or UPIN are also required.

You may submit claims directly without incurring clearinghouse expenses. These claims are loaded into batches and immediately posted in preparation for adjudication. You can view these batches in several standard report formats via EDI tools on the UPMC Dental Advantage provider portal.

To submit EDI files directly to the Plan, you must:

- Use billing software that allows the generation of a HIPAA-compliant 837D file
- Have a sample 837D file containing only UPMC Dental Advantage claims exported from the billing system
- Have the ability to download and install a free Active-X secure FTP add-on
- Complete testing with UPMC Dental Advantage

Support for electronic submission is provided by our Dental Benefits Advisory Team. For direct EDI submitters, contact our EDI support team via email at hpedinotify@upmc.edu.

**Paper Claim Filing Methods**

Submit claim forms to:

**UPMC Dental Advantage**

PO Box 1600

Pittsburgh, PA 15230-1600

Please file all paper claims using the most current ADA dental claim form. We do not accept provider-specific billing forms. Predeterminations and actual services need to be submitted as separate transactions. Claim forms that are submitted with both predetermination for planned services and actual services rendered will be denied and sent back to the submitter.

To access a copy of the most current ADA claim form, visit the Forms section of the UPMC Dental Advantage website at [www.upmchealthplan.com/providers](http://www.upmchealthplan.com/providers).

UPMC Dental Advantage cannot accept claims via fax.

**Important information for claims submitted for EHB-eligible members:** Claims and predeterminations for EHB-eligible dependents will be submitted in the same manner as other UPMC Dental Advantage members. Please be sure to enter the child’s – not the subscriber member’s – identifying information when submitting claims. EHB-eligible dependents will have an 11-digit member ID with a suffix of 01, this number can be retrieved from the UPMC Dental Advantage portal by entering the patient’s demographic information.

**Claims Processing Policies**

UPMC Dental Advantage processes all properly submitted claims within 45 days from the date they are received. The Pennsylvania Insurance Department regulations stipulate that a claim is paid when the Plan mails the check or electronically transfers the funds.

In the event UPMC Dental Advantage fails to remit payment on a properly submitted claim within 45 days of receipt of that claim, interest at the rate of interest set forth by the United States Secretary of the Treasury, as published in the Federal Register, will be added to the amount owed on the claim. UPMC Dental Advantage is not required to pay interest that is calculated to be less than $2.

**Multiple Payee Addresses**

The Plan does not honor multiple payee addresses. You are required to submit a single payee address per tax ID number.

**Claim Follow-up**

To view claim status online, go to [www.upmchealthplan.com/providers](http://www.upmchealthplan.com/providers). To check the status of a claim without going online, call the Dental Benefits Advisory Team.

**Denials and Appeals**

All denied claims are reported on the explanation of payment (EOP). It will indicate whether you have the right to bill the member for the denied services and if the member is financially responsible for payment.

If you disagree with the Plan’s decision to deny payment of services, you must appeal in writing to the appeals coordinator within 30 business days of receipt of the denial notification. Your request must include the reason for the appeal and any relevant documentation, which may include the member’s medical record.
Appeals should be submitted to:

**UPMC Dental Advantage**  
Provider Appeals  
PO Box 2906  
Pittsburgh, PA 15230-2906

All appeals undergo the Plan’s internal review process, which meets all applicable regulatory agency requirements. You will receive written notification in all situations in which the decision to deny payment is upheld.

**Overpayment**

If the Plan has paid in error, you may return the Plan’s check or write a separate check from your account for the full amount paid in error. You should include a copy of the remittance advice, supporting documentation noting the reason for the refund, and the explanation of benefits (EOB) from other insurance carriers, if applicable.

Send refunds to the General Accounting Department at this address:

**UPMC Dental Advantage**  
General Accounting Department  
U.S. Steel Tower, 12th Floor  
600 Grant Street  
Pittsburgh, PA 15219

The Plan can also deduct the overpayment from future claims if you choose not to return our check or send in your check for the amount due.

**Benefit Limitations**

UPMC Dental Advantage administers employer group contracts that place limitations and exclusions on certain benefits. These may vary by employer group sponsor or state regulatory requirements. Placement limitations, such as one crown per tooth every 60 months, one full mouth series of x-rays every 36 months, and two prophylaxes in a benefit year, are the most common limitations. Charges for hospitalization, teeth bleaching, cosmetic services, treatment of TMJ, anesthesia services, treatment of malignancies or neoplasms, and house calls are the most common exclusions.

The examples above, however, are not all inclusive. If you would like to know the specific exclusions and limitations under which your patients are covered, visit [www.upmchealthplan.com/providers](http://www.upmchealthplan.com/providers) to obtain specific information related to the member’s contract.

Services that are not covered by UPMC Dental Advantage may be covered under the member’s medical plan.

Examples of services not covered by UPMC Dental Advantage but may be covered under medical include:

### Accident-Related Dental Services

Dental care for accidental injury to sound and natural teeth is usually covered under the member’s medical benefits. If your patient is a member of UPMC Health Plan, this coverage only applies to the emergency dental services made necessary by the injury itself and obtained in an emergency department within the first 72 hours following the accidental injury. The plan does not provide coverage for any follow up care. Injury as a result of chewing or biting is not considered an accidental injury. Please contact the medical carrier for additional information related to coverage for accident-related dental services.

### Oral Surgery

Some types of oral surgery, such as soft tissue extractions, are covered by UPMC Dental Advantage. Other types, such as the removal of impacted teeth, should be submitted to the medical plan if the member has UPMC Health Plan medical benefits. If the member has other medical benefits, verify what’s covered with the carrier of that policy.

### Anesthesia

Anesthesia should be considered under the member’s medical benefit. If the medical plan does not cover this service, anesthesia will require approval by UPMC Dental Advantage.

*For information on treating members under 7 years old or a member of any age who is developmentally disabled and requires anesthesia, please refer to the member’s medical carrier.*

### Pharmacy Services

Pharmacy benefits are considered part of the medical benefit. Please follow the procedures of the member’s medical plan when prescribing medications.

If the member has UPMC Health Plan medical coverage, contact the Pharmacy Services Department at 1-800-979-8762 Monday through Friday from 8 a.m. to 5 p.m. Representatives can answer questions about a member’s medication history, duplicate medications, or compliance issues.
Orthodontic Services

Payment
Orthodontic fees are generally based on the anticipated length of treatment. In most cases, orthodontic treatment will involve an initial payment followed by quarterly payments. Contractual and/or group-specific exceptions may apply.

Payments for orthodontic services are generally as follows: The initial payment is 25 percent of the member’s lifetime maximum and is paid upon placement of the bands or appliance. The remaining 75 percent is calculated into a monthly benefit, based on the number of months in active treatment, with payments issued quarterly. The member must be eligible for benefits during each quarter that payment is made. We automatically process quarterly payments. You do not need to submit claims quarterly.

Orthodontic Treatment in Progress — New Enrollee
The member must be enrolled on the date of banding or appliance placement to receive payment for these services. If the member is enrolled after appliance placement, he or she may be eligible to receive quarterly payments for treatment in progress. However, in these cases, there is no guarantee the member’s lifetime orthodontic maximum will be paid out. As soon as the member becomes eligible for orthodontic benefits, you should submit a claim for the orthodontic treatment in progress.

Be sure to include the diagnosis, treatment plan, total fee, banding or appliance date, and estimated total duration of treatment on the claim. UPMC Dental Advantage then calculates the amount the plan will cover for the remaining treatment in quarterly payments. The dental explanation of benefits (DEOB) indicates the amount the plan will cover for the remainder of the in-progress treatment.

Lifetime Maximum
All orthodontic payments are typically subject to the member’s lifetime orthodontic maximum. If the member’s orthodontic maximum has been met prior to the completion of the payment schedule, further payments are discontinued.

Orthodontic Treatment in Progress — Transfer
If the member transfers to a different orthodontist, the new orthodontist must submit a claim indicating the total remaining months of treatment, total fee, and the banding date. Payment for services provided by the new orthodontist will be calculated based on the remaining orthodontic benefits and remaining length of treatment. It is the orthodontist’s and the member’s responsibility to notify UPMC Dental Advantage if orthodontic treatment is discontinued or completed sooner than anticipated, or if the member transfers to another orthodontist. If you are re-banding the member, please indicate that the member was re-banded and the date. If the member was not re-banded, indicate the date the new orthodontist assumed responsibility for the treatment plan.

Orthodontic Treatment Under Essential Health Benefits
The Plan will only pay for orthodontic treatment for EHB members if it is considered medically necessary. Providers must complete an online Salzmann Index Evaluation – a screening used for assessing the severity of a malocclusion. The member must have a score of 25 or higher to be considered eligible for treatment. Online requests may be submitted via the UPMC Dental Advantage provider portal. Paper submissions will also be honored. To request a form, please contact the Dental Benefits Advisory Team or download a copy from www.upmchealthplan.com/providers.

The member must be approved by the Plan prior to treatment for the Plan to pay for services. In addition, EHB members must satisfy their shared medical/orthodontic deductible before the Plan will pay for orthodontic services. To determine if the member has satisfied his/her deductible, visit the UPMC Dental Advantage provider portal or call the UPMC Dental Advantage Benefits Advisory Team. If the member is approved for orthodontic treatment, UPMC Dental Advantage strongly encourages providers to submit a predetermination to estimate plan payments as well as member liability. If the member has been denied orthodontic treatment, providers may file an appeal on the member’s behalf. Appeals should be submitted to:

UPMC Dental Advantage
Provider Appeals
PO Box 1600
Pittsburgh, PA 15230-1600
Dealing With Services That Are Not Covered

If you determine that a member requires non-covered services, UPMC Dental Advantage expects you to discuss possible options with the member. If the member elects to receive a non-covered procedure or treatment, the member must agree in writing that he or she will be financially responsible for these services before treatment begins. If the member will be subject to collection action upon failure to make the required payment, the terms of the action must be kept in the member’s treatment record. Failure to comply with this procedure will subject you to sanctions up to and including termination from the network.

UPMC Dental Advantage requires you to include a non-covered services form in the member’s permanent record. The form should contain the following information:

- Member’s name and ID number
- Procedure code and description of service(s)
- Fee charged
- Dentist’s signature
- Member’s signature
- Statement of agreement and amount
- Date

It is not necessary to submit the form to UPMC Dental Advantage. However, the Plan may request copies of the forms.

Dental Record Documentation

UPMC Dental Advantage requires participating dentists to maintain member dental records in a manner that is accurate, timely, well-organized, confidential, and readily accessible by authorized personnel. Per UPMC Dental Advantage policy, all dental records must be retained for five years for adults and minors, or as required by applicable state law.

The Plan has adopted standards for dental record documentation. These standards are designed to promote communication between dentists and facilitate continuity of patient care.

Dental Record Confidentiality and Security

- Store dental records in a secure location that can be locked and protected when not being used, but still permits easy retrieval of information by authorized personnel only.
- Periodically train dental office staff and consistently communicate the importance of dental record confidentiality.

Basic Information

- Place the member’s name or ID number on each page of the dental record.
- Include marital status and address, employer name, and home and work telephone numbers.
- Include the author’s identification in all entries in the dental record. The author identification may be a handwritten signature, a unique electronic identifier, or his or her initials.
- Date all entries.
- Ensure that the record is legible to someone other than the writer.

Patient History

- Indicate significant illnesses and medical conditions on the problem list.
- List all medications and prominently note medication allergies and adverse reactions in the record. If the patient has no known allergies or history of adverse reactions, dentists should appropriately note this in the record.

Treatment

- Document clinical evaluation and findings for each visit.
- Document treatment plans and dental care services provided.
- Document prescriptions.

Follow-up

Note the specific time of recommended return visit in weeks, months, or as needed.

Review

In the event of a quality of care concern, a UPMC Dental Advantage representative may visit your office to review members’ records.

Access

You are required to comply with UPMC Dental Advantage’s rules for reasonable access to dental records during the agreement term and upon termination allowing the following parties access to the member’s dental records:

- Members may have access to their dental records
upon request and at no charge in accordance with the Health Insurance Portability and Accountability Act (HIPAA).

• UPMC Dental Advantage representatives or their delegates, the member’s subsequent dentist(s), or any authorized third party, including employees or agents of the Pennsylvania Department of Insurance or employer group sponsor, may have access for a maintenance period of five years from the last date of service or as otherwise required by state law.

Copies

UPMC Dental Advantage has the right to request copies of the member’s complete record. You may not charge a fee for the dental records when they are required by the Plan or the member upon transferring to another dentist.

It is the responsibility of the general/pediatric dentist to provide a copy of diagnostic quality radiographs to any successor dentist without charge.

Credentialing

Credentialing is the process of assessing and validating the qualifications and practice history of a dentist. All dentists in our network must be credentialed prior to joining UPMC Dental Advantage. Their application attests to their ability to practice and provides proof of insurance liability.

All dentists must be re-credentialed within three years of the date of their last credentialing approval. The re-credentialing process is the same as the initial credentialing process, except that dentists will also be evaluated on their professional performance, judgment, and clinical competence. Criteria used for this evaluation may include, but are not limited to:

• Compliance with the Plan’s policies and procedures
• Plan sanctioning related to utilization management, administrative issues, or quality of care
• Member complaints
• Member satisfaction survey
• Participation in quality improvement activities
• Quality of care concerns

You will receive your application for reappointment approximately six months before your re-credentialing date. This allows ample time to complete the credentialing process. Failure to return the completed reappointment application and supporting documentation within the requested time limit may result in termination from the network.

You can appeal credentialing denials for quality reasons. If you have been denied credentialing, the Plan will send you a letter with an explanation of the appeals process.

A dentist who does not meet credentialing standards may not appeal his or her denial.

Reporting Practice Changes

Please notify UPMC Dental Advantage of any additions, practice changes, or corrections within 30 days. You can submit changes by mail, email, or online.

Any mail or fax notifications must be typewritten on business letterhead and include the following information:

• Dentist name
• Office address
• Billing address (if different from office address)
• Phone number
• Fax number
• Office hours
• Effective date
• W-9 tax form

Fax all changes to Network Development at 412-454-8225 or scan and email to hpdental@upmc.edu or mail to:

UPMC Dental Advantage Network Development
U.S. Steel Tower, 14th Floor
600 Grant Street
Pittsburgh, PA 15219

Changes may also be submitted online at www.upmchealthplan.com/providers.

While on vacation or a leave of less than 30 days, you must arrange for coverage by another UPMC Dental Advantage participating dentist. If you go on extended leave for 30 calendar days or longer, you must notify the Dental Benefits Advisory Team.

Leaving the Network

You must give UPMC Dental Advantage at least 90 days written notice before voluntarily leaving the network. In order for your notice to be considered valid, you are required to send termination notices by certified mail (return receipt requested) or overnight courier. In addition, you must supply copies of medical records to the member’s new dentist and facilitate the member’s transfer of care at no charge to the Plan or the member.
Fax terminations to Network Development at 412-454-8225 or scan and email to hpdent@upmc.edu or mail to:

**UPMC Dental Advantage Network Development**
**U.S. Steel Tower, 14th Floor**
**600 Grant Street**
**Pittsburgh, PA 15219**

UPMC Dental Advantage will notify affected members in writing that their dentist is no longer participating in the network. You must continue to render covered services to members who are existing patients at the time of termination for 90 days, or until UPMC Dental Advantage can arrange for appropriate dental care with another participating dentist, whichever is later.

**Dentist Responsibilities**

Dentists have a responsibility to:

- Maintain the confidentiality of members’ protected health information, including dental records and histories, and adhere to state and federal laws and regulations regarding confidentiality and security.
- Comply with all federal and state requirements concerning the handling and reporting of breaches of security.
- Give members a notice that clearly explains their privacy rights and responsibilities as they relate to the dentist’s practice/office/facility.
- Provide members with the opportunity to request an accounting of the use and disclosure of their personal health information in accordance with HIPAA.
- Allow members to request restriction on the use and disclosure of their protected health information.
- Obtain and report information regarding other insurance coverage to the Plan.
- Follow all state and federal laws and regulations related to patient care and patient rights.
- Participate in Plan data collection initiatives and other contractual or regulatory programs.
- Review clinical practice guidelines distributed by the Plan.
- Notify the Plan in writing if the dentist is leaving or closing a practice.
- Disclose to the Plan overpayments or improper payments.
- Provide members, upon request, with information regarding the dentist’s professional qualifications, such as specialty, education, residency, and board certification status, if applicable.
- Conduct their practice in accordance with the Plan’s Code of Conduct and Ethics.
- Immediately report any compliance concerns and/or issues.
- Be alert to possible violations of the law, regulations, and/or accreditation standards, as well as any other type of unethical behavior.
- Providers are required to coordinate a member’s care with other in-network providers, not limited to specialists. When members use in-network providers, this helps them get the most from their medical benefits and reduces out-of-pocket expenses. Failure to comply with this requirement may lead to provider termination from the network. Also, network providers are responsible for determining the type of care the member needs and the appropriate provider to administer that care.
Compliance
To operate as a licensed dental insurer, UPMC Dental Advantage must comply with various laws, regulations, and accreditation standards. UPMC Dental Advantage established a Compliance Program to meet these requirements, as well as combat cost trends in the health care industry such as fraud, abuse, and wasteful spending.

The Plan’s Compliance Program serves to assist contracted dentists, staff members, management, and our Board of Directors with promoting proper business practices. Proper business practices include identifying and preventing improper or unethical conduct.

Your Role in Compliance Concerns and/or Issues
The UPMC Dental Advantage Help Line was established for you, your staff, and other entities to call and report compliance concerns and/or issues without fear of retribution or retaliation. The Help Line number, 1-877-983-8442, is available 24 hours a day, seven days a week. Callers may remain anonymous.

The success of UPMC Dental Advantage’s Compliance Program relies in part upon the actions you and other contracted dentists take. It is critical that you be aware of the goals and objectives of the UPMC Dental Advantage Compliance Program, as well as your responsibilities as dentists.

UPMC Dental Advantage prohibits retaliation against contracted dentists who raise, in good faith, a compliance concern and/or issue, or any other question about inappropriate or illegal behavior. The Plan also prohibits retaliation against contracted dentists who participate in an investigation or provide information relating to an alleged violation.

For any questions regarding the UPMC Dental Advantage Compliance Program and/or a contracted dentist’s responsibilities, Mary Hentosz, Associate Vice President of Compliance, at 412-454-5204.

Your Role in HIPAA Privacy & Gramm-Leach-Bliley Act Regulations
All UPMC Dental Advantage policies and procedures include information to ensure the Plan complies with the Health Insurance Portability and Accountability Act (HIPAA) and the Gramm-Leach-Bliley Act.

Hospitals and dentists subject to HIPAA are trained to understand their responsibilities under these privacy regulations as is the staff at UPMC Dental Advantage.

The Plan has incorporated measures in all its departments to make sure prospective, current, and former members’ protected health information, individually identifiable health information, and personally identifiable financial information are maintained in a confidential manner, whether that information is in oral, written, or electronic format. Plan employees may use and disclose this information only for those purposes permitted by federal legislation (for treatment, payment, and health care operations); by the member’s written request; or when required to disclose such information by law, regulation, or court order.

An authorization form permitting the disclosure of protected health information is available from the Plan’s Member Services Department or from the UPMC Dental Advantage provider portal. This form complies with the core elements and statements required by HIPAA Privacy Rules. This form must be completed, signed, and returned to the Plan before the Plan will release information.

The Plan’s Notice of Privacy Practices is separate and distinct from the Notice of Privacy Practices dentists are required to give to their patients under HIPAA. The Plan’s Privacy Statement and Notice of Privacy Practices are posted on the UPMC Dental Advantage provider portal.

Americans With Disabilities Act Compliance
Dental offices are considered places of public accommodation and must be accessible to individuals with disabilities. Dental offices are required to adhere to the Americans with Disabilities Act (ADA) guidelines, Section 504, of the Rehabilitation Act of 1973, and other applicable laws. You may contact the Dental Benefits Advisory Team to obtain copies of these documents and other related resources.

UPMC Dental Advantage requires that your offices or facilities comply with this act. Your office or facility must be wheelchair-accessible or have provisions to accommodate people in wheelchairs. Patient restrooms should be equipped with grab bars. Handicapped parking must be available near your office and be clearly marked.

Reporting Fraud and Abuse to UPMC Dental Advantage
UPMC Dental Advantage established a hotline to report suspected fraud and abuse committed by any entity providing services to members. The hotline number, 1-866-FRAUD-01 (1-866-372-8301), is available 24 hours a day, seven days a week. Voice mail is available at all times. Callers may remain anonymous and may leave a voice mail message. TTY users should call 1-800-361-2629.

Some common examples of fraud and abuse are:
• Billing for services that were never provided to the member
• Billing more than once for the same service
• Falsifying records
• Performing and/or billing for inappropriate or unnecessary services

You may report suspected fraud and abuse via the Plan’s website at www.upmchealthplan.com/providers or you may email the information to specialinvestigationsunit@upmc.edu.

If you are reporting fraud and abuse by mail, please mark the outside of the envelope “confidential” or “personal” and send to:

UPMC Dental Advantage
Special Investigations Unit
PO Box 2968
Pittsburgh, PA 15230

You may report information anonymously via the website, email, or regular mail. The Plan’s website contains additional information on reporting fraud and abuse.

Requirements and Standards of Care for Dental Offices

UPMC Dental Advantage has established standards that dentists’ offices are expected to fulfill. The following summarizes those standards:

Standard of Care

Each network dentist and dental specialist is expected to practice within the specified state board of dentistry’s standard of care. The Plan expects you to be aware of any state and federal laws that impact your position as an employer, a business owner, and a health care professional.

Sanctions

Sanctions are the consequences for noncompliance in UPMC Dental Advantage’s three areas of oversight. The Plan follows a three-phase process for addressing the actions of dentists who fail to observe the terms and conditions of the dentist agreement or UPMC Dental Advantage’s policies and procedures.

Actions That Could Lead to Sanctioning

Actions that could lead to sanctioning fall into three categories: administrative noncompliance, unacceptable resource utilization, and quality of care concerns.

Administrative Noncompliance

Administrative noncompliance is consistent or significant behavior that is detrimental to the success or functioning of UPMC Dental Advantage. Examples include:

• Conduct that is unprofessional or erodes the confidence of members
• Direct billing or balance-billing for covered/contractual services unless member exceeds the benefit limit
• Failure to coordinate or cooperate with UPMC Dental Advantage’s administrative, quality improvement, post-treatment review, and reimbursement procedures

Unacceptable Resource Utilization

Unacceptable resource utilization is a utilization pattern that deviates from acceptable standards and may adversely affect a member’s quality of care.

Quality of Care Concerns

A quality of care issue may arise from an episode that adversely affects the functional status of a member or a pattern of practice that deviates from acceptable standards. For quality of care concerns, the Quality Improvement Committee (QIC) has selected a severity scale. This scale ranks cases that may involve a practice pattern deviating significantly from the norm.

The sanctioning process and focused monitoring of the dentist remain in effect for no less than one year from the date UPMC Dental Advantage notifies the dentist. The Plan notifies the dentist when the process and follow-up activities are satisfied and the sanctioning is no longer in effect. In instances of recurring similar noncompliance activities, UPMC Dental Advantage reserves the right to expedite the sanctioning process.

Termination

The QIC, as part of the sanctioning process, may recommend the termination of a dentist’s contract. The dentist will be notified in writing and offered the opportunity to appear at a hearing, if appropriate. The termination process involves the following steps:

1. UPMC Dental Advantage notifies dentist about termination. The notice will state that a professional review action is recommended and the reasons for the proposed action. The dentist has the right to request a hearing within 30 calendar days.

2. The Appeals Committee will conduct the hearing and recommend to the QIC that it accept, reject, or modify its original recommendation. The right to the hearing
may be forfeited if the dentist fails, without good cause, to appear.

At the hearing, the dentist has the right to:

• Receive representation by an attorney or other person of the dentist’s choice.

• Have a record made of the proceedings, copies of which may be obtained upon payment of any reasonable charges associated with the preparation of the records.

• Call, examine, and cross-examine witnesses.

• Present evidence determined to be relevant by the hearing officer regardless of its admissibility in a court of law.

• Submit a written statement at the close of the hearing.

Upon completion of the hearing, the dentist has the right to receive the written recommendation of the Appeals Committee from the Plan, including a written statement giving the basis of the decision.

**Surveys and Assessments**

The Plan conducts a series of surveys and assessments of members and dentists in a continuous effort to improve performance. All dentists are urged to participate when asked.

**Member Administration**

**Member and Dentist Satisfaction Surveys**

The Plan conducts annual surveys of both member and dentist satisfaction. Participation by members and dentists enables the Plan to develop quality improvement plans.

The surveys assess:

• Access to care and/or services
• Overall satisfaction with the Plan
• Provider availability
• Quality of care received
• Responsiveness to administrative processes
• Responsiveness to inquiries

**Quality Improvement Program**

The goal of the Quality Improvement Program is to continually examine UPMC Dental Advantage’s clinical and administrative operations in an effort to continuously improve the Plan’s ability to deliver high-quality, timely, safe, and cost-effective care and services.

The Quality Improvement Program operates in accordance with the guidelines established by the National Committee for Quality Assurance (NCQA), the Pennsylvania Department of Health, and the Pennsylvania Insurance Department.

The program critically assesses the Plan’s performance regarding customer service, dentist satisfaction, credentialing, pharmacy, preventive services, utilization of resources, and various health care initiatives.

The doctors who serve on the Quality Improvement Committee (QIC) are at the center of the program. This committee, made up of both academic and community doctors, operates directly under the auspices of the board of directors. The QIC is vital to the Plan because it develops and evaluates clinical and operational standards for dentists.

The Dental Agreement requires that you comply with the UPMC Dental Advantage Quality Improvement Program.
UPMC Dental Advantage
Dental Discount Plan

The UPMC Dental Advantage Dental Discount Plan provides members with an in-network discount of 20 percent off your usual and customary fees on eligible Class I, II, and III services. The discount does not apply to any orthodontic-related services. Members enrolled in a Basic dental plan are eligible for a 20 percent discount only on Class II and Class III services. This discount will be applied to your charge, not the UPMC Dental Advantage fee schedule.

To verify a member’s eligibility for the UPMC Dental Advantage Discount Dental Plan, you can log in to the UPMC Dental Advantage provider portal or call the Dental Benefits Advisory Team at 1-877-648-9609. Note that members may enroll in the Discount Dental Plan even if they have group dental coverage through another carrier as long as their employer purchases the UPMC Dental Advantage Discount Dental Plan. However, the UPMC Dental Advantage discount would be considered secondary to their dental plan. The UPMC Dental Advantage Discount Dental Plan may not be used in conjunction with other UPMC Dental Advantage plans unless otherwise indicated on the plan document. Please refer to the plan documents available through the UPMC Dental Advantage Provider Portal.

UPMC Dental Advantage Discount Dental Plan provider benefits include:

- Providers are not required to submit claims for services received as part of the discount plan.
- An online provider portal for verifying eligibility, benefits, and coverage details.
- A dedicated network manager for any questions or concerns you may have.
Essential Health Benefits
Pediatric Dental Guide
Essential Health Benefits
Pediatric Dental Guide

UPMC Dental Advantage
Select UPMC Health Plan commercial members will have access to pediatric dental essential health benefits (EHB) in accordance with the Affordable Care Act (ACA). UPMC Dental Advantage will administer pediatric dental essential health benefits on behalf of UPMC Health Plan.

UPMC Health Plan members through the age of 19 enrolled in a commercial small group employer plan will be eligible for essential health benefits through UPMC Dental Advantage at the time of their enrollment or renewal period.

The pediatric dental EHB benefit is similar to most UPMC Dental Advantage plans. Below are a few highlights:

- Plans allow for plan and member cost sharing
- Class I, II, and III services are covered
- Deductible does not apply to Class I services
- Authorization for Class II and Class III services is not required
- Provider reimbursement is based on the current UPMC Dental Advantage fee schedule

Verifying Eligibility & Claims Submission

Member eligibility can be verified online by visiting the UPMC Dental Advantage portal. To view information for an EHB eligible member, you will need the patient’s Social Security number or the patient’s name and date of birth. Once you’ve entered this information, you will have access to the member’s plan information, including benefits, EHB rider, and the dates such benefits take effect. You can also verify eligibility by calling the UPMC Dental Advantage Benefits Advisory Team at 1-877-648-9609.

Claims and predeterminations for these patients will be submitted in the same manner as other UPMC Dental Advantage members. Be sure to enter the child’s – not the subscriber member’s – identifying information when submitting claims. EHB eligible dependents will have an 11-digit member ID with a suffix of 01. This number can be retrieved from the UPMC Dental Advantage portal by entering the patient’s demographic information.

Essential Health Benefits (EHB) Plan Design

On the next page is the Pediatric Dental Essential Health Benefits (EHB) plan design for 2016. The pediatric dental plan is the same for all eligible dependents, regardless of the medical plan offered by their employer.1

Dental Essential Health Benefits Rider

UPMC Dental Advantage will cover the services set forth below, related to the dental benefits provided in accordance with UPMC Dental Advantage policies and procedures. In the event that the terms and conditions set forth in other dental benefit materials conflict with those set forth in this plan document, the terms and conditions of the plan document control.

1UPMC Dental Advantage members who are in orthodontic treatment at the time Pediatric Dental Essential Health Benefits become effective will continue to have their orthodontic claims administered according to the plan design that they were enrolled in during treatment. Payments will continue until the end of treatment or when coverage ceases, whichever occurs first.
<table>
<thead>
<tr>
<th>In-Network</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Plan Year Deductible</strong></td>
<td>$50 Individual/$150 Eligible Dependents (waived for Class I)</td>
</tr>
<tr>
<td><strong>Class I: Diagnostic/Preventive</strong></td>
<td>100%</td>
</tr>
<tr>
<td><strong>Exams and Prophylaxis</strong></td>
<td>Payable for 2 services in a benefit year</td>
</tr>
<tr>
<td><strong>Bitewings</strong></td>
<td>Payable for 2 services in a benefit year up to age 14; 1 service in a benefit year for 14+ years</td>
</tr>
<tr>
<td><strong>Complete Series and Panoramic Films</strong></td>
<td>Payable for 1 service in a 36-month period and is not covered for members under the age of 5</td>
</tr>
<tr>
<td><strong>Topical Fluoride</strong></td>
<td>Payable to age 19 for 2 services in a benefit year</td>
</tr>
<tr>
<td><strong>Periodontal scaling/root planing</strong></td>
<td>Payable for 1 service every 24 months</td>
</tr>
<tr>
<td><strong>Sealants</strong></td>
<td>Payable to age 14 for 1 service per tooth (molars and premolars) every 36 months</td>
</tr>
<tr>
<td><strong>Space Maintainers</strong></td>
<td>Payable to age 19</td>
</tr>
<tr>
<td><strong>Class II: Basic Services</strong></td>
<td>70%</td>
</tr>
<tr>
<td><strong>Amalgam and Composite Fillings</strong></td>
<td>Payable</td>
</tr>
<tr>
<td><strong>Pulpal Therapy/ Anterior and Posterior</strong></td>
<td>Payable</td>
</tr>
<tr>
<td><strong>Endodontic Therapy (Including treatment plan, clinical procedures, and follow-up care)</strong></td>
<td>Payable</td>
</tr>
<tr>
<td><strong>Extractions and Oral Surgery</strong></td>
<td>Payable</td>
</tr>
<tr>
<td><strong>Class III: Major Services</strong></td>
<td>50%</td>
</tr>
<tr>
<td><strong>Crowns</strong></td>
<td>Payable for 1 service per tooth in a 60-month period</td>
</tr>
<tr>
<td><strong>Inlay/Onlay ¾ metallic/ porcelain/resin up to 4+ surfaces</strong></td>
<td>Payable for 1 service per tooth in a 60-month period</td>
</tr>
<tr>
<td><strong>Implants</strong></td>
<td>Payable for 1 service per tooth per lifetime</td>
</tr>
<tr>
<td><strong>Prosthodontics</strong></td>
<td>Payable</td>
</tr>
<tr>
<td><strong>Dentures Complete and Partial</strong></td>
<td>Payable for 1 service in a 60-month period</td>
</tr>
<tr>
<td><strong>Prefabricated stainless steel crown/primary tooth</strong></td>
<td>Payable for 1 service per tooth in a 60-month period</td>
</tr>
<tr>
<td><strong>Orthodontia: Child (under age 19)</strong></td>
<td>50%</td>
</tr>
</tbody>
</table>

***Orthodontia is only available if deemed medically necessary. Member must satisfy medical/dental shared deductible before plan pays for orthodontic treatment. To check eligibility and deductible information, visit the UPMC Dental Advantage portal. Exceptions may apply to patients currently in treatment.***

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**Orthodontic Treatment Under Essential Health Benefits**

UPMC Dental Advantage will only cover orthodontic treatment for new members, if it is considered medically necessary. Providers must complete an online Salzmann Index evaluation - a screening used for assessing the severity of a malocclusion. The member must have a score of 25 or higher to be considered eligible for treatment. Online requests may be submitted via the UPMC Dental Advantage portal. Paper submissions will also be honored. To request a form, contact the Dental Benefits Advisory Team or download a copy from [www.upmchealthplan.com/providers](http://www.upmchealthplan.com/providers).

In the event the patient does not qualify based on the Salzmann Index evaluation, certain medical conditions may warrant a review by the UPMC Dental Advantage orthodontist to be considered eligible. Narratives, supporting documentation, and materials should be sent to UPMC Dental Advantage.

The member must be approved by the plan prior to treatment for the plan to pay for services. In addition, EHB members must satisfy their shared medical/orthodontia deductible before the plan will pay for orthodontic services. To determine if the member has satisfied his/her deductible, visit the UPMC Dental Advantage portal or call the UPMC Dental Advantage Benefits Advisory Team. If the member is approved for orthodontic treatment, UPMC Dental Advantage strongly encourages providers to submit a predetermination to estimate plan payments as well as member liability.

**Important Information for Members Currently in Orthodontic Treatment**

If you are currently treating a UPMC Dental Advantage member who will be moving to an Essential Health Benefits plan, you will not be required to submit approval to continue treatment. UPMC Dental Advantage will continue to pay the remaining benefits based on the months of treatment and the plan maximum of the commercial group plan the member was enrolled in when payments were initiated. In addition, these members will not be required to satisfy their shared medical/orthodontia deductible. Payment of in-progress treatment is contingent on member’s eligibility in the plan. Should the member terminate coverage, payments will cease at the end of the month coverage ended.

Your office will not be required to submit new claims for UPMC Dental Advantage members who are currently in treatment.

Examples illustrating how the plan will process orthodontia payments are shown on the following pages.

For more information about orthodontia coverage or the approval process for eligible EHB members, contact the UPMC Dental Advantage Benefits Advisory Team at 1-877-648-9609.

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2Predeterminations are not a guarantee of payment and are subject to the member’s plan and eligibility at the time services are rendered.
How Orthodontic Benefits Are Paid for Pediatric Dental Essential Health Benefits (EHB) Members

Scenario 1 – Pediatric dental EHB coverage becomes effective prior to the start of orthodontic treatment – new and existing UPMC Dental Advantage members

UPMC Dental Advantage will require dentists to submit the Salzmann Scale Index for new and existing EHB eligible members starting orthodontic treatment prior to the start of treatment. If the member scores 25 or higher, payments will be based on the EHB plan design, including satisfying the shared medical/orthodontia deductible and the remaining months of treatment.

Note: The fees used in the examples do not reflect actual fees. Please refer to your UPMC Dental Advantage fee schedule.

Example A - Shared medical/orthodontia deductible not satisfied:

Member became effective in the pediatric dental EHB plan January 1, 2014, and is approved for orthodontic treatment April 15, 2014. The plan that the member is enrolled in has a $2,000 shared medical/orthodontia deductible that has not been satisfied.

Summary of payments:

<table>
<thead>
<tr>
<th>Description</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>UPMC Dental Advantage Contracted Amount</td>
<td>$4,000</td>
</tr>
<tr>
<td>Medical/Ortho Deductible (member responsibility)</td>
<td>$2,000</td>
</tr>
<tr>
<td>Remaining Balance</td>
<td>$2,000</td>
</tr>
<tr>
<td>Plan Payment (50% of remaining balance) (after deductible is satisfied)</td>
<td>$1,000</td>
</tr>
<tr>
<td>Member Responsibility (50% of remaining balance)</td>
<td>$1,000</td>
</tr>
<tr>
<td>Total Payments</td>
<td>$4,000</td>
</tr>
<tr>
<td>Total Plan Payments (paid quarterly throughout the course of treatment or when coverage ceases)</td>
<td>$1,000</td>
</tr>
<tr>
<td>Total Member Payments</td>
<td>$3,000</td>
</tr>
</tbody>
</table>

Example B - Shared medical/orthodontia deductible partially satisfied:

Member became effective in the pediatric dental EHB plan January 1, 2014, and is approved for orthodontic treatment April 1, 2014. The plan that the member is enrolled in has a $1,000 shared medical/orthodontia deductible with $500 remaining to be satisfied before the plan makes payments.

Summary of payments:

<table>
<thead>
<tr>
<th>Description</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>UPMC Dental Advantage Contracted Amount</td>
<td>$4,000</td>
</tr>
<tr>
<td>Remaining Medical/Ortho Deductible</td>
<td>$500</td>
</tr>
<tr>
<td>Remaining Balance</td>
<td>$3,500</td>
</tr>
<tr>
<td>Plan Payment (50% of remaining balance)</td>
<td>$1,750</td>
</tr>
<tr>
<td>Member Responsibility (50% of remaining balance)</td>
<td>$1,750</td>
</tr>
<tr>
<td>Total Provider Payments</td>
<td>$4,000</td>
</tr>
<tr>
<td>Total Plan Payments (paid quarterly throughout the course of treatment or when coverage ceases)</td>
<td>$1,750</td>
</tr>
<tr>
<td>Total Member Payments</td>
<td>$2,250</td>
</tr>
</tbody>
</table>

Scenario 2 – Pediatric dental (EHB) coverage becomes effective after the start of orthodontic treatment previously covered by a commercial UPMC Dental Advantage group plan

UPMC Dental Advantage will continue to make payments for treatment according to the plan the member was enrolled in when treatment was initiated on the commercial UPMC Dental Advantage group plan. Your office does not need to submit a new claim or complete the Salzmann Scale Index. Payments will continue as if there was no change in benefit.

Example:

Member started orthodontic treatment September 15, 2013, on a commercial UPMC Dental Advantage group plan with a lifetime maximum of $1,500. The member moves to a pediatric dental EHB plan effective January 1, 2014. UPMC Dental Advantage has already made payments of $625 under the commercial plan. The plan will pay the remaining $875 through quarterly installment payments throughout the course of treatment or when coverage ends, whichever occurs first.

Summary of payments:

<table>
<thead>
<tr>
<th>Description</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>UPMC Dental Advantage Commercial Group Allowance</td>
<td>$1,500</td>
</tr>
<tr>
<td>Payments Paid on UPMC Dental Advantage Group Plan</td>
<td>$625</td>
</tr>
<tr>
<td>Payments to Be Continued on Pediatric Dental EHB Plan</td>
<td>$875</td>
</tr>
</tbody>
</table>
Scenario 3 - New pediatric dental EHB eligible member in orthodontic treatment not previously covered by UPMC Dental Advantage

UPMC Dental Advantage will require dentists to submit a Salzmann Scale Index for new pediatric dental EHB members in treatment who were not previously covered by UPMC Dental Advantage. Payments for these members will be based on the EHB plan design, including satisfying the shared medical/orthodontia deductible and remaining months of treatment.

Example:
Member started treatment July 15, 2013, on a non-UPMC Health Plan dental plan. The member is enrolled in a pediatric dental EHB plan on February 1, 2014, and has eight months of treatment remaining and a balance of $750. The member has been approved to continue treatment. The plan that the member is enrolled in has a $0 shared medical/orthodontia deductible.

Summary of payments:

<table>
<thead>
<tr>
<th>Description</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Remaining Balance of Orthodontia Treatment</td>
<td>$750</td>
</tr>
<tr>
<td>Medical/Ortho Deductible</td>
<td>$0</td>
</tr>
<tr>
<td>Pediatric Dental EHB Benefit</td>
<td>50%</td>
</tr>
<tr>
<td>Plan Payment (50% of remaining balance)</td>
<td>$375</td>
</tr>
<tr>
<td>(paid quarterly throughout the course of treatment or when coverage ceases)</td>
<td></td>
</tr>
<tr>
<td>Member Responsibility (50% of remaining balance)</td>
<td>$375</td>
</tr>
<tr>
<td>Months of Remaining Treatment</td>
<td>8</td>
</tr>
<tr>
<td>Quarterly Payments</td>
<td>$140.63</td>
</tr>
</tbody>
</table>

(Final quarterly payment in this scenario would be $93.74. Payments would be made through three quarters, as long as the member remains eligible.)
Salzmann Evaluation Index Instructions
ORTHODONTIC SERVICE for EHB Members

SALZMANN EVALUATION INDEX INSTRUCTIONS

Instructions for using the “Handicapping Malocclusion Assessment Record”

This assessment record is intended to disclose whether a handicapping malocclusion is present and to assess its severity according to the criteria and weights (points values) assigned to them.

The weights are based on tested clinical orthodontic values from the standpoint of the effect of the malocclusion on dental health, function, and esthetics.

Assessments can be made from casts or directly in the mouth.

The patient must score 25 or higher on the Salzmann Evaluation Index to be eligible for comprehensive orthodontic treatment. However, proposed treatments that have conditions that appear medically beneficial but do not result in the necessary 25-point Salzmann qualifier for treatment will also be considered; however, an adequate narrative must be submitted to the UPMC Dental Advantage staff orthodontist.

Examples of conditions that are not described by the Salzmann Index but may be considered medically necessary are:

1.) Early (phase I) treatments

2.) Cases that can benefit by starting treatment with some primary teeth present and/or before all the permanent teeth are erupted. These would be treatments that, if delayed until all the permanent teeth fully erupt, could reasonably risk additional complications such as possible unnecessary teeth extractions or jaw surgery in the future.

3.) Cases that involve impacted teeth

4.) Cases involving orthognathic surgery

5.) Cleft palate cases

An additional assessment record form is provided to describe the patient’s overall condition, the intended diagnostic procedures, the treatment plan, and additional comments that may be relevant.

Also, treatments that require only minor tooth movements (such as molar uprighting) and removable appliance therapy that would be considered medically necessary can be submitted. Other orthodontic services that are not “typical” will be reviewed on a case-by-case basis to determine if medically necessary. Such cases will require narratives, study models, and panoramic and cephalometric radiographs to be sent to UPMC Dental Advantage for consideration.

Cosmetic (ceramic) appliances, broken and lost appliances will be the responsibility of the patient.

UPMC Dental Advantage recommends verifying the patient’s eligibility for service upon meeting malocclusion assessment. Providers may also submit a pre-determination to UPMC Dental Advantage to receive an estimate of the plan’s payment.
Completing the Handicapping Malocclusion Assessment Record

A. INTRA-ARCH DEVIATIONS

Study casts can be evaluated or the assessment can be made directly in the mouth. The number of teeth affected is entered as indicated in the Handicapping Malocclusion Assessment Record. Note that canines are considered part of the posterior segment in the Salzmann Index.

1. Anterior segment: A value of two (2) points is scored for each tooth affected in the maxilla and one (1) point in the mandible.
   a. Missing teeth are assessed by actual count. A tooth with only the roots remaining is scored as missing.
   b. Crowded refers to tooth irregularities that interrupt the continuity of the dental arch when the space is insufficient for alignment, without moving other teeth in the arch. Crowded teeth may or may not also be rotated. A tooth scored as crowded is not also scored as rotated.
   c. Rotated refers to tooth irregularities that interrupt the continuity of the dental arch when there is sufficient space for alignment. A tooth scored as rotated is not also scored as crowded or spaced.
   d. Spacing
      i. Open spacing — one or both interproximal tooth surfaces are visible between the anterior teeth. Score the number of teeth affected, not the spaces.
      ii. Closed spacing — space is not sufficient to permit eruption of a tooth, or a tooth that is partially erupted, without moving teeth in the same arch. Score the number of teeth affected. Example: if an incisor is blocked from the arch and all the other incisors have sufficient space, though it may be rotated, score one (1) point.

2. Posterior segment: A value of one (1) point is scored for each tooth affected.
   a. Missing teeth are assessed by actual count. A tooth with only the roots remaining is scored as missing.
   b. Crowded refers to tooth irregularities that interrupt the continuity of the dental arch when the space is insufficient for alignment. Crowded teeth may or may not also be rotated. A tooth scored as crowded is not also scored as rotated.
   c. Rotated refers to tooth irregularities that interrupt the continuity of the dental arch and all or part of the lingual or buccal surface that faces some part or all of the adjacent proximal tooth surfaces. There is sufficient space for alignment. A tooth scored as rotated is not also scored as crowded.
   d. Spacing
      i. Open spacing — one or both interproximal tooth surfaces are visible between the posterior teeth. Score the number of teeth affected, not the spaces.
      ii. Closed spacing — space is not sufficient to permit eruption of a tooth, or a tooth that is partially erupted, without moving teeth in the same arch. Score the number of teeth affected. Example: If a premolar is blocked from the arch and all the other posterior teeth have sufficient space, though it may be rotated, score one (1) point.
B. INTER-ARCH DEVIATIONS

The dentition is evaluated in centric occlusion.

1. Anterior segment: A value of two (2) points is scored for each affected maxillary tooth only (except for overbite see below).
   a. Overjet: Score the number of maxillary teeth affected only. Score the points when the maxillary incisors extend beyond the lower incisors in a horizontal direction.
   b. Overbite: Score the number of the maxillary or mandibular incisors affected. Score the points when the maxillary incisors vertically overlap the mandibular incisors in an excessive amount.
   c. Crossbite: Score the points when the maxillary incisors occlude lingual to the mandibular incisors.
   d. Open bite refers to vertical inter-arch dental separation between the upper and lower incisors when the posterior teeth are in centric occlusion. Open bite is scored in addition to overjet if the maxillary incisor teeth are above the incisal edges of the mandibular incisors when the posterior teeth are in centric occlusion. Edge-to-edge occlusion is not assessed as open bite.

2. Posterior segment: A value of one (1) point is scored for each affected maxillary tooth. (Note that the canines are considered part of the posterior segment along with the premolars and first molars.)
   a. Crossbite: Score the points when the buccal cusps of the mandibular posterior teeth are edge-to-edge or buccal to the buccal cusps of the opposing occlusion or when the buccal cusps of the lower posterior teeth are edge-to-edge or lingual to the lingual cusps of the opposing occlusion.
   b. Open bite refers to the vertical interdental separation between the upper and lower posterior teeth when the dentition is observed in centric occlusion. Cusp-to-cusp occlusion is not assessed as open bite.
   c. Anteroposterior deviation refers to the occlusion forward or rearward of the accepted normal (Class I) of the mandibular canine, first and second premolar and first molar in relation to the opposing maxillary teeth. The deviation is scored when the maxillary first molar extends one-half cusp or more, mesially or distally, as compared to a normal (Class I) occlusion. Also, a deviation is scored if the premolars or canines occlude mesially or distally to the accepted normal (Class I) positions. (Note: The Salzmann Index asks how the mandibular posterior teeth relate to the maxillary posterior teeth.)

C. DENTOFACIAL DEVIATIONS

The following deviations are scored as handicapping when associated with a malocclusion: Score eight (8) points for each deviation.

1. Cleft palate or cleft lip
2. Lower lip positioned completely palatal to the maxillary incisor teeth
3. Functional jaw limitations such as a functional shift of the mandible
4. Facial asymmetry to the extent that surgical intervention is necessary
5. Speech impairment that is related to the malocclusion and is documented by a licensed or certified therapist
### Handicapping Malocclusion Assessment Record

**A. Intra-Arch Deviation**

<table>
<thead>
<tr>
<th>Score Affected Teeth Only</th>
<th>Missing</th>
<th>Crowded</th>
<th>Rotated</th>
<th>Spacing</th>
<th>No.</th>
<th>Point Value</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Maxilla</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ant.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>x2</td>
<td></td>
</tr>
<tr>
<td>Post.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>x1</td>
<td></td>
</tr>
<tr>
<td><strong>Mandible</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ant.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>x1</td>
<td></td>
</tr>
<tr>
<td>Post.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>x1</td>
<td></td>
</tr>
</tbody>
</table>

**Total Score**

**B. Inter-Arch Deviation**

**Anterior Segment**

<table>
<thead>
<tr>
<th>Score of Maxillary Teeth Affected Only Except Overbite*</th>
<th>Overjet</th>
<th>Overbite</th>
<th>Crossbite</th>
<th>Open Bite</th>
<th>No.</th>
<th>Point Value</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>x2</td>
<td></td>
</tr>
</tbody>
</table>

**Total Score**

**Posterior Segment**

<table>
<thead>
<tr>
<th>Score Affected Teeth Only</th>
<th>Relate Mandibular to Maxillary Teeth</th>
<th>Score Affected Maxillary Teeth Only</th>
<th>No.</th>
<th>Point Value</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Distal Left</td>
<td>Distal Right</td>
<td>Mesial Left</td>
<td>Mesial Right</td>
<td>Crossbite</td>
</tr>
<tr>
<td><strong>Canine</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1ST Premolar</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2ND Premolar</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1ST Molar</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Total Score**
C. DENTOFACIAL DEVIATIONS

<table>
<thead>
<tr>
<th>LIST CONDITIONS</th>
<th>NO. OF CONDITIONS</th>
<th>POINT VALUE</th>
<th>SCORE</th>
</tr>
</thead>
<tbody>
<tr>
<td>DENTOFACIAL DEVIATIONS</td>
<td></td>
<td></td>
<td>x8</td>
</tr>
</tbody>
</table>

TOTAL SCORE

GRAND TOTAL
Welcome

Welcome to UPMC Dental Advantage Medicare. We are committed to providing quality coverage to our members. UPMC Health Plan,* a leading regional health insurer owned and led by providers, created UPMC Dental Advantage Medicare. We consider the dentists in our network to be leaders in providing quality care.

This manual is your main source of information about UPMC Dental Advantage Medicare’s products, services, and claims processes. We hope you find it helpful.

We value your participation and thank you for being a part of the UPMC Dental Advantage Medicare network.

UPMC Dental Advantage Medicare will update this manual and post revisions as needed. The back of this manual indicates the copyright date and the edition to show the timeliness of the information.

Advantages of Participating

UPMC Dental Advantage Medicare is dedicated to fostering a mutually beneficial relationship with participating dentists by offering the following business incentives:

• Rapid processing of claims and reimbursement
• Competitive fee schedules
• Live support from an organization known for excellence in customer service
• No prior authorization of services
• Simple, easy claims filing
• Payments are made directly to participating dentists; electronic funds transfer (EFT) payments are also available
• Names, addresses, and phone numbers of participating dentists available to all members on the Plan’s website at www.upmchealthplan.com/providers
• Dedicated Network Manager assigned to your practice to assist with operational issues and contractual questions

*The term UPMC Health Plan or “the Plan” collectively refers to UPMC Health Plan Inc., UPMC Health Benefits Inc., UPMC Health Network Inc., and UPMC Dental Advantage Medicare.

UPMC Dental Advantage Provider Portal

As a participating provider, you can access valuable information by visiting the UPMC Dental Advantage provider portal at www.upmchealthplan.com/providers. It’s easy to create an account. Log in and click on the Register box. Once you’re a registered user, you can:

• View up-to-date eligibility and covered benefits.
• View real-time patient and claims data.
• Receive 24-hour access to claims and coverage information.
• Get an immediate response if mistakes are made submitting a claim (using HIPAA 837 forms).

Product at a Glance

UPMC Dental Advantage Medicare Individual Plan gives UPMC for Life members access to coverage for preventive dental services. A copayment may apply to some services. Please refer to the plan documents available through the UPMC Dental Advantage Provider Portal.

Some plans may change on a calendar-year basis. For the latest updates, visit www.upmchealthplan.com/providers or call the Dental Benefits Advisory Team at 1-844-761-0081.

UPMC Dental Advantage Medicare Group includes options with varying plan benefits, including preventive and restorative care, based on the employer group, much like the Commercial Dental Advantage PPO product. The Medicare products will have two fee schedules. Please provide all additional Class I, II, and III services at a 20 percent discount of your standard office fee; discounts do not apply to orthodontic services.

Eligibility verification and claims submission information will be listed on the back of the member’s medical card. The member identification number presented on this card should not be used to submit claims to UPMC Dental Advantage. We encourage you to use the UPMC Dental Advantage Provider portal to verify eligibility, benefits, and coverage limitations, and to submit claims. This is also where you can determine a beneficiary’s eligibility. You will only need first name, last name, and date of birth for verification. NOTE: Medicare members are not required to share their Social Security number.

Regardless of Medicare plan type, an informed consent must be obtained for any NON-COVERED treatment. The consent form must include patient’s name, date, services to be provided, and member cost, including the 20 percent discount on all Class I, II, and III services. The member must sign the consent. A “blanket” financial agreement will not meet the consent requirement.
Non-Covered Services

If you determine that a member requires non-covered services, UPMC Dental Advantage Medicare expects you to discuss possible options with the member. If the member elects to receive a non-covered procedure or treatment, the member must agree in writing that he or she will be financially responsible for these services before treatment begins. If the member will be subject to collection action upon failure to make the required payment, the terms of the action must be kept in the member’s treatment record. Failure to comply with this procedure will subject you to sanctions up to and including termination from the network.

UPMC Dental Advantage Medicare requires you to include a non-covered services form in the member’s permanent record. The form should contain the following information:

- Member’s name and ID number
- Procedure code and description of service(s)
- Fee charged
- Dentist’s signature
- Member’s signature
- Statement of agreement and amount
- Date

It is not necessary to submit the form to UPMC Dental Advantage Medicare. However, the Plan may request copies of the form.

Discounted Services

For eligible Class I, Class II, and Class III services not covered by UPMC Dental Advantage Medicare, the provider may bill the eligible member directly. The provider must discount all non-covered Class I, II & III services by 20 percent. Please refer to the UPMC Dental Advantage Medicare fee schedule.

Verifying Eligibility

You can verify member eligibility online on the UPMC Dental Advantage provider portal. To view information about an eligible member, you can use the member’s Social Security number (if available) or the member’s name and date of birth. Once you’ve entered this information, you will have access to the member’s plan information, including benefits, plan documents, and the date such benefits take effect. You can also verify eligibility by calling the Dental Benefits Advisory Team at 1-844-761-0081.

Verifying eligibility does not guarantee claim payment, nor does it confirm benefits or exclusions. Members must acknowledge their financial responsibility in writing before you provide services.

Coordination of Benefits Information

Coordination of benefits (COB) is a provision to prevent overpayment when a member is covered by more than one dental plan.

When UPMC Dental Advantage Medicare is the secondary payer, claims are accepted with the Explanation of Benefits (EOB) from the primary carrier. This secondary claim must be received within 90 days of the primary EOB remittance date or up to the new claim filing limit, whichever is greater. Claims submitted after these deadlines will be denied for untimely filing.

Members cannot be billed for the Plan’s portion of the claims submitted after these deadlines; however, they may be billed for copayments. For further assistance, contact the Dental Benefits Advisory Team at 1-844-761-0081.

To assist with timely and accurate processing of COB claims and to minimize adjustments and overpayment recoveries, the Plan requires the following information:

- Insured ID number
- Member name
- Relationship to member
- Other insurance name
- Other insurance phone
- Other insurance address
- Effective date of coverage

Fee Schedule

UPMC Dental Advantage Medicare reimburses dental services on a fee-for-service basis. Network dentists agree to accept the network reimbursement, less copayments, as payment in full for covered services provided to members. UPMC Dental Advantage Medicare annually updates all fee schedules with CDT code additions and deletions. The Plan follows the American Dental Association (ADA) Current Dental Terminology (CDT) guidelines whenever appropriate. For a copy of the most current UPMC Dental Advantage Medicare fee schedule, contact your network manager.

You are only permitted to bill a member for your charge, less the discount, if the member elects to have a non-covered Class I, II, III service performed and has completed the financial liability waiver. Preventive treatment not covered by this plan should also be discounted.
• Termination date of coverage, if applicable
• Type of coverage (e.g., medical, dental, auto insurance, hospital only, vision, workers’ compensation, major medical, prescription, or supplemental)

If you see that a member’s COB or other dental insurance coverage information is missing or incorrect, please notify the Dental Benefits Advisory Team immediately.

COB determinations will not be made when a claim is submitted for predetermination. If you request a predetermination, we will only make a benefit determination as though no other insurance existed. Coordination of benefits will only occur when a claim is submitted for payment.

Determining Primary Insurance Coverage
These guidelines will help you determine primary dental insurance coverage:

• If a member has coverage under two dental plans, one as the beneficiary and the other as the spouse of an employee, the plan covering the member as a beneficiary is primary. The plan covering the beneficiary as a spouse is secondary.

For questions about determining primary insurance coverage, call the Dental Benefits Advisory Team at 1-844-761-0081.

Predetermination
Predetermination is a process where a dentist submits a treatment plan before he or she begins treatment. Predetermination lets members know what their benefits and what their out-of-pocket costs will be on a potential claim. Predeterminations are not a guarantee of payment. Predeterminations are not mandatory but are strongly recommended.

UPMC Dental Advantage Medicare’s individual plan does not require prior authorization in advance of a member’s treatment. Because UPMC Dental Advantage Medicare does not require prior authorization, radiographs are not required in advance of a member’s treatment. However, UPMC Dental Advantage Medicare may request a post-chart review in which you will need to supply documentation, including radiographs.

It is important to note that when you submit a predetermination, planned services should never appear on the same form as actual services. You need to submit a predetermination as a separate transaction. When you submit a predetermination on a paper claim form, check the box in Block 1 that is labeled “Request for Predetermination/Preauthorization.” Do not include a service date.

Processing Claims
UPMC Dental Advantage Medicare accepts new claims for services up to 365 days after the date of service. Follow these guidelines to avoid the most common claims billing problems:

• If you are billing on a paper claim form, make sure that the values submitted fall within the correct block or field on the claim form.
• Include all required substantiating documentation.
• Make sure there is no missing or incomplete information.
• Make sure there are no invalid, incorrect, or expired codes (e.g., the use of single-digit instead of double-digit place-of-service codes).
• Include an EOB for a member who has other coverage.

Electronic Filing Methods
UPMC Dental Advantage Medicare encourages you to submit claims and predeterminations for electronic processing. There are several options for electronic submission.

Individual Claim Entry
Individual claim entry is available to network dentists with a UPMC Dental Advantage provider portal account. If you don’t have an account, you can register as a new dentist or user at www.upmchealthplan.com/providers. This feature allows you to submit dental claims and predeterminations from our website.

Electronic Data Interchange (EDI)
UPMC Dental Advantage Medicare accepts electronic claims in data file transmissions. Electronic claim files sent directly to the Plan are permitted only in the HIPAA standard formats.

Dentists who have existing relationships with clearinghouses such as WebMD® can continue to transmit claims in the format their billing software produces. The clearinghouses are then responsible for reformatting these claims to meet HIPAA standards and forwarding the claims to UPMC Dental Advantage Medicare. Providers who submit claims through Emdeon should use Payer ID 23281.
For all EDI submissions, you must provide the National Provider Identifier (NPI) number. The NPI is an identification number that is a government-mandated requirement for electronic health care transactions and paper claims in some states. In addition, the member’s identification number is necessary, along with the member’s name and demographic information. When care is coordinated, the referring dentist’s name and NPI or UPIN are also required.

You may submit claims directly without incurring clearinghouse expenses. These claims are loaded into batches and immediately posted in preparation for adjudication. You can view these batches in several standard report formats via EDI tools on the UPMC Dental Advantage provider portal.

To submit EDI files directly to the Plan, you must:

- Use billing software that allows the generation of a HIPAA-compliant 837D file.
- Have a sample 837D file containing only UPMC Dental Advantage Medicare claims exported from the billing system.
- Have the ability to download and install a free Active-X secure FTP add-on.
- Complete testing with UPMC Dental Advantage Medicare.

Support for electronic submission is provided by our Dental Benefits Advisory Team. For direct EDI submitters, contact our EDI support team via email at hpedinotify@upmc.edu.

Paper Claim Filing Methods
Submit claim forms to:

**UPMC Dental Advantage Medicare**  
PO Box 1600  
Pittsburgh, PA 15230-1600

All paper claims must be submitted on the 2012 ADA dental claim form. We do not accept provider-specific billing forms. Predeterminations and actual services need to be submitted as separate transactions. Claim forms that are submitted with both predetermination for planned services and actual services rendered will be denied and sent back to the submitter.

To access a copy of the 2012 ADA claim form, visit [www.upmchealthplan.com/providers/dental/resources/](http://www.upmchealthplan.com/providers/dental/resources/). The Plan does not accept faxed claims.

**Claims Processing Policies**

UPMC Dental Advantage Medicare processes all properly submitted claims within 45 days from the date they are received. Pennsylvania Insurance Department (PID) regulations stipulate that a claim is paid when the Plan mails the check or electronically transfers the funds.

In the event UPMC Dental Advantage Medicare fails to remit payment on a properly submitted claim within 45 days of receipt of that claim, interest at the rate of interest set forth by the United States Secretary of the Treasury, as published in the Federal Register, will be added to the amount owed on the claim. UPMC Dental Advantage Medicare is not required to pay interest that is calculated to be less than $2.

**Multiple Payee Addresses**
The Plan does not honor multiple payee addresses. You are required to submit a single payee address per Tax ID number.

**Claim Follow-up**
To view claim status online, visit [www.upmchealthplan.com/providers](http://www.upmchealthplan.com/providers). To check the status of a claim without going online, call the Dental Benefits Advisory Team at 1-844-761-0081.

**Denials and Appeals**
All denied claims are reported on the Explanation of Payment (EOP). It will indicate whether you have the right to bill the member for the denied services and if the member is financially responsible for payment.

If you disagree with the Plan’s decision to deny payment of services, you must appeal in writing to the appeals coordinator within 30 business days of receipt of the denial notification. Your request must include the reason for the appeal and any relevant documentation, which may include the member’s medical record.

Appeals should be submitted to:

**UPMC Dental Advantage Medicare**  
Provider Appeals  
PO Box 2906  
Pittsburgh, PA 15230-2906

All appeals undergo the Plan’s internal review process, which meets all applicable regulatory agency requirements. You will receive written notification in all situations in which the decision to deny payment is upheld.

**Overpayment**
If the Plan has paid in error, you may return the Plan’s check or write a separate check from your account for the full amount paid in error. You should include a copy of the remittance advice, supporting documentation noting the reason for the refund, and the EOB from other insurance carriers, if applicable.
Benefit Limitations
UPMC Dental Advantage Medicare administers plans that place limitations and exclusions on certain benefits. One set of bitewing x-rays once every 36 months and one prophylaxis in a consecutive six-month period are the most common limitations. Charges for hospitalization, teeth bleaching, cosmetic services, treatment of TMJ, anesthesia services, treatment of malignancies or neoplasms, and house calls are the most common exclusions.

The examples above, however, are not all-inclusive. If you would like to know the specific exclusions and limitations under which your patients are covered, visit the UPMC Dental Advantage provider portal to obtain specific information related to the beneficiary’s contract.

Examples include:

Accident-Related Dental Services
Please contact UPMC for Life at 1-877-539-3080 for additional information related to coverage for accident-related dental services.

Pharmacy Services
Pharmacy benefits are covered by the Medicare Part D portion of UPMC for Life. Please follow the procedures of the member’s medical plan when prescribing medications. Only Medicare Part D covered prescriptions are covered. You can view the UPMC for Life formulary at www.upmchealthplan.com/medicare or contact the Pharmacy Services Department at 1-800-979-8762 Monday through Friday from 8 a.m. to 5 p.m. Representatives can answer questions about a member’s medication history, duplicate medications, or compliance issues.

Dental Record Documentation
UPMC Dental Advantage Medicare requires participating dentists to maintain member dental records in a manner that is accurate, timely, well-organized, confidential, legible, and readily accessible by authorized personnel. Per UPMC Dental Advantage policy, all dental records must be retained for ten years.

The Plan has adopted standards for dental record documentation. These standards are designed to promote communication between dentists and facilitate continuity of patient care.

Dental Record Confidentiality and Security
- Store dental records in a secure location that can be locked and protected when not being used, but still permits easy retrieval of information by authorized personnel.
- Train dental office staff and consistently communicate the importance of dental record confidentiality annually.

Basic Information
- Place the member’s name or ID number on each page of the dental record.
- Include marital status and address, employer name, if applicable, and home and work telephone numbers.
- Include the author’s identification in all entries in the dental record. The author identification may be a handwritten signature, a unique electronic identifier, or his or her initials.
- Date all entries.
- Ensure that all records are legible records.

Patient History
- Indicate significant illnesses and medical conditions on the problem list.
- List all medications and prominently note medication allergies and adverse reactions in the record. If the patient has no known allergies or history of adverse reactions, dentists should document accordingly.

Treatment
- Document and date clinical evaluation and findings for each visit.
- Document and date treatment plans and dental care services provided.
- Document prescriptions.

Follow-up
Note the specific time of recommended return visit in weeks, months, or as needed.

Review
In the event of a quality of care concern, a UPMC Dental Advantage Medicare representative may visit your office to review members’ records.
Access
You are required to comply with UPMC Dental Advantage Medicare’s rules for reasonable access to dental records during the agreement term, and upon termination allowing the following parties access to the member’s dental records:

- Members may have access to their dental records upon request and at no charge in accordance with the Health Insurance Portability and Accountability Act (HIPAA).
- UPMC Dental Advantage Medicare representatives or their delegates, the member’s subsequent dentist(s), or any authorized third party, including employees or agents of the Pennsylvania Insurance Department or employer group sponsor, may have access for a maintenance period of 10 years from the last date of service or as otherwise required by state law.

Copies
UPMC Dental Advantage Medicare has the right to request copies of the member’s complete record. You may not charge a fee for the dental records when they are required by the Plan or the member upon transferring to another dentist.

It is the responsibility of the general dentist to provide a copy of diagnostic quality radiographic images to any successor dentist without charge.

Credentialing
Credentialing is the process of assessing and validating the qualifications and practice history of a dentist. All dentists in our network must be credentialed prior to joining UPMC Dental Advantage Medicare. Their application attests to their ability to practice and provides proof of insurance liability.

All dentists must be recredentialed within three years of the date of their last credentialing approval. The recredentialing process is the same as the initial credentialing process, except that dentists will also be evaluated on their professional performance, judgment, and clinical competence. Criteria used for this evaluation may include, but are not limited to:

- Compliance with the Plan’s policies and procedures.
- Plan sanctioning related to utilization management, administrative issues, or quality of care.
- Member complaints.
- Member satisfaction survey.

- Participation in quality improvement activities.
- Quality of care concerns.

You will receive your application for reappointment approximately six months before your recredentialing date. This allows ample time to complete the credentialing process. Failure to return the completed reappointment application and supporting documentation within the requested time limit may result in termination from the network.

Credentialing Denials and Appeals
You can appeal credentialing denials for quality reasons. If you have been denied credentialing, the Plan will send you a letter with an explanation of the appeals process.

A dentist who does not meet credentialing standards may not appeal his or her denial.

Reporting Practice Changes
Please notify UPMC Dental Advantage Medicare of any additions, practice changes, or corrections within 30 days. You can submit changes by mail or online.

Any mail or fax notifications must be typewritten on business letterhead and include the following information:

- Dentist name
- Office address
- Billing address (if different from office address)
- Phone number
- Fax number
- Office hours
- Effective date
- W-9 tax form

Fax all changes to Network Development at 412-454-8225 or mail to:

UPMC Dental Advantage Medicare Network Development
U.S. Steel Tower, 14th Floor
600 Grant Street
Pittsburgh, PA 15219

Changes may also be submitted online at www.upmchealthplan.com/providers.

While on vacation or a leave of less than 30 days, you must arrange for coverage by another UPMC Dental Advantage Medicare participating dentist. If you go on extended leave for 30 calendar days or longer, you must notify the Dental Benefits Advisory Team at 1-844-761-0081.
Leaving the Network
You must give UPMC Dental Advantage Medicare at least 90 days written notice before voluntarily leaving the network. In order for your notice to be considered valid, you are required to send termination notices by certified mail (return receipt requested) or overnight courier.

Fax terminations to Network Development at 412-454-8225 or scan & email to hpdentals@upmc.edu or mail to:

UPMC Dental Advantage Network Development
U.S. Steel Tower, 14th Floor
600 Grant Street
Pittsburgh, PA 15219

In addition, you must supply copies of dental/medical records to the member’s new dentist and facilitate the member’s transfer of care at no charge to the Plan or the beneficiary.

UPMC Dental Advantage Medicare will notify affected members in writing that their dentist is no longer participating in the network. You must continue to render covered services to members who are existing patients at the time of termination for 60 days, or until UPMC Dental Advantage Medicare can arrange for appropriate dental care with another participating dentist, whichever is later.

Dentist Responsibilities
Dentists have a responsibility to:

• Maintain the confidentiality of members’ protected health information, including dental records and histories, and adhere to state and federal laws and regulations regarding confidentiality and security.
• Comply with all state and federal requirements concerning the handling and reporting of breaches of security.
• Give members a notice that clearly explains their privacy rights and responsibilities as they relate to the dentist’s practice/office/facility.
• Provide members with the opportunity to request an accounting of the use and disclosure of their personal health information in accordance with HIPAA.
• Allow members to request restriction on the use and disclosure of their protected health information.
• Obtain and report information regarding other insurance coverage to the Plan.
• Follow all state and federal laws and regulations related to patient care and patient rights.
• Participate in Plan data collection initiatives and other contractual or regulatory programs.
• Review clinical policies and procedures distributed by the Plan.
• Notify the Plan in writing if the dentist is leaving or closing a practice.
• Disclose to the Plan overpayments or improper payments.
• Provide members, upon request, with information regarding the dentist’s professional qualifications, such as specialty, education, residency, and board certification status, if applicable.
• Conduct their practice in accordance with the Plan’s Code of Conduct and Ethics.
• Immediately report any compliance concerns and/or issues.
• Be alert to possible violations of the law, regulations, and/or accreditation standards, as well as any other type of unethical behavior.
• Providers are required to coordinate a member’s care with other in-network providers, not limited to specialists. When members use in-network providers, this helps them get the most from their medical benefits and reduces out-of-pocket expenses. Failure to comply with this requirement may lead to provider termination from the network. Also, network providers are responsible for determining the type of care the member needs and the appropriate provider to administer that care.

Compliance
To operate as a licensed dental insurer, UPMC Dental Advantage must comply with various laws, regulations, and accreditation standards. UPMC Dental Advantage established a Compliance Program to meet these requirements, as well as combat cost trends in the health care industry such as fraud, abuse, and wasteful spending.

The Plan’s Compliance Program serves to assist contracted dentists, staff members, management, and our Board of Directors with promoting proper business practices. Proper business practices include identifying and preventing improper or unethical conduct.

Your Role in Compliance Concerns and/or Issues
The UPMC Dental Advantage Help Line was established for you, your staff, and other entities to call and report
compliance concerns and/or issues without fear of retribution or retaliation. The Help Line number, 1-877-983-8442, is available 24 hours a day, seven days a week. Callers may remain anonymous.

The success of UPMC Dental Advantage’s Compliance Program relies in part upon the actions you and other contracted dentists take. It is critical that you be aware of the goals and objectives of the UPMC Dental Advantage Compliance Program, as well as your responsibilities as dentists.

UPMC Dental Advantage Medicare prohibits retaliation against contracted dentists who raise, in good faith, a compliance concern and/or issue, or any other question about inappropriate or illegal behavior. The Plan also prohibits retaliation against contracted dentists who participate in an investigation or provide information relating to an alleged violation.

For any questions regarding the UPMC Dental Advantage Compliance Program and/or a contracted dentist’s responsibilities, contact Mary Hentosz, Associate Vice President of Compliance at 412-454-5204.

Your Role in HIPAA Privacy & Gramm-Leach-Bliley Act Regulations

All UPMC Dental Advantage policies and procedures include information to ensure the Plan complies with the Health Insurance Portability and Accountability Act (HIPAA) and the Gramm-Leach-Bliley Act.

Hospitals and dentists subject to HIPAA are trained to understand their responsibilities under these privacy regulations, as is the staff at UPMC Dental Advantage.

The Plan has incorporated measures in all its departments to make sure prospective, current, and former members’ protected health information, individually identifiable health information, and personally identifiable financial information are maintained in a confidential manner, whether that information is in oral, written, or electronic format. Plan employees may use and disclose this information only for those purposes permitted by federal legislation (for treatment, payment, and health care operations); by the member’s written request; or when required to disclose such information by law, regulation, or court order.

An authorization form permitting the disclosure of protected health information is available from the Plan’s Member Services Department or from the UPMC Dental Advantage provider portal. This form complies with the core elements and statements required by HIPAA Privacy Rules. This form must be completed, signed, and returned to the Plan before the Plan will release information.

The Plan’s Notice of Privacy Practices is separate and distinct from the Notice of Privacy Practices dentists are required to give to their patients under HIPAA. The Plan’s Privacy Statement and Notice of Privacy Practices are posted on the UPMC Dental Advantage provider portal.

Americans with Disabilities Act Compliance

Dental offices are considered places of public accommodation and must be accessible to individuals with disabilities. Dental offices are required to adhere to the Americans with Disabilities Act (ADA) guidelines, Section 504, of the Rehabilitation Act of 1973, and other applicable laws. You may contact the Dental Benefits Advisory Team to obtain copies of these documents and other related resources. You may contact the Dental Benefits Advisory Team at 1-844-761-0081 to obtain copies of these documents and other related resources.

UPMC Dental Advantage Medicare requires that your offices or facilities comply with this act. Your office or facility must be wheelchair-accessible or have provisions to accommodate people in wheelchairs. Patient restrooms should be equipped with grab bars. Handicapped parking must be available near your office and be clearly marked.

Reporting Fraud and Abuse to UPMC Dental Advantage

UPMC Dental Advantage established a hotline to report suspected fraud and abuse committed by any entity providing services to members. The hotline number, 1-866-FRAUD-01 (1-866-372-8301), is available 24 hours a day, seven days a week. Voice mail is available at all times. Callers may remain anonymous and may leave a voice mail message. TTY users should call 1-800-361-2629.

Some common examples of fraud and abuse include:

- Billing for services that were never provided to the member.
- Billing more than once for the same service
- Falsifying records.
- Performing and/or billing for inappropriate or unnecessary services.

You may report suspected fraud and abuse via the Plan’s website at www.upmchealthplan.com/providers or you may email the information to specialinvestigationsunit@upmc.edu.

If you are reporting fraud and abuse by mail, please mark the outside of the envelope “confidential” or “personal” and send to:
Sanctions
Sanctions are the consequences for noncompliance in UPMC Dental Advantage’s three areas of oversight. The Plan follows a three-phase process for addressing the actions of dentists who fail to observe the terms and conditions of the dentist agreement or UPMC Dental Advantage’s policies and procedures.

Actions That Could Lead to Sanctioning
Actions that could lead to sanctioning fall into three categories: administrative noncompliance, unacceptable utilization, and quality of care concerns.

Administrative Noncompliance
Administrative noncompliance is consistent or significant behavior that is detrimental to the success or functioning of UPMC Dental Advantage Medicare. Examples include:

- Conduct that is unprofessional or erodes the confidence of members.
- Direct billing or balance-billing for covered/contractual services, unless the member exceeds the benefit limit.
- Failure to coordinate or cooperate with UPMC Dental Advantage’s administrative, quality improvement, post-treatment review, and reimbursement procedures.

Unacceptable Resource Utilization
Unacceptable resource utilization is a utilization pattern that deviates from acceptable standards and may adversely affect members’ quality of care.

Quality of Care Concerns
A quality of care (QOC) issue may arise from an episode that adversely affects the functional status of a member or a pattern of practice that deviates from acceptable standards. For quality of care concerns, the Quality Improvement Committee (QIC) has selected a severity scale. This scale ranks cases that may involve a practice pattern deviating significantly from the norm.

The sanctioning process and focused monitoring of the dentist remain in effect for no less than one year from the date UPMC Dental Advantage Medicare notifies the dentist. The Plan notifies the dentist when the process and follow-up activities are satisfied and the sanctioning is no longer in effect. In instances of recurring similar noncompliance activities, UPMC Dental Advantage Medicare reserves the right to expedite the sanctioning process.

Termination
The QIC, as part of the sanctioning process, may recommend the termination of a dentist’s contract. The dentist will be notified in writing and offered the opportunity to appear at a hearing, if appropriate. The termination process involves the following steps:

1. UPMC Dental Advantage Medicare notifies dentist about termination. The notice will state that a professional review action is recommended and the reasons for the proposed action. The dentist has the right to request a hearing within 30 calendar days.

2. The Appeals Committee will conduct the hearing and recommend to the QIC that it accept, reject, or modify its original recommendation. The right to the hearing may be forfeited if the dentist fails, without good cause, to appear.

At the hearing, the dentist has the right to:

- Receive representation by an attorney or other person of the dentist’s choice.
- Have a record made of the proceedings, copies of which may be obtained upon payment of any reasonable charges associated with the preparation of the records.
- Call, examine, and cross-examine witnesses.
- Present evidence determined to be relevant by the hearing officer regardless of its admissibility in a court of law.
- Submit a written statement at the close of the hearing.

Upon completion of the hearing, the dentist has the right to receive the written recommendation of the Appeals Committee from the Plan, including a written statement giving the basis of the decision.

**Surveys and Assessments**

The Plan conducts a series of surveys and assessments of members and dentists in a continuous effort to improve performance. All dentists are urged to participate when asked.

**Member Administration**

**Member and Dentist Satisfaction Surveys**

The Plan conducts annual surveys on both member and dentist satisfaction. Participation by members and dentists enables the Plan to develop quality improvement plans.

The surveys assess:
- Access to care and/or services.
- Overall satisfaction with the Plan.
- Provider availability.
- Quality of care received.
- Responsiveness to administrative processes.
- Responsiveness to inquiries.

**Quality Improvement Program**

The goal of the Quality Improvement Program is to continually examine UPMC Dental Advantage Medicare’s clinical and administrative operations in an effort to continuously improve the Plan’s ability to deliver high-quality, timely, safe, and cost-effective care and services.

The Quality Improvement Program operates in accordance with the guidelines established by the National Committee for Quality Assurance (NCQA), the Pennsylvania Department of Health, and the Pennsylvania Insurance Department.

The program critically assesses the Plan’s performance regarding customer service, dentist satisfaction, credentialing, pharmacy, preventive services, utilization of resources, and various health care initiatives.

The physicians who serve on the QIC are at the center of the program. This committee, made up of both academic and community doctors, operates directly under the auspices of the board of directors. The QIC is vital to the Plan because it develops and evaluates clinical and operational standards for dentists.

The Dental Agreement requires that you comply with the UPMC Dental Advantage Medicare Quality Improvement Program.
Glossary
Glossary

Adjudication – Claim processing procedures to determine benefits.

Allowance – The benefit amount that UPMC Dental Advantage Medicare calculates for each covered service. It includes the amount UPMC Dental Advantage Medicare can pay, as well as the beneficiary’s coinsurance, if any.

Appeals – Procedures provided for participating dentists who disagree with UPMC Dental Advantage Medicare claim decisions.

Beneficiary (also eligible, enrollee, or member) – Individual who is either using or eligible to use insurance benefits, including health insurance benefits, under an insurance contract. An individual who receives benefits from or is covered by an insurance policy or other health care financing program.

Benefit Plan – The schedule of benefits establishing the terms and conditions pursuant to which beneficiaries enrolled in UPMC Dental Advantage Medicare products receive covered services. A benefit plan includes, but is not limited to, the following information: a schedule of covered services; if applicable, copayment or coinsurance; excluded services; and limitations on covered services (e.g., limits on amount, duration, or scope of services).

Benefits – Dental services received by enrolled members for which part of the cost is paid for by UPMC Dental Advantage Medicare.

Board-Certified – Term describing a dentist who has completed residency training in a dental specialty and has passed a written and oral examination established in that specialty by a national board of review.

Claim – Request for payment for services rendered.

Claim Form – Document that may be used either as a claim for payment or as a request for predetermination. If the date of service is left blank, the claim form will be considered a predetermination request.

Clean Claim – A claim for payment for a health care service that has no defect or impropriety. A defect or impropriety includes lack of required substantiating documentation or a particular circumstance requiring special treatment that prevents timely payment from being made on the claim. The term does not include a claim from a health care provider who is under investigation for fraud and abuse regarding that claim.

Clearinghouse – An intermediary that receives claims from dentists or other claimants and translates the data from a given format to one that is acceptable for the intended payer and then forwards the processed claim to the payer.

Coinsurance – The portion of the dentist’s fee for which the beneficiary is responsible. This amount is indicated on the Explanation of Benefits (EOB).

Complaint – A dispute or objection regarding a network dentist or the coverage, operations, or management policies of a plan that has not been resolved by the Plan and has been filed with the Plan or with the Pennsylvania Department of Health or the Pennsylvania Insurance Department.

Coordination of Benefits (COB) – Rules that determine payment of claims when the member has other dental coverage in addition to UPMC Dental Advantage Medicare.

Copayment – Cost-sharing arrangement in which the beneficiary pays a specified flat amount for a specific service (such as an office visit or prescription drugs).

Covered Services – Health care services for which a dental plan is responsible for payment according to the benefit package purchased by the member.

Credentialing – The Plan’s review procedure that requires potential or existing network dentists to meet certain standards in order to begin or continue participation in the network of the Plan. The credentialing process may include examination of a dentist’s certifications, licensures, training, privileges, and professional competence.

Date of Service – For purposes of determining coverage, the date of service is the date a service is completed (e.g., cementation date for a crown or fixed partial denture; insertion date of dentures; date root canal is sealed).

Deductible – Amount member must pay for covered services before the plan begins to pay for such services.

Dental Explanation of Benefits (DEOB) – Computer-generated notice mailed to members and dentists explaining benefit determinations. For example, the type of service received, the allowable charge, the amount billed, and cost-share amount. If a service is not paid, the DEOB also explains why payment was not allowed and how to appeal that decision.

Dental Hygienist – A person trained and licensed to provide preventive dental services, such as cleaning the teeth and taking radiographic images, usually in conjunction with a dentist.

Dentist – Dentists are the major providers of dental care and must be licensed to practice. Their major roles are to diagnose and treat dental problems related to the teeth, gums, and tissues of the mouth. Eight specialty areas are recognized by the American Dental Association: orthodontists (straightening teeth), oral and maxillofacial surgeons (operating on the mouth and jaws), pediatric dentistry (dentists for children), periodontics (treating
gums), prosthodontics (making artificial teeth or dentures), endodontics (root canal therapy), public health dentistry (community dental health), and oral pathology (diseases of the mouth).

**Dependent** - A child or spouse who gets coverage under a subscriber’s contract.

**Electronic Claims Submission (ECS)** - The process of transmitting insurance claims electronically from an office, billing service, or clearinghouse to an insurance company.

**Electronic Data Interchange (EDI)** - The electronic transmission of strategically important business data in a standard syntax by means of computer-to-computer exchange via a standard online transmission method.

**Electronic Funds Transfer (EFT)** - A method of reimbursement for claims that allows ACH transfer of funds instead of the default method of payment by check. To qualify, the provider must complete the proper paperwork that includes the identification of their financial institution and Demand Deposit Account (DDA).

**Electronic Health Information (EHI)** - Federal legislation that defines standard formats for health insurance transactions.

**In Progress Orthodontic Treatment** - Orthodontic treatment that has already begun prior to the member’s enrollment with UPMC Dental Advantage. Orthodontic treatment begins on the date appliances are inserted or bands are placed.

**Maximums** - Total dollar amount (per member) in a benefit year and/or lifetime payable by UPMC Dental Advantage. Maximum may be for the dental program, orthodontics, TMJ, or implants if stated in insured’s contract.

**Members** - Individuals who are enrolled in and eligible to receive benefits from UPMC Dental Advantage Medicare. Also known as beneficiaries.

**Non-Participating Dentist** - A dentist who has not signed a participating agreement with UPMC Dental Advantage Medicare.

**National Provider Identifier (NPI)** - An identification number that is a government-mandated requirement for electronic health care transactions and paper claims in some states.

**Oral Surgery** - Services relating to the treatment of teeth in relation to the functions of occlusion and speech.

**Pennsylvania Department of Health (DOH)** - Pennsylvania state agency that regulates/monitors Health Maintenance Organizations (HMO).

**Pennsylvania Insurance Department (PID)** - State regulatory agency that, along with the Pennsylvania Department of Health (DOH), regulates licensure and standards of operation of managed care organizations and health care insurers in Pennsylvania. PID also regulates all commercial health care insurance in this state along with the Children’s Health Insurance Program.
**Predetermination** – Written estimate provided by UPMC Dental Advantage Medicare in response to a request by a dentist or member for an estimate of coverage for future dental services.

**Preferred Provider Organization (PPO)** – Type of managed care in which dentists and hospitals agree to provide services at contracted rates. The Plan pays the network rates as long as the member sees a network dentist. Typically, members need not file claims or coordinate their care through a PCP. When out-of-network dentists are used, members pay more of their expenses and usually must file the claims.

**Prior Authorization** – A formal process requiring a provider obtain approval to provide particular services or procedures before they are done. This is usually required for nonemergency services that are expensive or likely to be abused or overused. A managed care organization will identify services and procedures that require prior authorization, without which the provider may not be compensated.

**Procedure Codes** – Codes used to identify and define specific dental services.

**Radiograph** – An image produced on a radiosensitive surface (e.g., a photographic film) by radiation other than visible light, as by x-rays passed through an object.

**Reasonable and Customary Charges** – The average fee charged by a dentist within a geographical area. A network dentist agrees to accept the plan’s payment as payment in full, even though the reasonable and customary charges may be greater than the amount paid by the health plan.

**Remittance Advice** – A summary of covered services for which the Plan paid a dentist. Also known as an explanation of payment (EOP), the remittance advice shows the date of service, diagnosis, and procedure performed as well as all payment information, including explanation codes for those claims denied or returned for correction.

**Rider** – An additional benefit package beyond the basic coverage package that plan sponsors may select. Examples of riders include pharmacy benefits, infertility treatment, and dental and vision services.

**UPMC Dental Advantage** – A group dental insurance Preferred Provider Organization Plan.

### Abbreviations

**ACA**: Affordable Care Act  
**ADA**: Americans with Disabilities Act or the American Dental Association  
**ASA**: American Society of Anesthesiologists  
**CMS**: Centers for Medicare & Medicaid Services  
**COB**: Coordination of Benefits  
**CRNA**: Certified Registered Nurse Anesthetist  
**DDS**: Doctor of Dental Surgery  
**DEOB**: Dental Explanation of Benefits  
**DMD**: Doctor of Dental Medicine  
**DOH**: Department of Health  
**ECS**: Electronic Claim Submission  
**EDI**: Electronic Data Interchange  
**EFT**: Electronic Funds Transfer  
**EOB**: Explanation of Benefits  
**EOC**: Evidence of Coverage  
**EOP**: Explanation of Payment  
**EVS**: Electronic Verification System  
**HEDIS**: Health Plan Employer Data and Information Set  
**HIPAA**: Health Insurance Portability and Accountability Act  
**ID**: Identification  
**NPI**: National Provider Identification  
**PID**: Pennsylvania Insurance Department  
**PPO**: Preferred Provider Organization  
**QIC**: Quality Improvement Committee  
**QOC**: Quality of Care  
**UB**: Uniform Billing  
**UPIN**: Universal Provider Identification Number
Explanation of Payment Example
### The Explanation of Payment (EOP)

The following are a few definitions that will help you better understand your EOP:

1. **Tooth number:** The two-digit number, quadrant, or arch that follows the procedure code, if applicable. In this sample EOP, the tooth number is “08” and the procedure code is “D0220.”
   - Note: Not all procedure codes require a tooth number, quadrant, or arch.

2. **Discount:** This is the difference between the billed amount and the contracted amount. This amount is not to be billed to the patient because you participate in the plan.

3. **Not cov:** This indicates the amount not covered by the plan and may be billed to the member.
   - For payment policies, please refer to the UPMC Dental Advantage Office Manual or access them through the i-answer tab of the UPMC Dental Advantage portal.

4. **Claim subtotal:** These amounts apply to procedures billed on the claim for this member.

5. **Member subtotal:** These amounts reflect a cumulative subtotal for the member on this EOP.
   - Note: Individual members could have more than one payment per EOP.

6. **Provider subtotal:** These amounts reflect a cumulative subtotal for this provider on this EOP.
   - Note: Individual providers could have more than one payment per EOP.

7. **Dental/Vision total:** These amounts reflect the totals for all claims that were submitted by and paid to the practice on the EOP.

8. **Explanation legends:** These include the Adjustment Code Legend and Not Covered Code Legend. These legends show explanations of the adjustment and reason codes that appear in the INT/DISC column.

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If you have any questions, call the UPMC Dental Advantage Benefits Advisory Team at 1-844-761-0081.
Electronic Funds Transfer Forms
Our records indicate your company receives paper reimbursement checks from UPMC Insurance Services Division. We ask that you partner with UPMC Insurance Services Division in going GREEN by switching to electronic funds transfer (EFT). By enrolling in EFT, your company will receive reimbursements sooner because the funds will be directly deposited into your bank account. Our Electronic Funds Transfer Authorization form is on the reverse side.

**INSTRUCTIONS FOR COMPLETING THE AUTHORIZATION FORM**

Please complete all lines of the authorization form to ensure accurate claims payment.

The provider number is located on the top of the Explanation of Payment document that accompanies your check. If you have multiple provider numbers listed, please include all of them.

The bank routing number is the nine-digit number located at the bottom of your check.

Please fax the authorization form and one copy of a **voided check** to 412-454-7744 or mail them to the following address:

UPMC Health Plan
Claims Payable Department
U.S. Steel Tower
600 Grant Street, 12th Floor
Pittsburgh, PA 15219

*Authorizations will not be considered if this form is incomplete or not accompanied by a voided check.*

If you have any questions regarding the EFT Authorization form, please contact UPMC Dental Advantage Provider Services at 1-877-648-9609 Monday through Friday from 8 a.m. to 5 p.m.
Electronic Funds Transfer Authorization form for electronic reimbursement by UPMC Insurance Services Division on behalf of UPMC Dental Advantage

If you are interested in receiving electronic payments, please complete the form below.

Our Company hereby (1) authorizes UPMC Insurance Services Division to make payments for services by EFT; (2) certifies that it has selected the following depository institution; and (3) directs that all such electronic funds transfers be made as provided below.

Name of Organization: ________________________________

Federal Tax ID Number: ________________________________

Organization’s UPMC Health Plan Provider Number: ________________________________

Depository Institution: ________________________________

Bank Routing Number: ________________________________ Checking Savings

Account Number: ________________________________

Account Name: ________________________________

** Please include one copy of a VOİDED CHECK for account verification. **

Our Company acknowledges and agrees that terms and conditions of all agreements with UPMC Insurance Services Division concerning the method and timing of payment for services shall be amended.

Our Company will give thirty (30) days advance notice in writing to UPMC Health Plan of any changes in its depository institution or other payment instructions.

When properly executed, this Authorization will become effective fifteen (15) days after its receipt by UPMC Insurance Services Division.

Dated: ________________________________

______________________________________________                     ______________________________________________

(Company Authorized Signature)                                                          (UPMC Insurance Services Division Authorized Signature)

______________________________________________

(Print Name)

______________________________________________

(Title)                                                                                                            UPMC Health Plan Finance Manager

______________________________________________

(Phone Number)
UPMC Dental Advantage

Authorization for Change/Termination of Electronic Funds Transfer by UPMC Health Plan

Select One:

☐ Change: Effective Date ___________________ or ☐ Termination: Effective Date ___________________

__________________________________________ hereby authorizes UPMC Health Plan to make the following changes and/or termination regarding the company's Electronic Funds Transfer agreement.

Prior Name of Organization: ________________________________________________________________________________

New Name of Organization: ________________________________________________________________________________

Prior Federal Tax ID Number: ________________________________________________________________________________

New Federal Tax ID Number: ________________________________________________________________________________

Prior Organization's UPMC Provider Number: ________________________________________________________________

New Organization's UPMC Provider Number: _________________________________________________________________

Prior Depository Institution: ________________________________________________________________________________

New Depository Institution: ________________________________________________________________________________

Prior Address: ____________________________________________________________________________________________

New Address: ____________________________________________________________________________________________

Prior Bank Routing Number: ________________________________________________________________________________

New Bank Routing Number: ________________________________________________________________________________

Prior Account Number: ____________________________________________________________________________________

New Account Number: ____________________________________________________________________________________

Prior Account Name: ______________________________________________________________________________________

New Account Name: ______________________________________________________________________________________

The above change/termination will become effective 15 days after its receipt by UPMC Health Plan.

Dated: ______________________

Authorized Signature

Print Name

Title

UPMC Health Plan Authorized Signature

Print Name

Title
This Dental Provider Manual is current as of January 31, 2016.