UDC Dental California Inc.
Provider Manual

Table of Contents

Introduction

Welcome to UDC Dental California, Inc. (UDC). We have invited you to join our panel because you and your practice meet the high standards we have established for our providers. We look forward to having you on our team.

About the Health and Managed Dental Care Industries

One can hardly pick up a magazine or newspaper without finding an article about the health care crisis facing our nation. Health care inflation is four to five times higher than the national inflation rate, and employers have come to expect staggering health care rate increases. To counteract the impact of these increases, employers are turning more and more to managed care forms of health insurance. Also, employees, who are being asked to shoulder more of the costs, have become more accepting of the managed care concept to keep costs affordable. So what does this mean to the dental profession? According to statistics from the National Association of Dental Plans (NADP), prepaid dental enrollment has grown 17 to 25 percent in the past several years. Estimates of future growth appear to be just as strong. This indicates the dental profession will see more managed care in the future, and the most successful practitioners will be the ones who embrace the concept in their dental offices.

About UDC

At UDC we believe our prepaid programs can have a positive impact on the dental health of members, and the dental professionals who provide their care. In addition, UDC is involved in establishing and maintaining dental industry standards through active service and membership in the NADP.

Our enrollment continues to increase because members recognize the benefits and value of our programs. Organized in accordance with the concepts of medical health organizations, UDC promotes prevention, early detection and dental health maintenance. Many diagnostic, preventive, routine restorative and oral surgical treatments may be provided without cost to members. Other procedures requiring more extensive care or specialist services are provided with a copayment. Members value the built-in savings features and ability to select their dentist from our large provider network. Clients value our accounting and billing efficiency, and our ability to control costs. Brokers appreciate our high quality, easy to sell plans.

UDC's managed dental programs have no deductibles, no annual dollar maximum limitations, no preexisting condition exclusions, no claim forms for the primary care dentists and virtually no paperwork. We are service-oriented and that philosophy puts us in the forefront of managed dental plans. We have developed and implemented an enviable quality improvement program and member-oriented incident reporting procedure. Should a problem develop, UDC responds promptly and responsibly.

Dentists selected to participate with UDC are all private practitioners who meet our qualification criteria. Our network of primary care dentists is augmented by Oral Surgery, Periodontic, Pedodontic, Endodontic and Orthodontic specialists. Our primary goal is to assure members of the highest possible professional standards and quality of care.

About This Manual

One reason UDC is uniquely positioned to take advantage of the rapid growth in the managed dental industry is our commitment to servicing our members. Another is our commitment to building and maintaining a first-rate provider network. Recruiting the best providers, being responsive to their concerns, building their patient base, making sure their capitation checks are accurate and timely, and working with them to provide the most appropriate, high-quality care to our members – this is the foundation we have built to make UDC the best plan in the states we serve.

This manual has been developed to familiarize you with our procedures and policies. It explains how we recruit and credential providers, how we service our members, and how we review utilization. It contains

copies of our dental agreement, copies of our current dental plan products and eligibility lists. It outlines our complaint resolution procedures and discusses how and when to refer members to specialists.

This manual is a living document that will be updated frequently. If you find areas you feel are unclear, please contact a member of our provider relations staff.

Working with UDC's provider relations staff

Through the credentialing process you have been working with one or more of the provider relations staff. Their job is to act as a liaison between UDC and our providers. If you ever have any questions or problems with UDC or one of its members, provider relations will be happy to assist you.

UDC has a dental director and dental consultants who will be working with you on office reviews. They are available should you wish to discuss a matter with a peer.

UDC encourages providers to utilize the knowledge and expertise of our provider relations department. We are committed to building and maintaining the best dental panel possible and one of the ways we do that is by keeping our providers happy. We look forward to a long and mutually prosperous relationship.

Once again, welcome!

Chapter 1

Quick Start Guide

- Service Standards
- Infection Control
- Member Satisfaction
- Patient Eligibility
- Capitation
- Schedule of Benefits
- Utilization Reporting
- Specialty Referrals
- Provider Agreement

Quick Start Guide

The following Quick Start Guide has been developed to give you a brief overview of UDC's program. This information is not meant as a substitute for reading the entire manual, which we encourage you to do as time allows.

SERVICE STANDARDS

Appointments

Appointments should be available 3 (three) days per week minimum.

Scheduling

No discrimination of member on hour of day when scheduling an appointment.

Emergency Care

Emergency care appointments should be made for the same day if requested during regular business hours; in no event to exceed one day from the date of request for appointment for general dentist and specialists. After hours response system must enable a member to reach the on-call dentist 24 (twenty-four) hours a day, 7 (seven) days a week.

Urgent care

All urgent care services shall be provided within 72 hours from the date of the request for an appointment.

Routine Care

Routine care appointments must not exceed three weeks from the date of request for appointment for general dentists or six weeks from the date of request for appointment for specialists.

Preventive care

Appointments for preventive care must not exceed forty (40) business days from the date of request for appointment.

Treatment Plan

Patients will be informed of the costs of services prior to providing treatment.

Recall Program

All patients will be placed on an appropriate preventive recall program. However, current patients should be determined by the treatment plan, but no less than once per year.

Wait time in office should not exceed 30 (thirty) minutes.

Telephone wait time should not exceed 30 (thirty) minutes.

Interpreter services should be coordinated with the scheduled appointments in a manner to ensure the provision of interpreter services at the time of the appointment.

Appointment rescheduling should be prompt in a manner that is appropriate for the member's health care needs, ensuring continuity of care consistent with good professional practice and UDC's appointment standards.

INFECTION CONTROL

Instruments

There must be hot or cold sterilization for those reusable items that cannot be autoclaved, bagged and placed in protective storage. Weekly spore testing of the autoclave with documentation of results must be available.

Gloves and Masks

Must be used for all clinical patient encounters where splatter may occur.

Operatory

Operatories must be disinfected after each patient.

MEMBER SATISFACTION

Member's Perception

Members provide UDC with feedback not only of their treatment, but how they were treated by dental office staff. UDC will pass along this information to your office to help you enhance your patient service.

Third Party Resolution

UDC works with the dentist to resolve any adverse perceptions, quality of care issues or scheduling concerns via telephone, site visits or letters.

PATIENT ELIGIBILITY

Dentist Selection Process

Members usually choose their primary care dentist at the time of enrollment; however, it is not mandatory. Patients may change dentists by contacting UDC.

Eligibility Reporting

Member eligibility reports will be delivered on a monthly basis. You will also receive a capitation report monthly along with your capitation payment.

Electronic Verification

Eligibility verification is available 24 hours a day by accessing our website at www.assurantemployeebenefits.com. The toll free phone number to call for eligibility verification is listed at the bottom of the cover letter, which accompanied this manual.

CAPITATION

No Dentist Selected

Although we make every effort to encourage members to select a primary care dentist in a timely fashion, members who do not select a dental office may be auto-assigned by UDC. These members are notified of their primary care dentist in writing, along with instructions on how to change dental offices if desired.

Retro-Adjustments

If a member or group terminates their participation in the plan, the maximum retroactive capitation deduction your office may be liable for is one month.

Capitation Adjustments

The Plan provides dental offices with an adjustment form to submit for any errors in the capitation reimbursement. Member services center will provide further assistance if needed.

SCHEDULE OF BENEFITS

Member Copayment Determination Copayment is due at the time of service.

Determine the member's plan from the eligibility list and follow the appropriate plan benefit matrix to avoid mischarging members. For any services not on the Schedule of Benefits, the dentist's normal fee should be collected from the patient.

Missed Appointment Letter

These should be sent by the practice to any patient who cancels an appointment without providing 24-hours notice. Prompt follow up of missed appointments ensures continuity of care.

LIMITATIONS AND EXCLUSIONS

The provider relations representative should discuss and review each item with the dentist as it pertains to the practice. In some plans, the removal of ASYMPTOMATIC WISDOM TEETH IS NOT A COVERED BENEFIT. Please refer to the plan material for further information or contact your provider relations representative.

UTILIZATION REPORTING

Purpose

To monitor the number of visits and types of services provided to our members in a given period. Utilization information is used by UDC for tracking and trending purposes.

Forms/Processing

Copies of UDC's Utilization Data Forms are included in this manual. It is not mandatory to use the UDC form since your own version and/or a claim form can be utilized for data submission, as long as the practice identification and procedure codes are adequate. UDC forms are available online and may be obtained by visiting our website at www.udcdentalcalirornia.com or by contacting our provider relations department.

SPECIALTY REFERRALS

Not required for most UDC plans. If the member's plan requires preauthorization for specialty services, submit the referral form, with the required documentation, x-ray and diagnostic information to:

UDC Dental California Inc.
6310 Greenwich Drive Ste. 210
San Diego, CA 92122

Copies of UDC's Specialty Care Referral Forms are included in this provider manual. Additional forms may be obtained by contacting our provider relations department. In the event of an emergency requiring immediate specialty care, the Plan members may contact our member services center for emergency preauthorization.

Endodontia

Routine root canals on anterior and bicuspid teeth are the primary care dentist's responsibility. All other endodontic procedures are by contract.

Periodontia

Root planing, scaling, patient education, and other nonsurgical periodontal treatments are the primary care dentist's responsibility. All other periodontic procedures are by contract.

Oral Surgery

Simple and surgical extractions of erupted teeth, the extraction of erupted third molars and the soft tissue impactions are the primary care dentist's responsibility. All other oral surgery is by contract.

Pedodontia

Routine care for children past their 5th (fifth) birthday will be provided by the primary care dentist. UDC's programs to not include coverage for specialty treatment arising from patient compliance or behavioral problems. Pedodontic specialty care for these situations is the responsibility of the parent or guardian.

Orthodontia

No referral is necessary to an orthodontist's office. In order for primary care dentists to provide orthodontic care, they must provide both Phase I and Phase II treatment.

Primary Care Dentist Provider Agreement

Highlights:.

Discrimination Clause

Members will be treated the same as any other patients with respect to standards, services, and appointment availability.

Inactivation Clause

90 (ninety) days written notice must be given. The practice should have reached a 500 (five hundred)-member minimum in order to apply. Special situations may be negotiated. Call the provider relations manager in your area.

Termination Provisions

The dentist must give at least a 90 (ninety) day written notice to UDC and continue to provide treatment to all members during that time.

Recredentialing

Failure to maintain adequate and current malpractice coverage, active and sanction-free license and DEA registration, can result in termination of the contract.

Chapter 2

Plan Mechanics

- Making Appointments for Member
- Verifying Eligibility
- Online Advantage
- Explaining Benefits to Members
- Determining the Member's Copayment
- Payment of Copayments by Members
- Coordination of Benefits
- Missed Appointment Charges
- Utilization Reporting
- Services Not Covered by UDC Dental California Inc.
- Emergency Treatment – In Area
- Emergency Treatment – Out of Area
- Changing Dentists – Requested by Members
- Transferring Members – Requested by the Provider
- Specialty Provider Referrals
- Inactive/Reserve Status
- Capitation Payments
- Complaint Reports/Resolution

CHAPTER 2
PLAN MECHANICS

Making Appointments for Members
Appointment for UDC members should be made the same way you make appointments for your other patients. As a general guideline, waiting times for appointments should fall within the following minimum range as follows:

Emergency patients should be seen within 24 (twenty-four) hours of their call for an appointment, seven days a week.

New patients, without emergency problems, should be seen for an examination within 3 (three) weeks. Routine care appointments must not exceed three weeks from the date of request for appointment for general dentists or six weeks from the date of request for appointment for specialists.

Current patient, should be encourage to return for recall visits as required by the treatment plan, but no less than once per year.

As part of our quality improvement program, UDC monitors appointment availability and after hour response times. These times should not be substantially different from the non-plan patients in your office.

Verifying Eligibility
UDC will provide your office with an Eligibility Report each month. Your Capitation Report, which is sent monthly, also serves as eligibility report. **Eligibility and Capitation Reports are the primary source for the confirming of the eligibility of a member.**

If a Member is not on your Eligibility or Capitation report, simply call the member services center number listed on the cover letter, which accompanied this manual to verify eligibility. **The fact that a member has an identification card with your office listed as the provider does not guarantee eligibility.**

It is important that you use your monthly Eligibility Roster to verify eligibility every time a member visits your office for services. If a member presents an ID card with your office listed as the provider and the member is not on your eligibility list, call the UDC's member services center immediately.

Online Advantage
Your patients' dental information is available online and may be obtained by visiting our Online Advantage website at www.assurantemployeebenefits.com. Please refer to the "For Providers" tab to determine the most current eligibility roster at any time. Online Advantage allows you to view members' eligibility, members' benefit details, view their claim status, search for a network dentist or specialist, request EOB copies and much more.

Explaining Benefits to Members
Dental coverage can be confusing for patients and you will often be asked about benefits and copayments. This communication is very important and UDC appreciates the time and patience you give our members in explaining how our plan works. Should you feel the member needs more information than you can provide, have them call our member services center.

Determining the Member's Copayment

Member copayments and coverage's vary according to plan. To determine the correct copayment, find the plan name next to the member's name on your office's eligibility list. Using this plan name find the appropriate Schedule of Benefits. Next to the services performed you will find the copayment(s) which should be collected at the time services are rendered. For any services performed which are not covered benefits, your usual and customary fees should be collected.

Payment of Copayment from Members

UDC recommends that plan providers collect copayments from our members at the time services are rendered.

Coordination of Benefits

The group contract and applicable California State laws ensure every member is entitled to their plan benefits regardless of any other dental coverage. If a member chooses to utilize other benefits and waive UDC's benefits, they may do so at their sole discretion. If a member has a second form of dental insurance and our plan is "primary," the member may file a claim with their "secondary" carrier for the amount of the copayment.

Missed Appointment Charges

Each of the UDC's benefit plans allow providers to charge a missed appointment fee in the event a member cancels an appointment with less than 24 hours notice. Providers should collect this fee directly from the member.

Utilization Reporting

Primary care dentists must report utilization to UDC following all member encounters. Copies of UDC's Utilization Data Forms are included in this manual. It is not mandatory to use the UDC form since your own version and/or a claim form can be utilized for data submission, as long as the practice identification and procedure codes are adequate. The Plan's forms are available online and may be obtained by visiting our website at www.udcdentalcalifornia.com or by contacting our provider relations department.
Send all forms monthly to:

UDC Dental California Inc.
6310 Greenwich Drive
San Diego, CA 92122
Or by Facsimile to: 858.678.0692

The statistics from these reports are utilized for tracking and trending of member encounters, which are monitored through our ongoing quality improvement activities.

Services Not Covered by UDC

The following items are not covered under any UDC plans (specific limitations are also listed in the Evidence of Coverage that each member receives when they join UDC):

- Any procedure not specifically listed in the Copayment Schedule is not a Plan Benefit.
- Treatment for malignancies, neoplasms or cycts, including biopsy, is not covered.
- Implants, surgery for the insertion of implants, all related implant appliances and restorations, removable or fixed, are not covered.
- The surgical removal of implants or any surgery required to adjust, replace or treat any problem related to an existing implant, or implant appliance, is not covered.
- Extractions for non-symptomatic third molars (wisdom teeth) are not covered. This exclusion also applies to extractions for non-symptomatic third molars after the completion of orthodontic treatment.

- Examples of symptomatic conditions include decay, odontogenic cysts, chronic pericoronitis and infections.
- Complete oral rehabilitation or reconstructions involving replacement of six (6) or more missing teeth using fixed prosthetic restorations and/or appliances is not covered.
- Restorations and splints used to increase vertical dimension, restore occlusion, or replace/stabilize tooth structure loss by attrition are not covered.
- Replacement of dentures, appliances or bridgework due to loss or theft is not covered.
- Except for emergency or urgent services outside the service area or in situations in which a plan provider is not available, services provided by non-plan dentists are not covered unless pre-authorized by UDC.
- Hospital benefits for any dental procedure.
- Any procedure of implantation or experimental procedures unless specifically included.
- Fees incurred for broken or missed appointments (without 24 hours notice) are the member's responsibility.
- Dental expenses incurred in connection with any dental procedure started after termination of eligibility for coverage.
- Elective or esthetic dentistry, if specifically excluded by the plan.
- Reimbursement for out-of-pocket costs and copayment charges. The plan dentist should bill these charges directly to the member.
- Oral surgery requiring the setting of fractures or dislocations, and orthognathic surgery.

Emergency Treatment – In Area

UDC defines emergency treatment as those dental services a layperson reasonably believes are required for alleviation of severe pain, bleeding, swelling or immediate diagnosis and treatment of unforeseen dental conditions which, if not treated, could reasonably be expected to result in placing a member's dental health in serious jeopardy even if it is later discovered that a dental emergency did not exist. The Family Dentist/Specialty Provider Agreement, which each dentist signs when they become a UDC provider, requires dentists to "be available for patient care on a twenty-four hour per day basis, seven days per week…..or to make arrangements for suitable coverage based on plan guidelines."

Of course, UDC does not expect a provider to keep their office open 24 hours a day, but providers are expected to be available for normal care during regular business hours and for emergency care 24 hours a day. When your office is closed, you must have a referral number which members can contact if they need emergency care.

Emergency Treatment – Out of Area

If a member has an emergency and is more than 50 (fifty) miles from the selected provider's office, they may visit any licensed dentist to temporarily relieve pain, bleeding or infection until they can get back to see their selected UDC provider. UDC will provide some reimbursement for the visit (according to the contract) once the member has submitted the necessary paperwork for a reimbursement. As the member's selected provider, you will not be penalized for out of area emergency treatment; however, you will be expected to complete any treatment begun by the provider who performed the emergency services.

Changing Dentists – Requested by Members

If a member wishes to change providers they may do so by calling our Member Services Center. Transfers take place on or before the 20th of the month if the member has not seen their current provider during the month. If a member has seen their current provider during the month, their change will become effective the first of the following month.

Transferring Members – Requested by the Provider

In every office, there are instances where a patient and the provider or the office staff has a compatibility problem. Should this happen with a UDC member, please contact our member services center and we will handle transferring the member to another provider.

Specialty Provider Referrals

Most of the UDC plans do not require authorization for specialty services. Check the plan requirement before making referrals. More information regarding referrals appears later in this manual.

Inactive/Reserve Status

Participating dentists may apply for inactive/reserve status, which means you will continue to see members who are currently on your roster but will not accept new patients. Being placed on interactive/reserve status does not prevent you from returning to active status if your patient load lightens. This return to active status should also be coordinated with your provider relations representative.

Capitation Payments

Capitation payments are mailed monthly along with a Capitation Report indicating the UDC members who are presently enrolled in your practice. This Capitation Report reflects additions or deletions as a result of members joining or leaving your practice. Applicable capitation adjustments will be noted.

Accompanying each Capitation Report will be a Provider Activity Summary listing members from your office who are no longer eligible to receive benefits. This report should be reviewed carefully each month to ensure your scheduled member patients are eligible to receive benefits.

UDC's goal is that every check and report we provide you is accurate. If you should find an error, please contact the Member Services Center immediately so we may make any corrections.

Due to internal data processing procedures, new members who are enrolled after the 20th of the month may not appear on your current month's capitation report. These members will appear on your next month's capitation report and you will receive capitation payments retroactive to the member's effective date in your practice.

Complaint Reports/Resolution

Quality care provided in an atmosphere of efficient and effective service is the primary goal of UDC and its affiliated dental network. he following procedures have been established to address and resolve any concerns or problems identified by our members against our dentists and vice-versa.

When a member or dentist reports a complaint to member services center, the information is relayed to the resolution department for review, comment and investigation. The dental office or member about whom the complaint is reported will also be notified and a copy of the report sent to them for their review and response. The Plan's Dental Director and/or peer review committee will investigate all cases involving quality of care issues.

UDC recognizes two forms of complaints, informal and formal.

Informal – If a complaint between a dentist and member cannot be resolved between them, the member or dentist should contact the UDC member services center to report the complaint. A member services representative will attempt to resolve the issue immediately over the telephone.

Formal – If a member or dentist is unhappy with the finding/decision of the Informal Complaint

Resolution, he/she has the right to submit a complaint either verbally or in writing. Your member services representative will provide the member or dentist with information including a complaint form, which can be completed and returned to UDC's resolution department. Upon receipt of a formal complaint, a member of UDC's resolution department will contact the reporting party in writing, acknowledging receipt of the complaint; verifying the facts of the report, giving the member a Release of Information Form (HIPAA form) to complete and return, and advising them when to expect a response.

UDC will then investigate the reported complaint and will send a written response of our findings and resolution within 30 (thirty) days. The resolution of a written report shall be considered binding unless either party seeks to appeal the decision. The member and/or dentist shall be advised in writing of his/her right to appeal. The Unusual Incident Form (Grievance Form) may be used to gather information from both sides. This form is available in English and Spanish and should be maintained in the dental office for distribution to the Plan's members upon request. In all cases, the Plan will encourage the parties to resolve the issues between themselves before beginning the resolution procedure.

Grievance Forms are available online on our website: www.UDCDentalCalifornia.com. Please refer to the "Additional Resources section" for both English and Spanish Online Grievance Form or simply by clicking the buttons below. If you prefer to submit your grievance by facsimile, please print out the form below. Simply fill in and fax the document to the Plan's Resolution Department fax number: 858.678.0692.

Chapter 3
QUALITY IMPROVEMENT AND UTILIZATION REVIEW PROGRAM

- The Quality Improvement Program
- Credentialing
- Recredentialing
- Accessibility of Services
- The Patient Record
- Infection Control Techniques
- Overall Office Cleanliness
- Protocols for Patient Care
- California Language Assistance Program
- Internal Review Procedures
- Onsite Provider Reviews
- Utilization Review Program
- Analysis of Dental Procedures
- CADP Audit Program

CHAPTER 3
QUALITY IMPROVEMENT AND UTILIZATION REVIEW PROGRAMS

Quality Improvement Program
UDC has developed exemplary Quality Improvement Programs specifically to ensure that all members receive quality dental care. The Quality Improvement and Utilization Review Programs include stringent credentialing criteria, ongoing review of provider performance and review of utilization patterns.

UDC's programs fulfill the Department of Managed Health Care's requirements for managed dental care programs. Collectively we monitor the delivery of dental care provided to the residents in the State of California.

Background
The Quality Improvement Program is designed to be a friendly but firm guide for our providers. If you run your office using good dental practice guidelines, you will find our standards are no higher than you already expect of yourself. The Quality Improvement Committee, which is part of the review team, is comprised of Plan Participating dentists such as yourself.

If the dentist or facility is selected for an onsite Quality Assessment (QA) review, a written report of the results of the review is maintained by UDC and is reviewed with the dentist. In the event of any discrepancies, deficiencies or variances from UDC's standards, the Dental Director will issue a written notice to the dentist clearly delineating the areas in which deficiencies exits and/or items, which require correction.

UDC reserves the right, at the discretion of the Dental Director, to terminate contractual agreements with any affiliated dentist who fails to comply with our dental practice standards.

Quality Improvement Committee
The Quality Improvement Committee is comprised of the following individuals:
- Dental Director
- Plan Participating Providers

The Quality Improvement Committee meets quarterly to assess the care provided to members. Areas that are evaluated include, but are not limited to, appointment availability, accessibility of providers, tabulated member grievances, continuity of care issues, member satisfaction survey results etc. The committee tracks and trends all confirmed member complaints and potential quality issues (PQI's) for intervention as appropriate.

Quality Improvement Program Focus
Our Quality Improvement Program is designed to provide an ongoing analysis of the quality of dental services being provided to our members using, but not limited to, the following administrative and monitoring procedures:
- Credentialing/Recredentialing of Plan Dentists
- Accessibility of Services
- Patient Records
- Infection Control and Office Cleanliness
- Protocols for Patient Care
- Provider/Office Review
- Acceptable Performance in Patient Care

Credentialing

Dentists will be considered for approval as UDC participating providers by the Quality Improvement Committee based upon the following qualifications:

- Completed and signed application
- Signed Primary or Specialty Dentist Agreement
- Current California Dental License
- Current DEA Certificate (where indicated)
- Current Malpractice Insurance Certificate
- Proof of Board Certification (for Specialists)
- Acceptable rating on facility on-site review

In addition, the applicant will be screened for sanction free status and malpractice history.

UDC has developed exemplary Quality Improvement Programs specifically to ensure that all members receive quality dental care. The Quality Improvement Committee has the authority to:

- Accept a dentist's application
- Deny a dentist's application

Examples of reasons to deny a dentist's application may include:

- History of State Dental Board Sanctions and/or disciplinary actions
- Failure to meet the mandatory qualifications
- Unacceptable rating on facility on-site review

Recredentialing

Every 3 (three) years, a dentist is evaluated by the Quality Improvement Committee as part of the recredentialing process. Dentists will be considered for re-approval as participating providers based upon the same qualifications utilized for initial credentialing. In addition, a dentist's performance to date with UDC will be evaluated including information regarding member complaints and PQI trending results.

Accessibility of Services

General

Dental offices are responsible for maintaining normal business hours consistent with the local business community and for being accessible and available to members in the same manner and to the same degree as any other patient. The member services center should be notified of any changes in the hours of operation of your office.

At no time may services be refused to any eligible member on your roster because of race, color, national origin, ancestry, religion, sex, marital status or age.

Emergency Care

Every affiliated family dental office must maintain a 24-hour telephone service or answering machine to handle emergency calls and to tend to member emergencies within 24-hours of initial contact.

Substitute Dentists

If you are going to be on a vacation and/or if your office will be closed for any extended period of time, it is the responsibility of the dentist, during the time of absence, to arrange for a substitute dentist who shall be responsible for the emergency care and treatment of members who are eligible for care at your office. Proper planning and working closely with other affiliated dental offices and your provider relations representative will help successfully accomplish our mutual goal of continuity of care to members.

Appointments and Scheduling

All members should normally receive an appointment with a reasonable length of time as follows:

Emergency Services	24-hours
Routine Care	3 weeks for general dentists and 6 weeks for specialists
Urgent Care	72-hours from the date of request for an appt.
Preventive Care	Must not exceed 40-business days from the date of request for appt.

The Patient Record

The patient record must be orderly in structure, concise in content and must include the following:

- A complete health history that is part of each patient record. The health history must be dated and signed by the member and initialed by the dentist. Each history must contain and explicit diagnosis including documentation of major clinical symptoms and conditions and is updated on a regular basis. Evidence of the update must be clearly dated and initialed by the dentist on the patient record.
- An appropriate treatment plan following a logical sequence to eliminate and control dental disease and improve the patient's oral health. Any alternative methods of patient treatment, if applicable, should also be included.
- Any medications which the patient taking and outside referrals for specialty care should be noted.
- Medical alerts should be easily recognized by anyone treating the patient; however, do not let this information to be visible on the outside of the folder.
- Name and telephone number of the patient's physician must be listed.
- All "loose" chart components (i.e., radiographs, prescription, insurance forms, patient correspondence, etc.) must be filed in the same order in all patient records so that easy access is available. Each loose component must be clearly marked with the patient's name.

Infection Control Techniques

All dental offices must be operated within OSHA guidelines for the protection of our members and your dental office staff. UDC has a particular interest in the following items:

- All reusable instruments must be sterilized between each use.
- Instruments are to be packed or bagged and processed in an autoclave. Autoclave effectiveness shall be verified by weekly spore testing which is documented.
- Instruments, which cannot be processed in the autoclave, must be decontaminated in an appropriate disinfecting solution.
- Fixed surfaces (i.e., lights, hand pieces, switches, countertops, etc.) must be cleaned after each patient visit with alcohol or other decontamination agents and sterile wipes.
- Disposable headrest covers should be changed after each patient use.
- Disinfecting solutions must be replaced on a regular basis according to manufacturer's instructions. Responsibility for this task should be specifically assigned.
- All professional and auxiliary personnel must demonstrate a working knowledge of required infection control techniques.
- Food, pencils, pens and personal items (coats, purses, etc.), must not be stored in any treatment or sterilization control area.
- Smoking must not be permitted in any patient treatment "lab" or sterilization control area.
- For protection of personnel and patients, gloves must be work when touching blood, saliva or mucous membranes. All work must be completed on one patient and hands washed and re-gloved before performing procedures on another patient. Surgical masks and eye protection should be worn by staff when splashing or splattering of blood or other body fluids is like or an aerosol is present.
- Eye protection is recommended for patients during treatment.

Overall Office Cleanliness

All dental offices must maintain a high standard of cleanliness, which includes but is not limited to:

- Patient reception areas must be maintained in a clean and orderly manner.
- The reception area must be pleasant, in good repair and have adequate lighting.
- Restrooms for patient use must be available and must be immaculately clean with adequate supplies of tissue, towels and soap.
- Staff lounge areas must be clean and orderly. No open containers of food or unwrapped foods shall be left unattended.
- The office must provide evidence of a regular cleaning and maintenance program – either in the form of a janitorial service or designated staff members responsible for cleaning the office.

Protocols for Patient Care

The practice should maintain written protocols, which define the following patient care requirements:

- A complete patient health history must be obtained prior to delivery of patient care.
- A diagnostic radiographic database must be in place, which balances patient need vs. radiation exposure.
- A prioritized treatment plan must be complied for each patient. Where appropriate, an alternate dental treatment plan should be prepared for presentation to the patient. Informed consent should be obtained.
- Preventive dentistry must be the orientation of the practice.
- Dental emergencies have priority over routine care and each practice shall demonstrate that provisions exist for emergency patients to be worked into the daily schedule.
- Staff must be aware of their roles during an in-house medical emergency.
- Emergency telephone numbers must be posted by each telephone.
- Positive pressure oxygen must be available at all times.
- An emergency patient care kit must be kept in each facility and all office staff must be aware of its location and contents. Drugs contained in it must be inspected and at least semiannually and updated as required.

California Language Assistance Program

In 2003, the California legislature passed Senate Bill 853 mandating that all California health plans provide language assistance services to their enrollees with limited English proficiency in order to alleviate language and/or cultural barriers. In compliance with this mandate, UDC created a Language Assistance Program to address language and/or cultural barriers that may be present within our enrollee population. Because you are a partner in providing quality dental care for our Plan enrollees, UDC is sharing important information with you regarding our enrollee demographic data and our Language Assistance Program, including requirements that may affect your dental practice. Please review this information and make any necessary changes to your office procedures in order to remain in compliance with UDC's Program.

Highlights of UDC's Program and requirements for Plan Participating Providers

- Interpretation services are provided to Plan enrollees, without charge to the enrollee or dentist, by contacting UDC's member service department at 800.443.2995. These services are available even if the enrollee is using a family member or friend as an interpreter. Dentists may contact the Plan for information on an individual enrollee's language preference.
- To maintain accurate records regarding languages spoken at participating offices, UDC requires all offices to complete a Language Capability Disclosure Form(s). If the language capabilities of your office change, you are required to notify UDC's provider relations department at 800.434.2638 so that our records can be updated.

- You are required to maintain copies of UDC's grievance procedures and copies of UDC's grievance forms in English and Spanish. Copies of this information are included in this manual for easy reference. Please maintain these copies and provide them to any UDC enrollees who express a desire to file a complaint with UDC regarding any aspect of their dental care or coverage.
- Plan enrollees have the right to contact UDC, file a complaint with UDC, obtain assistance from the Department of Managed Care (DMHC) and seek independent medical review. This information is available in non-English languages through the DMHC's web site. The notice and translations can be obtained online at www.hmohelp.ca.gov for downloading and printing. Hard copies may be requested by submitting a written request to: Department of Managed Health Care, Attention: HMO Help Notices, 980 9th Street, Suite 500, Sacramento, CA 95814.
- UDC requires all participating dentists to document an enrollee's request for, or refusal of, interpreter services in the dental record. In addition, it is recommended that chart labels be utilized on the outside of a chart to identify an enrollee's language preference, along with any other special accommodations requested, for future reference to expedite the delivery of care.

UDC Enrollee Demographics

Based upon information provided by the American Community Survey (ACS) data and completion of a written survey of UDC enrollees, UDC has identified Spanish as a Threshold Language.* Plan information regarding benefits and grievance information is available in Spanish, free of charge, upon request. In addition to identifying Spanish as a Threshold language, survey results revealed the following regarding UDC enrollee language preference and demographics:

UDC enrollee membership completing the survey indicated non-English language preferences as follows:
Spanish (10%)
Cantonese/Mandarin (1%)
Vietnamese (0.5%)
Tagalog (0.5%)
Japanese (0.5%)
Other (less than 0.5%)

UDC enrollee membership completing the survey indicated race and ethnicity data as follows:
Non-Hispanic/Non-Latino (31%)
Hispanic/Latino (28%)
Declined to answer (41%)

UDC would like to thank you in advance for your assistance in assuring that all UDC enrollees have access to the information necessary for full participation in our Language Assistance Program. Should you have any questions regarding this correspondence, or if you would like additional copies of the complaint forms, do not hesitate to contact your provider relations representative.

* Threshold Language includes any language, other than English, when 5 percent of 3,000 or the enrollee population (whichever is less), indicates in the enrollee assessment a preference for written materials in that language.

Internal Review Procedures

Dental practices should have an internal quality review team responsible for conducting ongoing internal review to assure quality patient care. Patient records should be reviewed no less than monthly, emphasizing the following areas of patient care:

- Appropriate diagnostic radiographs such as initial full mouth or panoramic x-rays, right or left bitewing x-rays and any other x-ray required for proper diagnosis and treatment are current and marked with each patient name.
- The diagnosis and treatment plan is included in the patient record. Informed consent is obtained.
- All treatment is thoroughly recorded in the patient record.
- Consultations are documented in a concise but thorough manner.
- Patient input, including, but not limited to, complaints, refusal of treatment, refusal of free interpreter services, questions or statements of concern are noted in the patient record.
- A complete health history signed by the member is in each patient record. The health history must be updated regularly an annotated by the doctor.

Onsite Provider Reviews

Some matters within a quality assessments program can only be accomplished with an onsite review. As is the case with all quality of care procedures, the emphasis must be on the quality of patient care. An on onsite review is not an inspection.

An onsite review recognizes that dentists like most professionals, tend to be very busy and can often overlook variations from their own standards of care within their practice. Most dentists appreciate the assistance and guidance offered by the onsite review visit. All review procedures are intended to assess quality through observation and education. Confrontational tactics are not within the spirit or policy of UDC.

Secondary Review

Should a secondary review be initiated, it will be completed by UDC's dental director, or other designated dentist. The provider being reviewed will be informed in 2 (two) weeks in advance of the visit and their cooperation will be solicited.

Utilization Review Program

UDC uses an effective utilization review system, which examines the number and type of procedures performed by participating dentists. UDC believes the collection and analysis of this information provides valuable insight into the quality of our dental care. In addition, the utilization data also provides us with information to ensure participating dentists receive fair and equitable compensation for services rendered to UDC members.

Failure to capture utilization data increases the potential for lower quality services and member dissatisfaction, which in turn negatively impacts our group retention goals and objectives. Ongoing utilization reviews are used to ensure UDC has created the highest level of provider compensation while maintaining an exceptional level of quality and consistency of dental care services.

Analysis of Dental Procedures

The utilization review system examines the dental care procedures performed. In addition, the system audits member copayments. This evaluation is used to assess treatment for variations against the norm and to make an ongoing determination of equitable compensation for participating dentists. This is also an essential component in analysis of member benefit enhancement and plan design.

Qualitative Analysis

Another element of the utilization review system is the analysis of the treatment patterns of individual participating dentists as compared to the overall professional profile of UDC's provider panel. This comparison provides the information required to conduct comparative profiles for the individual participating dentists and the entire UDC panel on the basis of specific geographic area or on any other basis for which data is available.

Group Utilization Analysis

UDC's utilization review system generates a monthly and cumulative annual percentage of member encounters and total number of procedures per visit. This report provides UDC with the information necessary to generate dental care benefit plans that are responsive to group and member needs while being sensitive to the provider concerns.

CADP Audit Program

The California Association of Dental plans (CADP) Audit program allows UDC to obtain information on some dental facilities, without conducting an audit of our own. This too allows UDC to ensure quality care while maintaining a cost-effective plan.

Please refer to the buttons below to see the details of audit tools that are used by the CADP Audit Program:

UDC Dental California Inc.
CADP Compliant
STRUCTURAL REVIEW AUDIT TOOL

Date: _____ **Consultant Name: Dr. Michael Pink**

Facility ID #: _____ **Facility Name:_____**

Refer to the CADP Structural Review Evaluation Measures for specific review criteria

	Scores			
1. ACCESSIBILITY	A	U	N/A	Comments
*A. * 24 hour emergency contact system?*				
B. Reasonable appointment scheduling for plan members? Minimal access regulations: • Urgent appointments – within 72 hours • Non-urgent appointments within 36 business days. • Preventive appointments – within 40 business days.				
C. Language Assistance Program and Documents Instruction to auditor: • Provide UDC's language assistance phone number, grievance forms in English and Spanish and answer questions as needed. • Record languages spoken at office and collect completed Language Capability Disclosure form as needed. • Verify that provider knows how to contact the plan for interpretation/translation services. • Verify that provider knows to document a patient's refusal of assistance in the dental record.				❑ Spanish ❑ Russian ❑ Chinese ❑ French ❑ Tagalog ❑ German ❑ Vietnamese ❑ Hindi ❑ Korean ❑ Hmong ❑ Farsi ❑ Lao ❑ Arabic ❑ Khmer ❑ Armenian ❑ Bengali ❑ Others: o _____ _____ o _____ _____

Based upon the tool developed by the California Association of Dental Plans
*Identifies critical elements for PQI monitoring
** Add details as needed

UDC Dental California Inc.
CADP Compliant
STRUCTURAL REVIEW AUDIT TOOL

	Scores			
2. Facility and Equipment	A	U	N/A	Comments
A. Clean, safe, neat and well maintained?				
B. Compliance with mercury hygiene, safety regulations?				
C. Nitrous Oxide recovery system?				
D. Lead apron (with thyroid collar) for Patient?				

	Scores			
3. Emergency Procedures and Equipment	A	U	N/A	Comments
A. Written emergency protocols?				
*B. * Medical emergency kit on-site?*				
*C. * Portable emergency oxygen available?*				

	Scores			
4. Sterilization and Infection Control	A	U	N/A	Comments
A. * Sterilization and infection control protocols followed?				
*B. * Protocol posted for sterilization Procedures.*				
*C. * Weekly biological (spore) monitoring of sterilizer?*				
*D. * All instruments and hand-pieces properly cleaned, sterilized, and stored?*				
*E. * Log kept monitoring changing of sterilization solutions?*				
*F. * Staff wears appropriate personal protective equipment?*				
*G. * Proper and adequate use of barrier techniques?*				
*H. * Hand-pieces & waterlines flushed appropriately?*				
*I. * Infection control and cross contamination prevention procedures followed in the office and laboratory?*				

Next Audit Date: _____ **Total Score: _____**

**Potential Quality Issue (PQI): If auditor identifies a PQI – Please provide comprehensive detail on the back of this sheet

Based upon the tool developed by the California Association of Dental Plans
*Identifies critical elements for PQI monitoring
** Add details as needed

UDC Dental California Inc.

CHART REVIEW AUDIT TOOL

Date: _____ **Consultant Name:**

Facility ID#: _____ Facility Name: _____

Audited Charts by Member Birthdate and Patient Name

	Birthdate	Name (Last, First)
1		
2		
3		
4		
5		

	Birthdate	Name (Last, First)
6		
7		
8		
9		
10		

I. DOCUMENTATION

	Chart No. Fill in with *A – U – N/A										Comments
A. MEDICAL HISTORY	1	2	3	4	5	6	7	8	9	10	
* Comprehensive information											
Medical follow-up											
Appropriate medical alert											
* Doctor signature and date											
Periodic update											

	Chart No. Fill in with *A – U – N/A										Comments
B. DENTAL HISTORY/CHIEF COMPLAINT	1	2	3	4	5	6	7	8	9	10	
Comprehensive information											

	Chart No. Fill in *A – U or N/A										Comments
C. DOCUMENTATION OF BASELINE INTRA/EXTRA ORAL EXAMINATION	1	2	3	4	5	6	7	8	9	10	
Status of teeth/existing conditions											
TMJ/Occlusion evaluation											
Prosthetics											
Status of periodontal condition											
Soft tissue/oral cancer exam											

Based upon the tool developed by the California Association of Dental Plans

* Identifies critical elements for PQI monitoring

** A (Acceptable) – U (Unacceptable) – N/A (Non Applicable)

UDC Dental California Inc.

CHART REVIEW AUDIT TOOL

II. QUALITY OF CARE

	Chart No. Fill in with *A – U – N/A										Comments
A. RADIOGRAPHS	1	2	3	4	5	6	7	8	9	10	
* Quantity/frequency											
* Technical quality											
Mounted, labeled and dated											

	Chart No. Fill in with **A – U – N/A										Comments
B. TREATMENT PLAN	1	2	3	4	5	6	7	8	9	10	
Present and in ink											
Sequenced											
Informed consent											

III. TREATMENT OUTCOMES OF CARE

	Chart No. Fill in with **A – U – N/A										Comments
A. PREVENTIVE SERVICES	1	2	3	4	5	6	7	8	9	10	
Diagnosis											
Oral hygiene instructions											
Recall											

	Chart No. Fill in with **A – U – N/A										Comments
B. OPERATIVE SERVICES	1	2	3	4	5	6	7	8	9	10	
Diagnosis											
Restorative outcome / follow-up											
Specialist Referral											

	Chart No. Fill in with **A – U – N/A										Comments
C. CROWN AND BRIDGE SERVICES	1	2	3	4	5	6	7	8	9	10	
Diagnosis											
Restorative outcome / follow-up											
Specialist Referral											

	Chart No. Fill in with **A – U – N/A										Comments
D. ENDODONTIC SERVICES	1	2	3	4	5	6	7	8	9	10	
Diagnosis											
* Rubber dam use											
Endodontic outcome / follow-up											
Specialist Referral											

	Chart No. Fill in with **A – U – N/A										Comments
E. PERIODONTIC SERVICES	1	2	3	4	5	6	7	8	9	10	
Diagnosis											
Treatment per visit											
Periodontal outcome / follow-up											
Specialist Referral											

Based upon the tool developed by the California Association of Dental Plans

* Identifies critical elements for PQI monitoring

** A (Acceptable) – U (Unacceptable) – N/A (Non Applicable)

UDC Dental California Inc.

CHART REVIEW AUDIT TOOL

	Chart No. Fill in with **A – U – N/A										Comments
F. PROSTHETIC SERVICES	1	2	3	4	5	6	7	8	9	10	
Diagnosis											
Prosthetic outcome / follow-up											
Specialist Referral											

	Chart No. Fill in with **A – U – N/A										Comments
G. SURGICAL SERVICES	1	2	3	4	5	6	7	8	9	10	
Diagnosis											
Surgical outcome / follow-up											
Specialist Referral											

	Chart No. Fill in with **A – U – N/A										Comments
H. PROGRESS N OTES	1	2	3	4	5	6	7	8	9	10	
Legible and in ink											
Signed and dated by provider											
Anesthetics note											
Prescriptions noted											

IV. OVERALL PATIENT CARE

	Chart No. Fill in with **A – U – N/A										Comments
*** A. OVERALL PATIENT CARE**	1	2	3	4	5	6	7	8	9	10	

Potential Quality Issue (PQI) If auditor identifies a PQI – Please provide detail on this sheet

Based upon the tool developed by the California Association of Dental Plans
* Identifies critical elements for PQI monitoring
** A (Acceptable) – U (Unacceptable) – N/A (Non Applicable)

Chapter 4

BENEFITS PLANS AND COPAYMENTS

- Introduction
- Plus Plan Copayment Schedule
- Secure Plan Copayment Schedule

BENEFITS PLANS AND COPAYMENTS
Introduction

As one of the nations largest and most respected managed dental plans, UDC has two benefit plans, the Plus Plan and the Secure Plan. A copy of the Copayment Schedule for each plan follows this page.

The Copayment Schedule determines the amounts to collect from UDC members for services rendered.

Chapter 5

SPECIALTY REFERRALS

- Introduction
- Specialty Referral Overview
- How to process Routine Referrals
- How to Process Emergency Referrals
- Evaluation Referral Guidelines
- Endodontic Referral Guidelines
- Oral Surgery Referral Guidelines
- Pedodontic Referrals Guidelines
- Periodontal Referral Guidelines
- Orthodontic Referral Guidelines

Chapter 5
Specialty Referrals

Introduction
In this chapter, you will find information concerning all aspects of the specialty referral Process. For ease in using this chapter, we have divided the information into 3 (three) sections. Below is a list of each section and the information contained in each:

Section 1: Specialty Referral Overview
Basic information required to ensure that correct and complete referrals are submitted.

Section 2: Policies and Procedures for Referral.
Recommending a specialty Referral:
1. Routine Referrals
2. Emergency Referrals

Section 3: Specialty Guidelines.
Guidelines and conditions regarding referrals in each specialty area, The American Academy of Periodontology Summary of Classification of Adult Periodontal Disease is included in this section:

1. Endodontic Referral Guidelines
2. Oral Surgery Referral Guidelines
3. Orthodontics Referral Guidelines
4. Pedodontic Referral Guidelines
5. Periodontal Referral Guidelines

Obviously, not every situation can be covered in the procedures and guidelines. Special situations may require the dentist or office staff to contact the dental director directly to obtain a determination of benefits.

SECTION 1: SPECIALTY REFERRAL OVERVIEW

The Primary Care Dentist is responsible for initiating the referral process and must access the member's condition prior to recommending referral.

For most plans, prior authorization from the plan is not required when a member is referred to a specialist.

If a member requires dental specialty services that cannot be provided by the selected UDC dentist, the member may obtain such services from a UDC specialist. The member's out-of-pocket expense may vary depending on the members plan. For specific benefit question please refer the member to the member services department at (800) 443-2995.

Approved Referrals (where applicable).

Referrals that have been approved will be processed promptly. Notes are entered into the member's computer file designating what procedures have been approved and to which specialist the referral has been sent. An Explanation of Benefits is then distributed to the member and the specialist with any radiographs and other documentation. A notice of information that to make an appointment will be sent to the member. Approved referrals are valid for 60 (sixty) days. The member or the Specialist may call the member services department to request an extension.

Declined Referrals (where applicable)

The purpose of the referral review process is to make a determination of benefits and responsibility for services. It is not intended to question or countermand the primary care dentist's diagnosis. The referring dentist has the right to discuss any declined referrals directly with UDC's dental director at (800) 348-1460 ext. 5033.

If a referral is declined, the referral, along with accompanying materials, will be returned to the primary care dentist along with an Explanation of benefits (EOB) within 24 (twenty-four) hours. A copy of the EOB will also be sent to the member. The primary care dentist may re-submit the denied referral with additional information by using a new referral form. A new form is required since the voucher number of a declined referral is considered spent and therefore is invalid.

The most likely reasons for a referral to be declined are:

- Procedure(s) that are the primary care dentist's responsibility due to contractual obligations.
- Not a covered service based on the member's schedule of benefits.
- Insufficient information

The primary care dentist needs to clearly explain to the patient their dental needs and then relate those to the plan coverage.

Incomplete Referrals.

Referrals which do not contain sufficient information to make a determination of benefits require special attention and may take longer to process. Written requests may be sent to the referring dental office seeking more information. While the Plan is awaiting the additional information, the referral is held in a pending file. If the information has not arrived within 21 (twenty-one) days, the referral may be returned as declined for lack of information.

Changes or Additions to Referrals

Should the specialist determine a change is needed in an approved emergency referral; he/she should contact the member services department for a referral correction. If the change(s) in treatment is normally the responsibility of the family dentist, the family dentist should be notified of the change by the specialist. This will give the primary care dentist the opportunity to accept the patient back for treatment.

SECTION 2: POLICIES AND PROCEDURES FOR REFERRALS.

Routine Referrals

The following information is completed on the referral form by the primary care dentist:

1. Complete all member information, type of specialty care, procedure(s) necessary, complications and pathology noted clinically.
2. Completed referral form with appropriate diagnostic radiographs is sent to the Plan for review and approval or denial, according to Plan referral guidelines. Information on the referral is checked for accuracy. If further information is needed before review, the referral is returned to the provider or, when appropriate, the provider is called for the necessary information.
3. Complete/clean referrals are submitted to the Dental Director for review within 10 (ten) days. Referrals that have been approved are processed, with an EOB generated, going out to both the specialist and member within 5 (five) business days of receipt of a complete/clean referral. The x-rays will then be sent under separate cover with a letter explaining the EOB is to follow.
4. Routine referrals are valid for 90 (ninety) days. An extension is allowed if the member or specialist contacts Member Services Department. Referrals that are denied are entered, generating an EOB, explaining the denial and reason. This EOB is sent to the referring Primary Care Dentist and the member. Denied referrals are also faxed to the Primary Care Dentist within 24 (twenty-four) hours with an explanation for the denial. The Primary Care Dentist may re-submit the denied referral with a new referral form attaching additional information for further review.

Emergency Referrals

Dental emergencies by their nature usually require treatment within 24 (twenty-four) hours to alleviate pain or prevent a more serious conditions. If the treatment is not required within 24 (twenty-four) hours, a routine specialty referral should be submitted.

1. The primary care dentist assesses the member's condition prior to calling member services department for an emergency referral.
2. Call the member services department at: (800) 443-2995.
3. The primary care dentist will provide all necessary Information to the member services representative, including all the complications present and the reason for referral. The member services representative will give the specialist's information to the primary care dentist so that he/she is aware of where the patient is being referred.
4. The member services representative will give the referral authorization, the reference authorization number and will contact the specialist's office to advise them of the patient's impending arrival and the patient's need to be treated.
5. The primary care dentist will give the patient the appropriate diagnostic radiographs and inform the member of their copayment responsibility at the referred specialist office.
6. The specialist will submit a claim for payment once the authorized work is completed. If there is a need to change to the approved procedure, the specialist calls the member services department, who then contacts the primary care dentist for approval or referral of the patient back to the primary care dentist.
7. All claims and payment for emergency care are subject to review by the dental director. Emergency referrals will be completed within 72 (seventy-two) hours following the receipt of the information necessary to make the determination.

SECTION 3: SPECIALTY GUIDELINES.

Endodontic Referral Guidelines

1. The Primary Care Dentist is responsible for providing root canal treatment for anterior and premolar teeth (ADA codes 3310, 3320).
2. There are some complicating factors, which may make certain treatment of these teeth beyond the expertise of the primary care dentist. These complications may be considered for referral, and they include, but are not limited to, calcified canals, previous endodontic treatment, curved roots, difficult access, and teeth with internal resorption.
3. The primary care dentist may refer molar teeth for endodontic treatment (3330) and apical surgery including apicoectomy (3410, 3411), retrograde fillings (3430), and root amputations (3450).

Oral Surgery Referral Guidelines

1. The primary care dentist is responsible for routine extractions (7110, 7120), removal of exposed roots above the gumline (7130), surgical extraction of erupted teeth (7210), and extraction of soft tissue impactions (7220).
2. The primary care dentist may refer for the removal or partial or full bony impactions (7230, 7240, and 7241).
3. The removal of asymptomatic third molars without demonstrated pathology is not a covered benefit, even for orthodontic purposes.

Orthodontics Referral Guidelines

1. The primary care dentist is to evaluate and determine if there is a need for orthodontic treatment.
2. Upon evaluation, the patient is to be referred to an orthodontist on the Plan's panel.

Orthodontics Malocclusion Guidelines

- Class 1 with crowding
- Class 2 division 1
- Class 2 division 2
- Class 3

1. Mixed Dentition or early interceptive treatment is not a covered benefit.
2. Primary care dentist to provide appropriate radiographs for the orthodontist.

Pedodontic Referral Guidelines

1. Treatment for children under the age of 5 (five) may be referred to a pediatric dentist after having been assessed by the primary care dentist.
2. Treatment for children between their 5th (fifth) and 6th (sixth) birthdays may be referred if widespread decay is present. Widespread decay includes involvement of the pulp.
3. Referral for lack of patient compliance (behavioral management) is not a covered benefit.

Periodontic Referral Guidelines

1. The Plan advocates a Soft Tissue Management Program (STMP) for all adults, to arrest periodontal disease. This STMP is necessary prior to referral. Members who refuse to participate in this program must sign refusal of treatment form and are responsible for their own periodontal treatment.
2. Periodontal surgery will only be considered in cases, which will not respond to a conservative non-surgical approach. The program provided by the primary care dentist includes:
    a. Examination and consultation
    b. Full-mouth radiographs
    c. Full-mouth periodontal pocket charting

d. Prophylaxis and subgingival curettage
e. Full-mouth debridement
f. Scaling and root planing
g. 2 (two) recall visits within 6 (six) months
h. Does not include irrigation, mechanical plaque removing devices, or placement of antibacterial products

3. Some case Type III and most case Type IV will not respond to STMP unless combined with other treatment such as osseous surgery. Cases of this nature may be referred without a full STMP if they have demonstrated good home care and have a reasonable prognosis.

Chapter 6

Parameters of Care

- Introduction
- Dental Record
- Basic Clinical Diagnostic Information
- Radiographs
- Diagnosis
- Treatment Plan
- Preventive Dentistry
- Endodontics
- Periodontics
- Oral and Maxillofacial Surgery
- Operative Dentistry
- Fixed Partial Prosthodontics
- Removable Partial Prosthodontics
- Complete Denture Prosthodontics
- Pediatric Dentistry
- Orthodontics

Introduction

UDC's Quality Improvement Committee has established the enclosed parameters of care as an evaluation mechanism for those procedures most commonly performed in dentistry. These guidelines represent a broad consensus based on contributions of practicing dentists in multiple clinical specialties and has been developed based upon existing recommendations of the American Dental Association (ADA) and other published guidelines. These parameters are designed to serve as an aid for quality evaluation and are not intended to represent the legal standard of care for practicing dentists. In the review of dental care, many factors must be considered such as the pre-existing state of the patient's medical and dental condition, the patient's cooperation at the time the dental care is rendered, the patient's level of responsibility, the patient's oral hygiene program, the regularity of the patient's return to the dental office for maintenance of care, recognized complications which can occur during a dental procedure and other risk factors.

Dental Record

Records must include documentation of the following:

(1) Patients name.
(2) Date of visit.
(3) Reason for visit.
(4) Vital signs, including but not limited to blood pressure and heart rate.
(5) If not recorded, an explanation why vital signs were not obtained.

Further, records must include documentation of the following when services are rendered:

(1) Written review of medical history and limited review of medical exam.
(2) Findings and charting of clinical and radiographic oral examination.

- Documentation of radiographs taken and findings deduced from them, including radiograph films or digital reproductions.
- Use of radiographs at a minimum, should be in accordance with guidelines set forth on "Dental Radiographic Examinations" published by the United States Department of Health and Human Services, October 1987, as amended or reprinted from time to time.

(3) Diagnosis.
(4) Treatment plan, recommendation, and options.
(5) Treatment provided.
(6) Medication and dosages given to patient.

- The dispensing, administering, or prescribing of all medications to or for a dental patient shall be made a part of such patient's dental record. The entry in the patient's dental record shall be in addition to any record keeping requirements of the DPS or DEA prescription programs.
- All records pertaining to Controlled Substances and Dangerous Drugs shall be maintained in accordance with the Texas Controlled Substances Act.
- Record entry for a prescribed drug will include instructions for taking.

(7) Complications.
(8) Written informed consent.

The medical record should allow for a thorough physical evaluation of the patient's physical and emotional ability to tolerate dental procedures safely, as well as a general evaluation of his/her health. The elements of the history and clinical examination are the same, regardless of the patient or the dental service to be performed.

The general medical history should contain information pertaining to:

- General Health
- Systematic diseases; such as cardiac condition, history of rheumatic fever, diabetes, hepatitis, etc.
- Allergies and sensitivity to drugs.
- Reactions to dental anesthetics.

- Past and present medication and present treatment.
- Bleeding problems.
- Nervous disorders.
- Bacterial Endocarditis.
- Any other pertinent information.

The medical and dental history, which is taken initially, should be updated periodically. Base line observations should be recorded for comparisons with future observations as the patient returns for periodic examination and treatment. Patient should be questioned for any new illness or changes in the health status.

Basic Clinical Diagnostic Information

The purpose of the clinical examination exam is to assess and record the pertinent information necessary to arrive at a rational diagnosis and treatment plan. The elements of the history and clinical examination are the same, regardless of the patient or the dental service to be performed. These elements include an evaluation of the head and neck in addition to the dental evaluation. The clinical examination should focus on "SOAP". SOAP includes the following criteria:

S – Subjective:	The patient conveys concerns to the dentist
O – Objective:	The dentist makes an observation
A – Assessment:	Assessment of the dental condition
P – Plan of treatment:	Plan of treatment

The clinical examination records or charts should include an oral charting indicating the oral condition as:

- Teeth present
- Missing teeth
- Caries
- Restorations, defective or acceptable
- Fixed and removable prostheses including implants
- Oral Hygiene
- Pathologic migration of teeth
- Attrition, abrasion and erosion of teeth
- Periodontal status based on existing conditions including gingival color, bleeding on probing, location and measurement of periodontal pockets, presence of plaque and/or calculus, mobility of teeth, occlusal status, recession.
- Description of the general health and appearance of the neck, lip, oral mucosal membranes, tongue, pharynx, evidence of bruxism, harmful habits, and attitude.
- Incipient and other types of lesions.

The medical and dental history, which is taken initially, should be updated periodically. Baseline observations should be recorded for comparisons with future observations as the patient returns for periodic examination and treatment.

Radiographs

Records should include documentation of radiographs taken, including radiograph films or digital reproductions, and findings deduced from them. The use of radiographs, at a minimum, should be in accordance with guidelines set forth on "Dental Radiographic Examinations" published by the United States Department of Health and Human Services, October 1987, as amended or reprinted from time to time. That publication will include information such as the following excerpt from the Health and Human Services publication regarding the Guidelines for Prescribing Dental Radiographs (HHS Publication FDA 88-8273, pp 12-13 of The Selection of Patients for x-ray Examination)*:

- New Patient (All new patients to assess dental diseases and growth and development-Dentulous Adult and Adolescent with permanent dentition prior to eruption of third molars) – Individualized radiographic examination consisting of posterior bitewings & selected periapicals. A full mouth intraoral radiographic examination is appropriate when the patient presents with clinical evidence of generalized dental disease or a history of extensive dental treatment.
- A full radiographic series for edentulous adults shall include a full mouth intraoral radiographic examination or a panoramic examination.
- The initial radiographic survey for a child prior to eruption of the first permanent tooth shall include posterior bitewing films.
- The initial radiographic survey for a child with transitional dentition (following eruption of the first permanent tooth) will be an individualized radiographic examination consisting of periapical/occlusal views and posterior bitewings or panoramic examination and posterior bitewings. The films should be adequate to assess growth and development.
- Recall radiographs are justified when there is a history of a proneness to caries, a periodontal change, and presence of symptoms that are new or continuing, delayed growth and development, or delayed eruption.

***The recommendations in this chart are subject to clinical judgment and may not apply to every patient. They are to be used by dentists only after reviewing the patient's health history and completing a clinical examination. The recommendations do not need to be altered because of pregnancy. The nature and extent of diagnosis for required patient care constitute a basis for determining the need, type and frequency of radiographic examination. The specific frequency norms contained in the following guidelines must be considered flexible to accommodate individual patient need.**

Radiographs should be kept on file for reference and reviewed in subsequent evaluations and treatment. Radiographic equipment must be in compliance with state and federal regulations for radiation hygiene and safety. A dentist shall furnish copies of dental records to a patient who requests his or her dental records. Requested copies including radiographs shall be furnished within 30 (thirty) days of the date of the request, provided however, that copies need not be released until payment of copying costs has been made. Records may not be withheld based on a past due account for dental care or treatment previously rendered to the patient.

Diagnosis

Diagnosis is the determination of the patient's dental condition based on the examination findings. Examination findings must be appropriate and adequate to make a correct diagnosis.

Treatment Plan

A treatment plan is a statement of summary of the services to be performed for the patient. It is based on the diagnosis and is a logical plan to eliminate or alleviate the patient's dental symptoms, eliminate or control both problems and diseases, and to prevent future degenerative changes. The treatment plan should follow a logical sequence, such as:

- Relief of pain and discomfort.
- Elimination of infection, irritations, traumatic conditions.
- Appropriate periodontal therapy and instruction in preventive practices.
- Treatment of carious lesions.
- Restoration and replacement of teeth.
- Placement of the patient on a recall schedule to suit the assessed needs.

The treatment plan should include consultation and/or referral for treatment when the nature of the disease, complexity of treatment, or health of the patient is beyond the normal range of practice or personal capabilities of the treating dentist. After the dentist presents the diagnosis, the treatment plan,

prognosis, possible complications, and the consequences of no treatment; the patient has the choice to accept or reject the dentist's recommendations. The dentist's responsibility to the patient is discharged upon informing the patient of the diagnosis, recommended treatment plan, prognosis, possible complications, and the consequences of no treatment. The principal of informed consent requires the dentist to inform the patient of their condition and treatment necessary and for the patient to accept or reject the proposed treatment plan. In general, informed consent includes the following:

- Reason for treatment.
- Diagnosis.
- Prognosis.
- Alternate plans of treatment.
- Nature of care and treatment.
- Inherent risks and complications.
- Possible results if treatment is not done.
- Anticipated costs.

Preventive Dentistry

Preventive dentistry includes all clinical procedures, plus dental health education programs, whose goals are to prevent and/or eliminate caries or other oral disease and to control or eliminate gingival disease:
Caries Prevention: A comprehensive program of plaque control by both the dentist and patient is the first step toward caries prevention. This is coordinated with patient education, diet counseling, fluoride use and periodic professional plaque removal.
Prevention/Control of Periodontal Diseases: A comprehensive program including home plaque removal and control, dental health education, professional prophylaxis (the frequency of the prophylaxis is dependent on the patient's rate of plaque and calculus formation), scaling and root planing, surgical procedures, adjunctive therapy, occlusal evaluation, recommendations regarding diet and lifestyle (i.e.: smoking), and periodontal maintenance.
Prevention of Other Oral Diseases: The reduction or elimination of any factors of constant mechanical and/or chemical irritation. The recognition of potentially harmful tissue changes is the diagnostic responsibility of the dental practitioner.

Endodontics

Endodontics is the branch of dentistry, which is concerned with the morphology, physiology, and pathology of the human dental pulp and periradicular tissues. Its study and practice encompass the basic and clinical sciences including biology of the normal pulp, the etiology, diagnosis, prevention and treatment of both diseases of and injuries to the pulp and associated periradicular conditions. Examination of the endodontic patient should include an evaluation of the pain and the stimuli that induce or relieve pain. Such tests as thermal, electric, percussion, palpation, and mobility may be used. Treatment planning should include the strategic importance of the tooth or teeth considered for treatment, the prognosis, and other factors such as excessively curved canals, periodontal disease, occlusion, tooth fractures and calcified or occluded canals. Teeth that are predisposed to fracture following endodontic treatment should be adequately protected.

Endodontic services may include:

1. Vital pulp treatment
   - Indirect pulp capping
   - Direct pulp capping
   - Pulpotomy

2. Endodontic Therapy
   - **Endodontic therapy** may be indicated on teeth with diseased or potentially diseased pulp with our without evidence of periapical pathology. Treatment procedures consist of debridement of the

pulp chamber and canal system and obturation of pulp chamber and canal system with suitable radiopaque material. Procedures must be performed under rubber dam isolation.

- **Apexification** treatment may be indicated on a tooth with a necrotic pulp, which has an immature root.
- **Surgical treatment** may be indicated when a tooth cannot be acceptably treated non-surgically.
- **Hemisection** may be indicated when there is a fracture dividing the crown and/or roots or there is extensive loss of bone support for one or more of the roots and retention of one half of the tooth is considered necessary for maintenance of function.
- **Root Amputation** may be indicated on multi-rooted teeth when there is extensive loss of bone support on one root and amputation will significantly aid the periodontal condition and the patient's access for cleaning the involved area. Root canal treatment on the retained portions of the canal system is preferably completed prior to the hemisection or root amputation.

Periodontics

Periodontics is that specialty of dentistry which encompasses the prevention diagnosis and treatment of diseases of the supporting and surrounding tissues of the teeth or their substitutes and the maintenance of the health function and esthetics of these structures and tissues. The clinical examination of the periodontal patient should record the presence or absence of the inflammatory and non-inflammatory abnormalities, the condition and stability of the dentition, the depth of periodontal pockets, and attachment loss. Existing conditions should be recorded and include:

- Measurement and location of periodontal pockets or Periodontal Screening and
- Recording (PSR)
- Location of bleeding on probing
- Gingival color
- Recession or attachment loss
- Mobility of teeth
- Occlusal trauma
- TMD
- Alveolar bone loss

Periodontal surgery may be accomplished by a variety of procedures. Gingival curettage, gingivectomy, flap, osseous, muco-gingival and all other periodontal surgery should result in the elimination of periodontal pathology. The gingiva should be restored to appropriate physiologic form. Deformities in the alveolar bone are to be corrected. The patient should be trained in skills for plaque control procedures. A follow-up program for evaluation of the success of treatment, continuous supportive therapy and maintenance program should be established. Patients should be recalled for periodic periodontal maintenance and evaluation depending on their individual rate of plaque and calculus formation.
Implants: An implant may be appropriate as a foundation for replacing a missing tooth.
This is **not** a benefit of the prepaid plan.

Oral and Maxillofacial Surgery

Oral and Maxillofacial Surgery is the specialty of dentistry which includes the diagnosis and the surgical and adjunctive treatment of the diseases, and injuries and defects of the hard and soft tissues of the oral and maxillofacial regions.
Exodontia, Hard Tissues, and Soft Tissues: Extractions may be indicated in the presence of non-restorable caries, untreatable periodontal disease, pulpal and periapical disease not amenable to

endodontic therapy and malposed, unerupted or impacted teeth or when overriding medical conditions exist which provide compelling justification to eliminate existing or potential sources of oral infection. Other areas of treatment include alveoloplasty, alveolectomy, biopsy, cosmetic surgery and reconstructive surgery.

Fractures and Trauma: Immobilization of oral structure to provide good stabilization whether in treatment of traumatic injury, adjunctive care in oncologic surgery, or other conditions.
Implants: An implant may be appropriate as a foundation for replacing missing teeth or support mastication.

Operative Dentistry

Operative dentistry includes the restoration of hard tooth structure lost as a result of caries, erosion, attrition or trauma. Restorative materials for operative dentistry include dental amalgam, glass ionomer, composite, cast restorations (inlays or onlays), crowns, porcelain, as well as various temporary materials. The dentist's choice of restorative material for a given patient depends upon the nature and extent of the defect to be restored, its location in the tooth and in the mouth, the stress distribution expected during mastication, and the aesthetic requirements. A conservative treatment plan should be considered prior to providing a patient with one or more crowns. If amalgam or composite restorations are deemed inappropriate for properly restoring a tooth, then a crown must be considered. Typical situations where a crown may be appropriate are:

- The restoration will receive excessive masticatory force that might fracture the remaining tooth structure or restorations.
- There is a fractured or missing cusp or incisal edge.
- 75% of the tooth surface is a series of restorations.
- Gross decay on all tooth surfaces.
- Tooth with completed root canal therapy that cannot be resorted and maintained with amalgam or composite materials.
- Patient has a failing crown.
- A tooth with "cracked tooth syndrome."

The patient's age, health, and general condition and hygiene of the oral cavity as well as the patient's wishes and attitude must be considered in the dentist's choice of restorative material. The clinical quality of operative dentistry depends not only upon the proper choice of material for a given restoration, but also upon strict adherence to good technique on the part of the dentist and his auxiliary personnel. The properties of most restorative materials are highly susceptible to manipulative variations.

Fixed Partial Prosthodontics

Fixed partial prostheses (bridges) are indicated for replacement of one or more missing teeth when abutment teeth can be expected to have a minimum prognosis of five years of service. Placing an implant instead of a bridge should be considered. The patient's age, health and general condition of the oral cavity, as well as the patient's wishes and attitude must be considered.

Removable Partial Prosthodontics

Removable partial prosthodontics is that part of the dental practice which deals with the restoration of the occlusion by means of removable appliances which may be either entirely tooth supported or tooth and tissue supported. Removable partial prostheses are indicated when conditions contraindicate replacement of missing teeth with fixed prosthetic appliances or with implants. Conditions that may indicate removable partial prosthetics are as follows:

- Replacement of two or more teeth when a distal abutment tooth is missing.
- Replacement of an anterior tooth or teeth immediately following extractions to provide adequate esthetics during the healing period.
- Use as a provisional appliance.

- Where edentulous areas are too extensive and/or resorbed to be successfully restored by fixed partial prostheses or implants.
- The prostheses should function passively, fit the natural teeth accurately, be well adapted to the soft tissues, and provide increased masticatory function for the patient.

Complete Denture Prosthodontics

Complete dentures are appropriate when the prognosis for the remaining teeth is hopeless or when all maxillary and/or mandibular teeth have been removed. These prostheses are important for improved mastication of food, for proper facial appearance, and for speech. Aesthetically, the denture should harmonize with the patient's facial appearance. Position, size, and shade of the teeth and of the denture base should appear natural and unobtrusive. Complete dentures should exhibit proper peripheral seal at the mucobuccal fold and cover those areas of the arches that provide maximum support. Centric occlusion should be in harmony with centric jaw relation in the most closed position of the teeth. The vertical dimension of the occlusion should be within the physiologic tolerance of the patient. Inter-occlusal contacts should be evenly distributed with no occlusal interference in lateral or protrusive excursions. The dentures should remain seated when a vertical biting pressure is applied bilaterally in the posterior segments of the arch.

Pediatric Dentistry

Pediatric dentistry is an age-defined specialty that provides both primary and comprehensive preventive and therapeutic oral health care for infants and children through adolescence, including those with special health care needs. Pediatric Dentistry is that part of the dental practice which deals with the growth and development of the dentition and the diagnosis and treatment of dental disease in children and adolescents. There should be particular concern to preserve the primary teeth for masticatory function and space maintenance, utilizing such procedures as pulpal therapy and stainless steel crowns. To preserve adequate space for the eruption of the permanent dentition, both space maintainers and space retainers should be employed with particular preference for fixed appliances. Tooth guidance and regulation of the growth and development of the dentition is also an important feature of pediatric dental care. Excessive and unnecessary treatment should be avoided. Topical fluorides should be applied at least annually in conjunction with a dental prophylaxis. Supplemental fluoride should be prescribed where the water supplies are deficient in fluoride. Application of pit and fissure sealants may be utilized where appropriate. Routine dental care provided by a pediatric dentist is appropriate under certain conditions: if the child is under the age of 4 (four), or if rampant caries are involved.

Orthodontics

Orthodontics and Dentofacial Orthopedics is that area of dentistry concerned with the supervision, guidance and correction of the growing or mature dentofacial structures, including those conditions that require movement of teeth or correction of malrelationships and malformations of their related structures and the adjustment of relationships between and among teeth and facial bones by the application of forces and/or the stimulation and redirection of functional forces within the craniofacial complex. Major responsibilities of orthodontics and dentofacial orthopedics practice include the diagnosis, prevention, interception and treatment of all forms of malocclusion of the teeth and associated alterations in their surrounding structures; the design, application and control of functional and corrective appliances; and the guidance of the dentition and its supporting structures to attain and maintain optimum occlusal relations in physiologic and esthetic harmony among facial and cranial structures.

Orthodontic treatment ranges from simple space maintenance to comprehensive fixed appliance therapy, and may include interceptive procedures (such as serial extraction) and limited tooth movement or guidance. More that one phase of active treatment may be necessary, and removable and/or fixed appliances may be utilized. Improved aesthetics and improved occlusion is the goal of orthodontic treatment. During treatment, every effort should be made to help the patient maintain good oral health and

to prevent the consequences of poor oral hygiene, namely gingival inflammation, decalcification and decay. Age, skeletal growth pattern, remaining facial growth and severity of malocclusion, as well as the patient's needs and desires, should all be considered when formulating the orthodontic diagnosis and treatment plan. Delivery and supervision of appropriate retention appliance should follow active treatment in order to enhance the stability of the orthodontic correction. Patient compliance with orthodontic instruction is critical to achieving functional