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Benefit Options

Envolve Dental, Inc.
Indiana Medicaid Provider Manual

Publication Date Month xx, year

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Contents

Quick Reference Guide

Provider Web Portal

Everything You Need • When You Need It • 24/7/365

Our user-friendly Provider Web Portal features a full complement of resources.

Real-time eligibility

Authorizations – submit & view status

Claims – submit & view status

Clinical guidelines

Referral directories

Electronic remittance advice

Electronic Funds Transfer (EFT)

Up-to-date Provider Manual

Access the Provider Web Portal by clicking this link:

https://pwp.envolvedental.com

Contacts

For information about...	Contact...
Provider Web Portal	https://pwp.envolvedental.com
Provider Services	1-855-609-5157
MHS Member Services (including translation assistance)	1-877-647-4848
MHS Member Services Transportation Assistance (with LCP Transportation, LLC)	1-877-647-4848
Credentialing	1-844-847-9807 fax
Fraud & Abuse	1-800-345-1642
Authorization Address	Envolve Dental Authorizations: IN PO Box 20847 Tampa, FL 33622-0847
Paper Claim Address	Envolve Dental Claims: IN PO Box 20847 Tampa, FL 33622-0847
Appeals and Corrected Claim Address	Envolve Dental Appeals and Corrected Claims: IN PO Box 20847 Tampa, FL 33622-0847

Summary

Quick Reference Guide	
Member Eligibility	Providers may access eligibility through one of the following. You must provide your NPI number to access member details. • Provider Web Portal - https://pwp.envolvedental.com • Call Interactive Voice Response (IVR) eligibility hotline: 1-855-609-5157 • Call Provider Services: 1-855-609-5157
Authorization Submission	Prior authorization submissions must be received in one of the following formats: • Provider Web Portal at - https://pwp.envolvedental.com • Electronic clearinghouses using payor ID 46278: ○ Include attachments with NEA *Fast*Attach® number • Alternate, pre-arranged HIPAA-compliant 837D file • Paper authorization via a recent ADA claim form and mailed to: Envolve Dental Authorizations: IN PO Box 20847 Tampa, FL 33622-0847
Pre-Payment Review Submission	Pre-payment reviews are post-treatment authorizations submitted with claims. Required documentation for each code must be included and meet specified clinical policy guidelines. Submit pre-payment review authorizations as claims, according to claim submission options.
Dental Services in a Hospital Setting	Providers must use a participating MHS hospital and receive prior authorization. To obtain the most recent listing of hospitals in your area: • Visit MHS' website: mhsindiana.com • Call MHS Provider Services: 1-877-647-4848 Prior authorization requests must be made to Envolve Dental at the same time that dental service authorization is requested.
Claims Submission	The timely filing requirement for MHS is 90 calendar days from the date of service. Turn-around time for clean paper claims is 30 calendar days and for electronic claims 21 calendar days. Submit claims in one of the following formats: • Envolve Dental Provider Web Portal at - https://pwp.envolvedental.com

	• Electronic claim submission through selected clearinghouses: Payor ID 46278 • Alternate pre-arranged HIPAA-compliant electronic submissions • Paper claims must be submitted on a recent ADA claim form and mailed to: Envolve Dental Claims: IN PO Box 20847 Tampa, FL 33622-0847
Corrected Claim Submission	Providers who receive a claim denial and need to submit a corrected claim may resubmit it on the Provider Web Portal or send a paper claim on a recent ADA form including ALL codes originally submitted, plus the corrected code with supporting documentation, within 60 calendar days from the date of notification or denial to: Envolve Dental Corrected Claims: IN PO Box 20847 Tampa, FL 33622-0847
Provider Appeals - Claims	Claim payment appeals must be filed within 60 calendar days from the date of notification of payment or denial. All written provider appeals will be resolved within 30 calendar days. To request a reconsideration of a claims denial, a provider may: • Call: 1-855-609-5157 for information • Write: Envolve Dental Appeals: IN PO Box 20847 Tampa, FL 33622-0847
Inquiries and Grievances	To make an inquiry or grievance: • Call: 1-855-609-5157 • Write: Envolve Dental Appeals: IN PO Box 20847 Tampa, FL 33622-0847

Quick Reference Guide	
Provider Appeals - Authorizations	Authorization appeals must be filed within 60 days following the date the denial letter was mailed. To request reconsideration of a denied authorization, a provider may: • Call: 1-844-464-5630 • Write: Envolve Dental Appeals: IN PO Box 20847 Tampa, FL 33622-0847
Member Appeals	Members must submit appeals within 60 calendar days of receiving an adverse Notice of Action. Members submit written appeals to: MHS Appeals 550 N. Meridian, Ste. 101 Indianapolis, IN 46204 Phone: 1-877-647-4848 Fax: 1-866-714-7993 Email: appeals@mhsindiana.com Members who are not satisfied with the MHS appeal decision may request an external, independent review within 120 calendar days. Members may also request a State Fair Hearing at the Indiana Family and Social Services Administration, but not at the same time as the external review. A State Fair Hearing must be requested within 60 days of exhausting MHS appeal procedures. Members can initiate a State Fair Hearing by calling MHS Member Services at 1-877-647-4848 or by writing to: Hearing and Appeals Section, MS-04 Indiana Family and Social Services Administration 402 West Washington Street, Room E034 Indianapolis, IN 46204
Additional Provider Resources	For information about additional provider resources: • Call Envolve Dental Provider Services: 1-855-609-5157 • Access the Provider Web Portal at https://pwp.envolvedental.com • Send an email to: providerrelations@envolvehealth.com

Welcome

Welcome to the Envolve Dental provider network! We are pleased you joined our provider network, composed of the best providers in the state to deliver quality dental healthcare. Envolve Dental, Inc. is a subsidiary of Centene Corporation, a Fortune 100 company with more than 30 years' experience in Medicaid managed care programs. We partnered with Managed Health Services (MHS), our sister company, to administer the dental benefit for their members. MHS is a managed care entity (MCE) that is contracted with the state of Indiana to serve Medicaid recipients enrolled in the Healthy Indiana Plan (HIP), Hoosier Healthwise (HHW) – including the Children's Health Insurance Program (CHIP) – and Hoosier Care Connect. The state of Indiana's Family and Social Services Administration (FSSA) administers the state and federal benefit plans through the Indiana Health Coverage Programs (IHCP).

This Envolve Dental provider manual supplies useful information about working with us. We strive to make information clear and user-friendly. If you have questions about specific portions of the manual or if you have suggestions for improvements, we welcome your input. Please contact Provider Services at 1-855-609-5157, Monday through Friday, 8:00 AM to 5:00 PM CST or send us an email at providerrelations@envolvehealth.com.

Envolve Dental retains the right to modify items in this provider manual.

Provider Participation, Contracting and Credentialing

Provider Participation

Why participate? The Medicaid program is the nation's largest health insurer, funding one sixth of total personal health care spending in the United States. More than one in three children is covered by Medicaid. However, participating in the Envolve Dental provider network has many advantages. Among them are the following:

- Envolve Dental has a user-friendly, state-of-the-art web portal, creating opportunities for providers to see more members, spend less time on administration, and receive claim payments and authorization determinations promptly.

- MHS' managed care model for dental services maintains a fee-for-service payment arrangement, so individual dental offices have less financial risk than a capitated model.

- Providers can choose a level of network participation based on their individual office needs. For example, providers can choose to:
    - accept only members who are currently patients in their office;
    - accept new patients and be listed in an Envolve Dental provider directory;
    - be excluded from a provider directory but accept new patients directed to the office by Envolve Dental;
    - treat only special needs cases or emergencies on an individual basis.

All licensed dentists interested in participating with Envolve Dental are invited to apply for participation in our network by signing a provider agreement (contract) and submitting a credentialing application. Details follow.

State-Required Provider Enrollment

The Indiana Family and Social Services Administration (FSSA) requires providers to be enrolled with the Indiana Health Coverage Program (IHCP) in order to provide services to Envolve Dental members. Providers who are not already enrolled with the IHCP must apply and obtain an IHCP identification (ID) number. Further information for completing the enrollment can be found at https://www.in.gov/medicaid/providers/465.htm. Providers must report their IHCP ID number to Envolve Dental as soon as it is obtained. Submit it to dentalcredentialing@envolvehealth.com.

Contracting

Dentists must sign a Provider Agreement and apply for network participation by submitting all credentialing documentation. Envolve Dental Provider Agreements are available from the following sources:

- Call Provider Services at 1-855-609-5157. Our corporate-based representatives can send a packet or arrange for your local Envolve Dental network representative to deliver one personally.
- Email Envolve Dental at providerrelations@envolvehealth.com with your specific requests.

Prior to applying, note that the following are required for Indiana dentists to participate:

1. A State of Indiana Provider Medicaid ID number by registering as an IHCP provider. To obtain one, go to https://www.in.gov/medicaid/providers/465.htm and complete the enrollment application.

2. Enroll as a provider with MHS using *the IHCP MCE Practitioner Enrollment Form* found here: https://www.in.gov/medicaid/providers/index.html.

3. A National Provider Identifier (NPI) number, as mandated by the Health Insurance Portability and Accountability Act (HIPAA) of 1996. You must have an individual NPI number and a billing NPI number. To apply for an NPI, do one of the following:
    - Complete the application online at https://nppes.cms.hhs.gov
    - Download and complete a paper copy from https://nppes.cms.hhs.gov
    - Call 1-800-465-3203 to request an application

To the extent that a provider executes a contract with any other person or entity that in any way relates to a provider's obligations under the Participating Provider Agreement or an Addendum, including any downstream entity, subcontractor or related entity, the provider shall require that such other person or entity assume the same obligations that the provider assumes under the Participating Provider Agreement and all Addendums.

If you have any questions about the contents of the Provider Agreement or how to apply, please call Provider Services at 1-855-609-5157.

Credentialing

The credentialing process is required to protect Medicaid beneficiaries from receiving services from unqualified providers, such as those with suspended licenses or Medicaid- or Medicare-excluded individuals. Envolve Dental adheres to all federal and state requirements for credentialing providers before they are approved for network participation. Specifically, the Envolve Dental Credentialing Committee evaluates applications according to the National Committee for Quality Assurance (NCQA) and URAC standards, as well as federal codes § 42 C.F.R. 438.214 and § 42 C.F.R. 438.12(A)(2), and state codes. See the sidebar for databases reviewed as part of the credentialing process.

Providers should complete the following steps for the Envolve Dental credentialing process:

Step 1: Call Provider Services to receive the paperwork.

Step 2: Return to Envolve Dental:

- Completed credentialing application online or a CAQH ID #
- Copy of Drug Enforcement Agency (DEA) license
- Copy of malpractice insurance
- Completed Disclosure of Ownership (DOO) form
- State Medicaid ID number

You can also return documents by

Email: dentalcredentialing@envolvehealth.com
Fax: 1-844-847-9807
Mail: Envolve Dental
Credentialing
PO Box 20606
Tampa FL 33622-0606

Databases Reviewed for Credentialing

- Office of Inspector General's List of Excluded Individuals and Entities
- General Services Administration System for Award Management
- CMS/Medicare Exclusion Database
- State Board of Examiners
- National Practitioner Data Bank
- Health Integrity and Protection Databank
- State listings of excluded providers

Step 3: Expect to receive an acknowledgement letter from the Envolve Dental Credentialing only if you need to submit missing documentation. The Credentialing Committee will review your application only when all documents have been received. All documents we receive are stored electronically and securely; we do not send them back or destroy them.

Step 4: Review the Envolve Dental Credentialing Committee determination about your application, which will be communicated with a letter mailed to your listed office address. The possible results and your options are listed in Table 1.

Table 1. Credentialing Committee Determination and Results

Committee decision	What this means	What you can do
1. Accept application without restrictions	You are accepted to the Envolve Dental provider network when the Provider Agreement is signed.	Sign and return the Provider Agreement (if not done so previously). Register on the Envolve Dental Provider Web Portal. Start seeing members on the effective date.
2. Accept application with restrictions	The Credentialing Committee will recommend to the Executive Subcommittee a specific action, which can be approved or denied. Examples: (1) A provider with sanctions may be accepted, but Cost Containment division will closely monitor claims for six months; (2) If a provider incurs additional sanctions after approval, Envolve Dental has the right to withdrawal credentialing acceptance and network participation.	Sign and return the Provider Agreement (if not done so previously). Register on the Envolve Dental Provider Web Portal. Start seeing members on the effective date. Cooperate with Cost Containment and Credentialing requests for new information. Advise Credentialing when external sanctions are lifted.

3. Table application	The Credentialing Committee wants additional information about a questionable matter before making determination. OR The Credentialing Committee is waiting for a known external investigation to be concluded before making a final decision.	Provide as soon as possible any requested information to our Credentialing Specialists. Envolve Dental will reach out to request information. Provide up-to-date information to Envolve Dental Credentialing when the investigation concludes.
4. Decline application	The Credentialing Committee recommends denial to the Executive Subcommittee and it concurs.	Providers can appeal initial denial by submitting new information. A second appeal is possible if denied twice.

Envolve Dental and MHS have the exclusive right to decide which dentists it accepts as participating providers in the network. As of this publication date, the Envolve Dental credentialing process is administered by Envolve Dental, Inc. Envolve Dental does not discriminate based on age, gender, lifestyle, race, ethnicity, religion, disability, specialty or licensure type, geographic location, or financial status in making credentialing determinations.

Envolve Dental will notify MHS if any provider incurs sanctions or disciplinary actions, after which time the provider will be evaluated for continued participation in the network. Other important credentialing details include the following:

- Each provider must be credentialed, but only one application per provider is required whether he or she practices in one or multiple locations.
- Re-credentialing is required every three years. Envolve Dental will mail you a letter by US Mail to your office address alerting you that an updated credentialing application and all supporting documents must be submitted by a certain date for continuous network participation.
- If a provider's malpractice insurance, Drug Enforcement Administration (DEA) license and/or state Controlled Substance (CDS) license expires prior to the three-year Envolve Dental re-credentialing timetable, the provider must submit updated copies to Envolve Dental as soon as they are received from the issuing organization.
- The Disclosure of Ownership (DOO) statement should be updated and submitted to Envolve Dental annually if any changes occur.

Appeals for Adverse Credentialing Determinations

Providers whose credentialing applications are denied have the option to appeal the determination. Information about how to appeal will be specified in the denial letter.

To begin the appeal process, a provider needs to submit a letter with the subject line "Credentialing appeal," and write a narrative explaining a) why specific sanctions and/or negative information are on the provider's record and b) what the provider has done to correct the deficiency. Providers should also submit any new documents, written testimonials and other information that would support the Credentialing Committee reversing its initial determination. The committee will consider all original documents and the new information.

Upon reviewing the entire appeal, the Credentialing Committee has the option to accept the application, accept the application with restrictions, table the application, or uphold the denial. Providers whose applications are denied at the appeal level have the option to submit a second-level appeal. Submit a letter with the subject line "Credentialing second-level appeal." Include with the letter any additional information that would support acceptance. The second-level appeal will be carried out by a Peer Review Committee and its determination will be considered final.

Call Envolve Dental Credentialing at 1-855-609-5157 if you have any questions or need further assistance with any credentialing details.

Electronic Funds Transfer (EFT)

Envolve Dental makes available to providers Electronic Funds Transfer (EFT) for claims payments that are faster than paper checks sent via US Mail. EFT payments are directly deposited into the Payee's selected and verified bank account. To begin receiving electronic payments, complete an EFT form and submit it – with a voided check – to providerrelations@envolvehealth.com or mail it with your credentialing documents. Forms are processed within one week; however, activation begins after four to five check runs, based on confirmation from your bank that the set-up is complete. Remittance statements explaining the payment will be available on the Provider Web Portal in the "Documents" tab for all providers active with EFT.

Member Rights & Responsibilities

Member Rights

Members have the right to:

- Receive information about MHS as well as MHS services, practitioners, providers and their rights and responsibilities. We will send them a member handbook when they become eligible and a member newsletter four times a year. In addition, detailed information on MHS is located on our website at mhsindiana.com. Or they may also call MHS Member Services at 1-877-647-4848.
- Be treated with respect and with due consideration for their dignity and privacy
- Receive information on available treatment options and alternatives, presented in a manner appropriate to their condition and ability to understand
- A candid discussion of appropriate or medically-necessary treatment options, regardless of cost or benefit coverage
- Participate with practitioners in decisions regarding their healthcare, including the right to refuse treatment
- Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation as specified in federal regulations on the use of restraints and seclusion
- Request and receive a copy of their medical records and request they be amended or corrected as allowed in federal healthcare privacy regulations
- Voice complaints, grievances or appeals about the organization or the care it provides
- Make recommendations about our Member Rights and Responsibilities Policy
- An ongoing source of primary care appropriate to their needs and a person formally designated as primarily responsible for coordinating their healthcare services
- Personalized help from MHS staff so they can ensure they are getting the care needed, especially in cases where they or their child have "special healthcare needs," such as dealing with a long-term disease or severe medical condition. We make sure they get easy access to all the care needed and will help coordinate the care with the multiple doctors and get case managers involved to make things easier for them. If they have been determined to have a special healthcare need by an assessment under 42 CFR 438.208(c)(2) that requires a course of treatment or regular care monitoring, we will work with them to provide direct access to a specialist as appropriate for their condition and needs.
- Have timely access to covered services
- Have services available 24 hours a day, seven days a week when such availability is medically necessary
- Get a second opinion from a qualified healthcare professional at no charge. If the second opinion is from an out-of-network provider, the cost will not be more than if the provider was in-network.

- Receive written notice of a decision to deny a service authorization request or to authorize a service in an amount, duration or scope less than requested. They will receive this information as quickly as needed so their medical needs are met and treatment is not delayed. We will not jeopardize their medical condition waiting for approval of services. Authorizations are reviewed based on their medical needs and made in compliance with state timeframes.

Member Responsibilities

Members are responsible for:

- Provide information (to the extent possible) needed by MHS, its practitioners and other healthcare providers so they can properly care for them
- Follow plans and instructions for care in which they have agreed to with their MHS doctors
- Understand their health problems and participate in developing mutually-agreed-upon treatment goals to the degree possible
- To follow plans and instructions for care they have agreed to with their practitioners

Provider Rights & Responsibilities

Envolve Dental applies the following rights and responsibilities to all network providers.

Provider Rights

Providers have the right to:

- Be treated with respect and dignity by members, other healthcare workers and Envolve Dental staff;
- Expect that members will keep appointments and follow agreed-upon treatment plans;
- Expect complete and accurate medical histories from members;
- Receive accurate and timely authorization determinations and claims payments;
- Access Envolve Dental quality improvement program information;
- Advise or advocate on behalf of their patients;
- Make a complaint against a member, MHS, or Envolve Dental; and
- File an appeal with Envolve Dental.

Provider Responsibilities

Providers are responsible for:

- Treating members with respect, fairness, and dignity, including HIPAA-compliant privacy standards;
- Not discriminating against members on the basis of race, color, national origin, age, gender, sexual orientation, religion, mental or physical disability, limited English proficiency, marital status, arrest record, conviction record, or military involvement;
- Following all state and federal laws regarding member care and patient rights;
- Making covered services available on a timely basis, based on medical appropriateness;
- Providing to members an understandable notice of your office's privacy rights and responsibilities;
- Confirming member eligibility on date of service;
- Providing members with access to and copies of their medical records when requested;
- Following Envolve Dental clinical policy guidelines and reporting responsibilities;
- Allowing a member to stop treatment when the member requests it, and accompany the action with information about the implications of stopping care;
- Allowing members (with written documentation) to appoint a family member or other representative to participate in care decisions
- Answering member questions honestly and in an understandable manner;
- Allowing members to obtain a second opinion and how to access healthcare services appropriately;
- Notifying Envolve Dental if members have other insurance coverage;
- Reporting improper payments or overpayments to Envolve Dental; and
- Reporting to appropriate channels possible fraud and abuse by a member or provider.

Eligibility & Member Services

Member Identification Card

MHS issues identification cards to members on a regular basis and members are responsible for presenting the card on the date of service. Envolve Dental recommends dental offices make a photocopy of the member's ID card each time treatment is provided. It is important to note the ID card does not need to be returned should a member lose eligibility. Providers are responsible for verifying member eligibility at the time services are rendered and for determining if members have other health insurance. Presenting a Member ID card does not guarantee eligibility.

Please refer to the MHS member ID card samples for each product on the most recent plan specific documents posted on the Provider Web Portal.:

Eligibility Verification

The local county office of the Division of Family Resources (DFR), a division of the Indiana Family & Social Services Administration, determines member eligibility. Eligibility data is updated to Envolve Dental nightly. On each date of service, providers are responsible for verifying member eligibility on the Envolve Dental Provider Web Portal or by phone on our Interactive Voice Response (IVR) system. The Indiana Provider Healthcare Portal is the source of truth for all eligibility.

You will need the following information to verify eligibility:

Member Details

- Member Medicaid identification number or Social Security number
- Member date of birth
- Member name
- Date of service

Provider Details

- Provider NPI number

When you have this information ready, verify eligibility on the internet or via telephone. Using the Provider Web Portal on the internet requires registration. If you have not yet registered, call Provider Services at 1-855-609-5157.

Note: Due to possible eligibility status changes, eligibility information provided does not guarantee payment.

Benefit Renewal Date Verification

Member benefit periods will reset with each new calendar year.

Transportation Assistance

MHS covers unlimited rides to and from doctor visits, to the pharmacy immediately following a doctor visit and to re-enrollment appointments, for certain member groups. Please refer to the MHS website for more details.

Member Translation/Interpreter and Hearing Impaired Services

Members requiring language assistance should contact MHS Member Services at 1-877-647-4848. MHS will provide members with access to trained, professional interpreters. MHS offers American Sign Language, face-to-face or telephonic interpreter services. MHS requires a five-day prior notification for face-to-face services. Telephonic interpreter services are available for many different languages 24 hours a day, seven days a week. There is no cost to members. TTY/TDD access is available to members who are hearing-impaired at 1-800-743-3333.

Appointment Availability Standards

Appointment availability standards are set by MHS and Envolve Dental to ensure members receive dental services within a time period appropriate to health conditions. Providers should meet or exceed the standards to provide quality service, maintain member satisfaction, and eliminate unnecessary emergency room visits.

Member calls for. . .	Appointment must be scheduled and services provided within . . .
routine dental care (for example, a cleaning)	three months
routine symptomatic care (non-urgent)	72 hours
urgent care – defined as situations involving severe pain, swelling, infection, uncontrolled hemorrhage, or traumatic injury, and the member will not suffer adverse consequences if treatment is received within 24 hours.	forty-eight (48) hours
emergency care – defined as situations involving severe pain, swelling, infection, uncontrolled hemorrhage, or traumatic injury that will result in the member having adverse consequences if not treated immediately.	Immediately

On the appointment date, waiting time in the office must not exceed one hour from the scheduled appointment time. Envolve Dental will keep providers informed about appointment standards, monitor office adequacy, and take corrective action if warranted.

After-Hours Care

All dental providers are required to supply after-hours coverage for member needs or emergencies, accessible by using the office's daytime phone number. The coverage must be available 24 hours a day, seven (7) days a week, and can be an answering service, call forwarding, or another method,

whereby the caller can speak to a qualified person who will make a clinical decision about the member's oral health status. MHS requires callback times to be no more than 30 minutes.

Referrals to Specialists

Envolve Dental does not require general or pediatric dentists to obtain an authorization or referral to dental specialists. If a specialist is needed, providers should recommend to members a specialist in the Envolve Dental network. Participating network specialists can be found on the MHS "Find a Provider" page at www.mhsindiana.com. If the *specialist* requires a referral before he/she will schedule an appointment for the member, please consult directly with the specialist for that office's referral requirements.

General dentists are responsible for providing necessary x-rays and chart documentation to the specialist. Records should also be available at no cost to members upon request.

Missed Appointments

Envolve Dental recommends that providers contact members by phone at least 24 hours prior to scheduled appointments to confirm the commitment and your office location. Please note:

- Providers can discontinue providing services to a member if he/she misses three appointments in a 12-month period. Be sure to keep a record of occurrences in the member's record, and refer the member to MHS at 1-877-647-4848 to identify a new dental provider.
- Your office's missed appointment and dismissal policies for MHS members cannot be stricter than your private or commercial patient policies.
- Providers are not allowed to charge MHS members for missed appointments.

Balance Billing and Payment for Non-Covered Services

Envolve Dental network providers are contractually obligated to abide by billing requirements, which are established by Envolve Dental, MHS, and the Centers for Medicare and Medicaid Services. These conditions include the following:

- Providers cannot bill members for any type of unauthorized cost sharing for covered dental services, including a co-payment, coinsurance, deductible, or deposit that is not dictated by the member's health plan.
- Providers must accept the Envolve Dental payment as "payment in full," and cannot balance bill members – that is, for the difference between the provider-billed amount and the Envolve Dental payment amount.
- Providers cannot bill members for medical records.

Providers may bill a member *only for non-covered* dental services, with the condition that the provider must inform the member in detail and obtain a signed, detailed agreement from the member (or his/her guardian) *prior to* services being rendered. Providers also agree to hold harmless Envolve Dental, MHS and the State for payment of non-covered services. Please refer to the example form posted on the Provider Web Portal.

Member Information and HIPAA

The Health Insurance Portability and Accountability Act

The Health Insurance Portability and Accountability Act of 1996, commonly known as "HIPAA," includes a Privacy Rule to protect individually identifiable health information and a Security Rule that specifies administrative, physical, and technical safeguards to ensure the confidentiality, integrity, and availability of electronic-protected health information. A major goal of the Security and Privacy rules is to allow the flow of health information to promote high quality health care while properly protecting individual health information.

Envolve Dental complies with HIPAA rules and expects network providers to adhere to HIPAA rules as well. Examples of important definitions and practical applications are listed in Table 3.

Table 3. HIPAA Definitions and Applications

Security Rule Requirement	Definition	Application Example
Confidentiality	Protected Health Information (PHI) and electronic PHI (e-PHI) is not disclosed or available to unauthorized persons.	Envolve Dental will ask callers for their name, Tax ID number, and/or NPI number to verify identity. Callers requesting patient information must also provide member name, date of birth, and member ID or social security number before Envolve Dental will share member-related information.
Integrity	E-PHI is not altered or destroyed in an unauthorized manner.	Patient data should be backed up to prevent loss in case of system crashes. Controls should be in place to identify data changes due to human error or electronic failures. Clinical notes cannot be modified or deleted, but addendums can be added. Patients do have the right to ask for a change in their medical records.
Availability	The property that data or information is accessible and usable upon demand by an authorized person.	Envolve Dental enables only authorized, registered users to access the Provider Web Portal containing patient information. The portal is available 24 hours a day and seven days a week.

Table 3. HIPAA Definitions and Applications		
Security Rule Requirement	Definition	Application Example
Protect against threats or disclosures	Potential threats or disclosures to e-PHI that are *reasonably anticipated* must be identified and protected.	All email correspondence that includes patient name and personal health details must be sent via a secure email service. *Providers should never initiate to Envolve Dental an email that is not encrypted and contains patient details.* Envolve Dental can initiate a secure, encrypted email to providers who can then reply while maintaining the security of the email. Call Provider Services for details.
Staff compliance	People employed by provider offices and health plans (covered entities under HIPAA) adhere to rules.	At least one staff person must be designated as a security official responsible for implementing HIPAA requirements, ensuring training is completed by all staff upon hiring and annually, overseeing compliance, and carrying out appropriate sanctions for violations.
Source: Department of Health & Human Services @ www.hhs.gov/ocr/privacy/index.html		

For additional details about HIPAA, visit the U.S. Department of Health and Human Services' website at HHS.gov.

Utilization Management & Review

Utilization Management

Utilization management aims to manage health care costs before services are rendered according to our clinical policy guidelines that are based on accepted dental practices. Envolve Dental covers all state-required benefits and applies clinical standards to them, explicitly outlining for providers what conditions must be present in order for the covered benefits to apply. Please refer to the clinical policy guidelines available on the Provider Web Portal that include required documentation that substantiates the criteria.

The prior authorization and pre-payment review processes are additional means of managing utilization by appropriateness of care. Several procedures, such as orthodontia, always require prior authorization review and approval before services can be rendered and reimbursable. Other services require authorization but can be approved with a pre-payment review. That is, as long as the clinical policy guidelines for a service are met and the required documentation supports the criteria, then the authorization will be approved and the claim will be paid. See the next section for specific details about prior authorizations and pre-payment reviews and submission options for each.

Envolve Dental makes utilization management decisions based solely on medical necessity, appropriateness of care and benefit coverage parameters. Providers are not encouraged or rewarded to alter treatment decisions for financial gains, nor are they influenced to make decisions that result in underutilization. If providers disagree with an Envolve Dental utilization management decision, providers have the right to appeal.

Utilization Review

Utilization review considers practice standards and patterns based on claims data history, in comparison to other providers in the same geographic area. Envolve Dental conducts utilization reviews to analyze variations in treatment patterns that may be significantly different among providers in the same area. General dentists are not compared to specialty dentists.

If significant differences *are* evident, Envolve Dental may initiate an audit of member records to determine the practice's appropriateness of care.

Practical Applications

Providers can facilitate good utilization management by

- Reviewing clinical policy guidelines and comprehensively documenting member's condition based on them;
- Maintaining accurate, up-to-date dental records and medical histories for each member, including perio-charting and treatment plans, even for routine cases;
- Ensuring x-rays are high quality for accurate diagnoses;
- Submitting all required documentation for authorizations and claims accurately and completely; and

- Maintaining good communication with Envolve Dental by calling Provider Services with questions and concerns: 1-855-609-5157.

Patient Dental Records

All participating providers who deliver dental services to individuals whose dental insurance benefit is administered by Envolve Dental are subject to periodic chart audits and other record requests. Providers must comply with these requests, and audits may take place in the provider's office or at Envolve Dental's corporate office. Upon request, audit findings will be shared in writing with the provider's office. Providers are required to maintain patient dental records (clinical charts, treatment plans and other patient-related communications), financial records and other pertinent documentation according to the record retention policy found in the Envolve Dental Participating Provider Agreement, Article IV – Records and Inspections and the American Dental Association Dental Records policy.

Fraud, Abuse, and Waste

Envolve Dental is dedicated to upholding integrity in the Medicaid program. Most individuals who work with Medicaid and Medicare are honest, but some people take advantage of the system, costing the program – and ultimately taxpayers – unnecessary expenses. As a responsible administrator, Envolve Dental expects its providers, contractors and subcontractors to comply with all applicable laws and regulations pertaining to fraud, abuse, and waste, as required by law. The Centers for Medicare and Medicaid Services define them as

Fraud: When someone intentionally executes or attempts to execute a scheme to obtain money or property of any health care benefit program. Examples of fraud:

- Medicaid is billed for services never rendered.
- Documents are altered to gain a higher payment.
- Dates, descriptions of services, or the beneficiary's identity are misrepresented.
- Someone falsely uses a beneficiary's Medicaid card.

Abuse: When health care providers or suppliers perform actions that directly or indirectly result in unnecessary costs to the health care benefit program. Examples of abuse include:

- Billing for services that were not medically necessary;
- Charging excessively for services or supplies; and
- Misusing codes on a claim, such as upcoding or unbundling codes.

The primary difference between fraud and abuse is intention.

Waste: Providing medically unnecessary services.[1,2]

Envolve Dental is obligated to report suspected fraud or abuse by members and health care providers. Providers also are required to report possible incidents, which can be done so anonymously by calling a fraud and abuse hotline.

Fraud and Abuse Hotlines

Envolve Dental hotline: 1-800-345-1642

MHS Fraud and Abuse hotline: 1-866-685-8664

Indiana Family and Social Services Administration: 1-800-403-0864

Table 4 summarizes applicable federal laws pertaining to fraud and abuse. Additional details are available on the Centers for Medicaid Services website: www.cms.gov.

Table 4. Federal Laws for Medicaid Fraud and Abuse

Law or Regulation	Premise	Example and Penalty/Award
False Claim Act (FCA)	Knowingly submitting a false or fraudulent claim to a federally funded government program.	A provider submits claims for a higher level of services than provided. Fines of $5,500 to $11,000 per false claim and up to three times the amount of damages sustained by the government.
Qui Tam Provision (Whistleblower protection)	Under the FCA, allows citizens with evidence of fraud to sue, on behalf of the government, to recover stolen funds.	Awards 15 to 25 percent of recovered funds to the informant and provides protection for those who may be discharged for taking reasonable action under the FCA.
Physician Self-Referral Law (Stark Law)	Prohibits health care providers from making a referral for certain health services when the provider (or a family member) has an ownership interest in the referral designation.	A provider refers a patient to another office or business where the provider has a financial interest. Penalties include fines, claim repayment, and potential exclusion from federal health care programs.

[1] *Module: 10 Medicare and Medicaid Fraud and Abuse Prevention, 2014 National Training Program*, Centers for Medicare & Medicaid Services

[2] *Medicare Fraud & Abuse: Prevention, Detection, and Reporting*, Centers for Medicare & Medicaid Services.

Table 4. Federal Laws for Medicaid Fraud and Abuse		
Law or Regulation	Premise	Example and Penalty/Award
Anti-Kickback Statute (AKS)	Knowingly and willfully offering, paying, soliciting, or receiving remuneration to induce or reward referrals reimbursable by a federal health care program.	A provider receives cash or other benefits for referrals. Civil penalties can be up to three times the kickback amount.
Criminal Health Care Fraud Statue	Knowingly and willfully executing a scheme in connection with the delivery of or payment for health benefits or services to defraud the program or obtain under fraudulent pretenses any money from the program.	Several providers conspire to defraud the Medicaid program by coordinating a scheme for services that are not medically necessary. Penalties can include fines, imprisonment, or both.
Source: Centers for Medicare and Medicaid Services @ Medicare Fraud & Abuse		

Authorizations, Pre-Payment Reviews and Documentation Requirements

Envolve Dental has specific clinical policy guidelines and authorization processes to manage service utilization according to medical necessity and appropriateness of care. Providers should measure intended services to the clinical policy guidelines before treatment begins to assure appropriateness of care. Authorization requests are considered according to the following:

Authorization Type	Conditions	What to do
Prior Authorizations	Required prior to treatment for certain codes	Check the Plan Specifics and corresponding dental codes for requirements.
Urgent/Emergent Authorizations	Defined as situations involving severe pain, swelling, infection, uncontrolled hemorrhage, or traumatic injury.	Treat the member. **Call Envolve Dental within two business days to report the urgent service in the member's Envolve Dental record.** Submit the completed claim and all required documentation as a Pre-Payment Review no later than 90 calendar days from service date. If you choose to receive prior authorization for urgent cases, call Provider Services at 1-855-609-5157 for options and directions about submission via a HIPAA-compliant secure e-mail initiated by Provider Services.
Pre-payment Reviews	Provider is confident that the member's condition and the clinical policy guidelines are equivalent, and codes are (1) consistent for appropriate treatment and (2) are covered benefits.	Submit claim with all required authorization documentation within 90 days of the date of service.

Prior authorizations address issues of eligibility at time of request, medical necessity, and appropriateness of care. They are not a guarantee of payment. Approval for payment is based upon the member's eligibility on the date of service, dental record documentation, and any policy limitations on the date of service.

If you are uncertain whether a procedure will be paid when submitted as a Pre-payment Review due to potentially unmet clinical policy guidelines, you have the option of first submitting a request for prior authorization before services are rendered.

Prior Authorization

Due to the nature of dental services requests, please submit prior authorization requests with complete documentation requirements to Envolve Dental seven (7) calendar days before a scheduled procedure that requires prior authorization.

Determinations are made based on whether the service is a covered benefit, is medically necessary, if a less expensive service would adequately meet the member's needs, and whether the proposed service conforms to commonly accepted dental standards.

For standard requests, Envolve Dental will make an authorization determination within seven (7) calendar days from the date the request is received, provided all information is complete. For urgent/expedited requests, where you indicate that the member's ability to attain, maintain or regain maximum function would be compromised by waiting seven days, contact Provider Services at 1-855-609-5157 to request an urgent review. The authorization will be auto-granted if Envolve Dental does not make a determination within seven calendar days. Emergency services do not require prior authorization.

Envolve Dental notifies providers with an approval authorization number or with a denial notification via fax within one business day after the determination. *Be certain your fax number is always up to date with Envolve Dental.* Authorization determinations are also visible on the Envolve Dental Provider Web Portal.

- Your office should contact members to schedule appointments when you receive an approved authorization number. Members receive authorization notices *only* for denials or to authorize a service in an amount, duration or scope that is less than requested.
- Prior authorizations are valid for 180 days from the issue date; however, an authorization does not guarantee payment. The member must be eligible at the time services are provided. Providers are responsible for verifying eligibility on the service date.
- Providers are not allowed to bill the member, MHS or Envolve Dental if services begin before authorization is determined and authorization is subsequently denied.

Pre-payment Review Authorizations

Urgent/emergent oral health conditions are defined as situations that involve severe pain, swelling, infection, uncontrolled hemorrhage, or traumatic injury. Such authorization requests are immediately granted. Dental providers are encouraged to treat the member, then call Envolve Dental within two business days after the service to record the incident in the member's Envolve Dental record, and then submit within 90 calendar days the completed claim with all required authorization documents on a recent ADA claim form marked "Pre-payment Review" on the top of the form. All urgent/emergent authorization requests are evaluated by the Chief Dental Officer, a licensed physician, or a licensed dental consultant to certify that the services were urgent or emergent as defined above. All dental consultants, including the Chief Dental Officer, are graduates of an accredited dental school and licensed to practice dentistry in the state in which they reside, at a minimum. Providers starting treatment before authorization approval are at financial risk and

may not balance bill the member if the utilization management reviewer determines conditions were not met.

Providers who choose to pursue prior authorization for urgent cases before treatment should call Provider Services at 1-855-609-5157 for directions about submission via a HIPAA-compliant secure e-mail initiated by an Envolve Dental representative.

Pre-payment Reviews (PPR) are also available for selected codes as indicated on the provider web portal Submit the completed claim with all required authorization documents on a recent ADA claim form marked "Pre-payment Review."

Peer-to-Peer Review

Envolve Dental utilization management staff use clinical policy guidelines to make all authorization determinations. When determinations are made, Envolve Dental sends a notice of the outcome via facsimile (fax) to the provider's fax number on record. The determination is also available on the provider's account on the Envolve Dental Provider Web Portal.

For denied or partially denied authorization requests when additional clinical information exists which was not previously provided, the treating dentist may request a peer-to-peer phone call review within 30 calendar days from the date of the denial. The Envolve dental consultant who reviewed the authorization, claim, or appeal is the primary peer-to-peer dentist for the call. If the adverse determination dental consultant is not available for the peer-to-peer call, then another dentist is selected to complete the call. Information from the adverse determination will be made available to any dentist completing the peer-to-peer call. All Envolve dental consultants maintain active and current unrestricted dental licenses.

Note that only the treating dentist, and not an office assistant or dental hygienist, may request the peer-to-peer review and conduct the peer-to-peer review call during a mutually agreed time.

To request a peer-to peer review, write to Envolve Dental at:

Envolve Dental
Authorizations -IN
PO Box 20847
Tampa, FL 33622-0847

or call Envolve Dental Provider Services at 1-855-609-5157. The request will be processed by Envolve Dental utilization management staff who will call the office within one business day to schedule a phone appointment between the requesting dentist and the Envolve dental consultant at a mutually agreed date and time.

The peer-to-peer discussion includes, at a minimum, the clinical basis for Envolve Dental's decision and a description of documentation or evidence, if any, that can be submitted by the provider of record that, on appeal, might lead to a different utilization review decision. After discussion, the dental consultant will complete an additional advisor review. Using the new information obtained in the call, the dental consultant will decide to uphold, partially uphold, or reverse the previous determination. The decision is logged into the Envolve Dental system, where the provider can

access details in his/her Provider Web Portal account. The decision is also mailed to the requesting provider via US Postal Service.

Peer-to-peer review is not a part of the formal Envolve Dental appeal process. Providers have the option to submit an appeal instead of a peer-to-peer review, or providers can appeal a decision after a peer-to-peer review results in an upheld denial.

Authorization Submission Procedures

Authorization requests must be received at least seven business days in advance in one of the following formats:

1. Envolve Dental Provider Web Portal at - https://pwp.envolvedental.com
2. Electronic clearinghouses, using Envolve Dental payor identification number 46278
3. Alternate, pre-arranged, HIPAA-compliant electronic files
4. Paper request on a completed ADA claim form by mail
5. For urgent requests, call Provider Services at 1-855-609-5157.

1. Provider Web Portal Authorization Submissions

Providers can submit authorization requests directly to Envolve Dental on our Provider Web Portal, including attachment uploads. Submissions on the portal are quick and easy and facilitate faster processing and determinations. To submit, log on to https://pwp.envolvedental.com. If you have questions about submitting authorization requests or accessing the Envolve Dental Provider Web Portal, call Provider Services at 1-855-609-5157 or email providerrelations@envolvehealth.com.

2. Clearinghouse Authorization Submissions

Providers can use their preferred clearinghouse for authorization requests. .

Use Envolve Dental payor identification number **46278** for all clearinghouses.

Envolve Dental will receive the requests electronically and process them with our state-of-the-art authorization administration modules. Be sure to include all required documentation when submitting on their portals, using a NEA *Fast*Attach® tracking number in the remarks section. A Dental Review Specialist assigned to MHS will make the determination.

Electronic Attachments for Clearinghouse Submissions

Envolve Dental promotes electronic authorization and claim processing for fast and efficient decisions and payments. Our Envolve Dental Provider Web Portal is the preferred method for submissions that include attachments, but if your office uses a clearinghouse, we can accept attachments from National Electronic Attachment, Inc. (NEA).

NEA, through *Fast*Attach®, enables providers to securely send attachments electronically – x-rays, EOBs, intraoral photographs, perio charts, and more. To use the system, go to www.nea-fast.com, install the software, and follow the steps to begin using it. The steps are simple: a provider scans required documents, transmits them to NEA's secure repository, selects Envolve Dental as the payor (ID #46278) and receives an NEA unique tracking number. Next, the provider includes the NEA tracking number in the remarks section to Envolve Dental.

Images you transmit are stored for three years in NEA's repository and can only be viewed by your office and Envolve Dental. Data and images remain secure with HIPAA-compliant standards and you should only give your office's NEA account login and password to authorized users.

3. Alternate HIPAA-Compliant 837D File

Electronic authorization submissions must be HIPAA-compliant. Envolve Dental strongly recommends using our custom Provider Web Portal because we stay current with HIPAA regulations. If your office uses an alternative electronic system that requires direct integration using an 837D file, Envolve Dental will consider options to assist. To schedule an appointment with our technical specialist to discuss alternatives, please email us at providerrelations@envolvehealth.com or call 1-855-609-5157.

4. Paper Authorization Submission

Paper authorization requests must be submitted on a recent ADA claim form with the following information:

- Member name
- Member Medicaid ID Number
- Member date of birth
- Provider name and location
- Billing location
- Provider NPI and Tax Identification number (TIN)

For services requested, include:

- Approved ADA codes as published in the current CDT book
- All quadrants, tooth numbers and tooth surface identifications per dental code
- Required documentation, such as x-rays and treatment plansMissing or incorrect information could result in an authorization denial or determination delay. Mail paper authorization requests and all required documents with correct postage to:
  Envolve Dental Authorizations: IN
  PO Box 20847
  Tampa, FL 33622-0847

ADA forms may be obtained from the American Dental Association.

Prior Authorization for Facility and Hospital Services

Dental services that require treatment in a facility or hospital must receive prior authorization from Envolve Dental. Hospital or facility prior authorization requests must be made at the same time that the dental service authorization is requested. Providers must use a participating MHS Indiana hospital and receive prior authorization. To obtain the most recent listing of hospitals in your area:

- Visit MHS Indiana's website: mhsindiana.com
- Call MHS Indiana Provider Services: 855-609-5157

Prior Authorization for Orthodontic Care

Please refer to the state's IHCP Dental Manual for the most recent orthodontic care requirements
Visit MHS Indiana's website: mhsindiana.com

Claim Submission Procedures

Submit claims and encounters electronically or by mail within 90 calendar days of the date of service by using one of the following options. Important: Do NOT highlight any items on your submissions.

1. Envolve Dental Provider Web Portal at https://pwp.envolvedental.com
2. Electronic clearinghouses, using Envolve Dental payor identification number 46278
3. Alternate, pre-arranged HIPAA-compliant 837D electronic files
4. Paper claims on a completed ADA claim form by mail

Providers should have all required information for a claim ready to insert into the electronic fields or the paper claim form prior to initiating submission. Electronic attachment options for x-rays, charts, photos and other items are available as detailed below.

1. Provider Web Portal Claim Submissions

The Envolve Dental Provider Web Portal is user-friendly and is the fastest way for claims to be processed and paid. Our state-of-the-art web portal has specific fields to enter all required information. It also contains an upload feature to attach all required documents, x-rays and other supporting information. To avoid claim denials or delayed payments, refer to the clinical policy guidelines on the Provider Web Portal to ensure you include all required information before submitting.

To access the Envolve Dental provider web portal, go to

https://pwp.envolvedental.com

Log on with your username and password. If you have not yet registered for the web portal, or if you have questions about how to submit claims on it, call Provider Services at 1-855-609-5157 or send us an email at providerrelations@envolvehealth.com.

2. Electronic Clearinghouse Claim Submission

Envolve Dental works with selected electronic clearinghouses to facilitate dental offices that use one electronic source for all their insurances. Please check with your preferred vendor so that your software is up-to-date, and confirm your first submission to Envolve Dental using the clearinghouse was successful before sending additional claims. Electronic attachments may be available with your preferred clearinghouse, or can otherwise be submitted to us via *Fast*Attach® (details follow).

Use Envolve Dental payor identification number **46278** for all clearinghouses.

3. Alternate HIPAA-Compliant Electronic Submission

Electronic claim submissions must be HIPAA-compliant. Envolve Dental strongly recommends using our custom Provider Web Portal for all claim submissions because we stay current with HIPAA regulations. If your office uses an alternative electronic claims system that requires direct integration using an 837D file, Envolve Dental will consider options to assist. To schedule an

appointment with our technical specialists to discuss alternatives, please email us at providerrelations@envolvehealth.com or call 1-855-609-5157.

4. Paper Claim Submission

The following information must be included on a recent ADA claim form for timely claims processing:

- Member name
- Member Medicaid ID number
- Member date of birth
- Provider name
- Provider location and service setting
- Billing location
- NPI and Tax Identification number (TIN)
- Date of service for each service line
- ADA dental codes in the current CDT book for each service line
- Provider signature

Be sure to include all required identifiers (quadrants, tooth numbers, and surfaces).

Mail paper claims with any required supporting documentation to:

Envolve Dental
Claims
PO Box 20847
Tampa, FL 33622-0847

Postage due mail will be returned to sender.

Claim/Encounter Submission for FQHCs, CHCs and RHCs

Facilities such as Federally Qualified Health Centers (FQHCs), Community Health Centers (CHCs), and Rural Health Clinics (RHCs) are reimbursed in Indiana via a fee-for-service system. Providers can choose one of the four claim submission options to submit encounters. Note the following requirements:

- Submit claims for every service to ensure member utilization data is complete.
- Ensure every code includes corresponding tooth numbers, quads, arches and any other required identifiers.
- Include applicable authorization numbers.
- Include all documentation requirements for each code.

Electronic Attachments

Envolve Dental promotes electronic authorization and claim processing for fast and efficient decisions and payments. Our Envolve Dental Provider Web Portal is the preferred method for submissions that include attachments, but if your office uses a clearinghouse, we can accept attachments from National Electronic Attachment, Inc. (NEA).

NEA, through *Fast*Attach®, enables providers to securely send attachments electronically – x-rays, EOBs, intraoral photographs, perio charts, and more. To use the system, go to www.nea-fast.com, install the software, and follow the steps to begin using it. The steps are simple: a provider scans required documents, transmits them to NEA's secure repository, selects Envolve Dental as the payor (ID #46278) and receives an NEA unique tracking number. Next, the provider includes the NEA tracking number in the remarks section of authorization requests and claims submissions to Envolve Dental.

Images you transmit are stored for three years in NEA's repository and can only be viewed by your office and Envolve Dental. Data and images remain secure with HIPAA-compliant standards and you should only give your office's NEA account login and password to authorized users.

Billing for Crowns and Dentures

For crowns, the date of service must be billed according to the cementation date. For dentures, the billed date of service must be the "seat date"/ date of insertion.

Billing for Services in Emergency Situations

Members who have an urgent or emergent condition, defined as a situation involving severe pain, swelling, infection, uncontrolled hemorrhage, or traumatic injury should be treated immediately for covered benefits. Within two business days, call Envolve Dental at 1-855-609-5157 to verbally report the incident in the member's record. For billing, submit the claim with a narrative explaining the emergency and indicate "pre-payment review." Include with the claim all required documentation for the code(s) within 90 calendar days from the service date. If the call was not placed to Envolve Dental within two business days, include an explanation in the narrative, and submit as above.

Billing for Services Rendered Out-of-Office

Billing for all services should include the location code where services were rendered on a recent ADA claim formor on the appropriate section of an electronic claim submission. The code for treatment in an office setting is "11". For services provided in an out-of-service setting, such as a school or nursing home, bill with the appropriate location code. The most common are "03" for school, "15" for mobile unit, "22" for outpatient hospital, "24" for ambulatory surgical center, "31" for skilled nursing facility, "32" for nursing facility and "99" for "other". A comprehensive list of locations can be found on the Centers for Medicare and Medicaid Services website.

Billing Limitations

Envolve Dental advocates responsible billing practices and administers reimbursements of at least the minimum reimbursement required by the State. Note the following limitations when billing:

- **X-rays/Radiographs**: Maximum provider reimbursement per member per date of service is limited to the fee for a complete series. Limited x-rays may be billed by two different providers for the same member when one provider is a general dentist, the second is a

dentist specializing in treating the member's condition, and both providers do not share a common office location or billing practice.

- **Amalgams and Resins**: Payment for a restorative service includes tooth preparation and any base or liner placed beneath the restoration. Payment for a restorative service includes necessary local anesthesia.
- **Only one restoration code per tooth for restorations using the same material, performed on the same date by the same dentist for the same member.**
- **Endodontic therapy:** All diagnostic tests, evaluations, radiographs and post-operative treatment are included in the fee.
- **Denture-related services:** Lab fees are included in the denture placement reimbursement rate and cannot be billed separately to Envolve Dental or the member. All complete and partial denture relining procedures include six months of post-delivery care.
- **Cost-sharing:** Providers cannot bill members for any type of cost-sharing for covered dental services, including a co-payment, coinsurance, deductible, or deposit that are not dictated by the member's plan.
- **Balance billing:** Providers must accept the Envolve Dental payment as "payment in full," and cannot balance bill members – that is, for the difference between the provider-billed amount and the Envolve Dental payment amount.
- **Missed appointment billing:** Providers are not allowed to charge members for missed appointments.

Coordination of Benefits (COB)

Claim submissions for MHS members who have benefits with another insurer must be coordinated. In most cases, MHS will be the secondary insurer. Providers are responsible for asking members if they have multiple insurances and for submitting claims in the proper order:

- Submit claims to the primary insurer first.
- After receiving the primary insurer's Explanation of Benefits (EOB), submit a claim for any remaining balance to Envolve Dental with the EOB statement within 90 days of the primary payer's determination. Please contact us for further instructions if the third party does not respond within this timeframe.
- For electronic submissions, indicate the payment amount by the primary carrier on the claims entry page on the Provider Web Portal.

Payments to providers will not exceed the contracted Envolve Dental fee schedule. Claims are considered paid in full when the primary insurer's payment meets or exceeds the contracted rate.

Claims Adjudication, Editing and Payments

Envolve Dental adjudicates all claims weekly with an automated processing system that imports the data, assesses it for completeness, and then analyzes it for correctness in terms of clinical policy guidelines coding, eligibility, and benefit limits, including frequency limitations. The system also

evaluates claims requiring prior authorizations and automatically matches them to the appropriate member authorization records.

Once editing is complete, our system updates individual claim history, calculates claim payment amounts – including copayment amounts and deductible accumulations, if applicable – and generates a remittance statement and corresponding payment amount. Most paper clean claims are paid within 30 days of submission and electronic claims within 21 calendar days. Payments are made to the provider's EFT account or to a check printer that delivers the paper check and remittance statement by US Mail. Remember:

- EFT is the quickest means to receive payments.
- Electronic remittance statements are available in the "Documents" tab in your Envolve Dental Provider Web Portal account. Insert the date span for remittances you want to view.
- Clearinghouses will not transmit Envolve Dental remittance statements to providers.
- Remittance statements will remain available on the Envolve Dental web portal indefinitely.
- You can call Provider Services at 1-855-609-5157 with questions about claims and remittances.

If Envolve Dental requires additional clean claim elements or changes to clean claim elements or attachments, or if Envolve Dental has an address or telephone number change, Envolve Dental will notify providers in writing, via fax, email, Provider Web Portal bulletin, or mail, at least 60 days in advance of the change.

Corrected Claim Processing

Providers who receive a claim denial due to incorrect or missing information can submit a "corrected claim" within 60 days of the EOB. Claims are considered "corrected claims" if at least one code on the original submission was denied due to missing information such as a missing tooth number or surface identification, an incorrect member ID, an incorrect code, or an incorrect amount. To submit a corrected claim, providers may mail the corrected claim or resubmit the claim through the Provider Web Portal as follows:

Mail Submission

- Complete a recent ADA claim form with:
  - ALL codes originally submitted, including accurate code(s) and the corrected code(s), even if previously paid.
  - ALL required documentation only for the corrected, unpaid codes.
  - "CORRECTED CLAIM" written on the top of the form, with the original claim number.
- Corrections must be indicated on the ADA claim form as follows:
  - Make the correction on the service line that was in error (e.g., cross through the error and write in correct information.
  - In the "Remarks" section of the form (box #35), write in the details of the correction (e.g., add a tooth number, change to accurate service date, code, etc.).

- Do NOT highlight any items on the form – doing so prevents our scanners from importing the information.
- Mail with correct postage to:

  Envolve Dental
  Corrected Claims
  PO Box 20847
  Tampa, FL 33622-0847

Provider Web Portal Submission

Providers may resubmit previously processed claims directly through the web portal to correct inaccurate data. Please refer to the Provider Web Portal training posted online for more details.

Corrected claim determinations are published on your remittance statement within 30 days of Envolve Dental receiving the corrected claim.

Claim Denials

Provider claims that are denied can be appealed when submitted to Envolve Dental within 60 calendar days after the denial was issued, or the non-payment notification was made, as indicated on the remittance advice. Please review the clinical policy guidelines available on the Provider Web Portal when formulating a written appeal, citing why you believe the claim should be paid. To submit, mail an appeal with your name, NPI, contact details, and all supporting documentation to:

Envolve Dental
Appeals
PO Box 20847
Tampa, FL 33622-0847

Appeals, Complaints & Grievances

Envolve Dental is committed to providing high-quality dental services to all members and superior administrative services to all network providers. As part of this commitment, Envolve Dental supports MHS' member grievances and appeals protocol and leads MHS' dental provider appeals process. Table 4 summarizes the definitions and actions for each, and a more detailed narrative follows.

Table 4: Distinguishing Complaints, Grievances and Appeals

	Providers	Members
Complaint	A verbal or written communication to Envolve Dental or MHS of dissatisfaction with a policy, procedure, or administrative function.	An expression of dissatisfaction about any matter *other than an action*.* Complaints are made by phoning MHS Member Services. Members not satisfied with the way a complaint is managed, or if it is not resolved within 24 hours, can file a grievance.
Grievance	Not formally defined for providers.	Any expression of dissatisfaction about any matter *other than an action*.* Can be filed verbally or in writing to MHS. Contact should be made as soon as possible after the incident, and no later than 60 days after the initial complaint date. Members should follow up calls in writing to support the grievance.
Appeal	A request for denied authorization or denied claim review, submitted in writing to Envolve Dental within 60 calendar days of receiving the authorization denial notice or denied claim notice.	A request for "Notice of Adverse Action"* review, submitted verbally or in writing to MHS within 60 calendar days of receiving the action.
External Independent Review	Within 120 calendar days of an appeal decision, providers can request an external, independent review about matters of medical necessity or experimental or investigational services.	Within 120 calendar days of an appeal decision, members can request an external, independent review about matters of medical necessity or experimental or investigational services.
State Fair Hearing Appeal	Not available.	An appeal to the state about an Adverse Action* or appeal result that is not resolved to the member's satisfaction. Must be requested within 60 calendar days of exhausting MHS appeal procedures.

Table 4: Distinguishing Complaints, Grievances and Appeals
*An "action" or "Notice of Adverse Action" occurs when a member receives a denial or limited authorization for a provider-requested service, a provider receives a denied authorization or claim, or a member is not happy with the result of a grievance.

Provider Complaint and Appeal Procedures

Differences may develop between Envolve Dental and a network dentist concerning prior authorization decisions or payment for billed services. Differences can also result from misunderstanding of a processing policy, service coverage or payment levels. The following explains how to initiate a complaint or appeal.

Provider Complaints

The first level of managing a disagreement begins when a provider with a *complaint* – defined as an expression of dissatisfaction received verbally or in writing about a policy, procedure, claim, contracting, or other function about working with Envolve Dental. Envolve Dental strives to resolve complaints while on the call with the office representative.

Call, email, or write with complaints to:

Provider Services 1-855-609-5157	dentalappeals@envolvehealth.com	Envolve Dental Grievances and Appeals-IN PO Box 20847 Tampa, FL 33622-0847

Provider Appeals

An *Appeal* is the mechanism for providers to request a reconsideration of actions by Envolve Dental, such as a claim denial, prior authorization denial on behalf of the member or if the provider is aggrieved by any rule, policy or decision made by Envolve Dental. Providers must file an appeal within 7 calendar days of receiving the Envolve Dental notice of action (NOA) for authorizations. Verbal appeals must be followed up with a written appeal, and include a statement supporting the appeal and any corresponding records. Envolve Dental will confirm receipt of the appeal within three business days, and will indicate if any additional information is required to consider the appeal request.

Providers may email dentalappeals@envolvehealth.com with the provider name, NPI, contact details and supporting documentation. They also may continue to submit their appeals via the U.S. postal service address listed in the following pages.

Envolve Dental will resolve each Hoosier Care Connect appeal within 20 business days of receipt and HIP/Hoosier Healthwise appeal within 30 calendar days of receipt, and provide written notification of the decision, including

- The Envolve Dental decision;

- The date of the decision;
- For appeal decisions not in favor of the member, information about how a member or provider can pursue an independent external review or State Fair Hearing; and
- The member's right to receive benefits pending the hearing, explaining the member may be liaible for the cost of services if the hearing results in a denial.

Expedited medical management appeals may be filed when the member's provider determines that the standard resolution process could seriously jeopardize the member's life, health or the ability to attain, maintain or regain maximum function. If the request for an expedited appeal is denied, the standard appeal resolution time limits will be followed.

Decisions for expedited medical management appeals are issued as expeditiously as the member's health condition requires. Within 48 hours of receiving the Hoosier Care Connect request (72 hours for HIP and Hoosier Healthwise requests), Envolve Dental will make a determination and communicate it to the provider verbally, or will notify the provider if there is missing information needed to make the determination. Envolve Dental will follow up the determination with a written notice within three business days.

External Independent Review

Providers or members can request an external, independent review for decisions made by MHS and Envolve Dental about matters of medical necessity or if a service is experimental or investigational. To request a review, a provider must have the member's verbal and written consent, and then the provider must call or write to MHS within 120 calendar days of the appeal decision. MHS will send the complete case file to an external, independent review agency with the Indiana Department of Insurance. The agency will have a same-specialty provider review the case and answer the provider and MHS within 15 business days.

Provider Claim Disputes

Informal claim disuptes and objections must be submitted in writing to Envolve Dental within 67 calendar days from the date on the EOB. Upon receipt, Envolve Dental will review the claim and notify the provider within 30 days of the result when the denial is upheld, or via EOB if the denial is overturned. If a provider disagrees with the informal claim dispute resolution, the provider may file a formal claim dispute.

Formal Claim Disputes – Administrative Claim Appeals

Providers who are not satisfied with the informal claim dispute resolution can file an administrative claim appeal, or formal claim dispute, within 67 calendar days of the informal dispute resolution notice, or 90 calendar days from the date of the informal claim dispute submission. Administrative claim appeals must be submitted in writing on company letterhead with "appeal" and the claim number in the subject line, and must include all details to justify reconsideration. Envolve Dental will send an acknowledgement letter to the provider within five buiness days of receiving the administrative claim appeal.

If the original determination is upheld, the provider will be notified within 45 calendar days of receipt of the appeal. The written determination will include a detailed explanation of the factual

and legal basis of the determination, as well as a notice of the provider's right to submit to binding arbitration within 60 calendar days.

In the event that Envolve Dental does not deliver a written determination within 45 calendar days of receiving the claim appeal, the initial decision will be overturned and the appeal ruled in favor of the provider.

If the original denial determination is overturned, the provider is notified via a new EOB showing the claim reprocessing and payment within 30 calendar days of the final determination date.

If a claim appeal lacks sufficient supporting documentation, Envolve Dental will make a determination of "denial for lack of supporting documentation." The provider will be notified and have 30 days to submit the requested information. If after 30 days the appeal still lacks sufficient documentation, the denial will be upheld and final.

Arbitration

Envolve Dental follows the provider dispute process outlined in 406 Indiana Administrative Code 1-1.6-1 *et. seq.* for contracted and non-contracted providers. In the event that a provider is not satisfied with the outcome of the administrative claim appeal process, the provider may request arbitration.

To begin arbitration, providers must mail a written request on company letterhead to MHS within 60 calendar days after receiving the administrative claim denial. The letter should reference the appeal number, the request for arbitration, reasons the provider believes the claim should be paid, and any other supporting details. Mail the request to:

Managed Health Services
Attention: Arbitration
550 N Meridian St
Suite 101
Indianapolis, IN 46204

MHS will work with Envolve Dental to research the case within 30 calendar days of receipt and respond by contacting the provider to (1) set up the arbitration hearing; (2) request additional information from the provider and discuss the case in detail; or (3) offer to settle the matter.

Binding arbitration is conducted in accordance with the rules and regulations of the American Health Lawyers Association, pursuant to the Uniform Arbitration Act as adopted in the state of Indiana at Indiana Code 34-57-2-1 *et.seq.,* unless the provider and MHS mutually agree to an alternative binding resolution process.

Member Complaints, Grievances and Appeals

Member Complaints

Members who are not satisfied with MHS programs and services, or services from a provider, can call MHS Member Services at 1-877-647-4848 to verbalize a complaint. MHS records each complaint and follows up with the member about a resolution. Members who are not satisfied with the result can file a grievance.

Member Grievances

A member grievance is defined as a member expression of dissatisfaction about any matter other than an adverse action. An adverse action is a denial or limitation of a service, communicated to members in writing, and is only considered via an appeals process.

Members or their designated representatives should file a grievance with MHS about their dental or medical care as soon as possible after the event causing dissatisfaction occurred, and no later than 60 calendar days following the date a complaint was placed. Envolve Dental will support the MHS Complaint and Grievances Coordinator with information gathering that can assist in formulating a response to the member.

Member grievances should be directed to:

MHS Member Services
550 North Meridian, Ste. 101
Indianapolis, IN 46204
Phone: 1-877-647-4848

MHS will send members a letter within three business days to acknowledge the grievance and advise about next steps and patient rights. All member grievances are resolved within 20 business days, and the decision is sent to the member in writing within 25 business days. Members who are not satisfied with the grievance result can file an appeal.

Member Appeals

An appeal can be filed when a member is not satisfied with a grievance result or other decision made by MHS or Envolve Dental, such as a denial for a prior authorization request. When a dental prior authorization request for services is denied, limited, reduced or terminated, Envolve Dental mails to the member (and faxes to the provider) a notice of the adverse action. The member has the option to appeal the decision to MHS within 60 calendar days from the date on the notice of action. The member may choose to ask a provider or another person to represent him/her in the appeal process. MHS will resolve each appeal within 20 business days from the date MHS receives the appeal, and a written notice is mailed within 25 business days. Expedited appeals may be filed if the member's ability to attain, maintain, or regain maximum function would be jeopardized. In such cases, appeals are decided within two calendar days (48 hours) from the initial receipt.

External, Independent Review State Fair Hearing

Members can request an external, independent review for decisions made by MHS and Envolve Dental about matters of medical necessity or if a service is experimental or investigational. To request a review, members must call or write to MHS within 120 calendar days of the appeal decision for Hoosier Care Connect or 60 calendar days for HIP and Hoosier Healthwise. MHS will send the complete case file to an external, independent review agency with the Indiana Department of Insurance. The agency will have a same-specialty provider review the case and answer the member and MHS in approximately two weeks. Members can request an external, independent review and a State Fair Hearing, but not concurrently.

State Fair Hearing

Members can request a State Fair Hearing when an appeal and external independent review are not resolved in the member's favor. The request must be made within 60 calendar days of exhausting MHS appeal procedures. Members can request assistance in filing a State Fair Hearing by calling MHS Member Services at 1-877-647-4848 or by writing to the Family and Social Services Administration directly at:

Hearing and Appeals Section, MS-04
Indiana Family and Social Services Administration
402 West Washington Street, Room E034
Indianapolis, IN 46204

Members are entitled to receive all covered benefits while an appeal or State Fair Hearing is pending. If the final decision on the appeal is to deny the services, the member may have to pay for the services.

Clinical Definitions

Teeth should be identified as follows:

Teeth	Identified by
Primary	Letters A through T
Permanent	Numbers 1 through 32
Supernumerary	Letters AS through TS* Numbers 51 through 82*

*Supernumerary designation can be determined by using the nearest erupted tooth. If the tooth closest to the supernumerary tooth is #1, then the supernumerary tooth should be charted as #51. Likewise, if the nearest tooth is A, the supernumerary tooth should be charted as AS.

Reimbursement Limitations for Selected Benefits

Envolve Dental advocates responsible billing practices and administers reimbursements accordingly. Note the following limitations when billing:

- **X-rays/Radiographs**: Maximum provider reimbursement per member per date of service is limited to the fee for a complete series. Limited x-rays may be billed by two different providers for the same member when one provider is a general dentist, the second is a dentist specializing in treating the member's condition, and both providers do not share a common office location or billing practice.
- **Amalgams and resins**: Payment for a restorative service includes tooth preparation and any base or liner placed beneath the restoration. Payment for a restorative service includes necessary local anesthesia.

Appendix A: Dental Benefit Codes

For the most current covered dental benefit codes and details, please refer to the Provider Web Portal.

Appendix B: Provider Web Portal User Guide

For the most current instructions on using the Provider Web Portal, please refer to the Provider Web Portal training posted separately online.

Envolve Dental Provider Manual

We welcome your input for future editions: providerrelations@envolvehealth.com