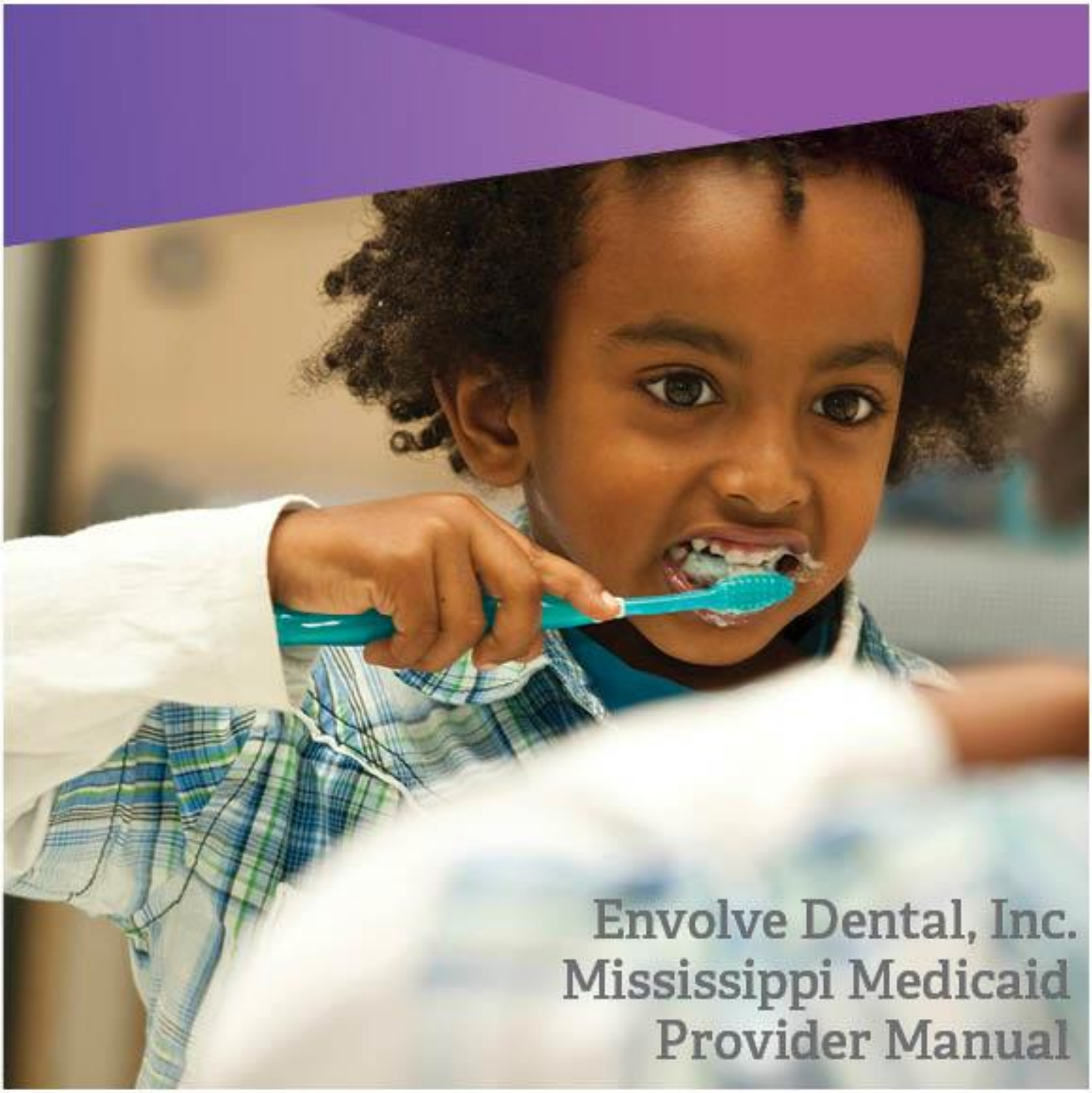
magnolia health

envolve
Benefit Options



# Envolve Dental, Inc. Mississippi Medicaid Provider Manual

Envolve Dental, Inc.

# 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
- 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<br>(Claims, authorizations, remittances) | https://pwp.envolvedental.com |
| Customer Service | 844-464-5636 |
| Magnolia Member Services<br>(including translation assistance) | 866-912-6285 |
| Member Transportation Assistance<br>(MississippiCAN only) | 866-912-6285 |
| Credentialing | 844-847-9807 fax |
| Fraud, Waste and Abuse | 800-345-1642 |
| Authorization Address | Envolve Dental<br>Authorizations<br>PO Box 25255<br>Tampa, FL 33622-5255 |
| Paper Claim Address | Envolve Dental<br>Claims<br>PO Box 25255<br>Tampa, FL 33622-5255 |

# Summary

| Quick Reference Guide | |
|---|---|
| Member Eligibility | Check eligibility through one of the following. You must provide your NPI number to access member details.<br>• Log on to Provider Web Portal: https://pwp.envolvedental.com/<br>• Call the Interactive Voice Response (IVR) eligibility hotline: 844-464-5636<br>• Call Customer Service: 844-464-5636 |
| Member Cost Sharing | Excluded from cost sharing are routine preventive and diagnostic dental services and routine dental fillings. Check member eligibility to see if cost sharing applies to your patient. |
| Authorization Submission | Authorization request submissions must be received via one of the following:<br>• Provider Web Portal at **https://pwp.envolvedental.com**<br>• Electronic clearinghouses using payer ID 46278:<br>  ○ Electronic submission via Change Healthcare clearinghouse : Payer ID 46278 http://www.changehealthcare.com<br>  ○ DentalXChange (www.dentalxchange.com)<br>  ○ Trizetto (www.trizetto.com)<br>  ○ Include attachments with NEA *Fast*Attach® number<br>• Alternate, pre-arranged HIPAA-compliant 837D file<br>• Paper authorization via ADA 2012 claim form and mailed to:<br>Envolve Dental<br>MSCAN Authorizations<br>PO Box 25255<br>Tampa, FL 33622-5255 |
| Retrospective Review Submission | Retrospective reviews are post-treatment authorizations submitted with claims. Required documentation for each code—listed in the benefit grids—must be included and meet specified clinical criteria.<br>Submit retrospective review authorizations as claims, according to claim submission options. |
| Dental Services in a Hospital Setting | Providers must use a participating Magnolia Health Plan hospital. For a current list of hospitals in your area:<br>• Visit Magnolia Health's website under "Find a Provider": www.magnoliahealthplan.com<br>• Call Magnolia Health Customer Service: 866-912-6285<br>Providers must request facility authorization from Envolve Dental at the same time that dental service authorization is requested. |

# Quick Reference Guide

## Claims Submission

All claims and encounters must be submitted within 180 calendar days of the date of service. This is a Magnolia Health timely filing requirement.

Submit claims in one of the following formats:

- Envolve Dental Provider Web Portal at https://pwp.envolvedental.com
- Electronic clearinghouses using payer ID 46278:
    - Change Healthcare clearinghouse (http://www.changehealthcare.com)
    - DentalXChange (www.dentalxchange.com)
    - Trizetto (www.trizetto.com)
    - Include attachments with NEA *Fast*Attach® number
- Alternate pre-arranged HIPAA-compliant electronic submissions
- Paper claims:

  Envolve Dental Claims
  PO Box 25255
  Tampa, FL 33622-5255

All claims submitted must include the member's Medicaid ID number. All claims should also include the provider NPI number.

## Corrected Claim Submission

Providers who receive a claim denial and need to submit a corrected claim must send a paper claim including ALL codes originally submitted, plus the corrected code with supporting documentation, within 90 calendar days of the notification of payment or denial to:

Envolve Dental
MSCAN Corrected Claims
PO Box 25255
Tampa, FL 33622-5255

## Provider Claim Reconsideration or Claim Dispute

Claim payment reconsiderations or disputes must be submitted within 90 calendar days from the date the denial was issued or the non-payment notification date (as indicated on the remittance advice).

To make this request, write to:

Envolve Dental
MSCAN Reconsideration/Claim Dispute
PO Box 25255
Tampa, FL 33622-5255

## Grievances and Complaints

To file a grievance or complaint:

- Call: 844-464-5636
- Write to:

  Envolve Dental
  Grievance or Complaint
  PO Box 25255
  Tampa, FL 33622-5255

## Quick Reference Guide

### Member Appeals

Members must submit appeals within 60 calendar days of receiving the Adverse Benefit Determination. Members submit written appeals to:

Magnolia Health Plan
Clinical Appeals Coordinator
111 East Capitol St, Suite 500
Jackson, MS 39201

MississippiCAN members can request a State Fair Hearing after exhausting all health plan-level Grievance and Appeal procedures. State Fair Hearing requests must be received within 120 calendar days of the member receiving the final decision, or Notice of Appeal Resolution, by the health plan, by writing to:

Division of Medicaid
Attention: Office of Appeals
550 High St, Suite 1000
Jackson, MS 39201
800-421-2408

For more information about filing an appeal for MississippiCAN members, contact the Magnolia clinical appeals coordinator at 866-912-6285.

### Additional Provider Resources

For information about additional provider resources:

- Call Customer Service: 844-464-5636
- 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 have joined our provider network, composed of the best providers in the state and established to deliver quality dental healthcare. Envolve Dental is a subsidiary of Centene Corporation, a Fortune 100 company with nearly 30 years of experience in Medicaid managed care programs. We have partnered with Magnolia Health, our sister company, to administer dental benefits for their members in the Magnolia Health managed care program called the Mississippi Coordinated Access Network (MississippiCAN).

This Envolve Dental provider manual supplies useful information about working with us for the MississippiCAN plan. 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 Customer Service at 844-464-5636, Monday through Friday, 8 a.m. to 5 p.m. (Central Time) or send us an email at providerrelations@envolvehealth.com.

Envolve Dental retains the right to modify items in this provider manual. Contracted providers must acknowledge this provider manual and any other written materials provided by Envolve Dental as proprietary and confidential.

# 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. Historically, providers cite low payment rates and administrative burdens as reasons for not participating in the Medicaid program.[1] 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.

- Magnolia Health's 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 Magnolia Health members who are currently patients in their office;
    - accept new patients and be listed in a Magnolia Health provider directory;
    - be excluded from a provider directory but accept new patients directed to the office by Envolve Dental; and
    - 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.



[1] *Medicaid: A Primer*, March 2013. The Kaiser Commission on Medicaid and the Uninsured

# 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 Customer Service at 844-464-5636. 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 Mississippi dentists to participate:

1. A State of Mississippi Provider Medicaid ID number. To obtain one, go to https://www.ms-medicaid.com/msenvision/pef/Login.do and complete the enrollment application.
2. 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 800-465-3203 to request an application

If you have any questions about the contents of the Provider Agreement or how to apply, please call Customer Service at 844-464-5636.

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.

# Credentialing

The credentialing process is required to protect Medicaid beneficiaries from receiving services from unqualified providers, such as those with restricted 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.

Envolve Dental will honor claims from contracted providers who are provisionally credentialed only for the first 60 days after plan commencement or contract signing date.

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

Step 1: Obtain *Mississippi Participating Physician Application* from Envolve Dental or https://www.avesis.com/stateapps/Mississippi.pdf.

Step 2: Return the following to Envolve Dental:

- Completed Mississippi credentialing data gathering form
- Copy of Drug Enforcement Agency (DEA) license
- Copy of malpractice insurance
- Completed Disclosure of Ownership (DOO) form
- State Medicaid ID number

You can return documents by

Email: dental credentialing@envolvehealth.com
Fax: 844-847-9807

Step 3: Expect to receive an acknowledgement letter from the Envolve Dental Credentialing that (a) all your documents have been received or (b) you need to submit missing documentation. The Credentialing Committee will review your application only when all documents have been received.

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.

## 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

## 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 and all participating providers are fully credentialed. | Sign and return the Provider Agreement (if not done so previously).<br><br>Register on the Envolve Dental Provider Web Portal.<br><br>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.<br><br>Examples:<br>(1) A provider with sanctions may be accepted, but Cost Containment division will closely monitor claims for six months;<br>(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).<br><br>Register on the Envolve Dental Provider Web Portal.<br><br>Start seeing members on the effective date.<br><br>Cooperate with Cost Containment and Credentialing requests for new information.<br><br>Advise Credentialing when external sanctions lifted. |
| 3. Table application | The Credentialing Committee wants additional information about a questionable matter before making a determination.<br><br>OR<br><br>The Credentialing Committee is waiting for a known external investigation to conclude 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.<br><br>Provide up-to-date information to the 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 Magnolia Health have the exclusive right to decide which dentists it accepts as participating providers in the network. Envolve Dental does not discriminate based on age, race, ethnicity, gender, national origin or religion in making credentialing determinations.

Envolve Dental will notify Magnolia Health 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:

- 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 request a reconsideration of the determination. Information about how to request a reconsideration will be specified in the denial letter.

To begin the reconsideration process, a provider needs to submit a letter with the subject line "Credentialing reconsideration," 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 reconsideration request, 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 reconsideration level have the option to submit a second-level reconsideration. Submit a letter with the subject line "Credentialing second-level reconsideration." Include with the letter any additional information that would support acceptance. The second-level reconsideration will be carried out by a Peer Review Committee and its determination will be considered final.

Call Envolve Dental at 844-464-5636 if you have any questions or need further assistance with 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.

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**ELECTRONIC FUNDS TRANSFER (EFT) AUTHORIZATION AGREEMENT**

To enroll in Envolve Dental's EFT payment program, complete this form and return it with a **voided check** via one of the following:

Mail: Envolve Dental
P.O. Box 25656
Tampa, FL, 33622-5656

Fax: 855-475-4374

Email: providerrelations@envolvehealth.com

**I – CHECK APPLICABLE REASON FOR SUBMISSION**

❑ New EFT Authorization OR ❑ EFT setup revision (e.g. account number or bank changes)

**II – PROVIDER/PAYEE INFORMATION**

Payee name: _____

Tax Identification Number (TIN): (Designate SSN ❑ or EIN ❑) _____

Payee street address, City, State, Zip Code: _____

**III – DEPOSITORY INFORMATION (Financial Institution)**

Your bank/depository name: _____

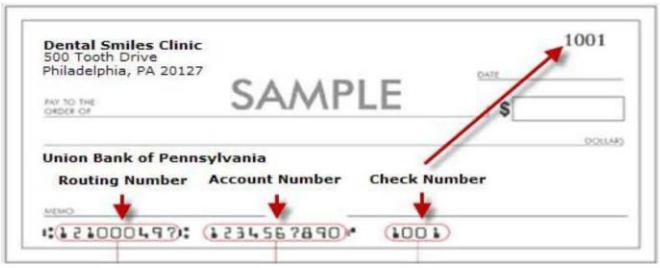
Account type (check one):
❑ Checking ❑ Savings

Depository routing transit number
(Nine digits. Include any leading zeroes):

_____

Depositor account number
(Include any leading zeroes):

_____




**IV – CONTACT INFORMATION**

Name of billing contact person: _____

Phone number of billing contact: _____

Email address of billing contact: _____

**V – AUTHORIZATION**

I hereby authorize Envolve Dental to initiate credit entries, and in accordance with 31 CFR part 210.6(f) initiate adjustments for any credit entries made in error to the account indicated above. I hereby authorize the financial institution/bank named above, hereinafter called the DEPOSITORY, to credit the same to such account. This authorization agreement is effective as of the signature date below and is to remain in full force and effect until the CONTRACTOR has received written notification from me of its termination in such time and such manner as to afford the CONTRACTOR and the DEPOSITORY a reasonable opportunity to act on it. The CONTACTOR will continue to send the direct deposit to the DEPOSITORY indicated above until notified by me that I wish to change the DEPOSITORY receiving the direct deposit. If my DEPOSITORY information changes, I agree to submit to the CONTRACTOR an updated EFT Authorization Agreement.

Signature of authorized billing contact: _____ Date: _____



ENVD EFT Form _Revised November 2019 current providers

**ELECTRONIC FUNDS TRANSFER (EFT) Terms of Use**

The following terms and conditions, as amended from time to time ("Agreement") apply to all use of the Envolve Dental's Electronic Funds Transfer solution, and the use of any service provided in connection therewith (collectively the "**EFT** Services"). In this Agreement, the words "you", "your" and "yours" means the individual(s) entity or entities identified on the attached Electronic Fund Transfer (EFT) Authorization Agreement, and the words "we," "our," "us" refers to Envolve Dental affiliates and designees. Your enrollment or use of the EFT Services signifies your agreement to be legally bound by the terms and conditions set forth herein. **ACH and Wire Transfers.** This Agreement is subject to Article 4A of the Uniform Commercial Code -- Funds Transfers. By signing this Agreement, you authorize Envolve Dental, acting on behalf of any third party administrator, health care coalition, or health plan carrier (each a "Carrier") that participates in the EFT Services, to credit or debit the accounts listed on your Enrollment Form (the "Accounts") in connection with processing transactions between you and the Carriers. We may rely upon all Account information and identifying numbers provided by you on the Authorization Agreement to receive payment. We may rely on the routing and account numbers you provided even if they identify a financial institution, person or account other than the one named on the Enrollment Form You agree to be bound by National Automated Clearing House Association (NACHA) rules. These rules provide, among other things, that payments made to you, are provisional until final settlement is made through a Federal Reserve Bank or payment is otherwise made as provided in Article 4A-403(a) of the Uniform Commercial Code. If we do not receive such payment, we are entitled to a refund from you in the amount credited to your Account and the Carrier that originated or instructed such payment will not be considered to have paid the amount so credited. We are not required to give you any notice of debits or credits to your Accounts. We may make adjustments to your Accounts whenever a correction or change is required. For example, if we make an error with respect to your Account, you agree that we may correct such error immediately and without notice to you. Such errors may include, but are not limited to, reversing an improper credit to your Account, making adjustments for returned items, and correcting calculation and input errors. Our right to make adjustments shall not be subject to any limitations or time constraints, except as required by law. **Accounts.** You represent and warrant that (a) you are the owner of each of the Accounts and (b) none of the Accounts is used primarily for personal, family or household purposes. **Confidentiality.** During the term of this Agreement, from time to time, we may disclose or make available to you, whether orally, electronically or in physical form, confidential or proprietary information concerning us and/or our business, products or services in connection with this Agreement(together, "Confidential Information"). Confidential Information includes, without limitation, business plans, health plan relationships, acquisition plans, systems architecture, information systems, technology, data, computer programs and codes, processes, methods, operational procedures, finances, budgets, policies and procedures, customer, employee, provider, member, patient and beneficiary information, claims information, vendor information(including agreements, software and products), product plans, projections, analyses, plans, results, and any other information which is normally and reasonably considered confidential. You agree that during the term of this Agreement and thereafter: (i) you will use Confidential Information belonging to us solely for the purpose(s) of this Agreement; and (ii) you will take all reasonable precautions to ensure that you do not disclose Confidential Information belonging to us to any third party (other than to your employees, contractors and/or professional advisors on a need-to-know basis who are bound by obligations of nondisclosure and limited use precautions at least as stringent as those contained herein) without first obtaining our written consent. **Confidentiality Exclusions.** For purposes hereof, "Confidential Information" will not include any information that you can establish by convincing written evidence: (i) was independently developed by you without use of or reference to any Confidential Information belonging to us; (ii) was acquired by you from a third party having the legal right to furnish same to the you without disclosure restrictions; or (iii) was at the time in question (whether at disclosure or thereafter) generally known by or available to the public (through no fault of you).**Amendments and Termination.** Envolve Dental may add, remove, change or otherwise modify any term of this Agreement at any time. We may also terminate or discontinue some or all of the EFT Services at any time without notice to you. **Governing Law and Venue.** The laws of the State of WI shall govern this Agreement and all disputes arising hereunder. You hereby consent that jurisdiction and venue are proper in the State of WI for the resolution of any dispute arising under this Agreement. **Severability.** If any provision of this document is found to be unenforceable according to its terms, all remaining provisions will continue in full force and effect. **Headings.** Headings in this document are for convenience or reference only and will not govern the interpretation of the provisions. **Construction.** Except where it would be unreasonable or illogical to do so, words and phrases used in this document should be construed so the singular includes the plural and the plural includes the singular. **Cooperation.** You agree to cooperate fully with us in furnishing any information, documentation or performing any action requested by us. You shall furnish us, upon forty-eight (48) hours notice, with true, accurate and complete copies of such records, documentation or any other information we or our authorized employees, representatives, agents and any regulatory agencies may request; provided, however, that you shall not be required to divulge any records to the extent prohibited by applicable law. **Ownership.** Except as provided in this Agreement, Envolve Dental shall have and own all rights, title and interests in the EFT Services and any information arising from or in connection therewith. You hereby acknowledge the specific ownership interests of Envolve Dental as set forth herein and you shall not acquire any ownership rights by virtue of this Agreement. **Assignment.** You agree not to assign this Agreement, directly or by operation of law or subcontract, delegate or appoint any third-party agent to perform any or all of its duties obligations or services hereunder without our written consent, and any such attempted assignment, subcontracting, delegation or appointment without such consent shall be void. All written notices shall be delivered by registered or certified mail, return receipt requested, and shall be deemed effective seventy-two (72) hours after the same is mailed via certified mail as described above with postage prepaid. Notice sent by any other method shall be effective only upon actual receipt. The parties to this Agreement, by notice in writing, may designate another to whom notices shall be given pursuant to this Agreement. **Relationship of the Parties.** The relationship between both parties under this Agreement is that of independent contractor. Nothing herein contained shall be construed as constituting a partnership, joint venture or agency between the parties hereto. **Entire Agreement.** This Agreement, which is an integral part hereof and are incorporated herein as a part of this Agreement, constitute the only agreement between the parties hereto relating to the subject matter hereof, except where expressly noted herein, and all prior negotiations, agreements and understandings relating to the subject matter hereof, whether oral or written, are superseded or canceled hereby. **Force Majeure.** Envolve Dental shall not be liable for a delay in performance or failure to perform any obligation under this Agreement to the extent such delay is due to causes beyond our control, including, but not limited to, governmental requests, regulations or orders, utility or communications failure, delays in transportation, national emergency, war, civil commotion or disturbance, war conditions, fires, floods, storms, earthquakes, tidal waves, failure or delay in receiving electronic data, equipment or systems failure or communication failures. **Warranties.** ENVOLVE DENTAL HEREBY DISCLAIMS ALL WARRANTIES WITH RESPECT TO THE SERVICES AND PRODUCTS PROVIDEDHEREUNDER, WHETHER EXPRESS, IMPLIED, STATUTORY OR OTHERWISE, INCLUDING WITHOUT LIMITATION ANYWARRANTY OFMERCHANTABILITY OR FITNESS FOR USE FOR A PARTICULAR PURPOSE. Under no circumstances shall the financial responsibility of Envolve Dental for any failure of performance by us under this Agreement exceed the fees or charges paid by you to Envolve Dental for the transaction, or activity that is or was the subject of the alleged failure of performance. IN NO EVENT SHALL ENVOLVE DENTAL, ITS PARENT,AFFILIATES, SUBSIDIARIES, DIRECTORS, OFFICERS, EMPLOYEES, AGENTS OR REPRESENTATIVES BE LIABLE FOR SPECIAL,INCIDENTAL OR CONSEQUENTIAL DAMAGES OR CLAIMS BY YOU OR ANY THIRD PARTY RELATIVE TO THE TRANSACTIONS HERE UNDER. **Indemnification.** You shall be liable to and shall indemnify, defend and hold Envolve Dental its directors, officers, employees, representatives, successors and permitted assigns harmless from and against any and all claims, demands by third parties, losses, liability, cost, damage and expense, including litigation expenses and reasonable attorneys' fees and allocated costs for in-house legal services, to which Envolve Dental, its directors, officers, employees, representatives, successors and permitted assigns may be subjected or which it may incur in connection with any claims which arise from or out of or as the result of (a) your breach of this Agreement; (b) your performance, duties and obligations under this Agreement; or (c) the negligence or willful misconduct of you, your directors, officers, employees, agents and affiliates in the performance of their duties and obligations under this Agreement. You shall bear all risk of loss of items, records, data and materials during transit from you to Envolve Dental's location or that of Envolve Dental's agents or sub-contractors. **Waiver.** No waiver or failure to exercise any option, right, or privilege under the terms of this Agreement on any occasion or occasions shall be construed to be a waiver of the same or any other option, right or privilege on any other occasion.



ED EFT Form _FINAL_20190319

# Provider Rights & Responsibilities

Consistent with Magnolia Health's policies, Envolve Dental applies the following rights and responsibilities to all network providers. [2]

## 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;
- complete and accurate medical histories from members;
- expect that other network providers will work as partners in member treatment plans;
- receive accurate and timely authorization determinations and claims payments;
- access Envolve Dental quality improvement program information;
- make a complaint against a member, Magnolia Health, 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;
- making covered services available on a timely basis, based on medical appropriateness;
- 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;
- 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 criteria 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.

[2] *Magnolia Family Health Plan Member Handbook* and *Magnolia Provider Manual*

# Member Rights & Responsibilities

Consistent with Magnolia Health's policies, Envolve Dental applies the following rights and responsibilities to all members.[3]

## Member Rights

Members have the right to receive

- available and accessible covered services on a timely basis, based on medical appropriateness;
- healthcare services according to federal and state law;
- information about treatment options, including a second opinion;
- a copy of his/her medical records;
- information in another language, including written materials and a free interpreter during any covered service;
- information about Envolve Dental Member Rights and Responsibility policy; and
- information about Envolve Dental services and providers.

Members also have the right to

- be treated with respect, non-discrimination and with attention to dignity and privacy;
- make decisions about their healthcare, including the right to refuse treatment;
- be free from restraint or seclusion as a means of force, control, convenience or retaliation;
- complain to Magnolia Health Member Services by phone or in writing about any issue;
- appeal to Magnolia Health by phone or in writing about a dental decision; and
- file a Medicaid Fair Hearing.

## Member Responsibilities

Members are responsible for

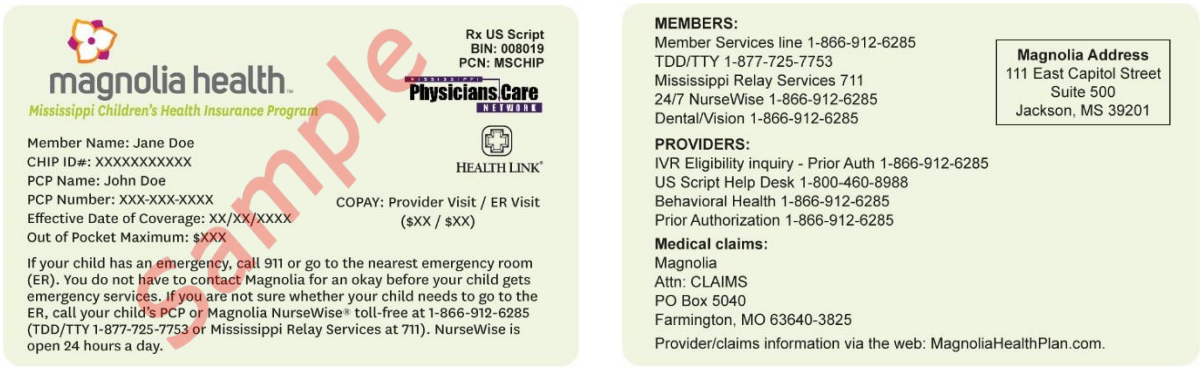
- participating in his/her healthcare;
- making and keeping appointments;
- notifying providers at least 24 hours prior to an appointment if they are unable to attend;
- presenting Magnolia Health ID card when obtaining services and informing Magnolia Health if the card is lost or stolen;
- informing providers about all personal information relevant to treatment and overall health;
- understanding and reaching agreement with the provider about a treatment plan;
- following their provider's treatment plan;
- keeping current all personal information with providers and Magnolia, including health-related details, address, and phone number;
- informing healthcare providers and case worker about other insurances in effect; and
- reporting to appropriate channels possible fraud and abuse by another member or provider.

[3] *Magnolia Member Handbook* and *Magnolia Provider Manual*

# Member Eligibility, Services, and Standards

## Member Identification Card

Magnolia Health issues identification (ID) cards to members on a regular basis and members are responsible for presenting the card on the date of service.




Envolve Dental recommends each dental office photocopy the member's ID card and ensure it is current in the office records at each visit. Please note: the identification card does not need to be returned should a member lose eligibility.

If a member reports a lost or missing card, please direct the member to call Magnolia Health Member Services at 866-912-6285 for a replacement. Note that possession of an identification card does *not* guarantee eligibility.

## Eligibility Verification and Cost Sharing

The Mississippi Division of Medicaid determines member eligibility and communicates membership data to Magnolia Health and Envolve Dental. 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.

You will need the following information to verify eligibility:

**Member Details**

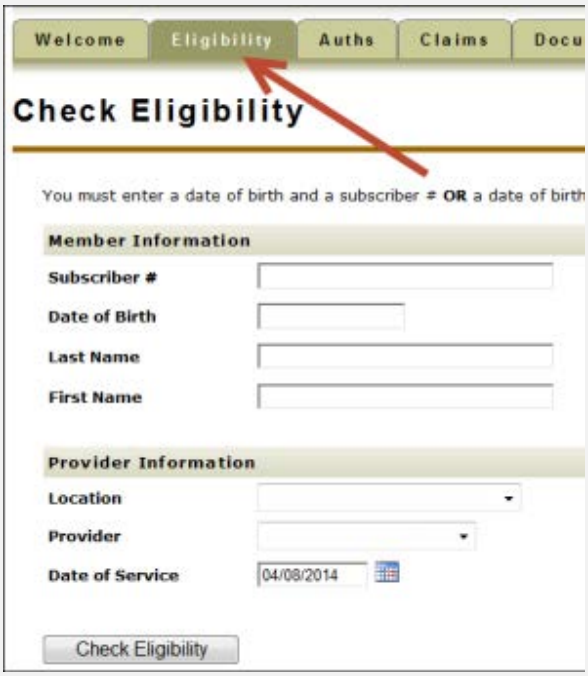
- Member Medicaid identification number or Social Security number
- Member date of birth
- Member name
- Date of service

**Provider Details**

- Provider NPI number

When you have this information ready, choose to verify eligibility on the internet or via telephone as follows. Using the Provider Web Portal on the internet requires registration. If you have not yet registered, call Customer Service at 844-464-5636.

When verifying eligibility, be sure to check if cost sharing applies for that member. Cost sharing does not apply to routine preventive services, diagnostic dental services, or routine dental fillings. Providers are responsible for collecting the $5.00 cost sharing amount per visit for all other services.

| Provider Web Portal via Internet | IVR via Telephone |
|---|---|
| Go to https://pwp.envolvedental.com.<br>Log in with your username and password. | Call 844-464-5636 for the<br>Envolve Dental IVR system. |
| Go to the “Eligibility” tab. Enter the member’s information and date of service.<br>  | Follow the prompts on the automated system to input information:<br>• Provider NPI number<br>• Press 1 to enter member ID<br>• Press 2 to enter member Social Security number<br>• Press 4 to return to main menu<br>• Press 5 to speak to a Provider Relations Representative |

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

# Member Transportation Services

Some Magnolia Health members are eligible for non-emergency transportation services to and from medical appointments when they do not have other options available. Magnolia Health may use gas reimbursement, public buses, vans, taxis, or paralifts to help members go to appointments. Members should call Member Services at 866-912-6285 to determine eligibility and schedule a ride at least three days before the appointment date. Transportation can be scheduled up to two months in advance.

# Member Interpreter and Hearing Impaired Services

Members requiring language assistance, including sign language, should contact Magnolia Health member services at 866-912-6285 (TDD/TTY 877-725-7753) or Mississippi Relay 711. The service is available free of charge and are available for many different languages. Members who are blind or visually impaired can call Member Services for an oral interpretation. Members should call at least several days prior to an appointment to schedule an interpreter.

# EPSDT Services

The Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) service is Medicaid's comprehensive and preventive child health program for individuals under the age of 21, provision of which is mandated by state and federal law. EPSDT services include periodic screening, vision, dental, and hearing services. In addition, the need for corrective treatment disclosed by such child health screenings must be arranged (directly or through referral) even if the service is not available under the State's Medicaid plan to the rest of the Medicaid population.

Magnolia provides the full range of EPSDT services as defined in, and in accordance with, DOM policies and procedures for EPSDT services. Such services shall include, without limitation, periodic health screenings and appropriate up-to-date immunization using the Advisory Committee on Immunization Practices (ACIP) recommended immunization schedule and the American Academy of Pediatrics periodicity schedule for pediatric preventive care.

Included in the minimum elements as part of the periodic health screening assessment are dental screening and services, including at a minimum, relief of pain and infections, restoration of teeth and maintenance of dental health. Although an oral screening may be part of a provider examination, it does not substitute for examination through direct referral to a dentist.

Envolve Dental requires that providers cooperate to the maximum extent possible with efforts to improve the health status of Mississippians, and to actively participate in the increase of percentage of eligible members obtaining EPSDT services in accordance with the adopted periodicity schedules.

# Benefit Limit Exception (BLE) Process

In accordance with the Mississippi Administrative Code, Envolve Dental allows a Benefit Limit Exception (BLE) process for medically necessary services for EPSDT eligible members. Requests for all other member populations will not be considered.

A checklist and BLE form are included in the following pages and on our Provider Web Portal at https://pwp.envolvedental.com. Prior to rendering services to members, please submit the BLE form and documentation to Envolve Dental by email to BLE@EnvolveHealth.com or mail to P.O. Box 25255, Tampa, FL 33622-5255.

Envolve Dental Utilization Management will review the following criteria to determine whether:

- Member has a serious chronic systemic illness or other serious health condition and denial of the exception will jeopardize the life of the member.
- Member has a serious chronic systemic illness or other serious health condition and denial of the exception will result in the serious deterioration of the health of the member.
- The exception is necessary in order to comply with federal law.

The BLE process may also allow for retrospective review for emergency procedures; however, the emergency services are subject to pre-payment review and whether medical necessity was met. Any retrospective reviews must be dated and submitted within 48 hours of the date the procedures were performed. After rendering emergency services to members, please submit the BLE form and documentation with the claim to Envolve Dental by mail only to P. O. Box 25255, Tampa, FL 33622-5255.

Note: Please do not submit the BLE form via the Provider Web Portal.

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Benefit Options

# Envolve Dental Benefit Limit Exception (BLE) Summary Request Form

All fields must be complete and legible. Submit this form with a written narrative of medical necessity, a completed 2012 ADA dental claim form and documentation described below.

PLEASE PRINT

Member Name _____ Member DOB _____

Member ID # _____ Provider NPI # _____

Provider Name _____ Provider Phone # _____

Provider Email _____ Provider Fax # _____

Services provided beyond a member's benefit limit are not covered unless a Benefit Limit Exception (BLE) is requested and approved by Envolve Dental, Inc. prior to services being rendered. Exceptions will be considered if treatment is performed as an emergency and claims are submitted within 2 days of treatment date with accompanying BLE form and necessary documentation. If a Benefit Limit Exception is approved, Envolve Dental will approve the more cost-effective professionally acceptable alternative service(s).

**Benefit Exception Request Type**: ☐ Prospective ☐ Retrospective Date(s) of Service: _____

**Benefit Limit Criteria to be reviewed**:

- Member has a serious chronic systemic illness or other serious health condition and denial of the exception will jeopardize the life of the member.
  ☐ Yes ☐ No *If yes, please explain and provide supporting documentation from the medical record.*

- Member has a serious chronic systemic illness or other serious health condition and denial of the exception will result in the serious deterioration of the health of the member.
  ☐ Yes ☐ No *If yes, please explain and provide supporting documentation from the medical record.*

- The exception is necessary in order to comply with federal law.
  ☐ Yes ☐ No *If yes, please explain and provide supporting documentation from the medical record and specific code.*

Request must include documentation from the treating dentist, substantiating the need for the service. Documentation may include but is not limited to: treatment chart, treatment plan, teeth and periodontal charting, radiographs, photographs, medical history, and dental history. A narrative of medical necessity and completed 2012 ADA claim form is always required. The narrative should contain reasoning why treatment exceeding the benefit maximum is unable to be delayed until the new benefit year. Photographs should be taken when radiographs are not possible or not diagnostic for the issue.

BLE requests will receive a response, or a request for additional information, within 30 business days of receipt of the request. When the required additional information is received, the exception request will be approved or denied within 30 business days after receipt of the information.

I attest that the information provided and statements made herein are true, accurate and complete, to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Provider Signature: _____ Date: _____

Questions: Call Provider Services at 844-464-5636.

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# Envolve Dental Benefit Limit Exception (BLE) Checklist

**When submitting the BLE Request Form, please provide the following additional information:**

- ☐ 2012 ADA Form
- ☐ Charting of Decayed/Missing/Restored Teeth
- ☐ Radiographs
- ☐ Medical History
- ☐ Additional Dental Needs/History
- ☐ Treatment Plan
- ☐ Periodontal Charting
- ☐ Photographs
- ☐ BLE Form
- ☐ Narrative of Medical Necessity

**BLE Reminders:**

- Submit **ALL** documentation to have BLE processed correctly.
- The turn-around time (TAT) is 30 days after BLE is received completed.
- If Envolve Dental has not reached out to you with a faxed request for additional information, and you have not received an Approval/ Denial fax within 30 days, please contact Customer Service to check the status of an existing BLE request.
- A BLE request approval is **NOT** a guarantee of payment.

**Please send the requested information by email or mail to the following:**

Email: BLE@EnvolveHealth.com

Mail: Envolve Dental, Mississippi Authorizations, Post Office Box 25255, Tampa, FL 33622-5255

Questions: Call Provider Services at 844-464-5636

# Appointment Availability Standards

Appointment availability standards are set by Magnolia Health 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) | 45 calendar days |
| urgent care | 48 hours |
| emergency care | immediately |

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 dental needs or emergencies, accessible by using the office's daytime phone number. The coverage must be available 24 hours a day, 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.

# 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 are found on the Magnolia "Find a Provider" page at http://apps.magnoliahealthplan.com/findadoc/home.

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.

# Missed Appointments

The Magnolia Health member handbook includes instructions for members to cancel an appointment no less than 24 hours in advance if unable to keep it. 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 repeatedly misses appointments. Be sure to keep a record of occurrences in the member's record, and refer the member to Magnolia Health at 886-912-6285 for a new dental provider.
- Your office's missed appointment and dismissal policies for Magnolia Health members cannot be more strict than your private or commercial patient policies.
- Providers are not allowed to charge Magnolia Health members for missed appointments.

# Panel Size

All providers reserve the right to state the number of members they are willing to accept into their panel. Envolve Dental does not guarantee that any provider will receive a certain number of members. If a provider declares a specific capacity for their practice and wants to change that capacity, the provider must contact Envolve Dental Provider Services at 844-464-5636.

A provider shall not refuse to treat members as long as the provider has not reached their requested panel size. Providers shall notify Envolve Dental in writing at least 45 calendar days in advance of their inability to accept additional Medicaid covered persons under Envolve Dental agreements.

In no event shall any established patient who becomes a covered person be considered a new patient. Envolve Dental prohibits all providers from intentionally segregating members from fair treatment and covered services provided to other non-Medicaid members.

# 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, Magnolia Health, the Mississippi Division of Medicaid, and the Centers for Medicare & Medicaid Services. These conditions include the following:

- Providers cannot bill members for any type of cost sharing for covered dental services, including a copayment, coinsurance, deductible, or deposit.
- 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 are not allowed to charge members for missed appointments.

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 and Magnolia Health for payment of non-covered services. A sample form follows.

## NON-COVERED SERVICES LIABILITY ACKNOWLEDGEMENT

Provider Name: _____

Provider NPI: _____

Member Name: _____

Member ID: _____

Health Plan: _____

Date of Service: _____

I (the member or if a minor, guardian of the member as listed above) acknowledge that it has been explained to me that certain health care services (s) or supplies that I have requested or wish to purchase will not be covered under the terms of my Health Plan benefit schedule. The non-covered services(s) that I have requested are:

_____ $_____

_____ $_____

_____ $_____

_____ $_____

_____ $_____

The total cost for the non-covered services/items is: $_____

I also acknowledge that I have been advised that these services are optional and as such, I will be responsible for payment for these non-covered services and agree to make payment arrangements directly with the Provider for these services.

Date Signed _____

Print Member Name _____

Member Signature _____

Name of Parent or Legal Guardian (if applicable) _____

Signature of Parent or Legal Guardian (if applicable) _____

**This form must be signed by the patient or legal guardian PRIOR to receiving any non-covered services or items and *must be maintained in the patient's dental record.***

# 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 2.

**Table 2. 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, 7 days a week. |

**Table 2. 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 Customer Service 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.

# Cultural Competency

At Magnolia, cultural competency is defined as the willingness and ability to value the importance of culture in the delivery of services to all segments of the population. Cultural competency is developmental, community-focused and family-oriented.

In particular, it is the appreciation of differences and integration of cultural attitudes, beliefs and practices into diagnostic and treatment methods and throughout the healthcare system to support the delivery of culturally relevant and competent care to all racial and ethnic groups. It is also the development and continued promotion of skills among providers and staff to ensure that services are delivered in a culturally competent manner.

Magnolia is committed to developing, strengthening, and sustaining provider/member relationships. Members may be unable or unwilling to communicate their health care needs in a culturally insensitive environment, reducing effectiveness of the entire healthcare process. Members are entitled to dignified, appropriate and quality care. When healthcare services are delivered without regard for cultural differences, members are at risk for sub-optimal care.

Magnolia, as part of its credentialing processes, will evaluate the cultural competency of its providers and provide access to training and tools to assist providers in developing culturally competent and culturally proficient practices.

Providers must ensure that:

- Members understand they have access to medical interpreters, signers, and TDD/TTY services to facilitate communication without cost to them.
- Medical care is provided with consideration of the member's race/ethnicity and language and its influences on the member's health or illness.
- Office staff that routinely interacts with members has access to and are encouraged to participate in cultural competency training and development.
- Office staff responsible for data collection makes reasonable attempts to collect race and language-specific member information. Staff will also explain race/ethnicity categories to a member so that the member is able to identify the race/ethnicity of themselves and their children.
- Treatment plans are developed and clinical guidelines are followed with consideration of the member's race, country of origin, native language, social class, religion, mental or physical abilities, heritage, acculturation, age, gender, sexual orientation, and other characteristics that may result in a different perspective or decision-making process.
- Office sites have posted and printed materials in English, and if required by the state, any other required non-English language.

# Utilization Management & Review

## Utilization Management

Utilization management aims to manage healthcare costs before services are rendered by specifically defining clinical criteria that are based on accepted dental practices. Envolve Dental considers 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. Clinical criteria should be used in conjunction with the benefit grids that include required documentation that substantiates the criteria.

The prior authorization and retrospective 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 retrospective review. That is, as long as the clinical criteria 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 retrospective 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. Generalist 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 criteria 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 communications with Envolve Dental by calling Customer Service with questions and concerns: 844-464-5636.

# Quality Management

The focus of the Quality Management [QM] Program is:

- Quality Improvement Studies
- Utilization Statistics
- Provider and Member Complaints and Appeals
- Member Satisfaction
- Provider Accessibility

The goals of the Quality Management Program are as follows:

- Objectively and systematically monitor and evaluate aspects of member care including the measures identified in the Mechanisms for Overseeing Program Effectiveness.
- Provide a system for the identification of opportunities for improvement and implement strategies to achieve improvement in care and services to members.
- Promote the coordination; documentation and communication of plan-wide quality improvement activities.
- Monitor the effectiveness of network quality improvement/peer review activities, including the selection and performance of dentists who review issues, the outcomes and effectiveness of those reviews, and their remedial actions.
- Promote inter-departmental collaboration in network-wide quality improvement activities.
- Promote compliance by network providers with defined standards of care in access, availability of services, dental record documentation, and guidelines for the use of preventive health services and clinical guidelines
- Provide a mechanism for the credentialing and recredentialing of network providers and oversight of delegated credentialing that complies with DBP-CA and NADP standards.
- Implement and oversee preventive dental health systems to improve the dental health status of members.

Provider Performance

- Schedule emergent care within 24 hours
- Schedule routine dental appointments within 10 business days
- Schedule hygiene appointments within 6 weeks

# Medically Necessary Services

Medical necessity is defined for Magnolia Health members as healthcare services, supplies or equipment provided by a licensed healthcare professional that are:

- Appropriate and consistent with the diagnosis or treatment of the member's condition, illness or injury;
- In accordance with the standards of good medical practice consistent with the member's condition(s);
- Not primarily for the personal comfort or convenience of the member, family or provider;
- The most appropriate services, supplies, equipment, or levels of care that can be safely and efficiently provided to the member;
- Furnished in a setting appropriate to the member's medical need and condition and, when applied to the care of an inpatient, further mean that the member's medical symptoms or conditions require that the services cannot be safely provided to the member as an outpatient;
- Not experimental or investigational or for research or education;
- Provided by an appropriately licensed practitioner; and
- Documented in the member's medical record in a reasonable manner, including the relationship of the diagnosis to the service.

Services for children are limited in that such services are necessary to correct or ameliorate defects, physical and mental illnesses, and conditions that are discovered during an EPSDT screen, periodic or inter-periodic, whether or not such services are covered or exceed the benefit limits in the MississippiCAN Medicaid state plan. All services determined to be medically necessary must be covered.

# 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, Waste, and Abuse

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 applicable laws and regulations pertaining to fraud, waste, and abuse. The Centers for Medicare & Medicaid Services define them as:

- **Fraud:** When someone intentionally executes or attempts to execute a scheme to obtain money or property of any healthcare 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 healthcare providers or suppliers perform actions that directly or indirectly result in unnecessary costs to the healthcare 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.[4,5]

## Fraud, Waste, and Abuse Hotlines

Envolve Dental is obligated to report suspected fraud, waste, or abuse by members and healthcare providers. Members and providers also are expected to report possible incidents, which can be done anonymously by calling a fraud, waste, and abuse hotline.

Envolve Dental Hotline: 800-345-1642

Medicaid Fraud Hotline: 800-880-5920

Mississippi Medicaid Fraud Control Unit: 800-852-8341

Table 3 summarizes applicable federal laws pertaining to fraud, waste and abuse. Additional details are available on the Centers for Medicare & Medicaid Services website: www.cms.gov.

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

[5] *Medicare Fraud & Abuse: Prevention, Detection, and Reporting*, Centers for Medicare & Medicaid Services, August 2014

## Table 3. 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.<br><br>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.<br><br>Penalties include fines, claim repayment, and potential exclusion from federal healthcare programs. |
| Anti-Kickback Statute (AKS) | Knowingly and willfully offering, paying, soliciting, or receiving remuneration to induce or reward referrals reimbursable by a federal healthcare program. | A provider receives cash or other benefits for referrals.<br><br>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.<br><br>Penalties can include fines, imprisonment, or both. |

For more information about the False Claims Act go to www.TAF.org.

Source: Centers for Medicare and Medicaid Services @ Medicare Fraud, Waste and Abuse

# Prior Authorization and Retrospective Review

Envolve Dental has specific clinical criteria and authorization processes to manage service utilization according to medical necessity and appropriateness of care. Please see the benefit descriptions and clinical criteria requirements for services listed in this manual. Required documentation to support authorization requests are listed per code in the benefit grids in Appendix A. Providers should measure intended services to the clinical criteria 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 identified in the benefit grids. | Check the appropriate benefit grid for requirements for each code and submit at least 14 calendar days but no later than 5 calendar days prior to scheduled service. |
| Urgent/Emergent Authorizations | Defined as situations involving severe pain, swelling, infection, uncontrolled hemorrhage, or traumatic injury. | Treat the member.<br>Call Envolve Dental within 2 business days to report the urgent service in the member's Envolve Dental record. Submit the completed claim and all required documentation as a Retrospective Review no later than 30 calendar days from service date.<br><br>If you choose to receive prior authorization for urgent cases, call Customer Service at 844-464-5636 for options and submission directions via a HIPAA-compliant secure email. |

| | | |
|---|---|---|
| Retrospective Reviews | Provider is confident that the member's condition and the clinical criteria in this manual are equivalent, and codes are (1) consistent for appropriate treatment and (2) are covered benefits. | Submit claim with all required authorization documentation within 30 calendar days from the date of service.<br>Note: 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. |

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

# Prior Authorization

Submit prior authorization requests with complete documentation requirements to Envolve Dental at least fourteen (14) calendar days but no later than five (5) 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.

Envolve Dental will make standard authorization decisions and provide notice within three (3) calendar days and/or two (2) business days following receipt of the request for services. This three (3) calendar day period may be extended up to fourteen (14) additional calendar days upon request of the member to Magnolia Health or the provider to Envolve Dental, or if Envolve Dental justifies to the Division of Medicaid a need for additional information and how the extension is in the member's best interest.

For urgent/expedited requests, where you indicate that the member's ability to attain, maintain, or regain maximum function would be compromised by waiting three days, contact Customer Service at 844-464-5636 to request an urgent review via a HIPAA-compliant email. A decision notice is faxed no later than twenty-four (24) hours after receipt of the expedited authorization request.

Envolve Dental notifies providers with an approval authorization number or with a denial notification via fax within one (1) 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. Remember:

- Your office should contact members to schedule appointments when you receive an approved authorization number. Members receive authorization notices *only* for denials.
- 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, the State of Mississippi, or any agents, or Envolve Dental if services begin before authorization is determined and authorization is subsequently denied.

# Peer-to-Peer Review

Envolve Dental utilization management staff use clinical criteria detailed in this manual 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 agreeable time.

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

Envolve Dental
Authorizations – MSCAN
PO Box 25255
Tampa, FL 33622-5255

Or call Envolve Dental Customer Service at 844-464-5636. 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 agreeable 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.

# Retrospective/Pre-payment Review Authorizations

Urgent/emergent authorization requests are immediately granted in situations that involve severe pain, swelling, infection, uncontrolled hemorrhage, or traumatic injury. Dental providers are encouraged to treat the member, call Envolve Dental within two business days to record the incident in the member's Envolve Dental record, and then submit within 180 calendar days the completed claim with all required authorization documents on a 2012 ADA claim form marked "Retrospective Review" or "Pre-payment Review." All urgent/emergent authorization requests are evaluated by the Chief Dental Officer, a licensed physician, or a dental consultant to certify that the services were urgent or emergent in nature under the prudent layperson standard. Benefit coverage and eligibility are also considered when making the determination.

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 844-464-5636 for submission directions via a HIPAA-compliant secure email initiated by an Envolve Dental representative.

Retrospective/Pre-Payment Reviews are also available for selected codes, identified in the benefit grids in Appendix A.

# Authorization Submission Procedures

Authorization requests must be received at least fourteen (14) calendar days, but no later than five (5) calendar days, prior to the requested service date 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 HIPAA-compliant electronic files
4. Paper request on a completed ADA 2012 claim form by mail

## 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.

A user guide is included in Appendix B in this manual. If you have questions about submitting authorization requests or accessing the Envolve Dental Provider Web Portal, call Customer Service at 844-464-5636 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. As of this manual publication date, we currently work with the following:

- Change Healthcare clearinghouse (Website: http://www.changehealthcare.com; Phone: 888-363-3361)
- DentalXChange (Website: www.dentalxchange.com; Phone: 800-576-6412)
- Trizetto (Website: www.trizetto.com; Phone: 800-556-2231)

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 listed in the benefit grids when submitting on their portals, using an NEA *Fast*Attach® tracking number in the remarks section. A Dental Review Specialist assigned to Magnolia Health 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 of authorization and claims submissions to Envolve Dental.

All images you transmit are stored retained in accordance with the provision of Section 11 Reporting Requirements, item 11-A Record System Requirements of the Magnolia Health State Contract. The images are stored 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. If you have specific questions about using *Fast*Attach®, call NEA at 800-782-5150.

# 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 844-464-5636.

# 4. Paper Authorization Submission

Paper authorization requests must be submitted on a 2012 ADA claim form with the following information:

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

For services requested, include:

- Approved ADA dental codes as published in the current CDT book or as defined in this manual
- All quadrants, tooth numbers and tooth surface identifications per dental code, for example, extractions, root canals, amalgams and resin fillings
- Required documentation, such as x-rays and treatment plans, listed in the benefit grids in Appendix A

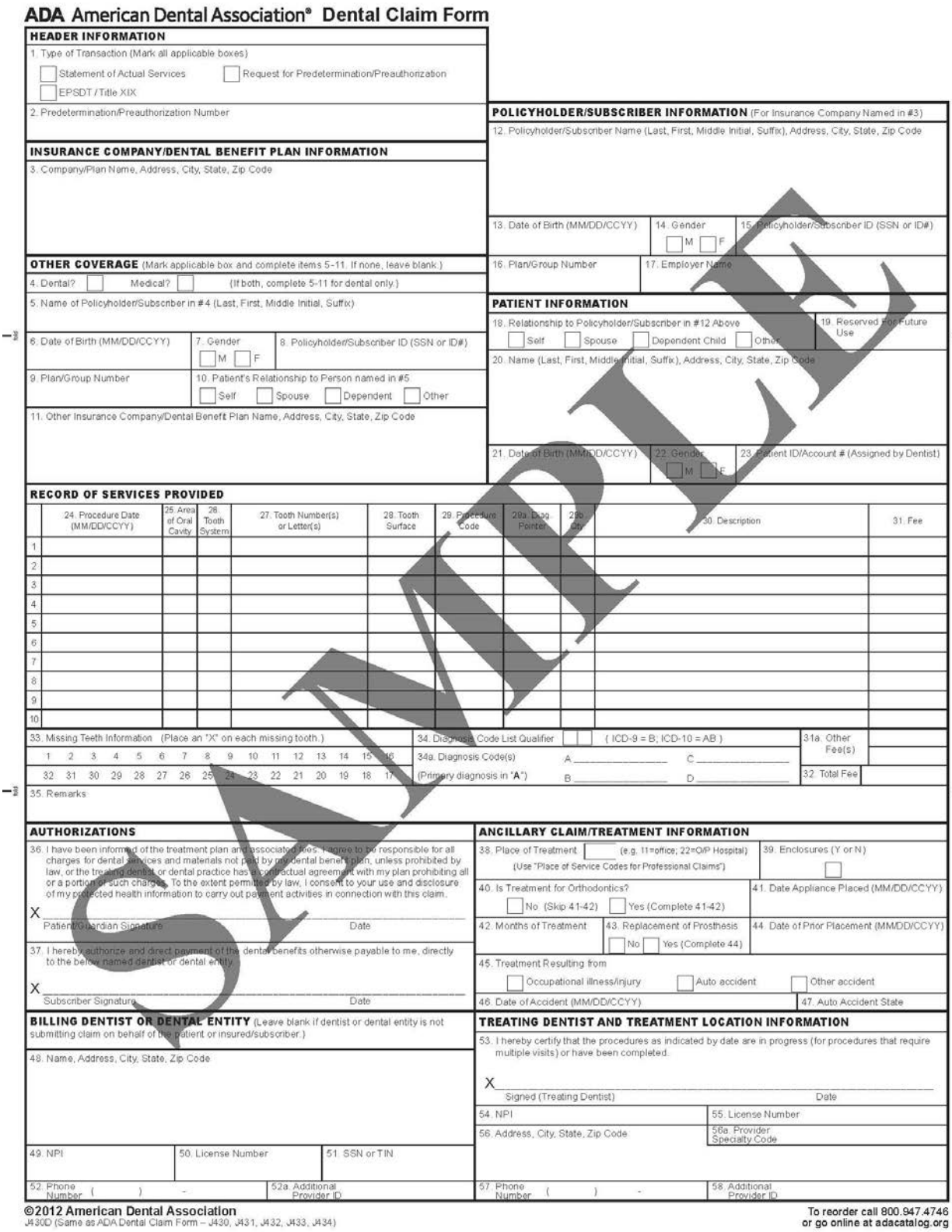
Missing or incorrect information could result in an authorization denial or determination delay. Mail paper authorization requests and all required documents with correct postage to:

Envolve Dental
Authorizations - MSCAN
PO Box 25255
Tampa, FL 33622-5255

A sample ADA form follows. Originals for use can be obtained from the American Dental Association.

# ADA-Approved Claim Form



**ADA American Dental Association® Dental Claim Form**

**HEADER INFORMATION**

1. Type of Transaction (Mark all applicable boxes)
☐ Statement of Actual Services ☐ Request for Predetermination/Preauthorization ☐ EPSDT / Title XIX

2. Predetermination/Preauthorization Number

**INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION**

3. Company/Plan Name, Address, City, State, Zip Code

**OTHER COVERAGE** (Mark applicable box and complete items 5-11. If none, leave blank.)

4. Dental? ☐ Medical? ☐ (If both, complete 5-11 for dental only.)

5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)

6. Date of Birth (MM/DD/CCYY) | 7. Gender ☐ M ☐ F | 8. Policyholder/Subscriber ID (SSN or ID#)

9. Plan/Group Number | 10. Patient's Relationship to Person named in #5 ☐ Self ☐ Spouse ☐ Dependent ☐ Other

11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code

**POLICYHOLDER/SUBSCRIBER INFORMATION** (For Insurance Company Named in #3)

12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code

13. Date of Birth (MM/DD/CCYY) | 14. Gender ☐ M ☐ F | 15. Policyholder/Subscriber ID (SSN or ID#)

16. Plan/Group Number | 17. Employer Name

**PATIENT INFORMATION**

18. Relationship to Policyholder/Subscriber in #12 Above ☐ Self ☐ Spouse ☐ Dependent Child ☐ Other | 19. Reserved for Future Use

20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code

21. Date of Birth (MM/DD/CCYY) | 22. Gender ☐ M ☐ F | 23. Patient ID/Account # (Assigned by Dentist)

**RECORD OF SERVICES PROVIDED**

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

33. Missing Teeth Information (Place an "X" on each missing tooth.)
1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16
32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17

34. Diagnosis Code List Qualifier ☐ ( ICD-9 = B; ICD-10 = AB )
34a. Diagnosis Code(s) (Primary diagnosis in "A") A _____ B _____ C _____ D _____

31a. Other Fee(s)

32. Total Fee

35. Remarks

**AUTHORIZATIONS**

36. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.

X _____
Patient/Guardian Signature Date

37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.

X _____
Subscriber Signature Date

**ANCILLARY CLAIM/TREATMENT INFORMATION**

38. Place of Treatment ☐ (e.g. 11=office; 22=O/P Hospital) (Use "Place of Service Codes for Professional Claims") | 39. Enclosures (Y or N) ☐

40. Is Treatment for Orthodontics? ☐ No (Skip 41-42) ☐ Yes (Complete 41-42) | 41. Date Appliance Placed (MM/DD/CCYY)

42. Months of Treatment | 43. Replacement of Prosthesis ☐ No ☐ Yes (Complete 44) | 44. Date of Prior Placement (MM/DD/CCYY)

45. Treatment Resulting from ☐ Occupational illness/injury ☐ Auto accident ☐ Other accident

46. Date of Accident (MM/DD/CCYY) | 47. Auto Accident State

**BILLING DENTIST OR DENTAL ENTITY** (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber.)

48. Name, Address, City, State, Zip Code

49. NPI | 50. License Number | 51. SSN or TIN

52. Phone Number ( ) - | 52a. Additional Provider ID

**TREATING DENTIST AND TREATMENT LOCATION INFORMATION**

53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed.

X _____
Signed (Treating Dentist) Date

54. NPI | 55. License Number

56. Address, City, State, Zip Code | 56a. Provider Specialty Code

57. Phone Number ( ) - | 58. Additional Provider ID




J430D (Same as ADA Dental Claim Form – J430, J431, J432, J433, J434)

To reorder call 800.947.4746 or go online at adacatalog.org

**ADA** American Dental Association®
America's leading advocate for oral health

The following information highlights certain form completion instructions. Comprehensive ADA Dental Claim Form completion instructions are printed in the CDT manual. Any updates to these instructions will be posted on the ADA's web site (ADA.org).

**GENERAL INSTRUCTIONS**

A. The form is designed so that the name and address (Item 3) of the third-party payer receiving the claim (insurance company/dental benefit plan) is visible in a standard #9 window envelope (window to the left). Please fold the form using the 'tick-marks' printed in the margin.

B. Complete all items unless noted otherwise on the form or in the CDT manual's instructions.

C. Enter the full name of an individual or a full business name, address and zip code when a name and address field is required.

D. All dates must include the four-digit year.

E. If the number of procedures reported exceeds the number of lines available on one claim form, list the remaining procedures on a separate, fully completed claim form.

**COORDINATION OF BENEFITS (COB)**

When a claim is being submitted to the secondary payer, complete the entire form and attach the primary payer's Explanation of Benefits (EOB) showing the amount paid by the primary payer. You may also note the primary carrier paid amount in the "Remarks" field (Item 35). There are additional detailed completion instructions in the CDT manual.

**DIAGNOSIS CODING**

The form supports reporting up to four diagnosis codes per dental procedure. This information is required when the diagnosis may affect claim adjudication when specific dental procedures may minimize the risks associated with the connection between the patient's oral and systemic health conditions. Diagnosis codes are linked to procedures using the following fields:

Item 29a – Diagnosis Code Pointer ("A" through "D" as applicable from Item 34a)

Item 34 – Diagnosis Code List Qualifier (B for ICD-9-CM; AB for ICD-10-CM)

Item 34a – Diagnosis Code(s) / A, B, C, D (up to four, with the primary adjacent to the letter "A")

**PLACE OF TREATMENT**

Enter the 2-digit Place of Service Code for Professional Claims, a HIPAA standard maintained by the Centers for Medicare and Medicaid Services. Frequently used codes are:

11 = Office; 12 = Home; 21 = Inpatient Hospital; 22 = Outpatient Hospital; 31 = Skilled Nursing Facility; 32 = Nursing Facility

The full list is available online at "www.cms.gov/PhysicianFeeSched/Downloads/Website_POS_database.pdf"

**PROVIDER SPECIALTY**

This code is entered in Item 56a and indicates the type of dental professional who delivered the treatment. The general code listed as "Dentist" may be used instead of any of the other codes.

| Category / Description Code | Code |
|---|---|
| **Dentist**<br>A dentist is a person qualified by a doctorate in dental surgery (D.D.S.) or dental medicine (D.M.D.) licensed by the state to practice dentistry, and practicing within the scope of that license. | 122300000X |
| **General Practice** | 1223G0001X |
| **Dental Specialty** (see following list) | Various |
| Dental Public Health | 1223D0001X |
| Endodontics | 1223E0200X |
| Orthodontics | 1223X0400X |
| Pediatric Dentistry | 1223P0221X |
| Periodontics | 1223P0300X |
| Prosthodontics | 1223P0700X |
| Oral & Maxillofacial Pathology | 1223P0106X |
| Oral & Maxillofacial Radiology | 1223D0008X |
| Oral & Maxillofacial Surgery | 1223S0112X |

Provider taxonomy codes listed above are a subset of the full code set that is posted at "www.wpc-edi.com/codes/taxonomy"

# Prior Authorization for Facility and Hospital Services

Dental services that require treatment in a facility or hospital must receive prior authorization from Envolve Dental. Note that facilities used must be Magnolia Health participating facilities. If no participating hospitals are within acceptable distance requirements, providers can make a non-par single case agreement request to Envolve Dental.

When submitting the authorization request, include the following:

1. A narrative of medical necessity
2. A completed Magnolia Health Outpatient Medicaid Prior Authorization Fax Form with detailed information about the facility
3. All procedure codes, including D9999 for the facility
4. All required documentation per code, as listed in Appendix A

Once all information is received, Envolve Dental makes a determination about the authorization request and the resulting response is initiated:

| Responses to Facility Authorization Requests | |
|---|---|
| Approved | Denied |
| • Envolve Dental will send an automated fax approval letter to the requesting dentist.<br>• Envolve Dental will fax the Magnolia Health Outpatient Form to Magnolia Health with the dental service authorization number.<br>• Magnolia Health will issue a facility/anesthesia authorization number and fax it to the hospital and the provider who initiated the request.<br>• The requesting provider calls the facility to schedule the services. | • Envolve Dental will fax a denial letter to the requesting provider, including information about how to appeal.<br>• Envolve Dental will mail a denial letter to the member, with information about how to appeal the determination.<br>• The provider or member can initiate an appeal. |

A copy of the Magnolia Health Outpatient Medicaid form follows.

magnolia health.

# OUTPATIENT MEDICAID
# Prior Authorization Fax Form

☐ Request for additional units. Existing Authorization _____ Units ____

☐ Standard Request - Determination within 3 calendar days and/or 2 business days of receiving all necessary information

☐ Expedited Request - I certify that following the standard authorization decision time frame could seriously jeopardize the member's life, health, or ability to attain, maintain, or regain maximum function.

X _____ URGENT REQUESTS MUST BE SIGNED BY THE REQUESTING PHYSICIAN TO RECEIVE PRIORITY.

*** INDICATES REQUIRED FIELD**

## MEMBER INFORMATION

Member ID/Medicaid ID *

Last Name, First

Date of Birth * (MMDDYYYY)

## REQUESTING PROVIDER INFORMATION

Requesting NPI *

Requesting TIN *

Requesting Provider Contact Name

Requesting Provider Name

Phone

Fax

## SERVICING PROVIDER / FACILITY INFORMATION

☐ *Same as Requesting Provider*

Servicing NPI *

Servicing TIN *

Servicing Provider Contact Name

Servicing Provider/Facility Name

Phone

Fax

## AUTHORIZATION REQUEST

**Primary** Procedure Code * (CPT/HCPCS) (Modifier)

**Additional** Procedure Code (CPT/HCPCS) (Modifier)

**Start Date *OR*** Admission Date * (MMDDYYYY)

Diagnosis Code * (ICD-10)

**Additional** Procedure Code (CPT/HCPCS) (Modifier)

**Additional** Procedure Code (CPT/HCPCS) (Modifier)

**End Date *OR*** Discharge Date (MMDDYYYY)

Total Units/Visits/Days

**For school-aged Members (Age 3-21) with disabilities/special needs as defined in the Individual with Disabilities Education Act (IDEA):**

Is/will the Member be receiving Therapy Services at school? Yes ☐ No ☐

Has Individualized Education Program (IEP) been completed? Yes ☐ No ☐ (If yes, please attach)

**OUTPATIENT SERVICE TYPE *** ***(Enter the Service type number in the boxes)*** ____

| | | | | | |
|---|---|---|---|---|---|
| 412 | Auditory Services | 600 | Home Infusion | 147 | Prosthetics |
| 422 | Biopharmacy | 290 | Hyperbaric Oxygen Therapy | 201 | Sleep Study |
| 712 | Cochlear Implants and Surgery | 240 | Inpatient Hospice | 701 | Speech Therapy |
| 771 | Dialysis | 729 | Neuropsych Testing | 472 | Stereotactic Radiosurgery |
| | | 410 | Observation | 724 | Transportation |
| | **DME** | 790 | Occupational Therapy | | |
| 417 | Rental | 997 | Office Visit/Consult (non par only) | | **Outpatient Services Examples:** |
| 120 | Purchase $ (Purchase Price) | 210 | Orthotics | | **- Skin Debridement/Wound Care** |
| | | 927 | Outpatient Hospice | | **- Hyperbaric Oxygen Therapy** |
| 299 | Drug Testing | 794 | Outpatient Services | | **Outpatient Surgery Examples:** |
| 709 | Genetic Testing | 171 | Outpatient Surgery | | **- Hysterectomy** |
| 249 | Home Health | 202 | Pain Management | | **- Mammoplasty** |
| 799 | Genetic Counseling | 101 | Physical Therapy | | **- Rhino/Septoplasty** |

***ALL REQUIRED FIELDS MUST BE FILLED IN AS INCOMPLETE FORMS WILL BE REJECTED. COPIES OF ALL SUPPORTING CLINICAL INFORMATION ARE REQUIRED. LACK OF CLINICAL INFORMATION MAY RESULT IN DELAYED DETERMINATION.***

**Disclaimer:** An authorization is not a guarantee of payment. Member must be eligible at the time services are rendered. Services must be a covered Health Plan Benefit and medically necessary with prior authorization as per Plan policy and procedures.

**Confidentiality:** The information contained in this transmission is confidential and may be protected under the Health Insurance Portability and Accountability Act of 1996. If you are not the intended recipient any use, distribution, or copying is strictly prohibited. If you have received this facsimile in error, please notify us immediately and destroy this document.

Rev. 01272016
**MS-PAF-0618**

# Prior Authorization for Sedation

To expedite the prior authorization of services requiring either IV sedation or general anesthesia in an outpatient setting, the Dental Sedation Scoring Tool must be submitted along with the prior authorization request. This scoring tool replaces the previously required medical necessity letter signed by the dentist. Please use the form on the Provider Web Portal.

# Prior Authorization for Orthodontia

Orthodontic services must receive prior authorization and will be considered for approval based on the member meeting at least one of the following criteria:

- Treatment is necessitated due to accidental injury or
- Documentation shows a history of cleft lip or palate condition
- Documentation shows a severe craniofacial condition where oral and maxillofacial surgery procedure is necessary to correct the condition
- Documentation shows a full cusp Class III malocclusion where minimally, the mesial cusp of the maxillary first molar is located in the interproximal space between the mandibular first and second molar on at least one side.

## Eligibility Criteria

The complete course of treatment must be completed by the member's 21st birthday. If a patient becomes ineligible for Medicaid benefits during the course of treatment, the authorization becomes void on the date eligibility ends or at the end of the birthday month in which the member turns 21 years of age.

If a member becomes ineligible during the course of treatment, the provider should complete the treatment. There is a possibility that the member's eligibility will be reinstated during the course of treatment. Member eligibility status can change monthly. The member or the member's guardian will be responsible for any bills accrued during the interim.

Submit the following required documentation for consideration:

1. Panorex or Full mouth x-ray(s)
2. Cephalometric x-ray
3. 5-7 diagnostic quality photos
4. Narrative of Medical Necessity (MS Orthodontic Treatment Need Criteria)

## Benefit Details

- Orthodontic benefits are limited to $4,200 maximum per lifetime.
- Only codes D8080 and D8670 are covered benefits.
- Prior authorization is required for D8080.
- Prior authorization is not required for D8670 (monthly orthodontic appointments).

- Envolve Dental will honor orthodontic prior authorization from another health plan for members who have already been banded. Envolve Dental will cover the remaining monthly visits based on the member's service history, up to 24 visits.

# Claim Submission Procedures

Providers must submit all claims and encounters within one hundred and eighty (180) calendar days of the date of service. When Magnolia is the secondary payer, claims must be received within three hundred and sixty five (365) calendar days of the final determination of the primary payer. Claims received after this time frame will be denied for failure to file timely. Submit claims and encounters electronically or by mail using one of the following options:

1. Envolve Dental Provider Web Portal at https://pwp.envolvedental.com
2. Electronic clearinghouses, using Envolve Dental payor ID number 46278
3. Alternate HIPAA-compliant electronic files
4. Paper claims on a completed ADA 2012 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 to have claims 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 benefit grids in Appendix A 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 Customer Service at 844-464-5636 or send us an email at providerrelations@envolvehealth.com. See Appendix B for claim submission instructions on the portal.

## 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 ID number **46278** for all clearinghouses. As of this manual publication date, we currently accept claims from the following:

- Change Healthcare (Website: www.changehealthcare.com; Phone: 888-363-3361)
- DentalXChange (Website: www.dentalxchange.com; Phone: 800-576-6412)
- Trizetto (Website: www.trizetto.com; Phone: 800-556-2231)

If you use a different electronic clearinghouse and would like us to consider participating, please send your request to providerrelations@envolvehealth.com. Include your practice name, technical point-of-contact

details, and average monthly claim volume.

## 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 844-464-5636.

## 4. Paper Claim Submission

The following information must be included on the 2012 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) as detailed in the benefit grids for each code (see Appendix A).

Mail paper claims with any required supporting documentation to:

Envolve Dental
MSCAN Claims
PO Box 25255
Tampa, FL 33622-5255

Postage due mail will be returned to sender.

# 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 through encounter payments. It is mandatory to submit encounter data per state and federal guidelines. These providers can choose one of the four claim submission options to submit encounters. Note the following requirements:

- Submit one encounter claim for each unique member visit.
- Submit codes *for every procedure performed* on the encounter claim to ensure member utilization data are complete.
- Ensure every code includes corresponding tooth numbers, quads, arches, and any other required identifiers, according to Appendix A.
- Include applicable authorization numbers.
- Include all documentation requirements in Appendix A 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, 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 the 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.

All images you transmit are retained in accordance with the provision of Section 11 Reporting Requirements, item 11-A Record System Requirements of the Magnolia Health State Contract. The images are stored 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. If you have specific questions about using *Fast*Attach®, call NEA at 800-782-5150.

# Billing for Orthodontia

Periodic treatment visits (D8670) are limited to a maximum of 24 per lifetime. Providers must check member eligibility before each D8670 visit, and each D8670 must be billed according to the date of service.

New Magnolia Health members who were banded prior to becoming eligible for Medicaid and enrolling in Magnolia Health can continue treatment with the current provider for at least the first 90 days after Magnolia Health enrollment. For payment consideration, the current provider must submit with the first claim to Envolve Dental:

1. A copy of the prior health plan's authorization;
2. A copy of the provider's ledger showing reimbursement of all services provided to the member, including all remits/EOBs received;
3. A narrative detailing the remaining treatment plan and request for continuing care; and
4. A W-9, if the current provider is out-of-network with Envolve Dental.

Our Appeals Specialist will review the case with a clinical consultant and will create an Envolve Dental authorization for remaining treatment benefits, based on the lifetime maximum ($4,200) and clinical criteria. If the current orthodontist is not an Envolve Dental network provider, the member *may* be required to transfer to an in-network provider after the initial 90-day Magnolia Health continuation of care period. The Appeals Specialist will make the determination.

# 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 Rendered Out-of-Office

Billing for all services should include the location code where services were rendered on the 2012 ADA claim

form (Box #38-Place of Treatment) or 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 & Medicaid Services website: CMS Place of Service Codes.

# Billing Limitations

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**: Restoration unbundling is not allowed. Total payment is based on the number of surfaces restored per day. It is not based on the number of restorations per surface or per tooth. Multiple one-surface restorations placed in the same tooth, on the same surface, on the same date of service will be paid as a single restoration. Restorations involving two or more contiguous surfaces should be billed with the applicable multiple-surface restoration code. Local anesthesia, tooth preparation, adhesives, liners, and bases are included in the restoration payment.
- **Cost-sharing:** Providers cannot bill members for any type of cost-sharing for covered dental services, including a co-payment, coinsurance, deductible, or deposit.
- **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 Magnolia Health members who have benefits with another insurer must be coordinated. In most cases, Magnolia Health will be the secondary insurer. Providers are responsible for asking members if they have multiple insurance policies 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.
- For electronic submissions, indicate the payment amount by the primary carrier in the "Capture Other Insurance Information" pop-up box from 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 criteria, 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 clean claims are paid within 30 days of submission. 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 Customer Service at 844-464-5636 with questions about claims and remittances.

# Claim Denials

If a provider has a question or is not satisfied with the information he/she has received related to a claim, the provider should first contact Envolve Dental at 844-464-5636 or via email at DentalPR@envolvehealth.com for more information.

If you believe the claim denial is in error, then you may consider submitting a corrected claim, a claim reconsideration request, or a claim dispute to the following address:

Envolve Dental
(Corrected Claims) (Claim Reconsiderations) (Claim Disputes) – MSCAN
PO Box 25255
Tampa, FL  33622-5255

All claim requests for reconsideration, corrected claims, or claim disputes must be received within 90 calendar days from the date of notification of payment or denial is issued.

Envolve Dental will process and finalize all adjusted claims, requests for reconsideration, and disputed claims to a paid or denied status within 45 business days of receipt of the corrected claim, request for reconsideration, or claim dispute.

If the corrected claim, request for reconsideration, or claim dispute results in an adjusted claim, the provider will receive a revised Explanation of Payment (EOP). If the original decision is upheld, the provider will receive a revised EOP or letter detailing the decision and steps for escalated reconsideration.

# Corrected Claims

Providers who receive a claim denial due to incorrect or missing information can submit a "corrected claim." A corrected claim is when a provider changes the original claim. 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 as follows to the address above:

Mail Submission

1. Complete a 2012 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.
2. Indicate corrections 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.

## Claim Reconsiderations

A request for reconsideration is when a provider disagrees with the original claim outcome (payment amount, denial reason, etc.). If a provider disagrees with the manner in which the claim was processed, the provider should write a letter to include a description of the reason of the request, along with the denial letter and any other supporting documentation, including your name, NPI number, contact details, all names and dates, any extenuating circumstances. Please review the clinical criteria and benefit limitations in this manual when formulating a written claim reconsideration, citing why you believe the claim should be paid.

## Claim Disputes

A claim dispute is to be used only when a provider has received an unsatisfactory response to a request for reconsideration. Please complete the Provider Claim Dispute form found on the Provider Web Portal at pwp.envolvedental.com, and include a copy of the Explanation of Payment (EOP) with the claim(s) to be adjusted clearly circled along with the response to the original request for reconsideration.

# 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, Magnolia Health, the Mississippi Department of Medicaid, and the Centers for Medicare & Medicaid Services. These conditions include the following:

- Providers cannot bill members for any type of cost sharing for covered dental services, including a copayment, coinsurance, deductible, or deposit.
- 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 are not allowed to charge members for missed appointments.

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 and Magnolia Health for payment of non-covered services. The form with specific required information can be obtained on the Envolve Dental Provider Web Portal.

# Reimbursement Limitation Definitions

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**: Restoration unbundling is not allowed. Total payment is based on the number of surfaces restored per 30 days. Multiple one-surface restorations placed in the same tooth, on the same surface, within 30 days will be paid as a single restoration. Restorations involving two or more contiguous surfaces should be billed with the applicable multiple-surface restoration code. Local anesthesia, tooth preparation, adhesives, liners, and bases are included in the restoration payment.

# Advance Notice

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.

# Complaint, Grievance, Appeal, and State Fair Hearing Processes

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 Magnolia Health's member complaint, grievance, appeal, and state fair hearing processes and leads Magnolia Health's dental provider complaint and grievance process.

## Member Complaints, Grievances, and Appeals

Magnolia has steps for handling any problems the member may have. Magnolia offers all of our members the following processes to achieve member satisfaction:

1. Internal grievance and complaint process
2. Internal appeal process
3. Access to Medicaid State Fair Hearing

Magnolia maintains records of each grievance and appeal filed by our members or by their authorized representatives, and the responses to each grievance and appeal, for a period of seven years.

### Internal Grievance and Complaint Process

A grievance is an expression of dissatisfaction about any matter or aspect of Magnolia or its operation. Grievances may be received orally or in writing and may be submitted to Magnolia by the member or the member's authorized representative, including the member's provider. Grievances must be submitted to Magnolia within 30 days of the date of the event causing dissatisfaction.

Examples of a grievance:

- Failure to respect the member's rights
- When a provider bills the member for unpaid claims (balance billing)
- Transportation issues

A complaint is an expression of dissatisfaction about any matter or aspect of Magnolia or its operation that can be resolved in one business day. Complaints may be received orally or in writing and may be submitted to Magnolia by the member or the member's authorized representative, including the member's provider. Complaints must be submitted to Magnolia within 30 days of the date of the event causing dissatisfaction.

### How to File a Grievance or Complaint

Filing a grievance or complaint will not affect the member's healthcare services. We want to know their concerns so we can improve our services.

To file a grievance or complaint, the member can call member services at 1-866-912-6285. Magnolia will provide reasonable assistance to members in filing a grievance or complaint. The member can also write a letter and mail or fax their grievance or complaint to Magnolia at 1-877-851-3995. The member will need to include:

- Their first and last name
- Their Medicaid ID number
- Their address and telephone number
- What they are not pleased with

- What they would like to have happen

A grievance or complaint may be filed in writing or by mailing it to the address below or by faxing it to 1-877- 851-3995. You can also call us at 1-866-912-6285 or file the grievance or complaint in person at:

Magnolia Health
Grievance and Appeal Coordinator
111 East Capitol Street, Suite 500
Jackson, MS 39201

If the member files a written grievance, the Grievance and Appeal Coordinator (GAC) will send the member a letter within five business days letting the member know that we have received their grievance. If the member filed a complaint, there is no need for written acknowledgement.

If someone else is going to file a grievance or complaint for the member, we must have the member's written permission for that person to file their grievance or complaint. The member can call member services to receive a form or go to www.MagnoliaHealthPlan.com. This form gives the member right to file a grievance or complaint to someone else. A provider acting for the member can file a grievance or complaint for the member with the member's written consent.

If the member has any proof or information that supports their grievance, they may send it to us and we will add it to their case. The member may supply this information to Magnolia by including it with a letter, by sending us an email or a fax, or by bringing it to Magnolia in person. The member may also request to receive copies of any documentation that Magnolia used to make the decision about their grievance.

To review the member's request, we may need to obtain additional information. If a signed Authorization to Release Information Form is not included with the member's grievance, a form will be sent to them for signature. If a signed authorization is not provided within 30 business days of the request, Magnolia may issue a decision on the grievance without review of some or all of the information. When a signed request is received by the member's authorized representative, appropriate proof of the member's designation must be provided.

The member can expect a resolution and a written response from Magnolia within 30 days of receiving their grievance. If Magnolia needs more than 30 days to resolve the grievance, we will send a letter to the member within two working days of the decision to extend the timeframe. The extra time may be better for the member's case. Magnolia will ask for the extra 14 days in writing. The letter will say why we need more time.

There will be no retaliation against the member or their representative for filing a grievance or complaint with Magnolia. Filing a grievance or complaint will not affect the member's health care services.

## Expedited Grievances

The member or their provider may want us to make a fast decision. The member can ask for an expedited review if the member or their provider feels that the member's health is at risk. If the member feels this is needed, the member will need to contact Magnolia for a review and investigation by the appropriate clinical staff.  Clinically urgent grievances will be resolved within 72 hours of receipt.

## Internal Appeal Process

## Filing an Appeal

An appeal is a request for Magnolia to review an Adverse Benefit Determination. The member can request this review by phone or in writing.

An Adverse Benefit Determination occurs when Magnolia:

- Denies or limits authorization of a service the member wants
- Reduces, suspends or terminates payment for a service the member is already getting
- Fails to authorize a service in the required timeframe
- Fails to decide a grievance, complaint, or appeal in the required time frame

The member will know that Magnolia is making an Adverse Benefit Determination because we will send them a letter. The letter is called an Adverse Benefit Determination. If the member does not agree with the Adverse Benefit Determination, they may request an appeal.

**Who may file an Appeal?**

- The member (or the parent or guardian of a minor member)
- A person named by the member
- A provider acting for the member

The member must give written permission if someone else files an appeal for them. Magnolia will include a form in the Adverse Benefit Determination letter. The member can contact Magnolia at 1-866-912-6285 if they need help. We can assist the member in filing an appeal.

## When Does an Appeal Have to be Filed?

The Adverse Benefit Determination will tell the member about this process. The member may file an appeal within 60 calendar days of the receipt of the Adverse Benefit Determination. If the member makes their request by phone or in person, the member must also send Magnolia a letter confirming their request for standard appeals.

The member may ask to keep getting care related to their review while we decide. The member may have to pay for this care if the decision is not in their favor.

Magnolia will give the member a written decision within 30 days from the date of their request. The decision will be made by a reviewer with the appropriate expertise. If more than 30 days is needed to make a decision, we will send a letter to the member. Magnolia will ask for extra time if more information is needed. The extra time may be better for your case. Magnolia will ask for the extra 14 days in writing. The letter will say why we need more time.

## Expedited Appeals

The member or their provider may want us to make a fast decision. The member can ask for an expedited review if the member or their provider feel that their health is at risk. If the member feels this is needed, they can call our Clinical Appeals Coordinator at 1-866-912-6285.

We will decide within 72 hours of receipt of the appeal request. However, the review period may be up to 14 days. Magnolia may extend up to 14 days if member requests an extension, or if Magnolia determines that the extension is in their best interest. The member will also receive a letter telling the reason for the decision and what to do if they don’t like the decision. Expedited appeals do not require a signed authorization form.

## Medicaid State Fair Hearing

## What if I am still not pleased?

If the member is still dissatisfied with the outcome of their appeal with Magnolia, the member may request a State Fair Hearing within 120 calendar days of receiving the Notice of Appeal Resolution. If the member requests a State Fair Hearing and they want their benefits to continue, they must file their request within 10 days from the date they received our decision. If the State Fair Hearing finds that Magnolia’s decision was right, they may be responsible for the cost of the continued benefits.

To request a State Fair Hearing, please write to:

Division of Medicaid
Attn: Office of Appeals
550 High Street, Suite 1000
Jackson, Mississippi 39201
Ph: 601-359-6050 or 1-800-884-3222
Fax: 601-359-9153

# Provider Complaints, Grievances, and Appeals

A provider complaint is an oral or written expression of dissatisfaction that is of a less serious or formal nature and that is resolved within one business day of receipt. Any provider complaint not resolved within one (1) business day shall be treated as a grievance. A provider complaint includes, but is not limited to inquiries, misunderstandings, or misinformation that can be promptly resolved by clearing up the misunderstanding or providing accurate information.

A provider grievance is an oral or written expression of dissatisfaction about any matter or aspect of Envolve Dental or its operation. A provider grievance includes, but is not limited to, the quality of care or services provided or aspects of interpersonal relationships such as rudeness of a provider or an employee.

Providers have 30 calendar days from the date of the incident, such as the date of the Explanation of Payment (EOP), to file a complaint/grievance. Please note that the reconsideration and/or claims dispute process must be followed prior to the initiation of a complaint/grievance based on a claim determination.

Envolve Dental
Provider Grievances and Complaints
PO Box 25255
Tampa, FL  33622-5255

## Acknowledgement

Upon receipt of a grievance Envolve Dental staff will acknowledge the grievance, document the substance of the grievance, and attempt to resolve it immediately. For written grievances, Envolve Dental will notate the date received and send an acknowledgment letter, which includes a description of the grievance procedures and resolution time frames, within five business days of receipt.

## Grievance Resolution Time Frame

Provider grievance resolution will occur as expeditiously as deemed appropriate, not to exceed 30 calendar days from the date of the initial receipt of the grievance. Envolve Dental may extend the time frame up to 14 calendar days. Grievances will be resolved by Envolve Dental in coordination with Magnolia Health as needed. In our experience, most grievances are resolved at the staff level to the satisfaction of the provider filing the grievance. Expedited grievance reviews will be available for providers in situations deemed urgent, such as a denial of an expedited appeal request, and will be resolved within 24 hours.

## Notice of Resolution

Envolve Dental will provide written resolution to the provider within thirty (30) calendar days of receipt. The letter will include the resolution and DOM requirements, including the right to a Level II Grievance Review by Envolve Dental, if the provider is not satisfied. The grievance response shall include, but not be limited to, the decision reached by Envolve Dental, the reason(s) for the decision, the policies or procedures which provide

the basis for the decision, and a clear explanation of any further rights available to the enrollee. A copy of verbal complaints logs and records of disposition or written grievances shall be retained for five (5) years. Complaints and/or Grievances may be submitted by written notification to:

Envolve Dental
Provider Grievances and Complaints
PO Box 25255
Tampa, FL 33622-5255

## Provider Appeal

Envolve Dental must resolve a provider appeal within forty-five (45) calendar days from the receipt of the provider appeal or as expeditiously as the member's health condition requires. Expedited provider appeals are to be resolved within three (3) business days from the receipt of the expedited resolution request. Envolve may extend the time frame for this request up to fourteen (14) calendar days upon receipt of information required to make a determination. An oral request for an expedited appeal does not require a written follow-up.

## State Administrative Hearing

A State Administrative Hearing is a hearing conducted by the Division of Medicaid of any provider appeal of an adverse benefit determination that is not resolved wholly in favor of the provider.

A request for a State Administrative Hearing should be submitted within thirty (30) calendar days of the final decision by Magnolia Health to the Division of Medicaid at the following address:

Division of Medicaid, Office of the Governor
Attn: Office of Appeals
550 High Street, Suite 1000
Jackson, Mississippi 39201
Phone: 601-359-6050 or 1-800-884-3222
Fax: 601-359-9153

# Dental Health Guidelines Ages 0–20 Years

The Mississippi Division of Medicaid follows the American Academy of Pediatric Dentistry (AAPD) guidelines and policies to promote optimal oral health for children, including recommended time frames for providing oral health assessments, preventive care, and anticipatory guidance to children and parents. The following chart represents the specific AAPD guidance for Mississippi children who are developing normally and do not have extenuating medical conditions. Providers should assess each child for his or her unique health needs and make appropriate adjustments intended to optimize the child's health.

| Recommended Pediatric Dental Periodicity Schedule for Mississippi | | | | | | |
|---|---|---|---|---|---|---|
| | Age | | | | | |
| **Recommended Services** | **0 to 6 Months** | **6 to 12 Months** | **12 to 24 Months** | **2 to 6 Years** | **6 to 12 Years** | **12-20 Years** |
| Clinical oral examination [1] | X | X | X | X | X | X |
| Assess oral growth and development [2] | X | X | X | X | X | X |
| Caries-risk assessment [2] | X (if indicated) | X | X | X | X | X |
| Radiographic assessment [3] | X (if indicated) | X | X | X | X | X |
| Prophylaxis and fluoride treatment [4] | X (if indicated) | X | X | X | X | X |
| Fluoride supplementation [5] | X (if indicated) | X | X | X | X | X |
| Anticipatory guidance/counseling [2] | X | X | X | X | X | X |
| Oral hygiene counseling [2] | Parent | Parent | Patient/ Parent | Patient/ Parent | Patient | Patient |
| Dietary counseling [2] | X | X | X | X | X | X |
| Injury prevention counseling [2] | X | X | X | X | X | X |
| Counseling for non-nutritive habits [2] | X | X | X | X | X | X |
| Counseling for speech/language development[2] | X | X | X | X | | |
| Substance abuse counseling[2] | | | | | X | X |
| Counseling for intraoral/perioral piercing[2] | | | | | X | X |
| Assessment and treatment of developing malocclusion[6] | | | | X | X | X |
| Assessment for pit and fissure sealants [7] | | | | X | X | X |
| Assessment and/or removal of third molars[8] | | | | | | X |
| Transition to adult dental care | | | | | | X |

1 Beginning at age three (3), children not already under the care of a dentist should be referred. Children with obvious dental problems may be referred at an earlier age. Comprehensive oral evaluation is covered every six (6) months. Limited oral evaluation for specific oral health problems are covered four (4) times per year. Additional exams may be covered if dentally necessary as approved by DOM.
2 Should be performed as part of comprehensive oral evaluation.
3 Full mouth radiographs or panorex covered once per two years.
4 Prophylaxis and fluoride treatment is covered every six months.
5 Fluoride supplementation is covered through the pharmacy benefit with DOM.
6 Orthodontic evaluation is covered. Orthodontic treatment is covered only when DOM clinical criteria policy is met.
7 Sealants are covered for primary teeth as approved by DOM for first and second molars/first and second pre-molars. Sealants are covered once every five years.
8 Removal of unerupted third molars is covered when there is radiographic evidence of severe impaction or there is evidence of chronic infection.

Source: Adapted from the American Academy of Pediatric Dentistry for Mississippi

# Quality Improvement

## Mission Statement

The Quality Improvement Program provides an effective, system-wide, measurable plan for monitoring, evaluating and improving the quality of care and services in a cost-effective and efficient manner for our members.

## Vision Statement

The vision of our Quality Improvement Program is to improve the quality of care and services provided to our members and to therefore improve the oral health of our community, one member at a time, which contributes to the improved overall health of individuals. To this end, our aim is to produce better oral health outcomes at lower costs for our members while enhancing the patient experience and lowering the total cost of care.

## Purpose of the Quality Improvement Program

Envolve Dental is committed to the provision of a well-designed and well-implemented Quality Improvement Program. This describes the Quality Improvement process as it relates to the coordination, safe delivery, and evaluation of high quality, cost-effective routine and medical dental care required by payors for their covered members. Envolve Dental continuously strives to maintain a quality dental care program that assures patients' access to routine and medical dental care services while ensuring the continuity of care that patients receive and utilizes provider oversight in assuring the quality and appropriateness of these services. This is measured through routine medical record reviews, potential quality of care reviews, grievance reviews and member/provider surveys. This collective information is tracked and analyzed to identify opportunities for improvement.

The Quality Improvement Program utilizes a systematic approach to quality using reliable and qualitative methods of monitoring, analysis, evaluation and improvement in the delivery of high quality dental services to all members, including those with special needs. This proven approach to quality improvement provides a continuous cycle for assessing the quality of care and service among Envolve Dental's initiatives of all routine and medical dental care services provided. Additionally, the Quality Improvement Program serves to assure the timely identification, assessment and resolution of known or suspected deficiencies in the quality of care or services received by members and to prevent their reoccurrence by continuous monitoring, evaluation and improvement of the routine and medical dental care services provided.

In order to fulfill its responsibility to members, the community, key stakeholders and regulatory/accreditation agencies, Envolve Dental's Board of Directors (BOD) has adopted the following Quality Improvement Program Description. The Program Description is reviewed and approved at least annually by the Quality Improvement Committee (QIC) and BOD.

Envolve Dental's Quality Improvement Program extends to all internal departments and business partners in the recognition that teamwork, collaboration and sharing of activities and outcomes are critical for successful quality improvement. Departmental leaders are charged with developing and overseeing quality improvement activities aimed at optimal care, services and organizational efficiency within their respective departments as well as coordinating interdepartmental quality improvement activities when applicable. This is accomplished by assisting with the identification, investigation, implementation, and evaluation of corrective actions that continuously improve and measure the quality of clinical and administrative services. Envolve Dental's Quality Improvement Program consists of components to monitor, analyze, and evaluate contract/industry standards and processes to improve the following:

- Continuity and coordination of care
- Member and provider complaint/grievance system
    - Member and provider satisfaction
- Quality management
- Timeliness and clinical appropriateness of care
    - Provider appointment accessibility/availability
    - Available member scheduling for urgent care within 24 hours
    - Available member scheduling for routine/preventative dental appointments within 30 days of request, unless member requested otherwise
    - Available member scheduling of non-urgent/sick appointments within 14 days, unless member requests otherwise
- Provider network adequacy and capacity
    - Network performance
- Patient safety
- Credentialing and re-credentialing of practitioners and providers
    - Compliance with state, federal, and professional standards and guidelines. Providers should be able to produce documentation of compliance at the request of Envolve Dental.
- Utilization management, including under and over-utilization
- Denials and administrative reviews

A formal evaluation of the Quality Improvement Program is performed annually. Specific elements of the Quality Improvement Program may include, but are not limited to:

- Measuring, monitoring, trending and analyzing the quality of patient care delivery against performance goals and/or recognized benchmarks
- Fostering continuous quality improvement in the delivery of patient care by identifying aberrant practice patterns and opportunities for improvement
- Evaluating the effectiveness of implemented changes to the Quality Program
- Reducing or minimizing opportunities for adverse impacts to members
- Improving efficiency, cost effectiveness, value and productivity in the delivery of services
- Evaluating the delivery of appropriate dental care according to professionally recognized standards
- Evaluating that written policies and procedures are established and maintained the ensure that quality dental care is provided to the members
- Quality Improvement Projects

## Goals and Objectives of the Quality Improvement Program

Quality Improvement goals include but are not limited to the following:

- Provide and build quality into all aspects of Envolve Dental’s organizational structure and processes and continuously strive for improvement in the delivery of care and patient safety to all members
- Provide a formal process for the continuous and systematic monitoring, evaluation, intervention for improvement, and reassessment of the adequacy and appropriateness of clinical and administrative services provided by Envolve Dental to members, practitioners, and other internal and external customers
- Develop appropriate quality guidelines and standards for implementation by the QI Committee and subcommittees, departments, and personnel involved in quality issues including providers and their staff
- Plan services will meet industry-accepted standards of performance
- Facilitate culturally sensitive and linguistically appropriate services
- Fragmentation and/or duplication of services will be minimized through integration of quality improvement activities across organization functional areas

- Continuously assess the overall effectiveness of the guidelines and standards in all levels of service and care with appropriate measurements
- Take corrective action when quality guidelines and standards are not followed or met
- Make best efforts to adapt and modify guidelines and standards, at least annually, in accordance with the most recent state and federal regulations (including HIPAA) and the most up-to-date clinical/medical studies and practice guidelines
- Support a high level of satisfaction as it pertains to the services provided by Envolve Dental to members, providers and clients

Quality Improvement objectives include but are not limited to the following:

- To establish and maintain a health system that promotes continuous quality improvement, which includes fostering long-term relationships with our provider network that are built on trust and collaboration to ensure consistent improvements in the quality and cost effectiveness of care and services delivered to members
- To adopt evidence-based clinical indicators and practice guidelines as a means for identifying and addressing variations in medical practice
- To develop standardized performance measures that are clearly defined, objective, measurable, and allow tracking over time
- To allocate personnel and resources necessary to:
- Support the Quality Improvement Program, including data analysis and reporting
- Meet the educational needs of providers and staff relevant to quality improvement efforts
- To seek input and work with providers and community resources to improve quality of care
- To oversee peer review procedures that will address deviations in medical management and health care practices and devise action plans to improve services
- Maintain National Committee for Quality Assurance (NCQA) accreditation
- Monitor for compliance with regulatory and NCQA requirements
- Monitor marketing practices

All information related to the Quality Improvement process is considered confidential. All Quality Improvement data and information, inclusive of but not limited to, minutes, reports, letters, correspondence and reviews, are housed in a designated, secured area. All aspects of quality review are deemed confidential. All persons involved with review activities will adhere to the confidentiality guidelines applicable to the appropriate committee.

# Benefits

## Benefit Descriptions

### Plan Eligibility

- MississippiCAN Children Ages 0-20
- MississippiCAN Adults Ages 21 and over

## MississippiCAN – Children Ages 0-20

Magnolia Health Plan covers periodic teeth cleaning, fluoride treatment, sealants, tooth restorations, radiographs, extractions, and other dental services as outlined in the benefit table starting in Appendix A. All ADA dental procedure codes included in the plan, except orthodontia-related services, are applied to a $2,500 benefit limit per calendar year. Benefits in this plan end at the end of the birthday month when the child turns 21, but the person may become eligible for coverage under the adult plan.

## MississippiCAN – Adults Age 21 and over

Magnolia Health Plan covers emergent and palliative care only. Extractions are only covered when considered medically necessary. Exams and x-rays are reimbursable only when performed in conjunction with covered services or to make a diagnosis for such a situation. Refer to the benefit tables in
Appendix A. All ADA dental procedure codes included in the plan are applied to a $2,500 benefit limit per calendar year.

## MississippiCAN – Adults Age 21 and over with Specific Qualifiers

All MississippiCAN eligible adults enrolled in Magnolia Health are eligible for adult dental benefits, regardless of the member’s Category of Eligibility (COE).

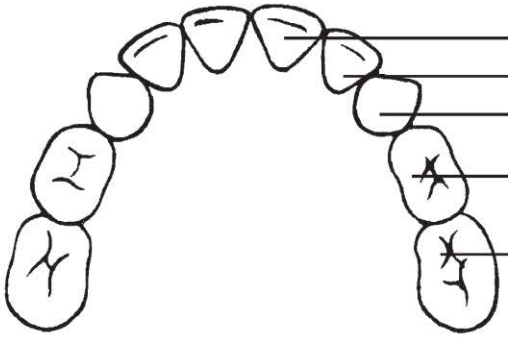
# Clinical Definitions

Teeth should be identified as follows:

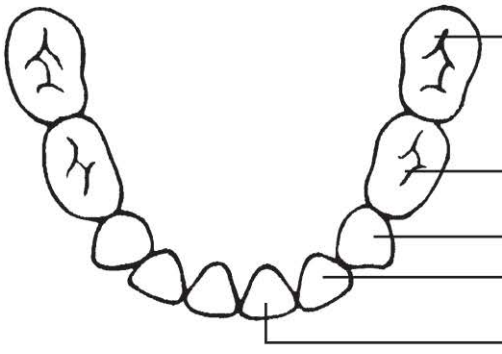
| Teeth | Identified by |
|---|---|
| Primary | Letters A through T |
| Permanent | Numbers 1 through |
| Supernumerary | Letters AS through TS* |

*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.

# Primary Tooth Development

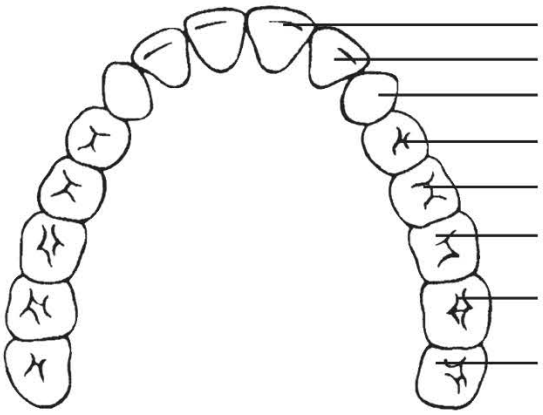


| Upper Teeth | Erupt | Shed |
|---|---|---|
| Central incisor | 8-12 mos. | 6-7 yrs. |
| Lateral incisor | 9-13 mos. | 7-8 yrs. |
| Canine (cuspid) | 16-22 mos. | 10-12 yrs. |
| First molar | 13-19 mos. | 9-11 yrs. |
| Second molar | 25-33 mos. | 10-12 yrs. |

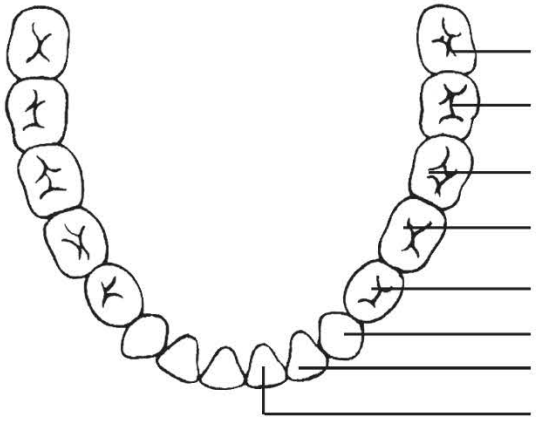


| Lower Teeth | Erupt | Shed |
|---|---|---|
| Second molar | 23-31 mos. | 10-12 yrs. |
| First molar | 14-18 mos. | 9-11 yrs. |
| Canine (cuspid) | 17-23 mos. | 9-12 yrs. |
| Lateral incisor | 10-16 mos. | 7-8 yrs. |
| Central incisor | 6-10 mos. | 6-7 yrs. |

# Permanent Tooth Development



| Upper Teeth | Erupt |
|---|---|
| Central incisor | 7-8 yrs. |
| Lateral incisor | 8-9 yrs. |
| Canine (cuspid) | 11-12 yrs. |
| First premolar (first bicuspid) | 10-11 yrs. |
| Second premolar (second bicuspid) | 10-12 yrs. |
| First molar | 6-7 yrs. |
| Second molar | 12-13 yrs. |
| Third molar (wisdom tooth) | 17-21 yrs. |



| Lower Teeth | Erupt |
|---|---|
| Third molar (wisdom tooth) | 17-21 yrs. |
| Second molar | 11-13 yrs. |
| First molar | 6-7 yrs. |
| Second premolar (second bicuspid) | 11-12 yrs. |
| First premolar (first bicuspid) | 10-12 yrs. |
| Canine (cuspid) | 9-10 yrs. |
| Lateral incisor | 7-8 yrs. |
| Central incisor | 6-7 yrs. |

# Appendix A – Benefit Plan Details and Authorization Requirements

## MississippiCAN (Coordinated Access Network)

Please see **Appendix A, Benefit Plan Details and Authorization Requirements,** posted separately to the Provider Web Portal, for the most recently updated specific dental codes covered, along with clinical criteria and authorization details.

# Appendix B: Provider Web Portal User Guide

The Envolve Dental secure Provider Web Portal simplifies and expedites benefit administration with easy-to-use web-based services. Benefits include:

- Faster authorization submissions and determinations
- Faster claim payments through streamlined submission and adjudication processes
- Lower administrative costs
- Access to view member information, claim and authorization history and payment records at any time

Access the Envolve Dental Provider Web Portal at:

**https://pwp.envolvedental.com**

The Provider Web Portal works on multiple web browsers, but screens are optimized when using Internet Explorer and Mozilla Firefox browsers. From the Provider Web Portal, providers and authorized office staff can log in for secure access to manage a variety of day-to-day tasks, including:

- Verify member eligibility
- Check patient treatment history
- Set up office appointment schedules, automatically verifying eligibility and prepopulating claim forms for online submission
- Submit claims and authorizations by simply entering procedure codes, relevant tooth numbers, etc.
- Send electronic attachments, such as digital X-rays and EOBs
- Check the status of in-process claims and authorizations, or review historical payment records
- Review provider clinical profiling data relative to peers (reports)
- Download and print provider manuals
- Check PCD Roster List

# Provider Web Portal Registration

A web browser, a valid user name, and a password are required for Provider Web Portal access. First-time users are required to register by calling Envolve Dental Customer Service at **1-844-464-5636** to obtain a unique Payee ID Number. Customer Service will verify your identity to ensure registration is completed and accessed only by an authorized user.

To register,

1. Go to **https://pwp.envolvedental.com**.
2. Click **Register Now**.
3. Call **1-844-464-5636** Monday through Friday, 8 a.m. to 5 p.m. to obtain your Payee ID Number.

4. On the “User Registration” pop-up screen, select “As a Payee” on the registration option.*
5. Add the Payee ID number from Customer Service.
6. Verify spelling/punctuation of Name, City, State and ZIP
7. Fill in details in every field, ensuring you remember your user name and password.
8. Click “Submit.”


*You can also register as a location or provider. Ask a Provider Relations Representative for more information.

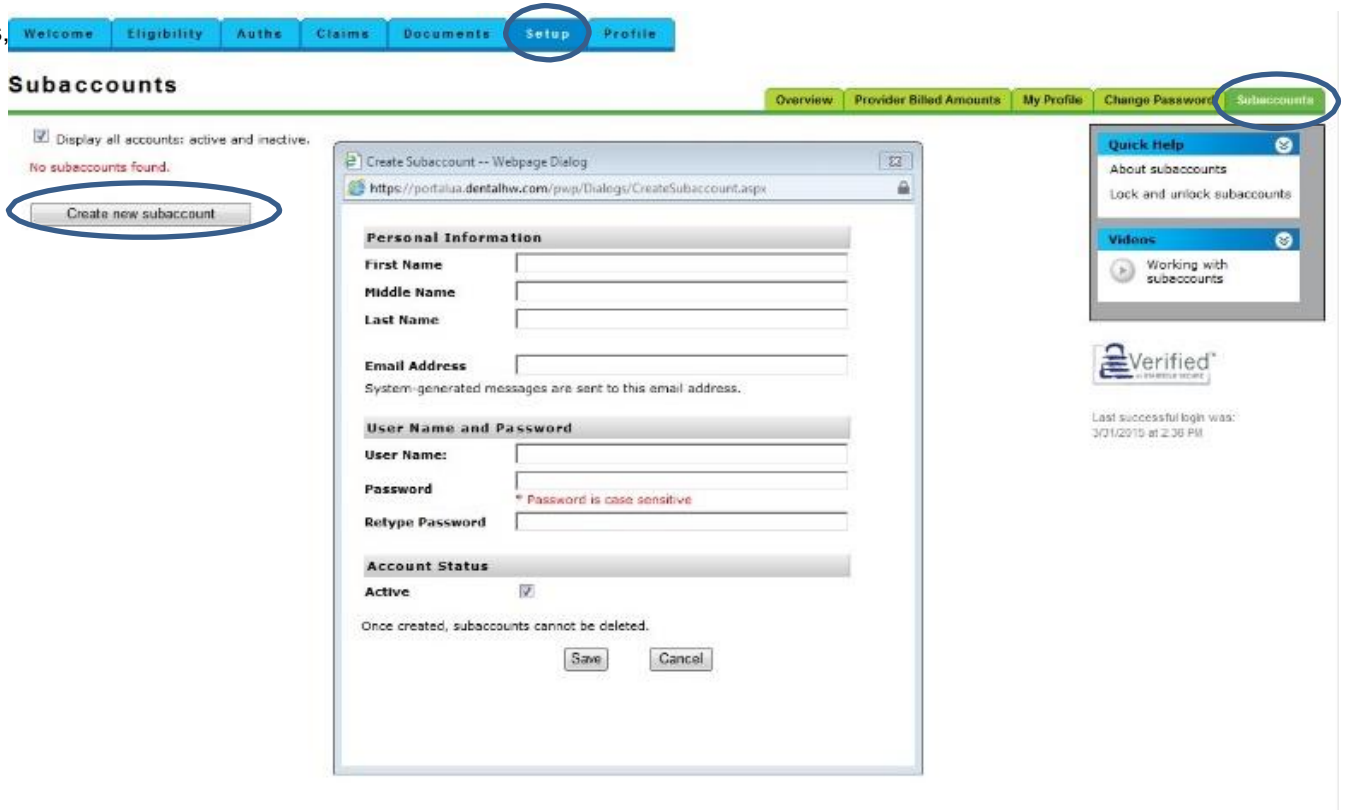
# Subaccounts

Subaccounts allow multiple users to share the same web portal access without sharing the same user name and password.

The subaccounts feature is available only for users who log in with "master" accounts. A master account is created when a user registers for the Provider Web Portal (PWP). A "subaccount" is a user account that is tied to a master account.

To set up a subaccount for other users,

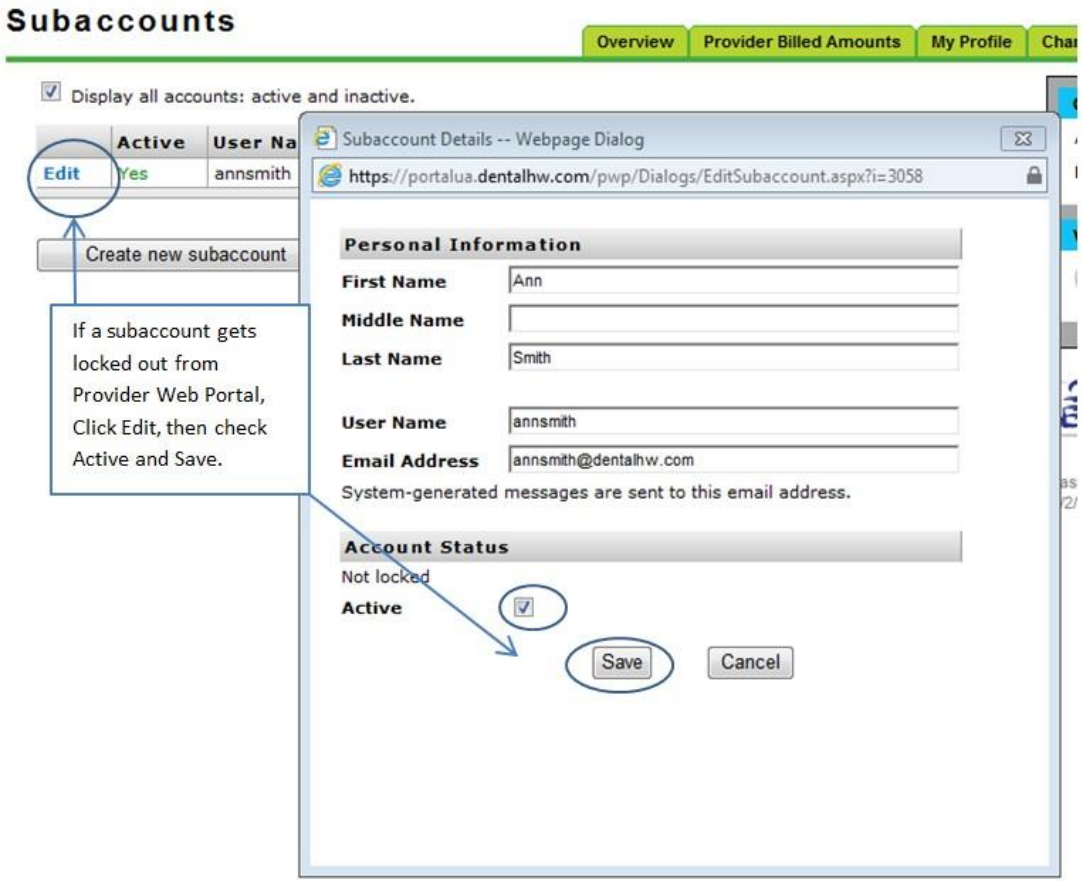
1. Log in to your Payee account.
2. Go to the “Setup” tab, then “Entity Management” tab.
3. Click on “+Add New User.”



# User Account Security

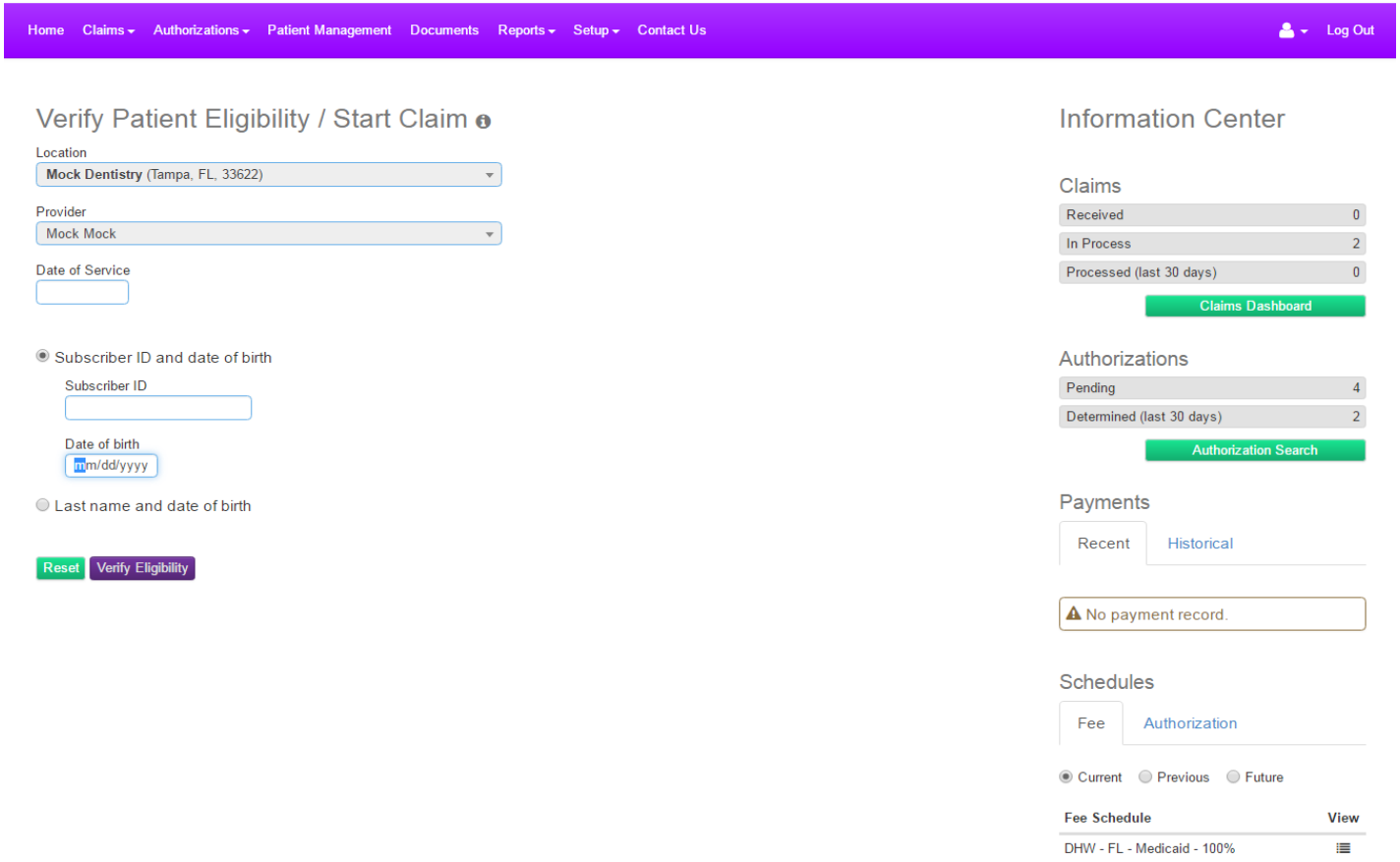
Master accounts can be manually locked and unlocked by a Customer Service Representative. If a master account is locked accidentally—for example, if the master account user enters an invalid password too many times, or if the password expires—the master account holder must call Provider Services to unlock account. In such cases, users with related subaccounts can continue to log on to the web portal.

Subaccounts can be managed only by the related master account. The master account user may check a subaccount as “inactive.” Subaccounts can be unlocked only by the associated master account. Subaccounts cannot be unlocked by Customer Service.



# Information Center

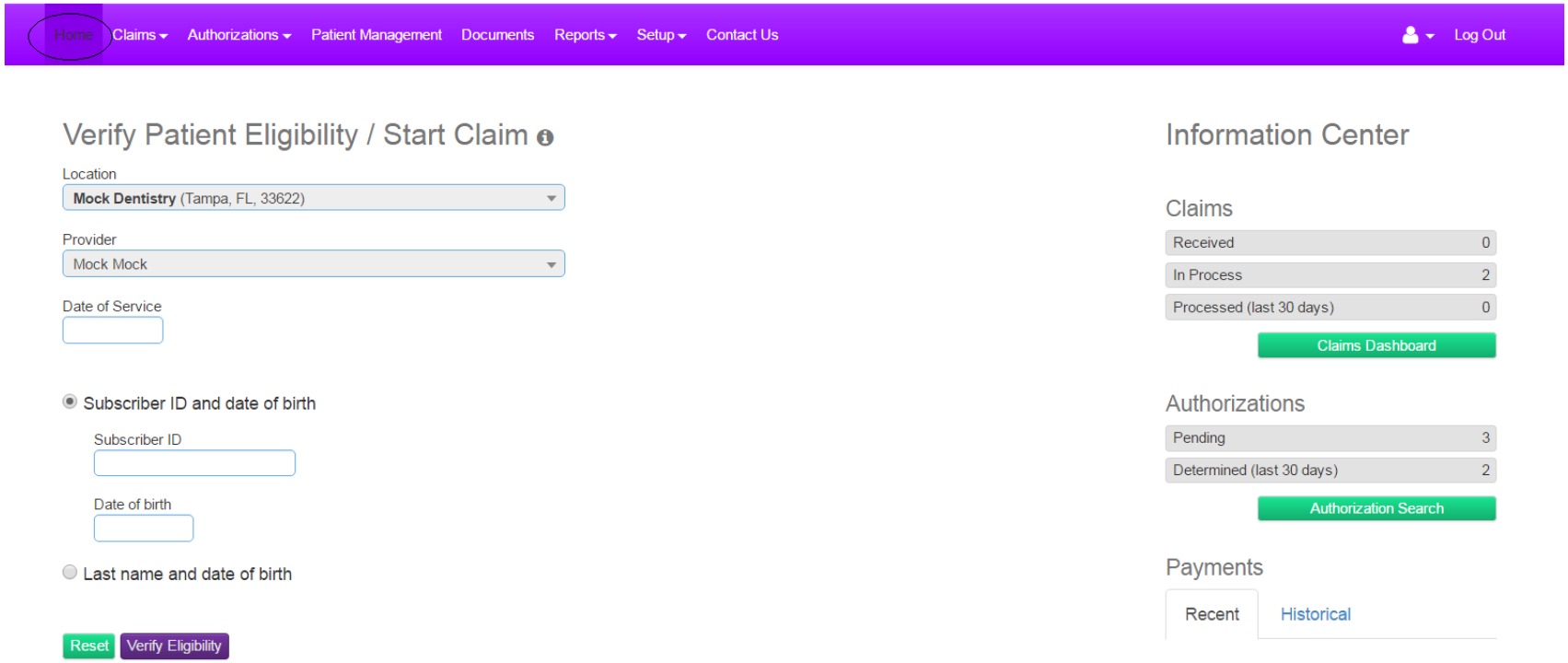
Once registered, use the Provider Web Portal to access the available resources and features to help streamline data entry. After logging in, you will view the Information Center on the home page. (Your dashboard may look slightly different if registered as “Provider” or “Location.”)




- **Review Fee Schedules** – All fee schedules that are linked to your participation are listed on the Payee Dashboard.
- **Track Open/Processed Authorization Records** – Status and final disposition of all authorizations can be reviewed on the Provider Web Portal. The number of open and processed authorizations is listed on the Information Center to allow providers to track authorization progress. Individual authorizations can be reviewed down to the service level by clicking on the Authorization Search.
- **Track Open/Processed Claim Records** – Status and final disposition of all claims can be reviewed via the Provider Web Portal. The number of open and processed claims is listed on the Information Center to allow providers to track payment progress. Individual claims can be reviewed down the service level by clicking on the linked pictured above. The Provider Web Portal also has search functionality allowing a specific claim to be retrieved by clicking on Claims Dashboard.
- **Access Electronic Remittances** – PDF copies of all EOPs/remittances are archived on the Provider Web Portal and can be retrieved at any time.

# Eligibility Verification

Use “Verify Patient Eligibility” on the Home tab to confirm a patient’s benefit coverage and eligibility for service on a specific date.




1. Click the Home tab.
2. Choose Location and Provider. Enter projected date of service, member’s Subscriber ID, and date of birth.
3. Click “Verify Eligibility” and review the *Eligibility Report* detailing the member’s coverage.

**TIP – When checking eligibility, enter [ID + DOB] **or** [First Initial + Last Name + DOB]. Entering more information than necessary can lead to room for errors.

# Example of Eligibility Report

## Patient Eligibility Report

*This report is only accurate on the date and time it is rendered. The patient's information may have changed after t has been generated.

This patient is eligible for services on 10/05/2016 from Mock Mock at Mock Dentistry.

### Patient Information

**Lauren Bicuspid**

1 Floss Way
Tampaf, FL 33603

DOB: 11/06/2002
Subscriber ID: 946458332

### Provider Information

**Mock Mock**

Mock Dentistry
12345 Mock Ln
Tampa, FL 33622

### Insurer Information

**Dental Health & Wellness, Inc. - Florida**

FL - MMA/CW Medicaid

### Eligibility Details

| | |
|---|---|
| Effective Date: | 08/01/2016 |
| Termination Date: | Open |
| *Total Dollars Consumed: | N/A |

## Patient Eligibility Report

*This report is only accurate on the date and time it is rendered. The patient's information may have changed after this report has been generated.

This patient is NOT ELIGIBLE for services 10/05/2016.

### Patient Information

### Provider Information

**Mock Mock**

Mock Dentistry
12345 Mock Ln
Tampa, FL 33622

### Insurer Information

**Dental Health & Wellness, Inc. - Florida**

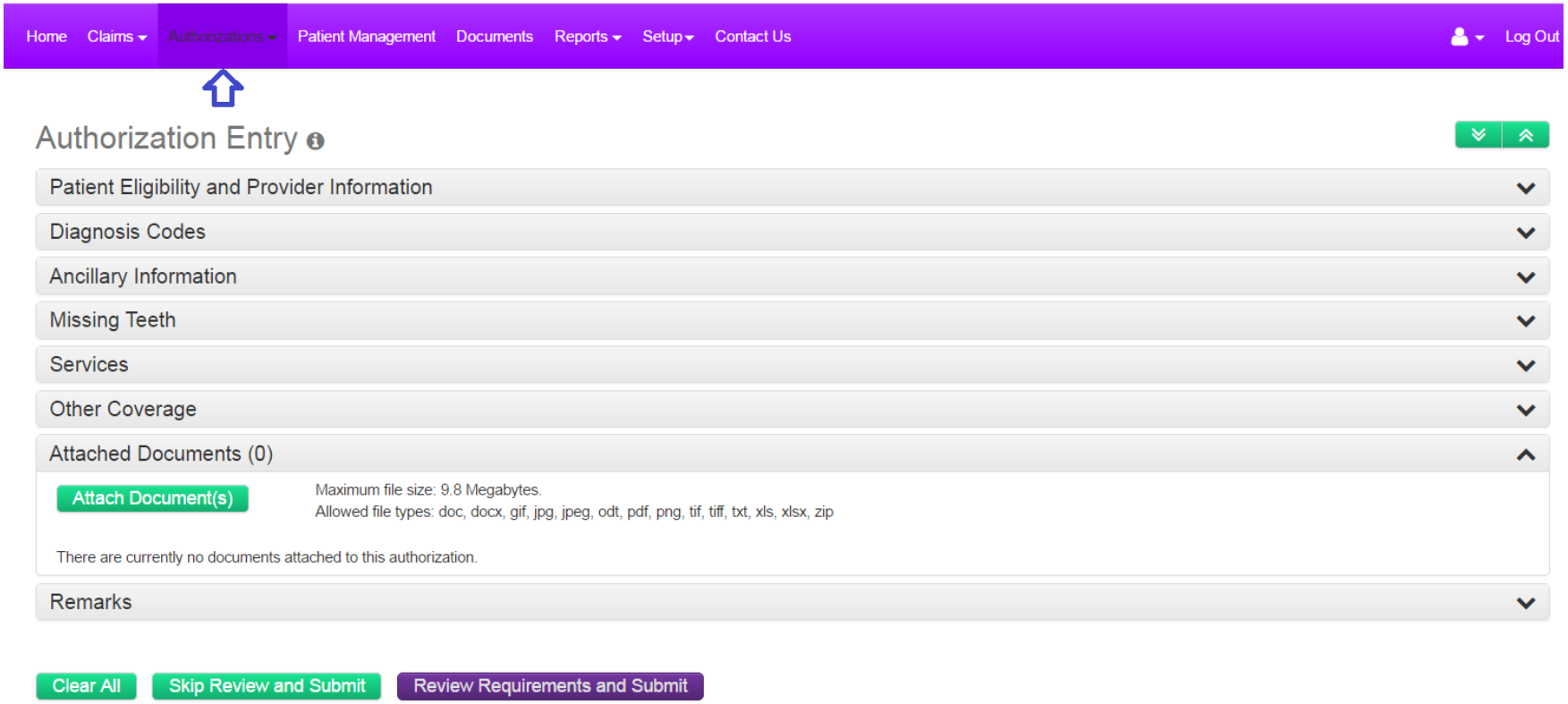
FL - MMA/CW Medicaid

### Eligibility Details

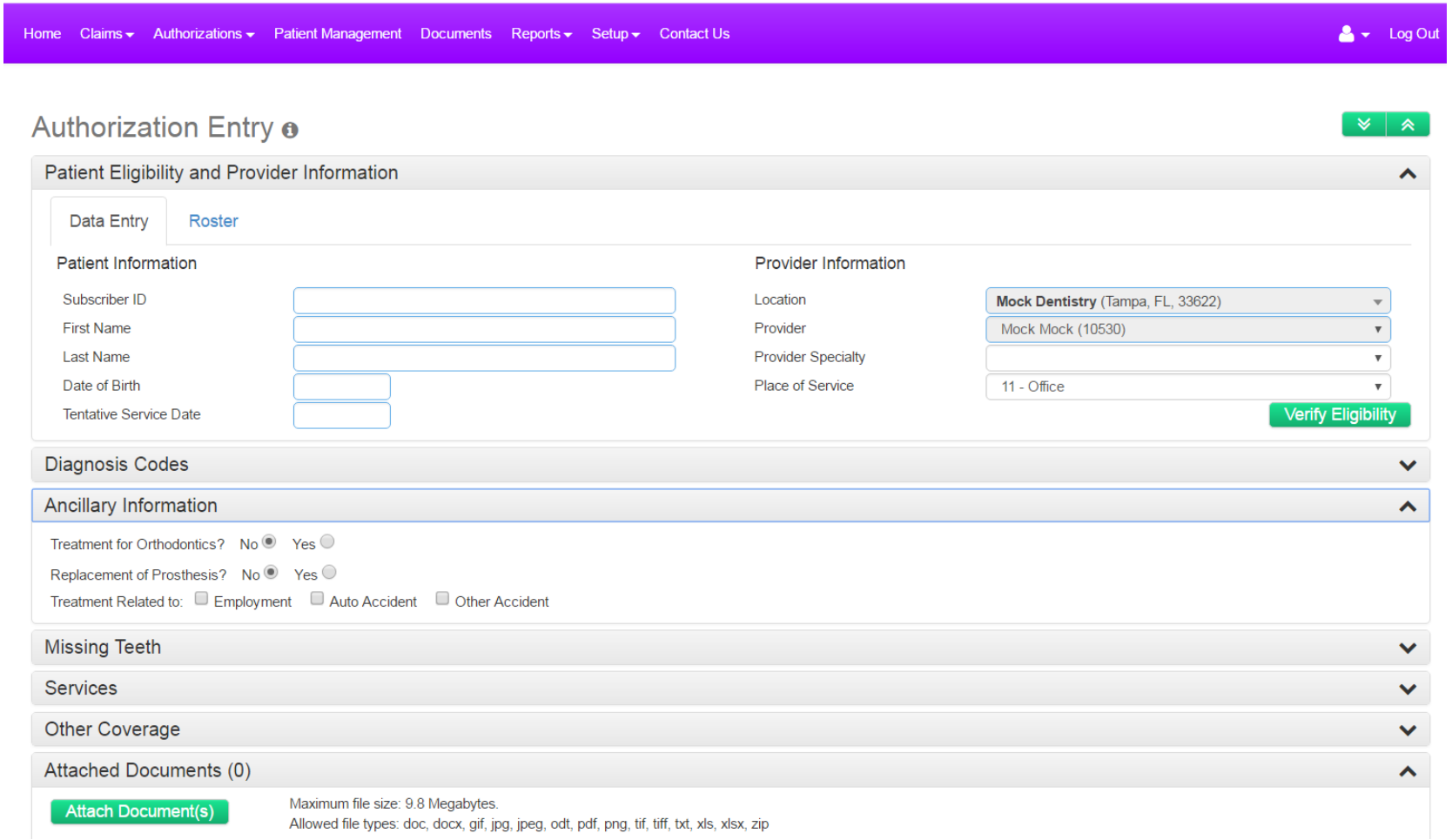
| | |
|---|---|
| Effective Date: | N/A |
| Termination Date: | N/A |
| *Total Dollars Consumed: | N/A |

# Authorization Entry & Submission

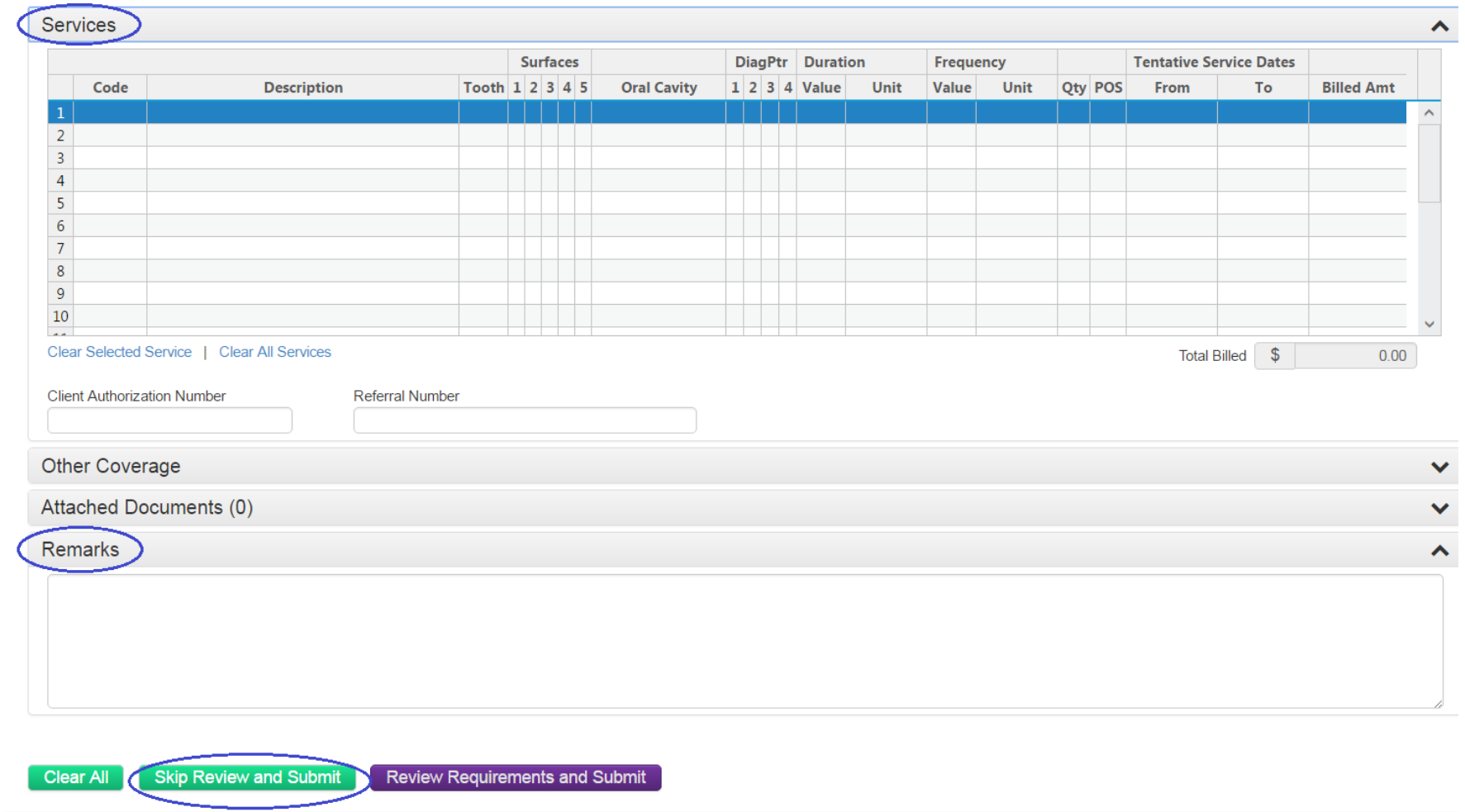
Submit authorization requests via the Provider Web Portal. Track authorization review status and determinations, as well as historical records for all authorizations processed.




Enter the “Authorizations” tab, provide applicable narratives and attach any required documentation using the Provider Web Portal’s Authorization Entry functionality.

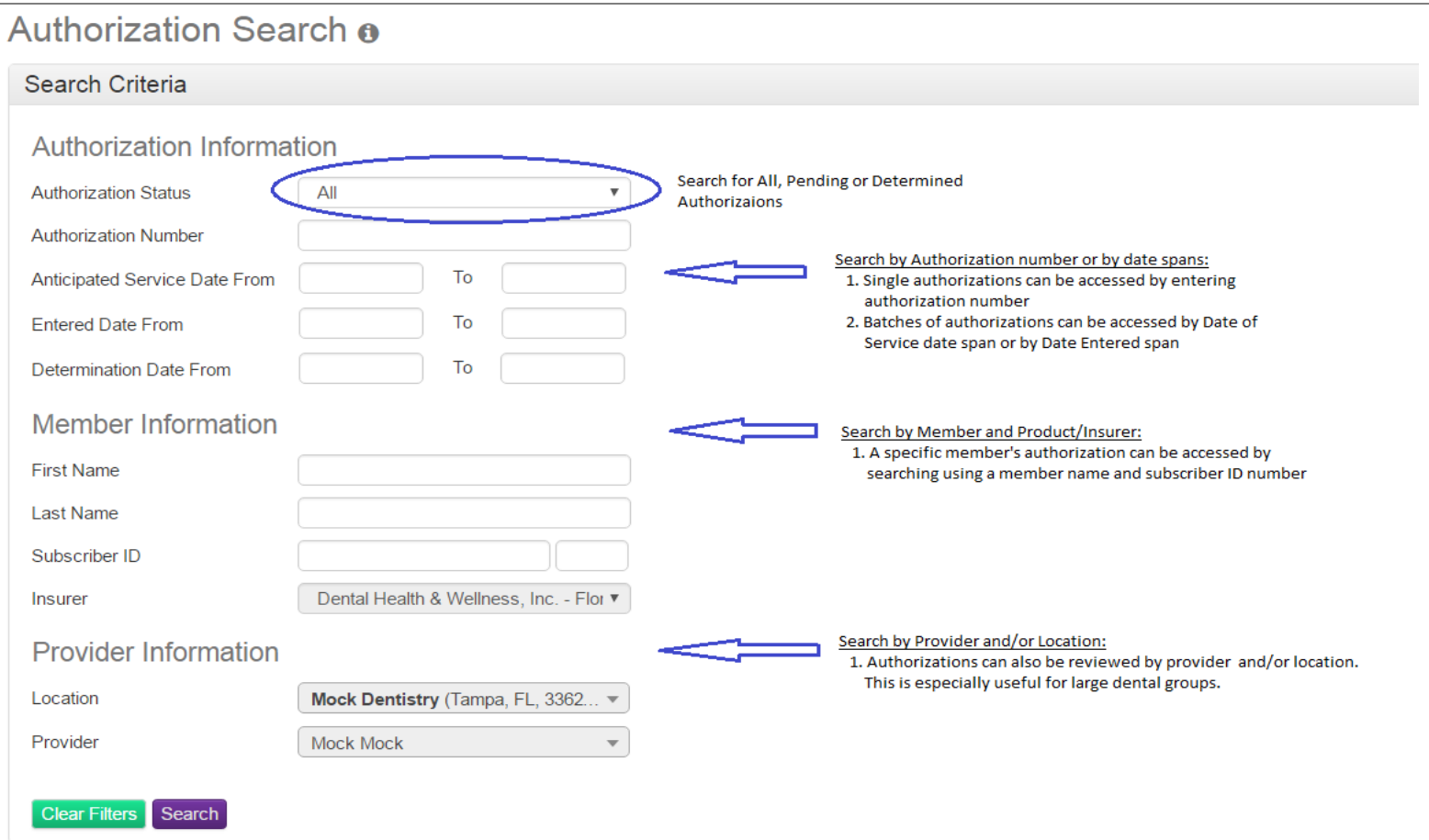



1. Click the Authorizations tab.
2. Enter member ID and date of birth, then choose location and provider from the drop-down menus.
3. Click “Verify eligibility” to confirm member’s coverage.
4. Use the check boxes inside the “Ancillary Authorization Information” box to notate service details, e.g., orthodontic treatment, accident-related, etc.




5. On the “Services” sub-tab, enter specific procedures by line, including tooth/surface/area information as required, projected date of service, quantity, and the billed rate.
6. Click on the “Remarks” sub-tab to add additional narratives, including an NEA number for attachment identification or other pertinent details.
7. Once submission data is entered, click the “Skip Review and Submit” button.
8. A pop-up window will open confirming that you want to submit the authorization.

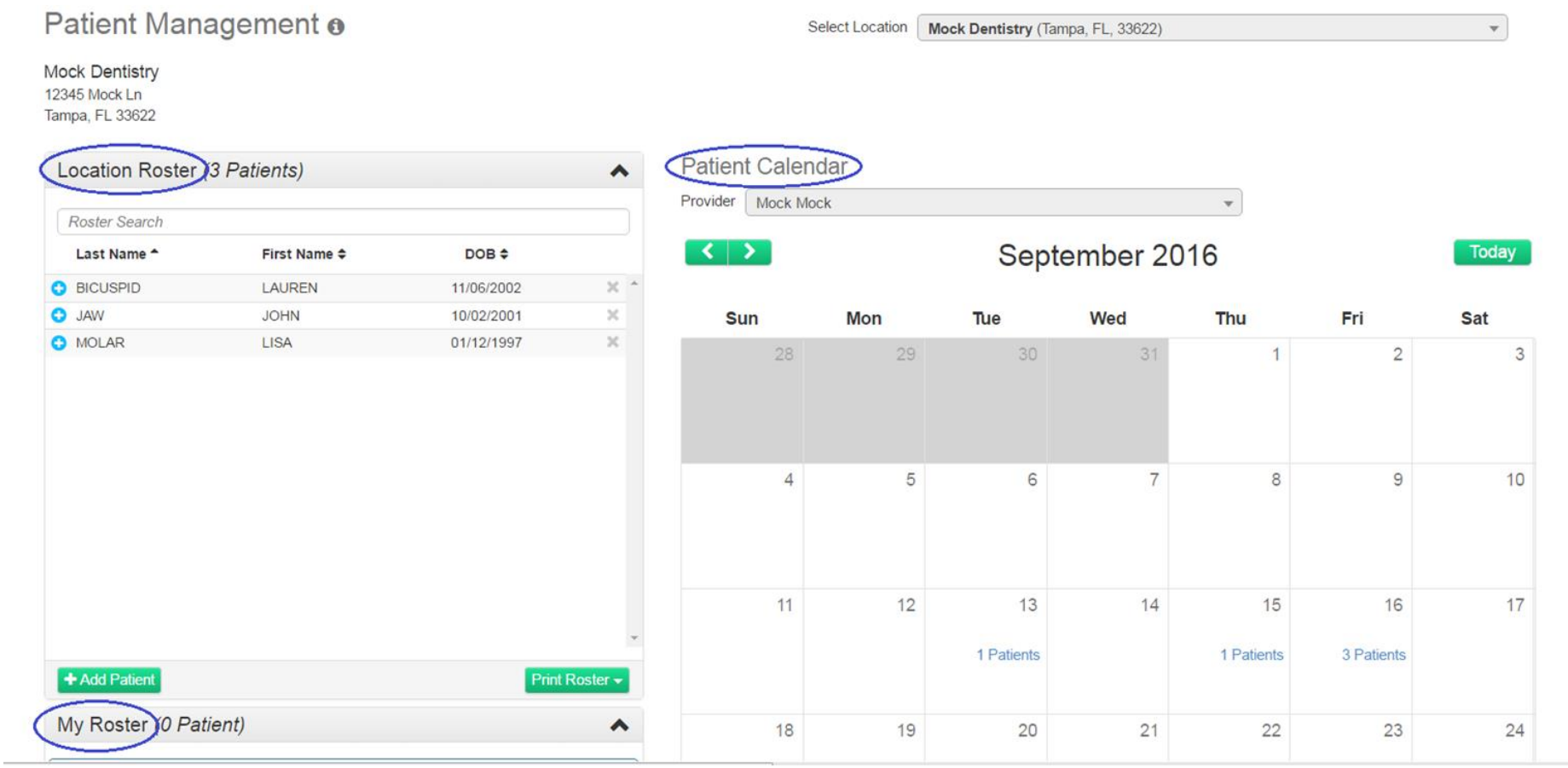
# Authorization Status




- The “Authorization Search” functionality allows a search for a single authorization by number or for batches of authorizations using various criteria.
- Searches can be made for “open,” “processed” or “all” authorizations.
- Batches of authorizations can be found using a variety of criteria:
    - Date span – search by tentative date of service span or date entered span
    - Member – search by using a member’s name and member ID to review all authorizations submitted for a specific member
    - Provider or location – search for all authorizations associated with a specific provider or location under a dental group

# Manage Roster

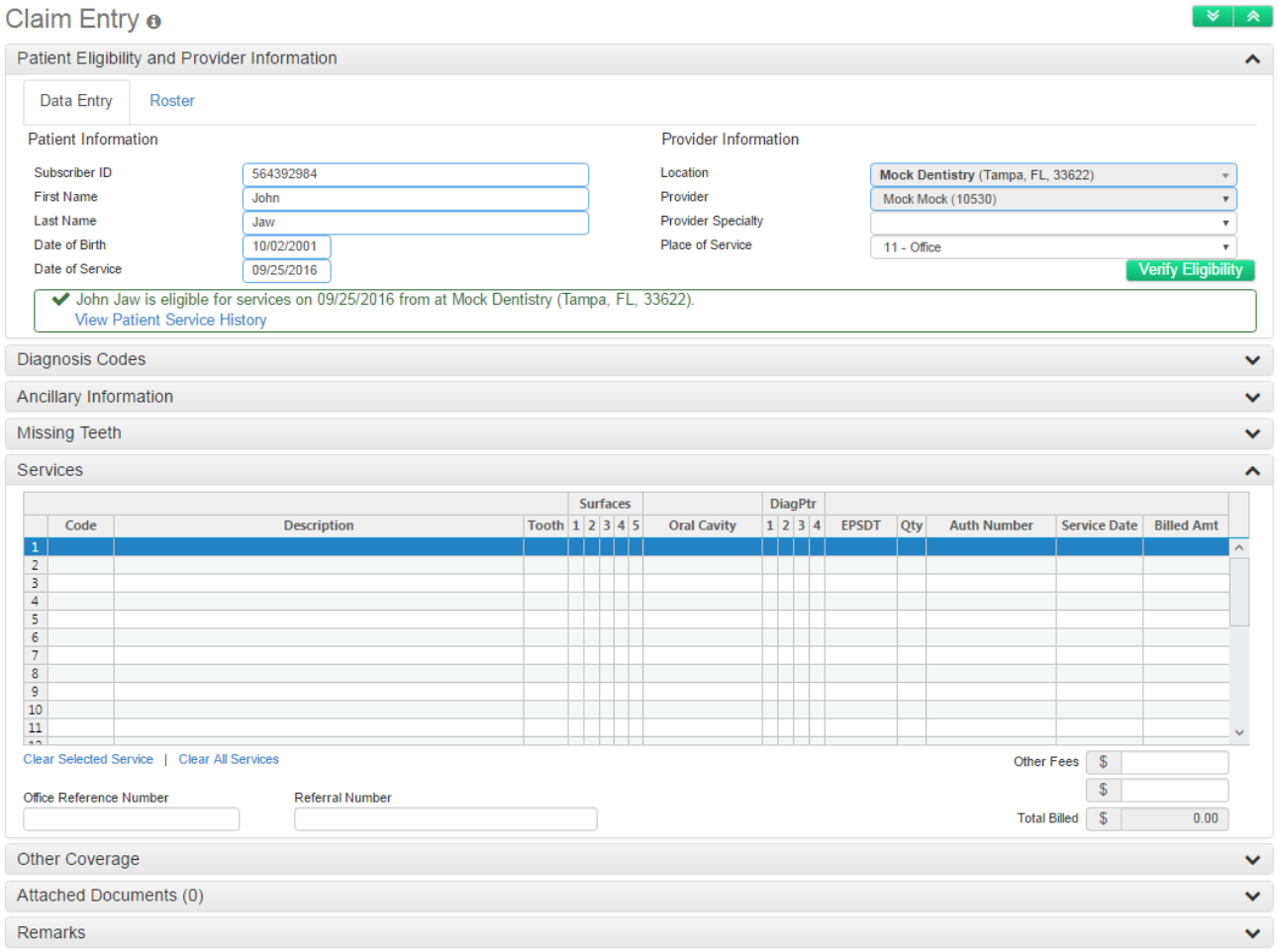
1. On the “Patient Management” tab, you will find the “Location Roster” and “My Roster” tab.
2. Select patient name on the roster list.
3. Rosters can be created by date in order to manage a daily patient schedule.



# Claim Entry & Submission

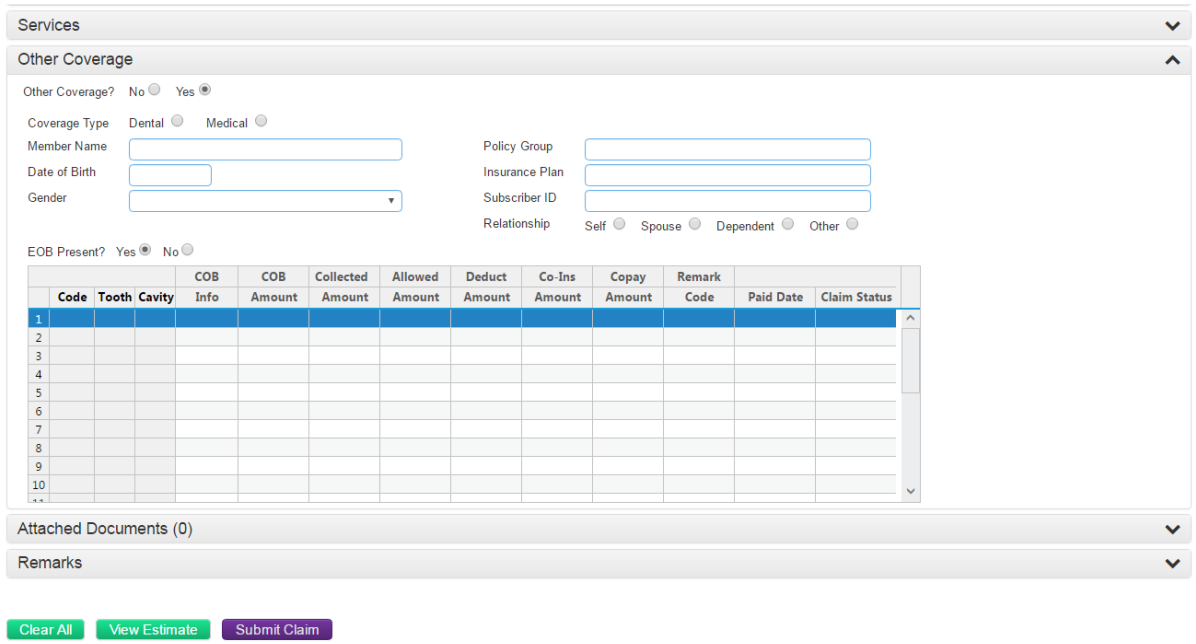
Enter claims on the Provider Web Portal. Provide applicable narratives and attach required documentation.

1. Click the “Claims” tab on the upper navigation bar. Then select “Submit Claim.”
2. Enter member’s ID and date of birth, then choose location and provider from the drop-down menu.
3. Click “Verify Eligibility” to check patient coverage. The field will turn green if the patient is covered and red if not covered.
4. Click “View Patient Service History” to review member’s treatment history and confirm the service is appropriate and within limitations and guidelines.
5. Under “Other Coverage” tab, check “EOB Present,” if applicable.
6. Use the check boxes inside the “Ancillary Claim Information” box to notate service details such as orthodontic treatment or accident- related.
7. Enter procedures rendered for each line using CDT Codes, including tooth/surface/are



a information as required, date of service, quantity, authorization number, if applicable, and billed rate. (At this time, **no** ICD-9 or ICD-10 codes are required.)

8. Click the "Remarks" tab to add any additional narratives, such as NEA numbers or other pertinent details.
9. Click "Attachments" tab to attach x-rays or other documents that are required for payment.
10. If an EOB is present and primary payment information needs to be entered; be sure the "EOB Present" box on the top of the screen is checked to enter COB details.



# Pre-Claim Estimate – Remaining Dental Benefit Amount

An important feature is the pre-claim estimate pop-up window, available on the claim entry tab. Once all fields have been entered, as above, click on the "View Estimate" button.

A pre-claim estimate pop-up window will show the reimbursement amount a provider can expect to receive for the reported CDT codes.

## Preclaim Estimate

**This preclaim estimate is not a guarantee of benefits**

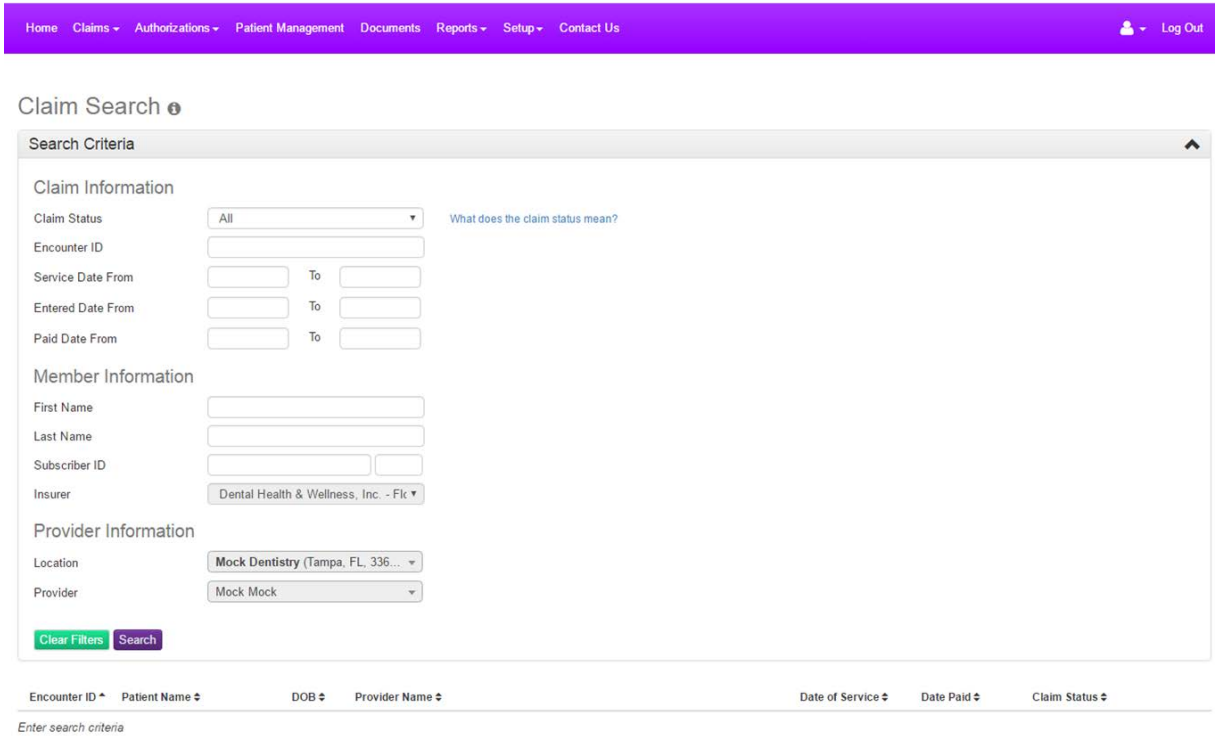
| | | | | | |
|---|---|---|---|---|---|
| Patient Name: | **JAW, JOHN** | Provider Name: | **Mock Mock** | Preclaim ID: | **44708** |
| Subscriber/Member: | 564392984 / 00 | Provider/Loc ID: | 10530 / 6762 | | |
| DOB: | 10/02/2001 | Plan: | Dental Health & Wellness, Inc. - Florida | | |
| | | Product: | FL - MMA/CW Medicaid | Benefit Level: | In Network |

| | | | | BILLED | | ALLOWED | | | PAYABLE | COPAY | COINS | DEDUCT | PATIENT | NET |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| ITEM | DOS | CODE | POS | QTY | AMOUNT | QTY | AMOUNT | PAY % | AMOUNT | AMOUNT | AMOUNT | AMOUNT | PAY | AMOUNT |
| 1 | 09/15/16 | D1110 00 | 11 | 1 | $75.00 | 1 | $26.75 | 100.00 % | $26.75 | $0.00 | $0.00 | $0.00 | $0.00 | $26.75 |
| | | | | | $75.00 | | $26.75 | | $26.75 | $0.00 | $0.00 | $0.00 | $0.00 | $26.75 |

# Claims Status

Track the status of claims currently in process and review payment records for past claims.

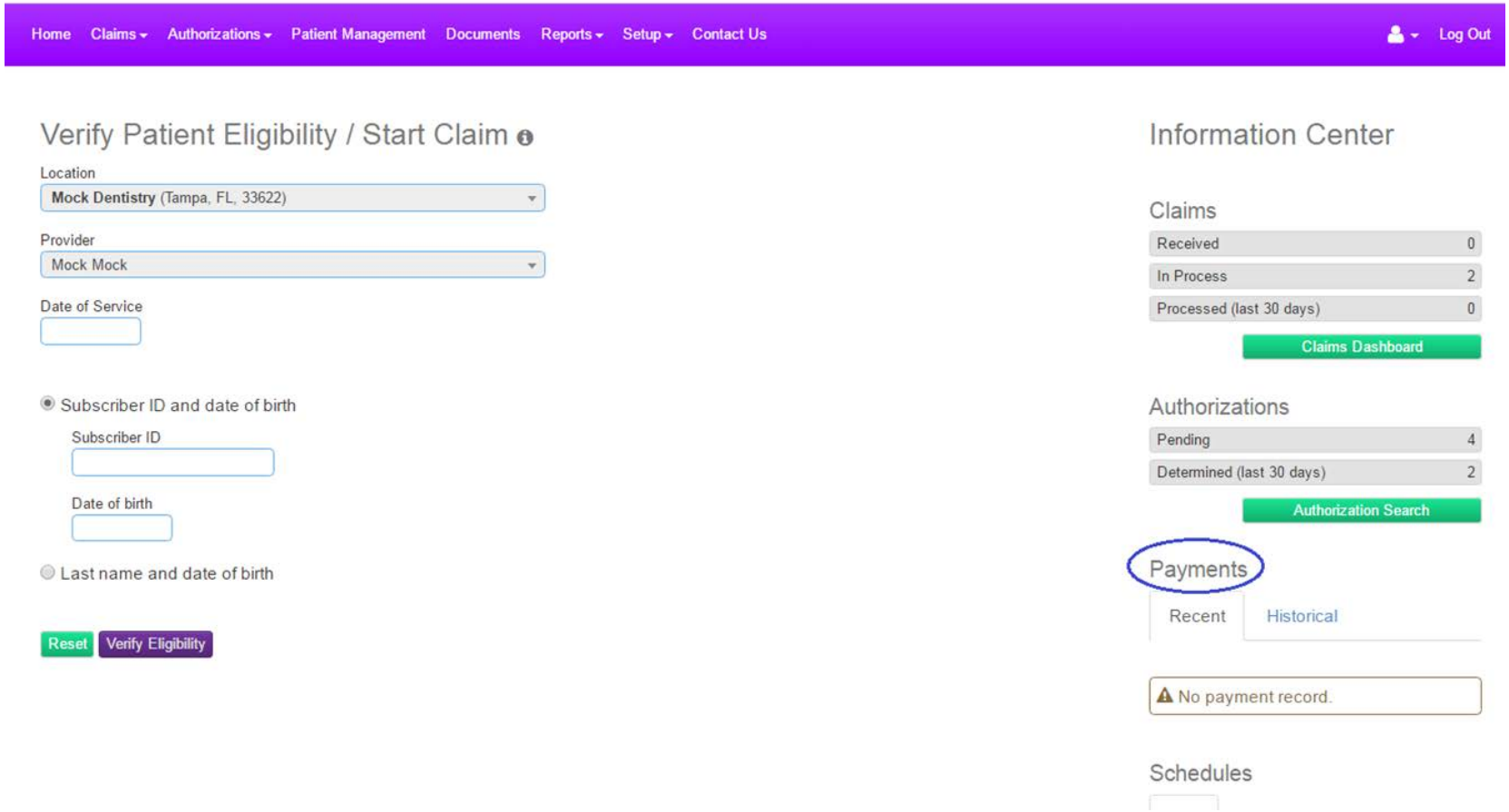
- The claim status functionality allows a provider to search for a single claim by encounter ID number or for batches of claims.
- Searches can be for “all,” “received,” “in process,” or “processed” claims. This allows a provider to track claims currently in the payment process, or to view paid claim records.
- Batches of claims can be searched using a variety of criteria:
    - Date span – search by tentative date of service span or date entered span
    - Member – search by using a member’s name and member ID to review all authorizations submitted for a specific member
    - Provider or location – search for all authorizations associated with a specific provider or location under a dental group



# Electronic Funds Transfer

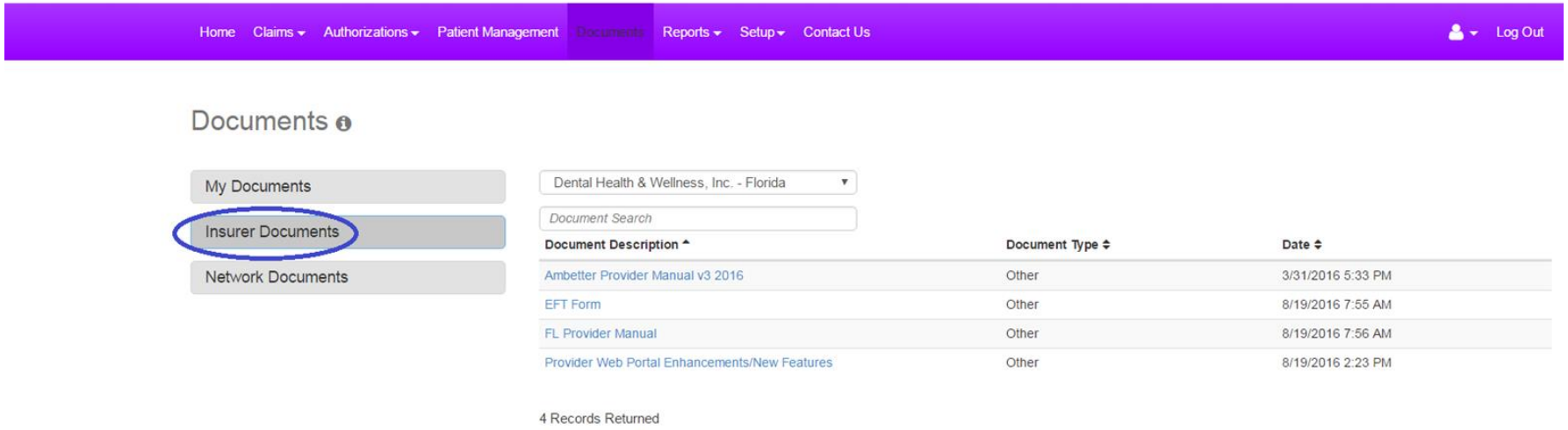
The Provider Web Portal displays remittance statements electronically. Electronic Fund Transfers (EFTs) offer direct deposit into a bank account more quickly than payments made by check. To set up EFT, complete an EFT form (found in your contracting packet or in the Provider Manual) and send with a copy of a voided check for verification to providerrelations@envolvehealth.com or fax to 844-847-9807. Allow four to six weeks for your EFT application to take effect, as the banks must verify all information is accurate.

To view online remittances, go to the “Documents” tab, then select “My Documents” and choose the applicable remittance statement date.



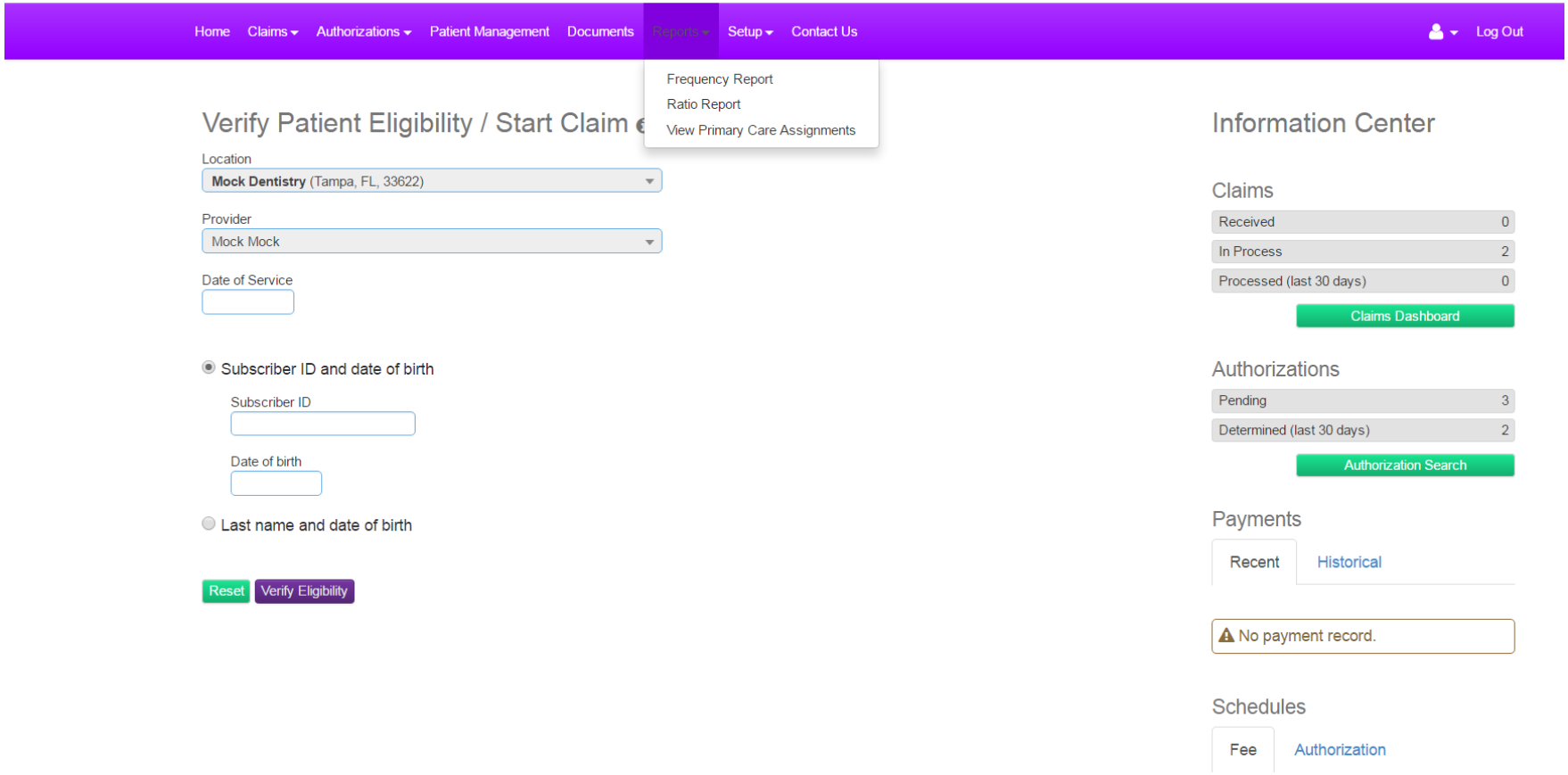
# Documents

A copy of the Envolve Dental Provider Manual can be found under the “Insurer Documents” tab.



# Frequency and Ratios Reports

To support utilization management functions, the Provider Web Portal allows providers to review clinical profiling data relative to peers. Go to the "Reports" tab, and select the "Frequency Report" or "Ratio Report" tab to view provider-specific comparisons.




If you have questions about the Envolve Dental Provider Web Portal, please contact Customer Service at **1-844-464-5636** for assistance.

Envolve Dental Provider Manual for Magnolia Health

If you have questions, please contact Customer Service at 844-464-5636 for assistance.

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