envolve®

Benefit Options

2021

Envolve Dental, Inc. Medicare Provider Manual

Arizona
Florida
Georgia
Indiana
Kansas
Louisiana
Mississippi
Missouri
Nevada
New Mexico
Ohio
Oregon
Pennsylvania
Texas

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Contents

Welcome

Welcome to the Envolve Dental provider network. Thank you for being part of our network of dentists and oral healthcare professionals. We look forward to working with you to improve the health of our community. Envolve Dental, Inc. is a wholly owned subsidiary of Envolve Benefit Options, Inc. and Centene Corporation, Inc.

We are committed to improving the oral health of the community one smile at a time, which leads to improved overall health of individuals. Envolve Dental's innovative client solutions, education programs, personal attention and provider support create a comprehensive dental care system that reduces administrative burden for providers and offers quality dental services for members.

Envolve Dental allows members to receive the care they need from trusted providers to feel their best. Envolve Dental has partnered with Medicare health plans in Arizona, Florida, Georgia, Indiana, Kansas, Louisiana, Mississippi, Missouri, Nevada, New Mexico, Ohio, Oregon, Pennsylvania, and Texas to administer the dental benefit for eligible members in 2021.

We believe quality healthcare is more than just treatment from a doctor and that health insurance is best delivered on a local level. Our plans are designed to give members:

- Affordable healthcare coverage
- Benefits members need to take good care of themselves
- Access to doctors, nurses and specialists who work together to help members feel their best
- Coverage for prescription drugs
- Extra benefits that aren't covered by Medicare Part A or Part B (Original Medicare)

This provider manual supplies useful information about working with us. We strive to make information clear and user-friendly. If you have questions about or suggestions for improvements, we welcome your input. Please contact Envolve Dental Provider Customer Service at providerrelations@EnvolveHealth.com or call your state-specific Provider Customer Service number.

Envolve Dental retains the right to add to, delete from, and otherwise modify this provider manual. Contracted providers must acknowledge this provider manual and any other written materials provided by Envolve Dental as proprietary and confidential.

Key Contacts

The following chart includes important telephone and fax numbers available to your office. When calling Envolve Dental, please have the following information available:

- NPI (National Provider Identifier) number
- Tax ID Number (TIN) number
- Member's Medicare ID number

REFERENCE	CONTACT		
Provider Web Portal	pwp.envolvedental.com		
EDI Payor ID	46278		
Provider Customer Service	**Arizona** 855-586-1416 **Florida** 888-983-4691 **Georgia** 844-464-5632	**Indiana** 855-609-5157 **Kansas** 855-434-9245 **Louisiana** 844-342-5582 **Mississippi** 844-464-5636 **Missouri** 855-434-9240	**Nevada** 833-605-6279 **New Mexico** 844-732-3046 **Ohio** 844-464-5634 **Oregon** 833-447-0693 **Pennsylvania** 844-524-8255 **Texas** 855-586-1417
Health Plan Member Services	**Arizona** 800-977-7522* **Florida** 877-935-8022* **Georgia** 844-890-2326 877-725-7748* HMO SNP **Indiana** 855-766-1541*	**Kansas** 855-565-9519* **Louisiana** 855-766-1572* **Mississippi** 844-786-7711* 833-260-4124* HMO SNP **Missouri** 855-766-1452* 833-298-3361* HMO SNP **Nevada** 833-854-4766	**New Mexico** 844-810-7965 **Ohio** 866-389-7690* **Oregon** 844-867-1156* (Trillium) 888-445-8913 (Health Net) **Pennsylvania** 855-766-1456* 866-330-9368* HMO SNP **Texas** 844-796-6811* 877-935-8023* HMO SNP *TTY: 711

Fraud, Waste, & Abuse	800-345-1642
Credentialing	844-847-9807 fax dentalcredentialing@EnvolveHealth.com
Provider Dental Claims and Appeals	**Arizona** P.O. Box 20132 Tampa, FL 33622-0132 **Florida** P.O. Box 20654 Tampa, FL 33622-0654 **Georgia** P.O. Box 22085 Tampa, FL 33622-2085 **Indiana** P.O. Box 20847 Tampa, FL 33622-0847 **Kansas** P.O. Box 25857 Tampa, FL 33622-5857 **Louisiana** P.O. Box 25974 Tampa FL 33622-5974 **Mississippi** P.O. Box 25255 Tampa, FL 33622-5255 **Missouri** P.O. Box 20262 Tampa, FL 33622-0262 **Nevada** P.O. Box 26564 Tampa, FL 33622-6564 **New Mexico** P.O. Box 20565 Tampa, FL 33622-0565 **Ohio** P.O. Box 22687 Tampa, FL 33622-2687 **Oregon** PO Box 20144 Tampa, FL 33622-0144 **Pennsylvania** P.O. Box 26631 Tampa, FL 33623-6631 **Texas** P.O. Box 26564 Tampa, FL 33622-6564
Health Plan Member Appeals	Attn: Appeals and Grievances 7700 Forsyth Blvd. St. Louis, MO 63105

Quick Reference Guide

Member Eligibility

Log on to the Envolve Dental Provider Web Portal at pwp.envolvedental.com.

- Call Provider Customer Service for the automated member eligibility IVR system to reach our automated member eligibility-verification system 24 hours a day.

Prior Authorizations

Prior authorizations are not required for Medicare dental procedures.

Provider Claims

The timely filing requirement is 365 calendar days from the date of service. Turnaround time is 30 calendar days from the date of the original submission. Claims with retrospective review submissions may take additional processing time. Submit claims in one of these formats:

- Envolve Dental Provider Web Portal at: pwp.envolvedental.com
- Electronic claim submission through selected clearinghouses: Payor ID 46278
- Alternate pre-arranged HIPAA-compliant electronic submissions
- Paper claims must be submitted on the 2012 ADA claim form and mailed to the market-specific address.

Provider Inquiries

Call Provider Customer Service using the applicable phone number for Provider Customer Service on the preceding page.

Provider Appeals

A provider has 30 calendar days from the date of incident, such as the original Explanation of Payment (EOP) date, to file a grievance or appeal. All written provider appeals will be resolved within 30 calendar days. Providers may write to the applicable P.O. box listed in the Dental Claims and Provider Appeals section on the preceding page.

Member Appeals

Members or their representatives may file an appeal or grievance by calling the health plan within 60 calendar days of the event or coverage decision.

Arizona
800-977-7522*

Florida
877-935-8022*

Georgia
844-890-2326
877-725-7748* HMO SNP

Indiana
855-766-1541*

Kansas
855-565-9519*

Louisiana
855-766-1572*

Mississippi
844-786-7711*
833-260-4124* HMO SNP

Missouri
855-766-1452*
833-298-3361* HMO SNP

Nevada
833-854-4766

New Mexico
844-810-7965

Ohio
866-389-7690*

Oregon
844-867-1156* (Trillium)
888-445-8913 (Health Net)

Pennsylvania
855-766-1456*
866-330-9368* HMO SNP
877-935-8023* HMO SNP

Texas
844-796-6811*

Members also may file a grievance or appeal by mail:

Attn: Appeals and Grievances
7700 Forsyth Blvd.
St. Louis, MO 63105

*TTY: 711

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 your state-specific Provider Customer Service number for a contracting packet.
- Email Envolve Dental at dentalnetwork@EnvolveHealth.com with your specific requests.

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

If you have any questions about the Provider Agreement or how to apply, call your state-specific Provider Customer Service number.

Credentialing and Re-credentialing

Overview

The purpose of the credentialing and re-credentialing process is to help make certain that Envolve Dental maintains a high-quality healthcare delivery system. The credentialing and re-credentialing process helps achieve this aim by validating the professional competency and conduct of our providers. This includes the verification of licensure, board certification and education, and disclosure of ownership or control interests, as well as identification of adverse actions, including malpractice or negligence claims, through the applicable state and federal agencies and the National Practitioner Data Base.

If a practitioner/provider already participates with Envolve Dental in the Medicaid product, the practitioner/provider will NOT be separately credentialed for the Advantage product.

For more information on credentialing, please email dentalcredentialing@EnvolveHealth.com.

Re-credentialing

To comply with accreditation standards, Envolve Dental confirms provider re-credentialing at least every 36 months from the date of the initial credentialing. The purpose of this process is to identify any changes in the practitioner's licensure, sanctions, certification, competence, or health status that may affect the ability to perform services the provider is under contract to provide. This process includes all providers, primary care providers, specialists and ancillary providers/facilities previously credentialed to practice within the Envolve Dental network.

In between credentialing cycles, Envolve Dental conducts ongoing monitoring activities on all network providers. This includes ongoing monitoring of the appropriate state licensing agencies to identify newly disciplined providers and providers with a negative change in their current licensure status. This monthly inquiry helps make certain that providers are maintaining a current, active, unrestricted license to practice in between credentialing cycles. Additionally, Envolve Dental reviews monthly reports released by the Office of Inspector General and other sources to identify network providers who have been newly sanctioned or excluded from participation in federal and state programs.

A provider's agreement may be terminated at any time if Envolve Dental's Credentialing Committee determines that the provider no longer meets the credentialing requirements.

Verifying Eligibility

To verify member eligibility, please use one of the following methods:

1. **Log on to the Envolve Dental Provider Web Portal** at pwp.envolvedental.com. Using the secure provider website, you can check member eligibility. You can search by date of service and either of the following: Member name and date of birth, or member ID and date of birth.
2. **Call the automated member eligibility IVR system.** Call Provider Customer Service from any touchtone phone and follow the appropriate menu options to reach our automated member eligibility-verification system 24 hours a day. The automated system will prompt you to enter the member ID and the month of service to check eligibility.
3. **Speak to Envolve Dental Provider Customer Service.** If you cannot confirm a member's eligibility using the methods above, follow the menu prompts to speak to a Provider Customer Service Representative to verify eligibility before rendering services. Provider Customer Service will need the member name, member ID, and member date of birth to verify eligibility.

Through Envolve Dental's Secure Provider Web Portal, providers are able to access a list of eligible members who have selected their services or were assigned to them. The Patient Roster is reflective of all demographic changes made within the last 24 hours. To view this list, log on to pwp.envolvedental.com.

Note: Eligibility changes can occur throughout the month, and the Patient Roster does not prove eligibility for benefits or guarantee coverage. Use one of the above methods to verify member eligibility on the date of service.

Member Identification Card

All new Medicare members receive a Medicare member ID card. A new card is issued only when the information on the card changes, if a member loses a card or if a member requests an additional card.

Whenever possible, members should present both their Medicare member ID card and a photo ID each time services are rendered by a provider. If you are not familiar with the person seeking care as a member of our health plan, please ask to see photo identification.

Remember: Possession of a member ID card is not a guarantee of eligibility. Use one of the methods listed previously to verify member eligibility on the date of service.

If you suspect fraud, please contact the Envolve Dental Fraud Hotline at 800-345-1642 immediately.

Provider Guidelines

Medicare Regulatory Requirements

As a Medicare contracted provider, providers are required to follow a number of Medicare regulations and CMS requirements. Some of these requirements are found in your provider agreement. Others have been described throughout the body of this manual. A general list of the requirements can be reviewed below:

- Providers may not discriminate against Medicare members in any way based on the health status of the member.
- Providers must ensure that members have adequate access to covered health services.
- Providers may not impose cost sharing on members for influenza vaccinations or pneumococcal vaccinations.
- Providers must allow members to directly access screening mammography and influenza vaccinations.
- Providers must provide female members with direct access to women's health specialists for routine and preventive healthcare.
- Providers must comply with Plan processes to identify, access, and establish treatment for complex and serious medical conditions.
- Advantage will provide you with at least 60 days written notice of termination if electing to terminate our agreement without cause, or as described in your Participation Agreement if greater than 60 days. Providers agree to notify Advantage according to the terms outlined in the Participation Agreement.
- Providers will ensure that their hours of operations are convenient to the member and do not discriminate against the member for any reason. Providers will ensure necessary services are available to members 24 hours a day, 7 days a week. PCPs must provide backup in case of absence.
- Marketing materials must adhere to CMS guidelines and regulations, and cannot be distributed to Advantage members without CMS approval of the materials and forms.
- Services must be provided to members in a culturally competent manner, including members with limited reading skills, limited English proficiency, hearing or vision impairments and diverse cultural and ethnic backgrounds.
- Providers will work with Advantage procedures to inform our members of healthcare needs that require follow-up and provide necessary training in self-care.
- Providers will document in a prominent part of the member's medical record whether the member has executed an advance directive.
- Providers must provide services in a manner consistent with professionally recognized standards of care.
- Providers must cooperate with Advantage to disclose to CMS all information necessary to evaluate and administer the program, and all information CMS may need to permit members to make an informed choice about their Medicare coverage.
- Providers must cooperate with Advantage in notifying members of provider contract terminations.
- Providers must cooperate with the activities of any CMS-approved independent quality

review or improvement organization.

- Providers must comply with any Advantage medical policies, QI programs and medical management procedures.
- Providers will cooperate with Advantage in disclosing quality and performance indicators to CMS.
- Providers must cooperate with Advantage procedures for handling grievances, appeals, and expedited appeals.
- Providers must fully disclose to all members before providing a service, if the service may not be covered by Advantage. The member must sign an agreement of this understanding. If the member does not, the claim may be denied and the provider will be liable for the cost of the service.
- Providers must allow CMS or its designee access to records related to Advantage services for a period of 10 years following termination of this agreement.
- Provider must comply with all CMS requirements regarding the accuracy and confidentiality of medical records.
- Provider shall provide services in accordance with Advantage policy: (a) for all members, for the duration of the Advantage contract period with CMS, and (b) for members who are hospitalized on the date the CMS contract with Advantage terminates, or, in the event of an insolvency, through discharge.
- Provider shall disclose to Advantage all offshore contractor information with an attestation for each such offshore contractor, in a format required or permitted by CMS.

Member Confidentiality and HIPAA

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 healthcare while properly protecting individual health information.

Envolve Dental complies with HIPAA rules and expects network providers to adhere to HIPAA rules as well.

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

HIPAA Security Rules and Applications

Confidentiality: Protected Health Information (PHI) and electronic PHI (e-PHI) are not disclosed or available to unauthorized persons.

Envolve Dental asks 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 shares 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.

Protect against threats or disclosures: Potential threats or disclosures to e-PHI that are reasonably anticipated must be identified and protected.

> All email correspondence that includes patient name and personal health details must be sent via a secure email service. Providers should never initiate to Envolve Dental an email that is not encrypted and contains patient details. Envolve Dental can initiate a secure, encrypted email to providers who can then reply while maintaining the security of the email. Call Provider 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***

Cultural Competency

Cultural Competency is the measure of a person or organization's willingness and ability to learn about, understand and provide excellent Provider Customer Service across all segments of the population. It is the active implementation of a system wide philosophy that values differences among individuals and is responsive to diversity at all levels in the community and within an organization and at all service levels the organization engages in outside of the organization. A sincere and successful Cultural Competency program is evolutionary and ever-changing to address the continual changes occurring within communities and families. In the context of healthcare delivery, Cultural Competency is the promotion of sensitivity to the needs of patients who are members of various racial, religious, age, gender and/or ethnic groups and accommodating the patient's culturally based attitudes, beliefs and needs within the framework of access to healthcare services and the development of diagnostic and treatment plans and communication methods in order to fully support the delivery of competent care to the patient. It is also the development and continued promotion of skills and practices important in clinical practice, cross-cultural interactions and systems practices among providers and staff to ensure that services are delivered in a culturally competent manner.

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

As part of Envolve Dental's Cultural Competency Program, providers must ensure that:

- Members understand that they have access to medical interpreters, signers, and TTY services to facilitate communication without cost to them
- Medical care is provided with consideration of the members' primary language, race and/or ethnicity as it relates to the members' health or illness
- Office staff routinely interacting with members have been given the opportunity to participate in, and have participated in, cultural competency training
- Office staff responsible for data collection makes reasonable attempts to collect race and language specific information for each member. Staff will also explain race categories to a member in order assist the member in accurately identifying their race or ethnicity
- Treatment plans are developed 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 influence the member's perspective on healthcare
- Office sites have posted and printed materials in English and Spanish or any other non-English language which may be prevalent in the applicable geographic area
- An appropriate mechanism is established to fulfill the provider's obligations under the Americans with Disabilities Act including that all facilities providing services to members must be accessible to persons with disabilities. Additionally, no member with a disability

may be excluded from participation in or be denied the benefits of services, programs or activities of a public facility, or be subjected to discrimination by any such facility.

- Envolve Dental considers mainstreaming of members an important component of the delivery of care and expects providers to treat members without regard to race, color, creed, sex, religion, age, national origin ancestry, marital status, sexual preference, health status, income status, program membership, physical or behavioral disabilities except where medically indicated. Examples of prohibited practices include:
  - Denying a member a covered service or availability of a facility
  - Providing a Medicare member a covered service that is different or in a different manner, or at a different time or at a different location than to other “public” or private pay members (examples: separate waiting rooms, delayed appointment times).

Americans with Disabilities Act (ADA)

Envolve Dental strives to assist providers in meeting the requirements in Title II and Title III of the ADA and Section 504, which requires that medical care providers provide individuals:

- Full and equal access to healthcare services and facilities; and
- Reasonable modifications to policies, practices, and procedures when necessary to make healthcare available to individuals with disabilities, unless the modifications would fundamentally alter the nature of the services

The term "disability" means, with respect to an individual:

- A physical or mental impairment that substantially limits one or more of the major life activities of such individual;
- A record of such an impairment; or
- Being regarded as having such an impairment.

When an individual meets any one of these three tests, he or she is considered to be an individual with a disability for purposes of coverage under the ADA.

General Requirements

General prohibitions against discrimination.

- No qualified individual with a disability shall, on the basis of disability, be excluded from participation in or be denied the benefits of the services, programs, or activities of a public entity, or be subjected to discrimination by any public entity.
- A public entity, in providing any aid, benefit, or service, may not, directly or through contractual, licensing, or other arrangements, on the basis of disability:
  - Deny a qualified individual with a disability the opportunity to participate in or benefit from the aid, benefit, or service;
  - Afford a qualified individual with a disability an opportunity to participate in or benefit from the aid, benefit, or service that is not equal to that afforded others;

    - Provide a qualified individual with a disability with an aid, benefit, or service that is not as effective in affording equal opportunity to obtain the same result, to gain the same benefit, or to reach the same level of achievement as that provided to others;
    - Provide different or separate aids, benefits, or services to individuals with disabilities or to any class of individuals with disabilities than is provided to others unless such action is necessary to provide qualified individuals with disabilities with aids, benefits, or services that are as effective as those provided to others;
    - Aid or perpetuate discrimination against a qualified individual with a disability by providing significant assistance to an agency, organization, or person that discriminates on the basis of disability in providing any aid, benefit, or service to beneficiaries of the public entity's program;
    - Deny a qualified individual with a disability the opportunity to participate as a member of planning or advisory boards;
    - Otherwise limit a qualified individual with a disability in the enjoyment of any right, privilege, or opportunity enjoyed by others receiving the aid, benefit, or service.
- A public entity may not deny a qualified individual with a disability the opportunity to participate in services, programs, or activities that are not separate or different, despite the existence of permissibly separate or different programs or activities.
- A public entity may not, directly or through contractual or other arrangements, utilize criteria or methods of administration:
    - That have the effect of subjecting qualified individuals with disabilities to discrimination on the basis of disability;
    - That have the purpose or effect of defeating or
    - substantially impairing accomplishment of the objectives of the public entity's program with respect to individuals with disabilities; or
    - That perpetuate the discrimination of another public entity if both public entities are subject to common administrative control or are agencies of the same State.
- A public entity may not, in determining the site or location of a facility, make selections:
    - That have the effect of excluding individuals with disabilities from, denying them the benefits of, or otherwise subjecting them to discrimination; or
    - That have the purpose or effect of defeating or substantially impairing the accomplishment of the objectives of the service, program, or activity with respect to individuals with disabilities.
- A public entity, in the selection of procurement contractors, may not use criteria that subject qualified individuals with disabilities to discrimination on the basis of disability.
- A public entity may not administer a licensing or certification program in a manner that subjects qualified individuals with disabilities to discrimination on the basis of disability, nor may a public entity establish requirements for the programs or activities of licensees or certified entities that subject qualified individuals with disabilities to discrimination on the basis of disability. The programs or activities of entities that are licensed or certified by a public entity are not, themselves, covered by this part.
- A public entity shall make reasonable modifications in policies, practices, or procedures when the modifications are necessary to avoid discrimination on the basis of disability, unless the public entity can demonstrate that making the modifications would fundamentally alter the nature of the service, program, or activity.

- A public entity shall not impose or apply eligibility criteria that screen out or tend to screen out an individual with a disability or any class of individuals with disabilities from fully and equally enjoying any service, program, or activity, unless such criteria can be shown to be necessary for the provision of the service, program, or activity being offered.
    - Nothing in this part prohibits a public entity from providing benefits, services, or advantages to individuals with disabilities, or to a particular class of individuals with disabilities beyond those required by this part.
    - A public entity shall administer services, programs, and activities in the most integrated setting appropriate to the needs of qualified individuals with disabilities.
        - Nothing in this part shall be construed to require an individual with a disability to accept an accommodation, aid, service, opportunity, or benefit provided under the ADA or this part which such individual chooses not to accept.
        - Nothing in the Act or this part authorizes the representative or guardian of an individual with a disability to decline food, water, medical treatment, or medical services for that individual.
    - A public entity may not place a surcharge on a particular individual with a disability or any group of individuals with disabilities to cover the costs of measures, such as the provision of auxiliary aids or program accessibility, that are required to provide that individual or group with the nondiscriminatory treatment required by the Act or this part.
    - A public entity shall not exclude or otherwise deny equal services, programs, or activities to an individual or entity because of the known disability of an individual with whom the individual or entity is known to have a relationship or association.

Referrals to Specialists

Envolve Dental does **not** require general or pediatric dentists to obtain a referral to dental specialists. If a specialist is needed, providers should recommend to members a specialist in the Envolve Dental network. Participating network specialists can be found on the designated Medicare “Find a Provider” page located at the health plan’s website.

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.

24-Hour Access

Envolve Dental providers are required to maintain sufficient access to facilities and personnel to provide covered services and shall ensure that such services are accessible to members as needed 24 hours a day, 365 days a year as follows:

- A provider’s office phone must be answered during normal business hours
- During after-hours, a provider must have arrangements for one of the following:
    - Access to a covering provider
    - An answering service

- Triage service
- A voice message that provides a second phone number that is answered
- Any recorded message must be provided in English and Spanish, if the provider's practice includes a high population of Spanish-speaking members.

Examples of unacceptable after-hours coverage include, but are not limited to:

- The Provider's office telephone number is only answered during office hours;
- The Provider's office telephone is answered after hours by a recording that tells patients to leave a message;
- The Provider's office telephone is answered after hours by a recording that directs patients to go to an Emergency Room for any services needed; and
- A clinician returning after-hours calls outside 30 minutes.

The 24-hour coverage must connect the caller to someone who can render a clinical decision or reach the provider for a clinical decision. Whenever possible, the covering dental professional must return the call within 30 minutes of the initial contact. After-hours coverage must be accessible using the provider office's daytime telephone number.

Envolve Dental will monitor providers' offices after-hour coverage through surveys and through mystery shopper calls conducted by Envolve Dental staff.

Telephone Arrangements

Providers must:

- Answer the member's telephone inquiries on a timely basis
- Prioritize appointments
- Schedule a series of appointments and follow-up appointments as needed by a member
- Identify and, when possible, reschedule broken and no-show appointments
- Identify special member needs while scheduling an appointment (e.g., wheelchair and interpretive linguistic needs, non-compliant individuals, or those people with cognitive impairments)
- Adhere to the following response time for telephone call-back waiting times:
  - After-hours telephone care for non-emergent, symptomatic issues within 30 minutes
  - Same day for non-symptomatic concerns
  - Schedule continuous availability and accessibility of professional, allied, and supportive personnel to provide covered services within normal working hours. Protocols shall be in place to provide coverage in the event of a provider's absence.
  - After-hours calls should be documented in a written format in either an after-hours call log or some other method, and then transferred to the member's dental record

Appointment Accessibility Standards

Envolve Dental follows the accessibility requirements set forth by applicable regulatory and accrediting agencies and monitors compliance with these standards on an annual basis. Envolve Dental will use the results of appointment standards monitoring to first, ensure adequate appointment availability and second, reduce unnecessary emergency room utilization.

TYPE OF APPOINTMENT	SCHEDULING TIME FRAME
Routine dental care	Within three weeks of request
Urgent care	Within 48 hours of request
Emergency care	Immediately or within 24 hours, as medically appropriate

Waiting time in the office should be within one hour of the appointment for previously scheduled appointments.

Missed Appointments

The health plan member manual includes instructions for members to keep appointments or call to cancel and reschedule an appointment if unable to keep it. Envolve Dental recommends that providers contact members by phone 48 hours prior to scheduled appointments to confirm the commitment and the location where services will be rendered.

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 the health plan at your state-specific Member Customer Service number to identify a new dental provider.
- Your office's missed appointment and dismissal policies for Medicare members cannot be stricter than your private or commercial patient policies.
- Providers are not allowed to charge Medicare members for missed appointments.

Member Services

Member Translation and Hearing Impaired Services

Members requiring language assistance, including sign language, should contact Medicare Member Services at least three days prior to an appointment to schedule an interpreter to be present for services. The health plan has a telephone language line available 24 hours a day, 7 days a week.

Utilization Management

Utilization Management and Review

The Envolve Dental Utilization Management (UM) program is designed to ensure members receive access to the right dental care at the right place and right time.

Envolve Dental seeks to optimize a member's oral health status and access to quality dental care, while at the same time actively managing cost trends. The program aims to provide services that are a covered benefit, medically necessary, appropriate to the patient's condition, rendered in the appropriate setting and meet professionally recognized standards of care.

The treating dental provider, in conjunction with the member, is responsible for making all clinical decisions regarding the care and treatment of the member. The dental provider, in consultation with Envolve Dental's Dental Director, is responsible for making UM decisions in accordance with the member's plan of covered benefits and established criteria.

Envolve Dental Affirmative Statement

Envolve Dental does not reward practitioners, providers, or employees who perform utilization reviews for issuing denials of coverage or care. UM's decision-making is based only on appropriateness of care, service, and existence of coverage. Financial incentives for UM decision makers do not encourage decisions that result in underutilization. Utilization denials are based on lack of medical necessity or lack of covered benefit.

Envolve Dental has utilization and claims management systems in place in order to identify, track, and monitor the care provided and to ensure appropriate care is provided to the members.

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.

Medical Necessity

The fact that a dental provider may prescribe, authorize, or direct a service does not itself make it medically necessary or covered by the contract. Medical necessity criteria for covered services will be furnished to a member or provider within 30 days of a request to do so.

Medical necessity determinations will be made in a timely manner by thorough review from Envolve Dental clinical staff. Determinations will be made utilizing guidelines based care, appropriate UM policies, and by applying clinical judgment and experience. Dental policies are developed through periodic review of generally accepted standards of dental practice and updated at least on an annual basis.

Medically necessary services are generally accepted oral healthcare practices provided in light of conditions present at the time of treatment. These include services that are:

- Appropriate and consistent with the diagnosis of the treating provider and the omission of which could adversely affect the eligible member's medical condition
- Compatible with the standards of acceptable medical practice in the community
- Provided in a safe, appropriate, and cost-effective setting give the nature of the diagnosis and severity of the symptoms
- Not provided solely for the convenience of the member or the convenience of the healthcare provider or hospital

In the event a member may not agree with the medical necessity determination, a member has the opportunity to appeal the decision. Please refer to the "Grievance Process" section of the provider manual. All such determinations must be made by qualified and trained dental care providers.

Prior Authorization

As noted in Appendix A of this manual, the 2021 Medicare dental benefits do not require authorization prior to the service.

All services are subject to benefit coverage, limitations, and exclusions as described in applicable plan coverage guidelines. Envolve Dental considers all benefits and applies clinical standards to them, explicitly outlining for providers what conditions must be present in order for the covered benefits to apply. Please refer to the clinical criteria section in the benefit grid appendix that substantiates the criteria. Providers should measure intended services to the clinical criteria before treatment begins to assure appropriateness of care.

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.

Claims and Billing

General Billing Guidelines

Dental providers contract directly with Envolve Dental for payment of covered services.

It is important that providers ensure Envolve Dental has accurate billing information on file. Envolve Dental will return claims when billing information does not match the information that is currently in our files. Claims missing the required information will be returned, and a notice sent to the provider, creating payment delays. Such claims are not considered “clean” and therefore cannot be entered into the system.

We recommend that providers notify Envolve Dental in advance of changes pertaining to billing information. Please submit this information on a W-9 form. Changes to a Provider’s Tax Identification Number (TIN) and/or address are NOT acceptable when conveyed via a claim form.

Claims eligible for payment must meet the following requirements:

- The member is effective on the date of service
- The service provided is a covered benefit under the member’s contract on the date of service
- Referral processes were followed

Payment for service is contingent upon compliance with referral policies and procedures and eligibility at the time of service as well as the billing guidelines outlined in this manual.

Encounters vs Claims

An encounter is a claim which is paid at zero dollars as a result of the provider being pre-paid or capitated for the services he/she provided our members. Encounters should be submitted using 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 is complete.
- Ensure every code includes corresponding tooth numbers, quads, arches, and any other required identifiers.
- Include all documentation requirements for each code.

A claim is a request for reimbursement, either electronically or by paper, for any dental service. A claim must be filed on the proper form, such as a 2012 ADA claim form. A claim will be paid or denied with an explanation for the denial.

Clean Claims

A clean claim means a claim received by Envolve Dental for adjudication, in a nationally accepted format in compliance with standard coding guidelines and which requires no further information, adjustment, or alteration by the provider of the services in order to be processed and paid by Envolve Dental.

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.

Non-clean Claims

Non-clean claims are submitted claims that require further documentation or development beyond the information contained therein. The errors or omissions in non-clean claims result in the request for additional information from the provider or other external sources to resolve or correct data omitted from the bill; review of additional medical records; or the need for other information necessary to resolve discrepancies. In addition, non-clean claims may involve issues regarding medical necessity and include claims not submitted within the filing deadlines.

Timely Filing Requirements

All claims must be received by the plan within 365 calendar days from the date the service was provided in order to be considered for payment. According to CMS guidelines, claims received after this time frame will be denied for failure to file timely, except for the following four situations:

- **Administrative Error:** This is where the failure to meet the filing deadline was caused by error or misrepresentation of an employee, the Medicare contractor, or agent of the department that was performing Medicare functions and acting within the scope of its authority. In these cases, Envolve Dental will extend the timely filing limit through the last day of the sixth month following the month in which the beneficiary, provider, or supplier received notice that an error or misrepresentation was corrected.
- **Retroactive Medicare Entitlement:** This is where a beneficiary receives notification of Medicare entitlement retroactive to or before the date the service was furnished. For example, at the time services were furnished the beneficiary was not entitled to Medicare. However, after the timely filing period has expired, the beneficiary receives notification of Medicare entitlement effective retroactive to or before the date of the furnished service. In these cases, Envolve Dental will extend the timely filing limit through the last day of the sixth month following the month in which the beneficiary, provider, or supplier received notification of Medicare entitlement retroactive to or before the date of the furnished service.
- **Retroactive Medicare Entitlement Involving State Medicaid Agencies:** This is where a State Medicaid Agency recoups payment from a provider or supplier six months or more

after the date the service was furnished to a dually eligible beneficiary. For example, at the time the service was furnished the beneficiary was only entitled to Medicaid and not to Medicare. Subsequently, the beneficiary receives notification of Medicare entitlement effective retroactive to or before the date of the furnished service. The State Medicaid Agency recoups its money from the provider or supplier and the provider or supplier cannot submit the claim to Medicare, because the timely filing limit has expired. In these cases, Envolve Dental will extend the timely filing limit through the last day of the sixth month following the month in which a State Medicaid Agency recovered Medicaid payment from a provider or supplier.

- **Retroactive Disenrollment from a Medicare Advantage (MA) Plan or Program of All-inclusive Care of the Elderly (PACE) Provider Organization:** This is where a beneficiary was enrolled in an MA plan or PACE provider organization, but later was removed from the MA plan or PACE provider organization retroactive to or before the date the service was furnished; and the MA plan or PACE provider organization recoups its payment from a provider or supplier six months or more after the date the service was furnished. In these cases, Envolve Dental will extend the timely filing limit through the last day of the sixth month following the month in which the MA plan or PACE provider organization recovered its payment from a provider or supplier.

Claims Submission Information

Providers may submit claims electronically or via U.S. mail. Please have all required information ready to insert into the electronic fields or the paper form prior to initiating submission. Do NOT highlight any items on your submission. Electronic attachment options for X-rays, charts, photos and other items are available as described below.

Electronic Claims Submission via Provider Web Portal or Electronic Clearinghouse

Network providers are encouraged to submit claims and encounters electronically through our Provider Web Portal or selected electronic clearinghouses. Providers who bill electronically are responsible for filing claims within the same filing deadlines as the providers who file paper claims.

Providers who bill electronically must monitor their error reports and evidence of payments to ensure all submitted claims and encounters appear on the reports. Providers are responsible for correcting any errors and resubmitting the affiliated claims and encounters.

Provider Web Portal

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

To access the provider web portal, go to pwp.envolvedental.com

Log on with your username and password. If you have not yet registered for the web portal, or if you have questions about how to submit claims on it, call Provider Customer Service or send us an email at providerrelations@EnvolveHealth.com.

Electronic Clearinghouse and Attachments

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).

For all clearinghouses, use Envolve Dental payor identification number 46278. As of this manual publication date, we currently accept claims from the following:

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

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, EOPs, intraoral photographs, perio charts, and more.

To use the system NEA system, **complete** the following steps:

1. Navigate to www.nea-fast.com.
2. Install the software.
3. Follow the prompts to scan required documents.
4. Transmit documents to NEA's secure repository.
5. Select Envolve Dental as the payor (ID #46278).
6. Receive an NEA unique tracking number.
7. Include the NEA tracking number in the remarks section of claims submissions to Envolve Dental.

Images you transmit are stored for three years in NEA's repository and can only be viewed by your office and Envolve Dental. Data and images remain secure with HIPAA-compliant standards and you should only give your office's NEA account login and password to authorized users. If you have specific questions about using *Fast*Attach, call NEA at 800-782-5150.

If you use a different electronic clearinghouse and would like us to consider participating, please send your request to providerrelations@EnvolveHealth.com indicating your practice name, technical point-of-contact details and average monthly claim volume.

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 your state-specific Provider Relations.

Paper Claims

The following information must be included on the 2012 ADA claim form for timely claims processing:

- Member name
- Member ID number
- Member date of birth
- Provider name
- Provider location and service setting
- Billing location
- NPI and 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 your market-specific address.

Postage due mail will be returned to sender.

Claims Imaging Requirements

Envolve Dental uses an imaging process for claims retrieval. To ensure accurate and timely claims capture, please observe the following claims submission rules:

Do's

- Do use the correct PO Box number
- Do submit all claims in a 9" x 12", or larger envelope
- Do type all fields completely and correctly
- Do use black or blue ink only

- Do submit on a proper form, such as the 2012 ADA claim form

Don’ts

- Don’t submit handwritten claim forms
- Don’t use red ink on claim forms
- Don’t circle any data on claim forms
- Don’t add extraneous information to any claim form field
- Don’t use highlighter on any claim form field
- Don’t submit photocopied claim forms
- Don’t submit carbon copied claim forms
- Don’t submit claim forms via fax

Provider Corrected Claims

Providers who receive a claim denial due to incorrect or missing information can submit a “corrected claim” on a 2012 ADA claim form **within 365 days from the denial/paid date.** Claims are “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 or an incorrect code. To submit a corrected claim, providers must mail the corrected claim as follows:

- Complete the 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” typed on the top of the form, with the original claim number.

- Corrections must be indicated on the 2012 claim form as follows:
  - Make the correction on the service line that was in error (e.g., cross through the error and write in correct information).
  - In the “Remarks” section of the form (box #35), write in the details of the correction (e.g., add a tooth number, change to accurate service date, code, etc.).
  - Do NOT highlight any items on the form—doing so prevents our scanners from importing the information.
- Mail with correct postage to your market-specific address.

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

Claims Adjudication, Editing, and Payments

Envolve Dental adjudicates all claims at least 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.

Claims will be adjudicated (finalized as paid or denied) within 30 calendar days from the date of the original submission or electronic claim receipt.

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 10 days of submission. Payments are made to the provider's Electronic Funds Transfer (EFT) account or to a check printer that delivers the paper check and remittance statement by U.S. mail. Please 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.
- Call Provider Customer Service with questions about claims and remittances.

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 U.S. 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. 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.

Third Party Liability/Coordination of Benefits

Third party liability refers to any other health insurance plan or carrier (e.g., individual, group, employer-related, self-insured or self-funded, or commercial carrier, automobile insurance and worker's compensation) or program that is or may be liable to pay all or part of the healthcare expenses of the member.

Envolve Dental providers shall make reasonable efforts to determine the legal liability of third parties to pay for services furnished to Medicare members. If a member has other insurance that is primary, you must submit your claim to the primary insurance for consideration, and submit a copy of the Explanation of Benefits (EOB) or EOP, or rejection letter from the other insurance when the claim is filed.

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.

If the provider is unsuccessful in obtaining necessary cooperation from a member to identify potential third party resources, the provider shall inform Envolve Dental that efforts have been unsuccessful. Envolve Dental will make every effort to work with the provider to determine liability coverage.

If third-party liability coverage is determined after services are rendered, Envolve Dental will coordinate with the provider to pay any claims that may have been denied for payment due to third-party liability.

Coordination of Benefits (COB) Timely Filing

Claims originally filed timely with a third party carrier must be received within 180 days of the date of the primary carrier's EOP, but never more than 12 months from the date of service.

Billing the Member/Member Acknowledgement Form

Providers may not seek payment from Medicare members for the difference between the billed charges and the contracted rate paid by Envolve Dental.

Non-Covered Services

Contracted providers may only bill Medicare members for non-covered services if the member and provider both sign an agreement outlining the member's responsibility to pay prior to the services being rendered. The agreement must be specific to the services being rendered and clearly state:

- The specific service(s) to be provided;
- A statement that the service is not covered by the health plan
- A statement that the member chooses to receive and pay for the specific service; and
- The member is not obligated to pay for the service if it is later found that service was covered by the health plan at the time it was provided, even if the health plan did not pay the provider for the service because the provider did not comply with health plan requirements.

In order for a provider to bill a member for services not covered under the Envolve Dental program, or if the service limitations have been exceeded, the provider must obtain a completed and signed Non-Covered Services Liability Acknowledgement form (see Provider Web Portal) that acknowledges the member's responsibility for payment of non-covered services.

Billing Limitations

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

- X-rays/Radiographs: X-rays from the bitewing series are covered under the member's annual preventive benefit.
- Amalgams and Resins: Restoration unbundling is not allowed. Total payment is based on the number of unduplicated 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.
- Denture-related services: Lab fees are included in the denture placement reimbursement rate and cannot be billed separately to Envolve Dental or the member. Date of service for billing is the denture seating date. The fee includes all necessary adjustments and/or denture relines during the six-month period following denture insertion
- Cost-sharing: Providers cannot bill members for any type of cost-sharing for covered dental services, including a co-payment, coinsurance, deductible, or deposit. Members cannot be billed for infection control costs.
- 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.

Billing for Crowns and Dentures

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

Billing for Services in Emergency Situations

Members who have an urgent or emergent condition, defined as a situation involving severe pain, swelling, infection, uncontrolled hemorrhage, or traumatic injury should be treated immediately for covered benefits. Within two business days, call Provider Customer Service to verbally report the incident in the member's record. For billing, submit the claim with a narrative explaining the emergency and indicate "pre-payment review."

Include with the claim all required documentation for the code(s) as documented in Appendix A within 180 calendar days from the service date. If the call was not placed to Envolve Dental within two business days, include an explanation in the narrative and submit as above.

Billing for Services Rendered Out-of-Office

Billing for all services should include the location code where services were rendered on 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.

Rights and Responsibilities

Member Rights

Providers must comply with the rights of members as set forth below.

- To participate with providers in making decisions about his/her healthcare. This includes working on any treatment plans and making care decisions. The member should know any possible risks, problems related to recovery, and the likelihood of success. The member shall not have any treatment without consent freely given by the member or the member's legally authorized surrogate decision-maker. The member must be informed of their care options.
- To know who is approving and who is performing the procedures or treatment. All likely treatments and the nature of the problem should be explained clearly.
- To receive the benefits for which the member has coverage.
- To be treated with respect and dignity.
- To privacy of their personal health information, consistent with state and federal laws, and Health plan policies.
- To receive information or make recommendations, including changes, about the health plan's organization and services, the network of providers, and member rights and responsibilities.
- To candidly discuss with their providers appropriate and medically necessary care for their condition, including new uses of technology, regardless of cost or benefit coverage. This includes information from the member's primary care physician about what might be wrong (to the level known), treatment and any known likely results. The provider must tell the member about treatments that may or may not be covered by the plan, regardless of the cost. The member has a right to know about any costs they will need to pay. This should be told to the member in a way that the member can understand. When it is not appropriate to give the member information for medical reasons, the information can be given to a legally authorized person. The provider will ask for the member's approval for treatment unless there is an emergency and the member's life and health are in serious danger.
- To make recommendations regarding the Medicare member's rights, responsibilities and policies.
- To voice complaints or appeals about any benefit or coverage decisions, Medicare coverage, or the care provided.
- To refuse treatment for any condition, illness or disease without jeopardizing future treatment, and be informed by the provider(s) of the medical consequences.
- To see their medical records.
- To be kept informed of covered and non-covered services, program changes, how to access services, primary care physician assignment, providers, advance directive information, referrals and authorizations, benefit denials, member rights and

responsibilities, and other Medicare rules and guidelines. The health plan will notify its members before the effective date of the modifications. Such notices shall include the following:
    - Any changes in clinical review criteria
    - A statement of the effect of such changes on the personal liability of the member for the cost of any such changes
- To have access to a current list of network providers. Additionally, a member may access information on network providers' education, training, and practice.
- To select a health plan or switch health plans, within the guidelines, without any threats or harassment.
- To adequate access to qualified medical practitioners and treatment or services regardless of age, race, creed, sex, sexual preference, national origin or religion.
- To access medically necessary urgent and emergency services 24 hours a day and 7 days a week.
- To receive information in a different format in compliance with the Americans with Disabilities Act, if the member has a disability.
- To refuse treatment to the extent the law allows. The member is responsible for their actions if treatment is refused or if the provider's instructions are not followed. The member should discuss all concerns about treatment with their primary care physician or other provider. The primary care physician or other provider must discuss different treatment plans with the member. The member must make the final decision.
- To know the name and job title of people providing care to the member. The member also has the right to know which physician is their primary care physician.
- To have access to an interpreter when the member does not speak or understand the language of the area.
- To a second opinion by a network physician, at no cost to the member, if the member believes that the network provider is not authorizing the requested care, or if the member wants more information about their treatment.
- To exercise these rights. Also, to know if they do, it will not change how they are treated by the plan and its providers.

Member Responsibilities

Medicare members have the following responsibilities:

- To read their health plan contract in its entirety.
- To treat all healthcare professionals and staff with courtesy and respect.
- To give accurate and complete information about present conditions, past illnesses, hospitalizations, medications, and other matters about their health. The member should make it known whether they clearly understand their care and what is expected of them. The member needs to ask questions of their provider so they understand the care they are receiving.

- To review and understand the information they receive about Medicare. The member needs to know the proper use of covered services.
- To show their ID card and keep scheduled appointments with their provider, and call the provider's office during office hours whenever possible if the member has a delay or cancellation.
- To know the name of their assigned primary care physician. The member should establish a relationship with their primary care physician. The member may change their primary care physician verbally or in writing by contacting the health plan Member Services Department.
- To read and understand to the best of their ability all materials concerning their health benefits or to ask for assistance if they need it.
- To understand their health problems and participate, along with their healthcare providers in developing mutually agreed upon treatment goals to the degree possible.
- To supply, to the extent possible, information that the health plan and/or their providers need in order to provide care.
- To follow the treatment plans and instructions for care that they have agreed on with their healthcare providers.
- To understand their health problems and tell their healthcare providers if they do not understand their treatment plan or what is expected of them. The member should work with their primary care physician to develop mutually agreed upon treatment goals. If the member does not follow the treatment plan, the member has the right to be advised of the likely results of their decision.
- To follow all health benefit plan guidelines, provisions, policies and procedures.
- To use any emergency room only when they think they have a medical emergency.
- To give all information about any other medical coverage they have at the time of enrollment. If, at any time, the member gains other medical coverage besides Medicare coverage, the member must provide this information to the health plan.
- To pay their monthly premium, all deductible amounts, copayment amounts, or cost-sharing percentages at the time of service.

Provider Rights

Envolve Dental providers have the **right** to:

- To be treated by their patients, who are Medicare members, and other healthcare workers with dignity and respect.
- To receive accurate and complete information and medical histories for members' care.
- To have their patients, Medicare members, act in a way that supports the care given to other patients and that helps keep the doctor's office, hospital, or other offices running smoothly.
- To expect other network providers to act as partners in members' treatment plans.

- To expect members to follow their healthcare instructions and directions, such as taking the right amount of medication at the right times.
- To make a complaint or file an appeal against the health plan and/or a member.
- To file a grievance on behalf of a member, with the member's consent.
- To have access to information about Medicare quality improvement programs, including program goals, processes, and outcomes that relate to member care and services.
- To contact Provider Customer Service with any questions, comments, or problems.
- To collaborate with other healthcare professionals who are involved in the care of members.
- To not be excluded, penalized, or terminated from participating with Medicare for having developed or accumulated a substantial number of patients in the health plan with high cost medical conditions.
- To collect member cost shares at the time of the service.

Provider Responsibilities

Envolve Dental providers have the **responsibility** to:

- To help or advocate for members to make decisions within their scope of practice about their relevant and/or medically necessary care and treatment, including the right to:
  - Recommend new or experimental treatments
  - Provide information regarding the nature of treatment options
  - Provide information about the availability of alternative treatment options, therapies, consultations, or tests, including those that may be self-administered
- Be informed of risks and consequences associated with each treatment option or choosing to forego treatment as well as the benefits of such treatment options.
- To treat members with fairness, dignity, and respect.
- To not discriminate against members on the basis of race, color, national origin, limited language proficiency, religion, age, health status, existence of a pre-existing mental or physical disability/condition including pregnancy and/or hospitalization, the expectation for frequent or high cost care.
- To maintain the confidentiality of members' personal health information, including medical records and histories, and adhere to state and federal laws and regulations regarding confidentiality.
- To give members a notice that clearly explains their privacy rights and responsibilities as it relates to the provider's practice and scope of service.
- To provide members with an accounting of the use and disclosure of their personal health information in accordance with HIPAA.
- To allow members to request restriction on the use and disclosure of their personal health information.
- To provide members, upon request, access to inspect and receive a copy of their personal health information, including medical records.

- To provide clear and complete information to members - in a language they can understand - about their health condition and treatment, regardless of cost or benefit coverage, and allow member participation in the decision-making process.
- To tell a member if the proposed medical care or treatment is part of a research experiment and give the member the right to refuse experimental treatment.
- To allow a member who refuses or requests to stop treatment the right to do so, as long as the member understands that by refusing or stopping treatment the condition may worsen or be fatal.
- To respect members' advance directives and include these documents in their medical record.
- To allow members to appoint a parent/guardian, family member, or other representative if they can't fully participate in their treatment decisions.
- To allow members to obtain a second opinion, and answer members' questions about how to access healthcare services appropriately.
- To follow all state and federal laws and regulations related to patient care and rights.
- To participate in Medicare data collection initiatives, such as HEDIS and other contractual or regulatory programs.
- To review clinical practice guidelines distributed by the health plan.
- To disclose overpayments or improper payments.
- To provide members, upon request, with information regarding the provider's professional qualifications, such as specialty, education, residency, and board certification status.
- To obtain and report to the health plan information regarding other insurance coverage the member has or may have.
- To give the health plan timely, written notice if provider is leaving/closing a practice.
- To contact the health plan to verify member eligibility and benefits, if appropriate.
- To invite member participation in understanding any medical or behavioral health problems that the member may have and to develop mutually agreed upon treatment goals, to the extent possible.
- To provide members with information regarding office location, hours of operation, accessibility, and translation services.
- To object to providing relevant or medically necessary services on the basis of the provider's moral or religious beliefs or other similar grounds.
- To provide hours of operation to Medicare members which are no less than those offered to other Medicare patients.

Complaint and Grievance Process

Provider Complaints, Corrected Claims and Appeals

Claim Complaints must follow the Dispute Process and then Complaint Process below. Please note that claim payments are not appealable. These must be handled via the Claim Dispute and Complaint Process. Claim Disputes may be mailed to the mailing address listed by state under Key Contacts for **Dental Claims and Provider Appeals**.

Complaint/Grievance

A Complaint/Grievance is a verbal or written expression by a provider that indicates dissatisfaction or dispute with the health plan's policies, procedure, or any aspect of the health plan's functions. The health plan logs and tracks all complaints/grievances whether received verbally or in writing. A provider has 30 calendar days from the date of the incident, such as the original EOP date, to file a complaint/grievance. After a complete review of the complaint/grievance, the health plan shall provide a written notice to the provider within 30 calendar days from the received date of the health plan's decision. If the complaint/grievance is related to claims payment, the provider must follow the process for claim reconsideration or claim dispute as noted in the Claims section of this Provider Manual prior to filing a Complaint.

Coverage Complaints

Coverage Complaints must follow the Appeal process below.

An Appeal is the mechanism which allows providers the right to appeal actions of the health plan such as if the provider is aggrieved by any rule, policy or procedure or decision made by Envolve Dental or the health plan. A provider has 30 calendar days from the health plan's notice of action to file the appeal. The health plan shall acknowledge receipt of each appeal within 10 business days after receiving an appeal. The health plan shall resolve each appeal and provide written notice of the appeal resolution, as expeditiously as the member's health condition requires, but shall not exceed 30 calendar days from the date the health plan receives the appeal. The health plan may extend the time frame for resolution of the appeal up to 14 calendar days if the member requests the extension or the health plan demonstrates that there is need for additional information and how the delay is in the member's best interest. For any extension not requested by the member, the health plan shall provide written notice to the member for the delay.

Expedited appeals may be filed with the health plan if the member's provider determines that the time expended in a standard resolution could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function. No punitive action will be taken against a provider that requests an expedited resolution or supports a member's appeal. In instances where the member's request for an expedited appeal is denied, the appeal must be transferred to the time frame for standard resolution of appeals.

Decisions for expedited appeals are issued as expeditiously as the member's health condition requires, not exceeding 72 hours from the initial receipt of the appeal. The health plan may extend

this time frame by up to an additional 14 calendar days if the member requests the extension, or if the health plan provides satisfactory evidence that a delay in rendering the decision is in the member's best interest.

Providers may also invoke any remedies as determined in the Participating Provider Agreement.

Member Grievances and Appeals

Grievances

Members must follow the complaint or dispute (grievance) process as listed below when a member is dissatisfied with the manner in which the health plan or a delegated entity provides healthcare services. Grievances may include:

- Timeliness
- Appropriateness
- Access to provided health services
- Setting of health services
- Procedures
- Items
- Standards for delivery of care

Members or their representative may submit a grievance verbally or in writing via phone, mail, facsimile, electronic mail or in person within 60 calendar days after the event. If the grievance meets the necessary criteria, a resolution is delivered to the member as expeditiously as the member's case requires, based on health status, but no later than 24 hours for expedited grievances and 30 calendar days. Extensions of up to 14 calendar days can be granted for standard grievances if the enrollee requests the extension or if the health plan justifies the need for additional information and the delay is in the best interest of the member.

Appeals

Members or their representatives may file a formal appeal if they are dissatisfied with a medical care or coverage decision made by the health plan. Appeals must be submitted within 60 days of the decision. Expedited determinations will be made on medical care or drug coverage not yet received if standard deadlines can cause serious harm to the member's health. Written appeals must be mailed to:

Attn: Appeals and Grievances
7700 Forsyth Blvd.
St. Louis, MO 63105

For process or status questions, members or their representatives can contact Member Services.

Fraud, Waste, and Abuse

Envolve Dental takes the detection, investigation, and prosecution of fraud, waste, and abuse very seriously and performs ongoing claims audits, which in some cases may result in taking actions against those providers who, individually or as a practice, commit fraud, waste, or abuse. These actions include but are not limited to:

- Remedial education and/or training to prevent the billing irregularity
- More stringent utilization review
- Recoupment of previously paid monies
- Termination of provider agreement or other contractual arrangement
- Civil and/or criminal prosecution
- Any other remedies available to rectify

Envolve Dental instructs and expects all its contractors and subcontractors to comply with applicable laws and regulations, including but not limited to the following:

- Federal and State False Claims Act
- Qui Tam Provisions (Whistleblower)
- Anti-Kickback Statute
- Physician Self-Referral Law (Stark Law)
- HIPAA
- Social Security Act
- U.S. Criminal Codes

Envolve Dental requires all its contractors and subcontractors to report violations and suspected violations on the part of its employees, associates, persons or entities providing care or services to all health plan members. Examples of such violations include bribery, false claims, conspiracy to commit fraud, theft or embezzlement, false statements, mail fraud, healthcare fraud, obstruction of a state and/or federal healthcare fraud investigation, money laundering, failure to provide medically necessary services, marketing schemes, prescription forging or altering, provider illegal remuneration schemes, compensation for prescription drug switching, prescribing drugs that are not medically necessary, theft of the prescriber's DEA number or prescription pad, identity theft or members' medication fraud.

CMS Definitions for Fraud, Waste, and Abuse

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

- Medicare 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 Medicare card.

Waste: Providing medically unnecessary services.[1]

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

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

The primary difference between fraud and abuse is intention.

Fraud, Waste, and Abuse Hotlines

- Envolve Dental Hotline: 800-345-1642
- Medicare Fraud Hotline of the HHS office Inspector General: 800-447-8477

[1] *Medicare Fraud & Abuse: Prevent, Detect, Report*, Centers for Medicare & Medicaid Services, February 2019

Quality Management

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, thereby improving 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.

Scope

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/preventive 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 to 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
- Seek input and work with providers and community resources to improve quality of care
- Oversee peer review procedures that will address deviations in medical management and healthcare 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.

Clinical Definitions and Guidelines

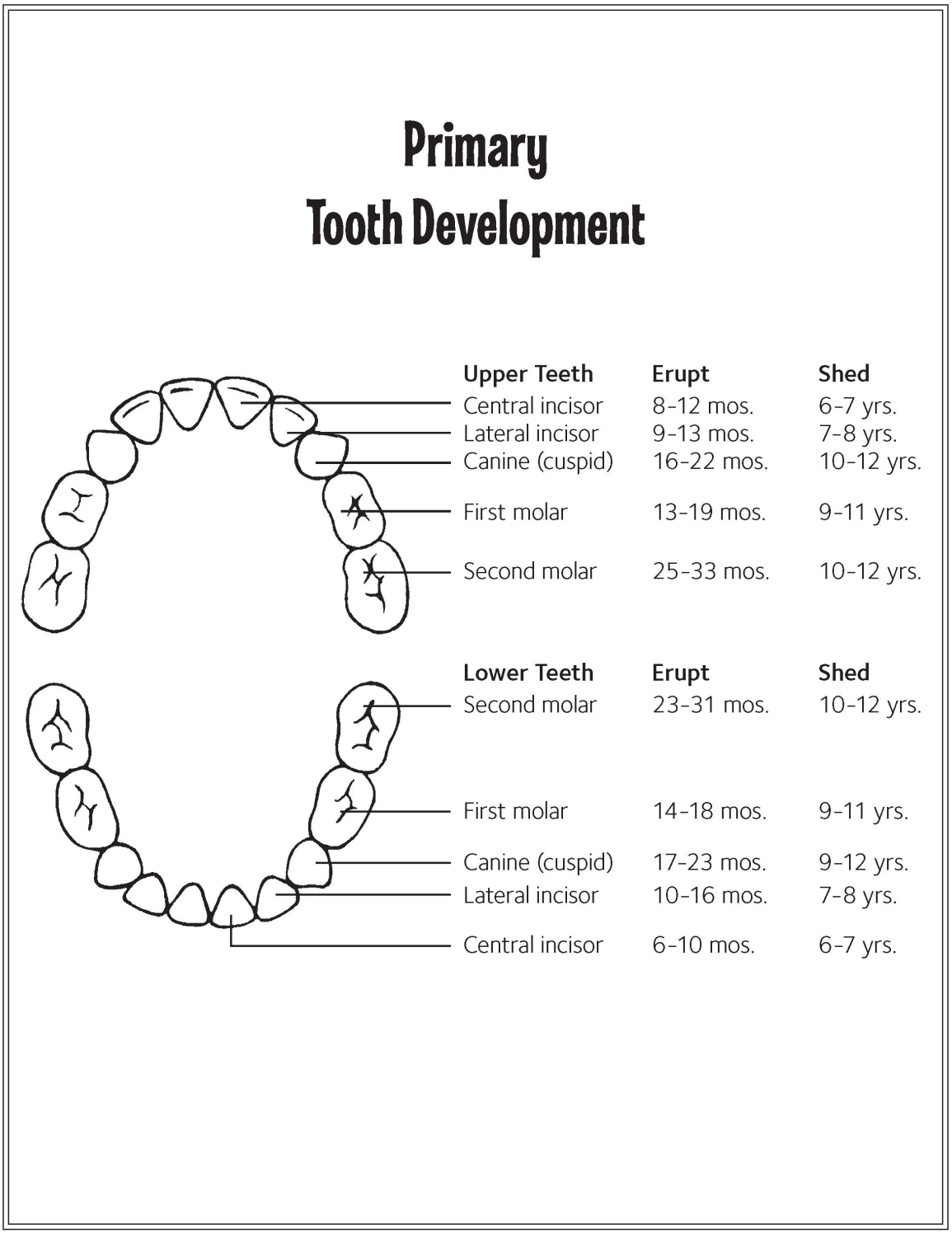
Clinical Definitions

Teeth should be identified as follows:

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

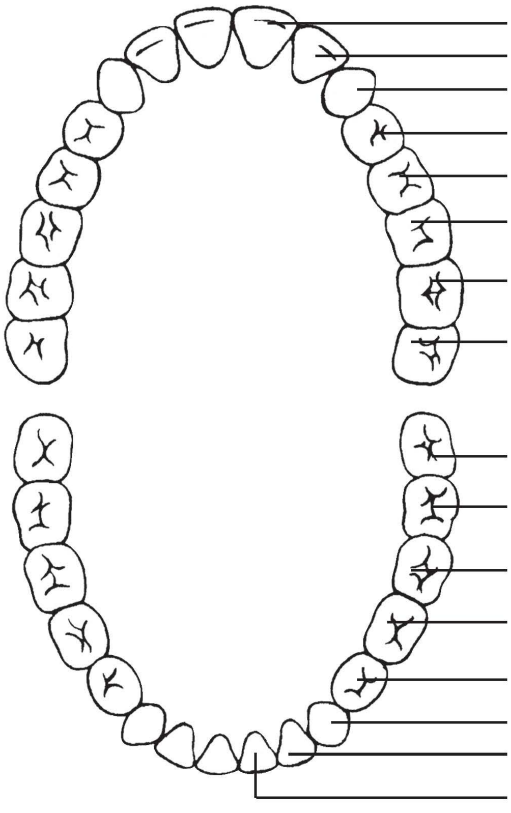
*Supernumerary designation can be determined by using the nearest erupted tooth. If the tooth closest to the supernumerary tooth is #1, then the supernumerary tooth should be charted as #51. Likewise, if the nearest tooth is A, the supernumerary tooth should be charted as AS.

ADA Eruption Chart – Primary Teeth



ADA Eruption Chart – Permanent Teeth

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.

Provider Forms

Please visit pwp.envolvedental.com or call Provider Customer Service for copies of applicable provider forms.

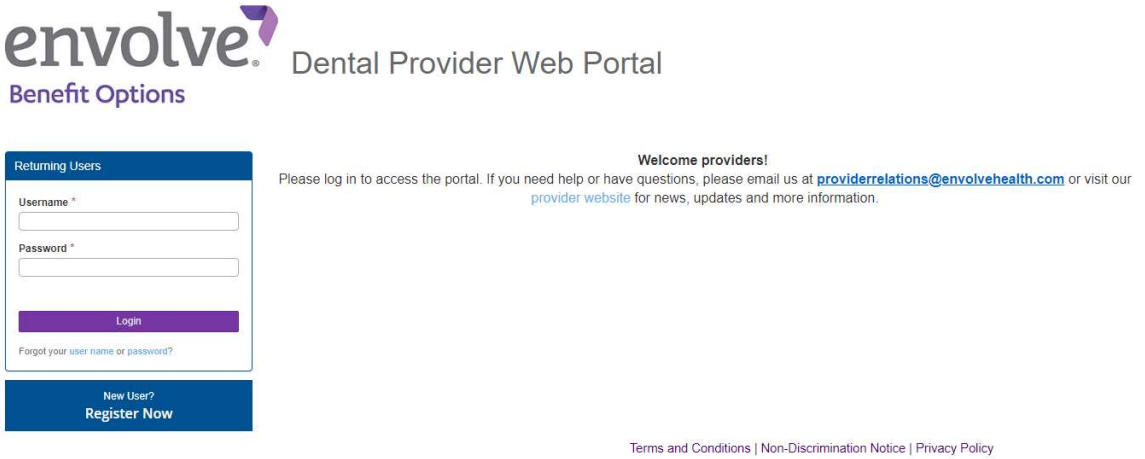
MEDICARE 2021 BENEFIT TABLES

For the most current covered dental benefit codes and details, please refer to the Medicare Benefit Tables posted separately on the Provider Web Portal.

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



Access the Envolve Dental Provider Web Portal at:

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:

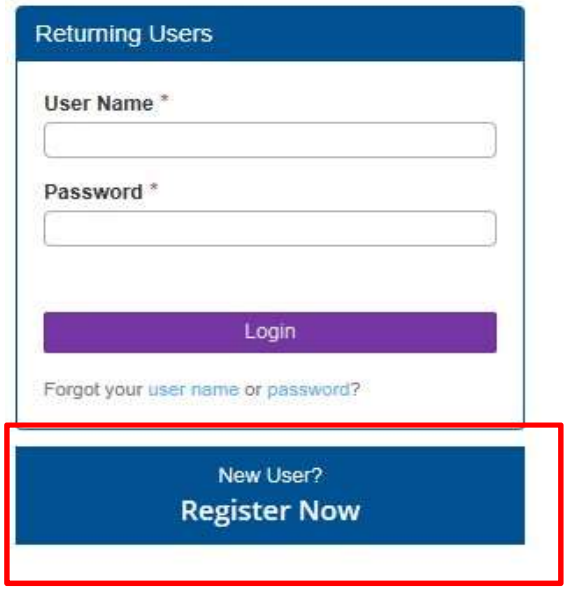
- Verify member eligibility
- Check patient treatment history
- Set up office appointment schedules, automatically verifying eligibility and prepopulating claim forms for online submission
- Submit claims by simply entering procedure codes, relevant tooth numbers, etc.
- Send electronic attachments,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

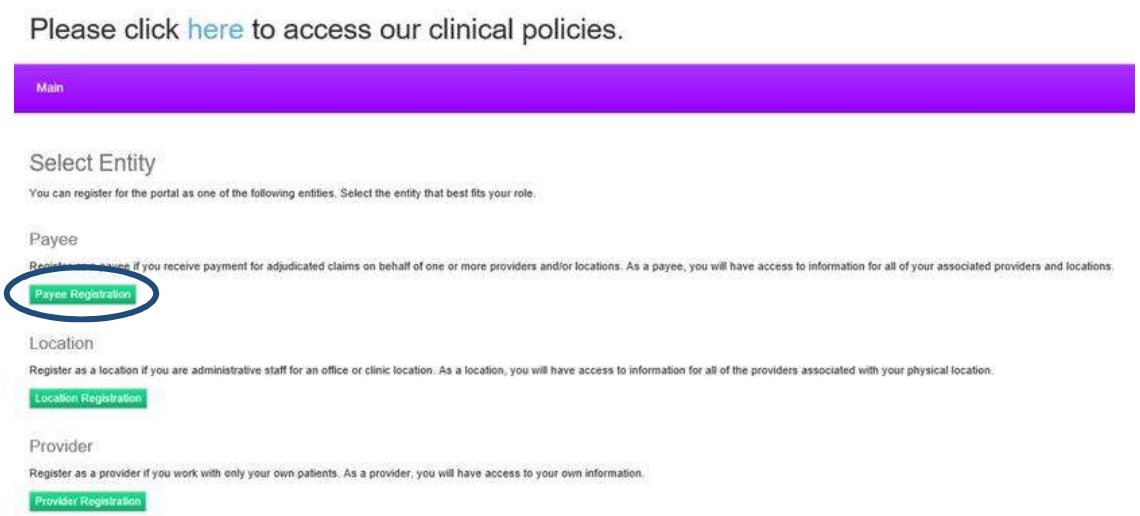
Provider Web Portal Registration

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 Provider Customer Service to obtain a unique Payee ID Number. Provider Customer Service will verify your identity to ensure registration is completed and accessed only by an authorized user.

To register, complete the following steps:

1. Visit the Provider Web Portal (PWP) at: pwp.envolvedental.com.
2. Click **Register Now.**
3. Call Provider Customer Service Monday through Friday, 8 a.m. to 5 p.m. local time to obtain your Payee ID Number.





4. On the User Registration pop-up screen, select Payee Registration.
5. Add the Payee ID number from Provider Customer Service.
6. Verify spelling/punctuation of Name, City, State and ZIP.
7. Fill in details in every field. Remember your user name and password for future use.
8. Click **Create**.

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

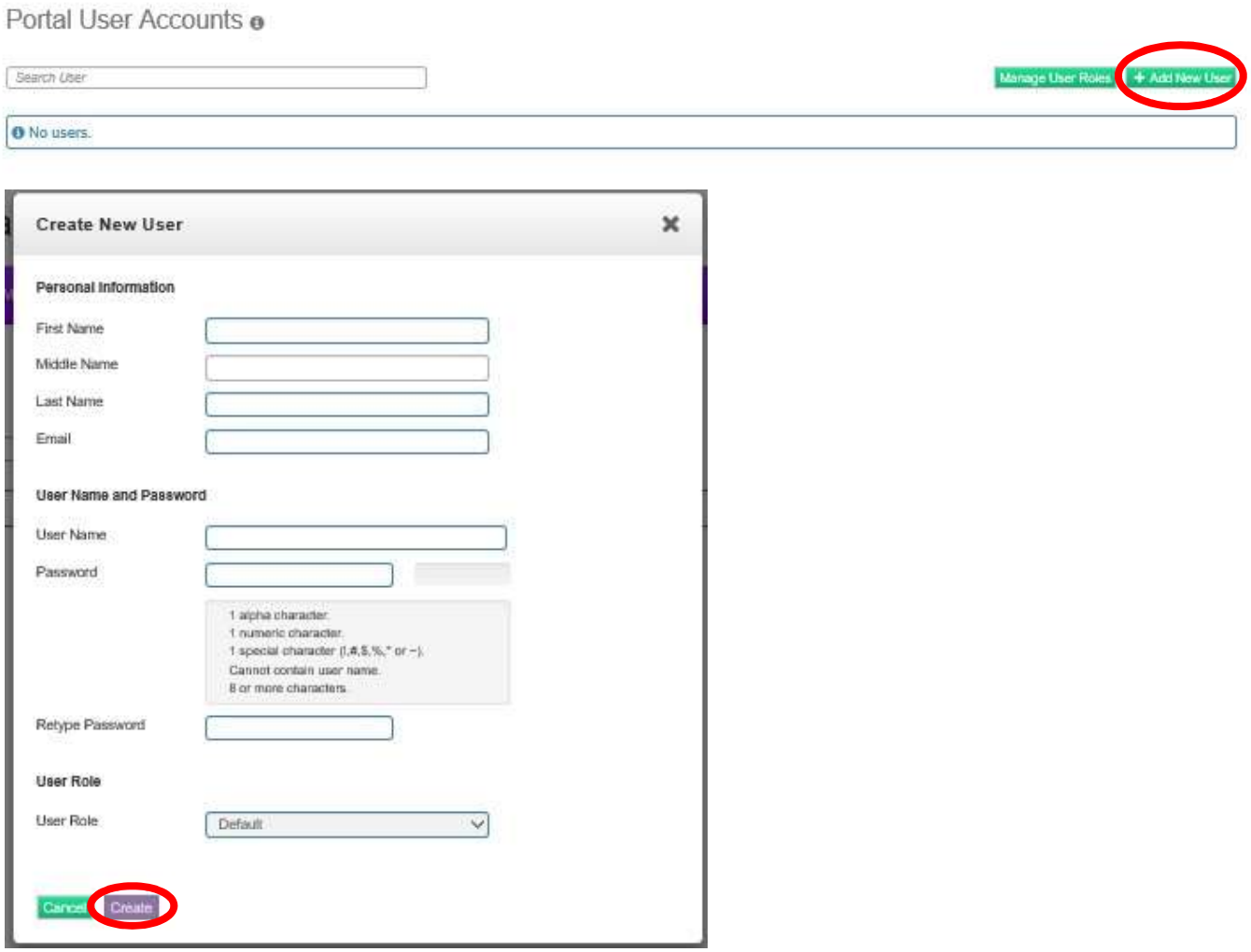
Subaccounts

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 to use 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, complete the following:

1. Log in to your Payee account.
2. From the Setup tab, click **Portal User Accounts**.
3. Select **Add New User**.
4. Complete all fields and click **Create**.
5. Select **Manage User Roles** to create/edit portal features for additional user roles.



User Account Security

Master accounts can be manually locked and unlocked by a Provider 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 Customer Service 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. Provider Customer Service cannot unlock subaccounts.

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 based on whether registered as “Provider” or “Location”.)

- **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 link 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

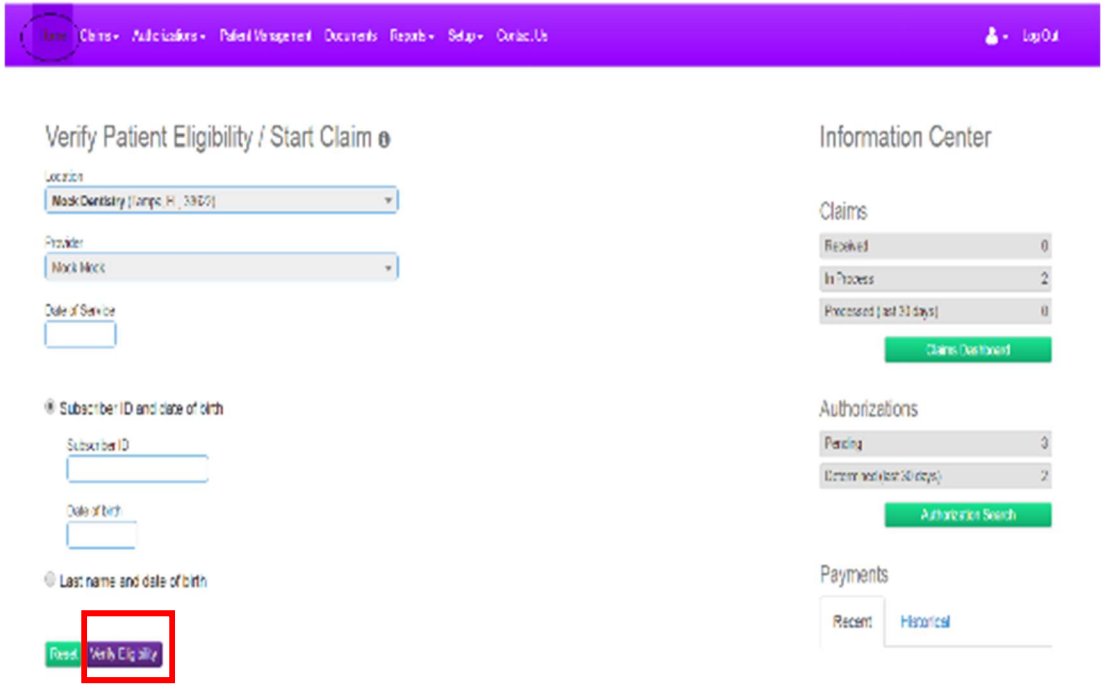
Complete the following to confirm a patient's benefit coverage and eligibility for service on a specific date:

1. Click the **Home** tab.

2. From the Verify Patient Eligibility drop-downs, select the 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.

NOTE: When verifying eligibility, enter [ID + DOB] **or** [First Initial + Last Name + DOB]. Entering more information than necessary can lead to 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 this report 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

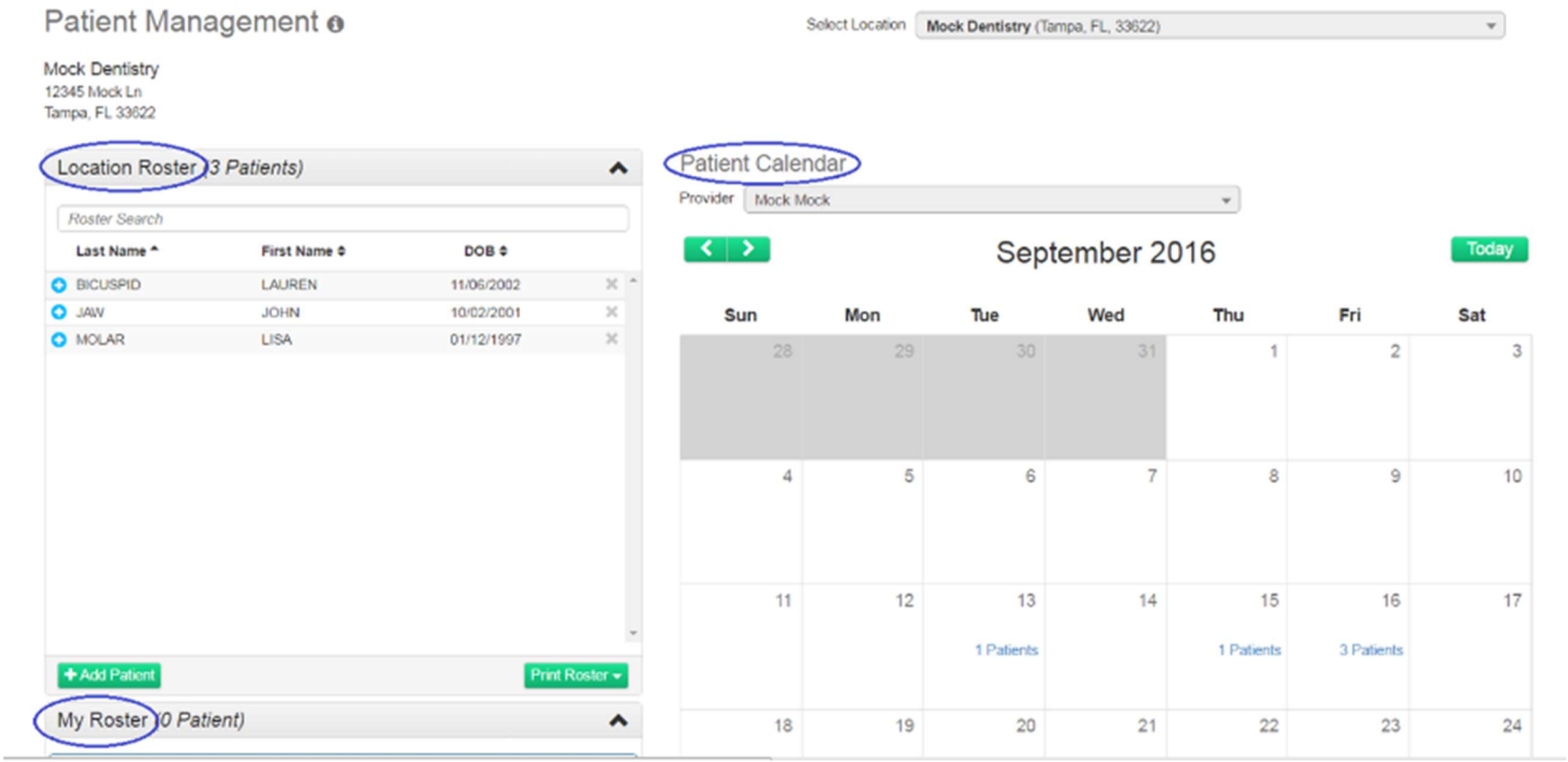
Eligibility Details

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

Manage Roster

To manage roster, complete the following:

1. Open the **Patient Management** tab.
2. From the Location Roster and My Roster drop-down, select patient name.
3. Rosters can be created by day in order to manage a daily patient schedule.

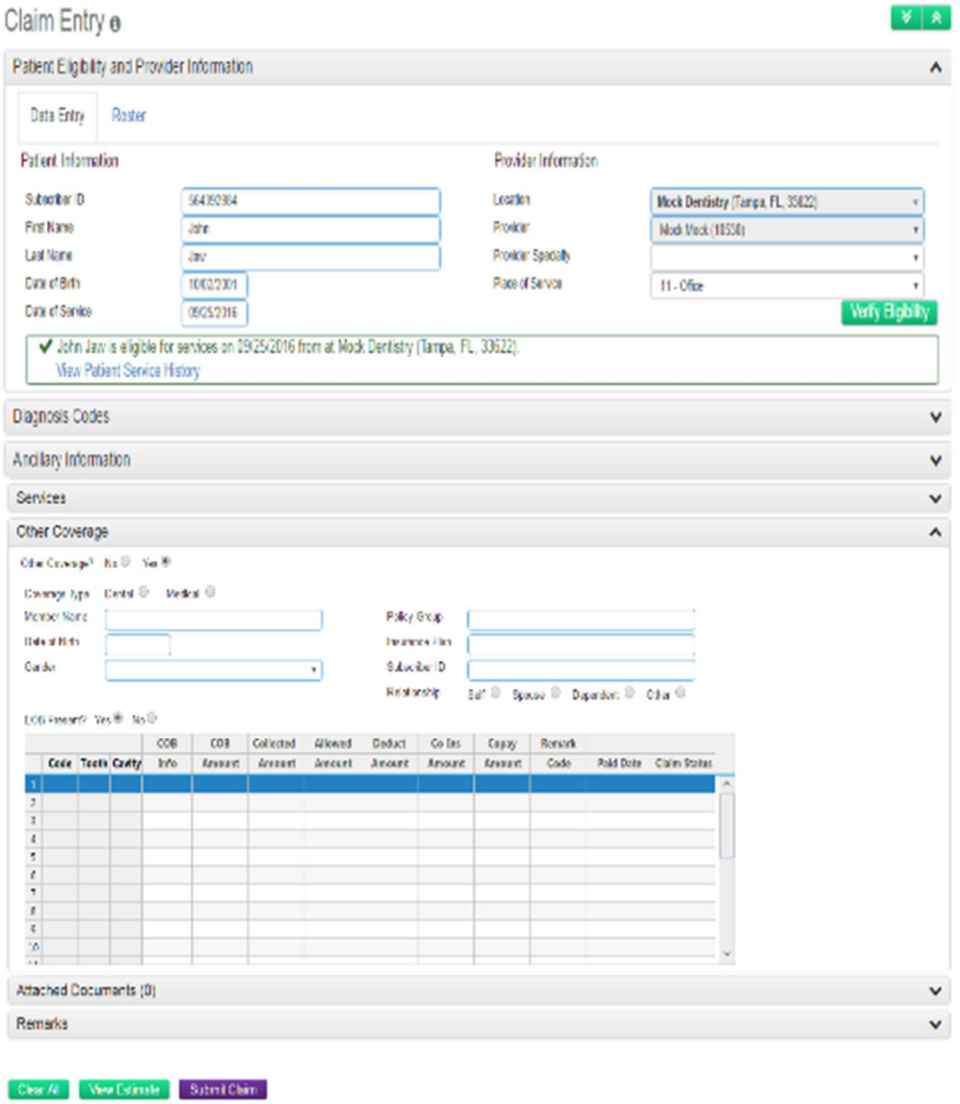


Claim Entry & Submission

To enter and submit claims, complete the following:

NOTE: Provide applicable narratives and attach required documentation.

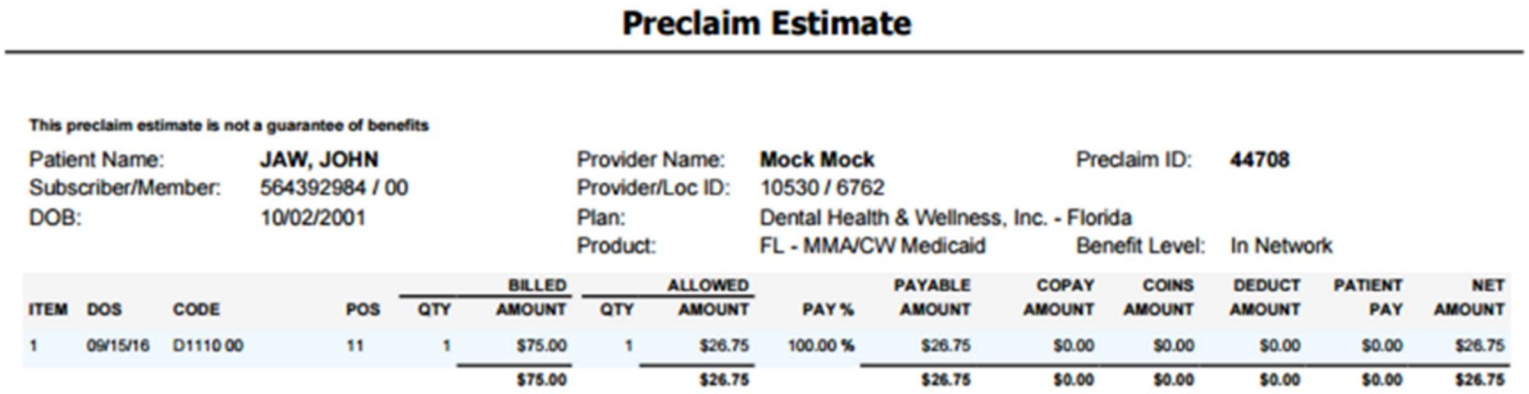
1. Click the **Claims** tab on the upper navigation bar and select **Submit Claim**.
2. Enter member's ID, date of birth, location and provider from the drop-down menu.
3. Click **Verify Eligibility** to check patient coverage. The field will turn green if the patient is covered, and red if not covered.
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.
   a. 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.
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/area 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** drop-down to add any additional narratives, such as NEA numbers or other pertinent details.
9. Click the **Attachments** drop-down to attach x-rays or other documents that are required for payment.



Pre-Claim Estimate – Remaining Dental Benefit Amount

An important feature is the pre-claim estimate pop-up window, available on the claim entry tab. After all fields above have been entered, 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

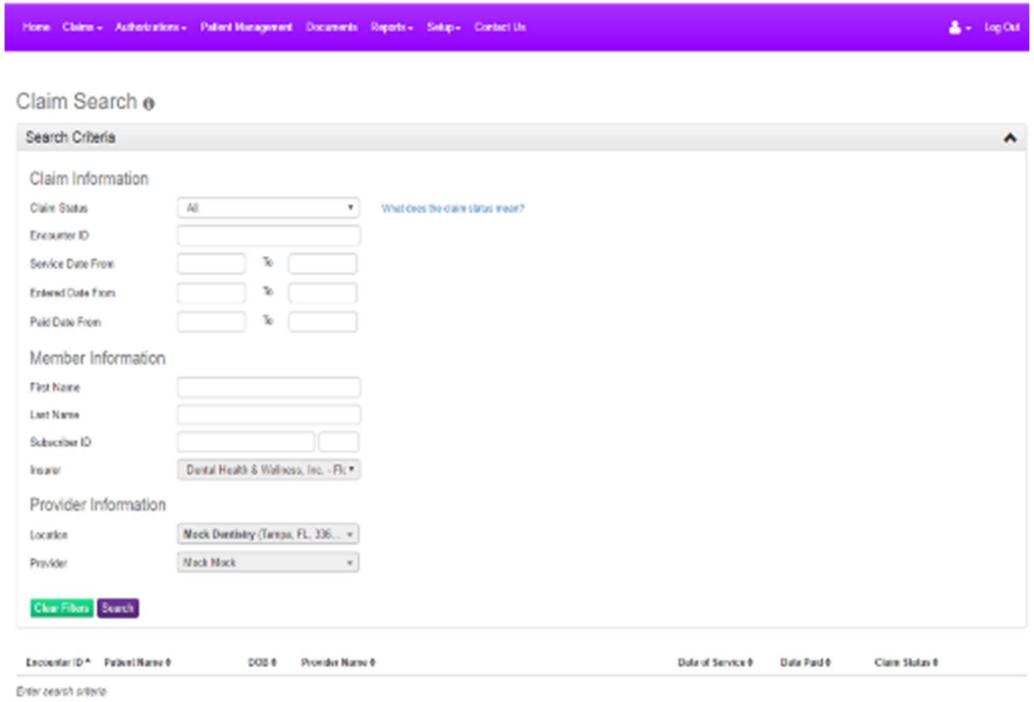
This preclaim estimate is not a guarantee of benefits

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

ITEM	DOS	CODE	POS	BILLED QTY	BILLED AMOUNT	ALLOWED QTY	ALLOWED AMOUNT	PAY %	PAYABLE AMOUNT	COPAY AMOUNT	COINS AMOUNT	DEDUCT AMOUNT	PATIENT PAY	NET 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.



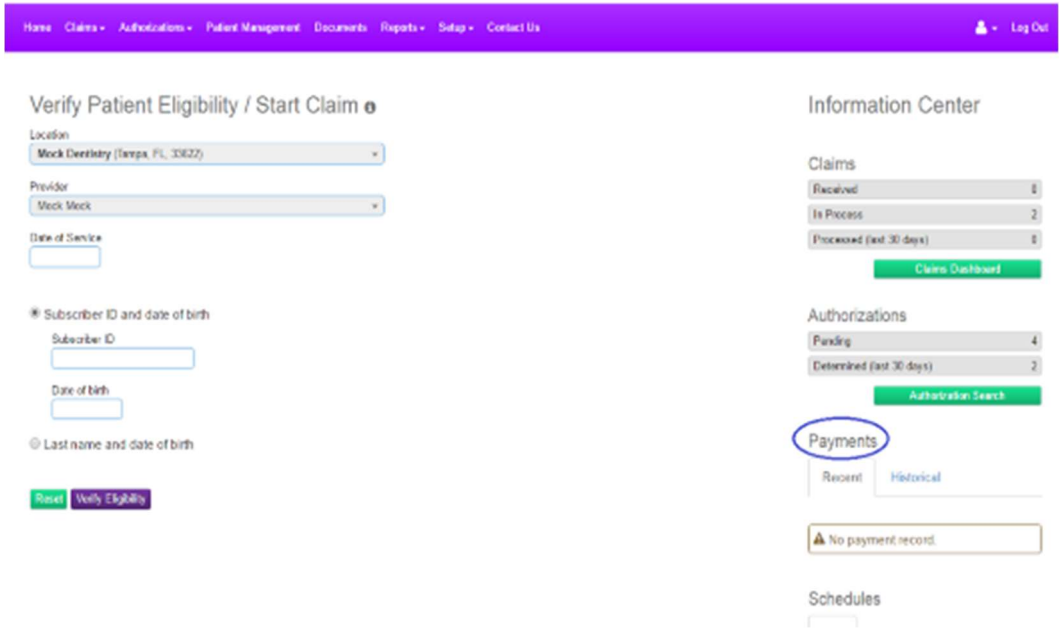
- From the Claim Search screen, the claim status functionality allows a provider to search for a single claim-by-claim encounter ID number or for batches of claims.
- Searches can be for **all, received, in process,** or **processed** claims. This allows a provider to track claims currently in the payment 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. 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 on the portal) 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.

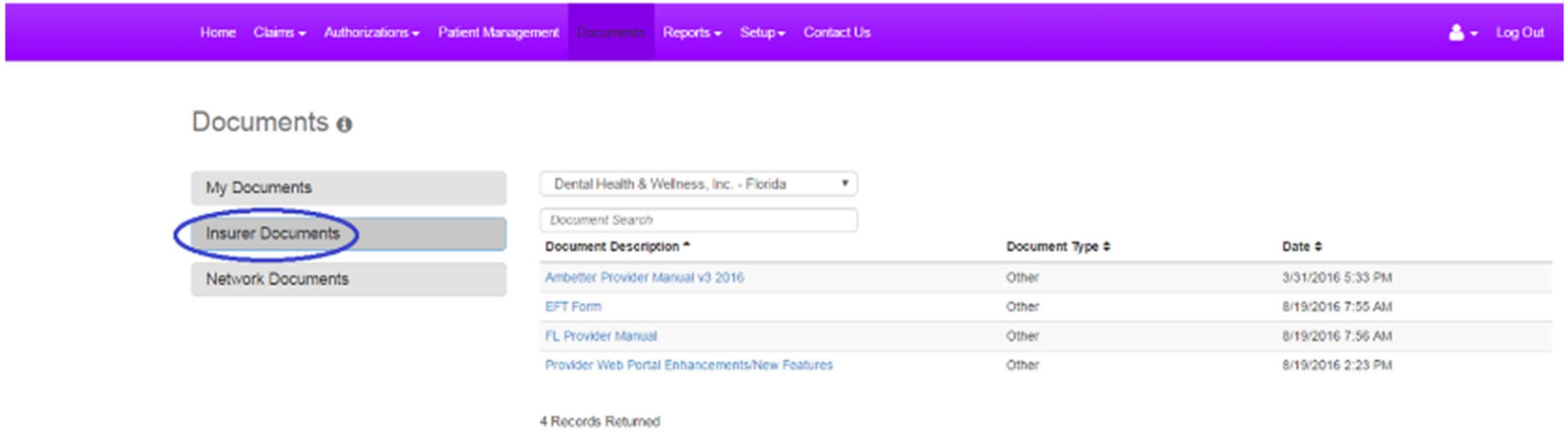
To view online remittances, complete the following:

1. Open the **Documents** tab.
2. Select **My Documents**.
3. Select the applicable remittance statement date.



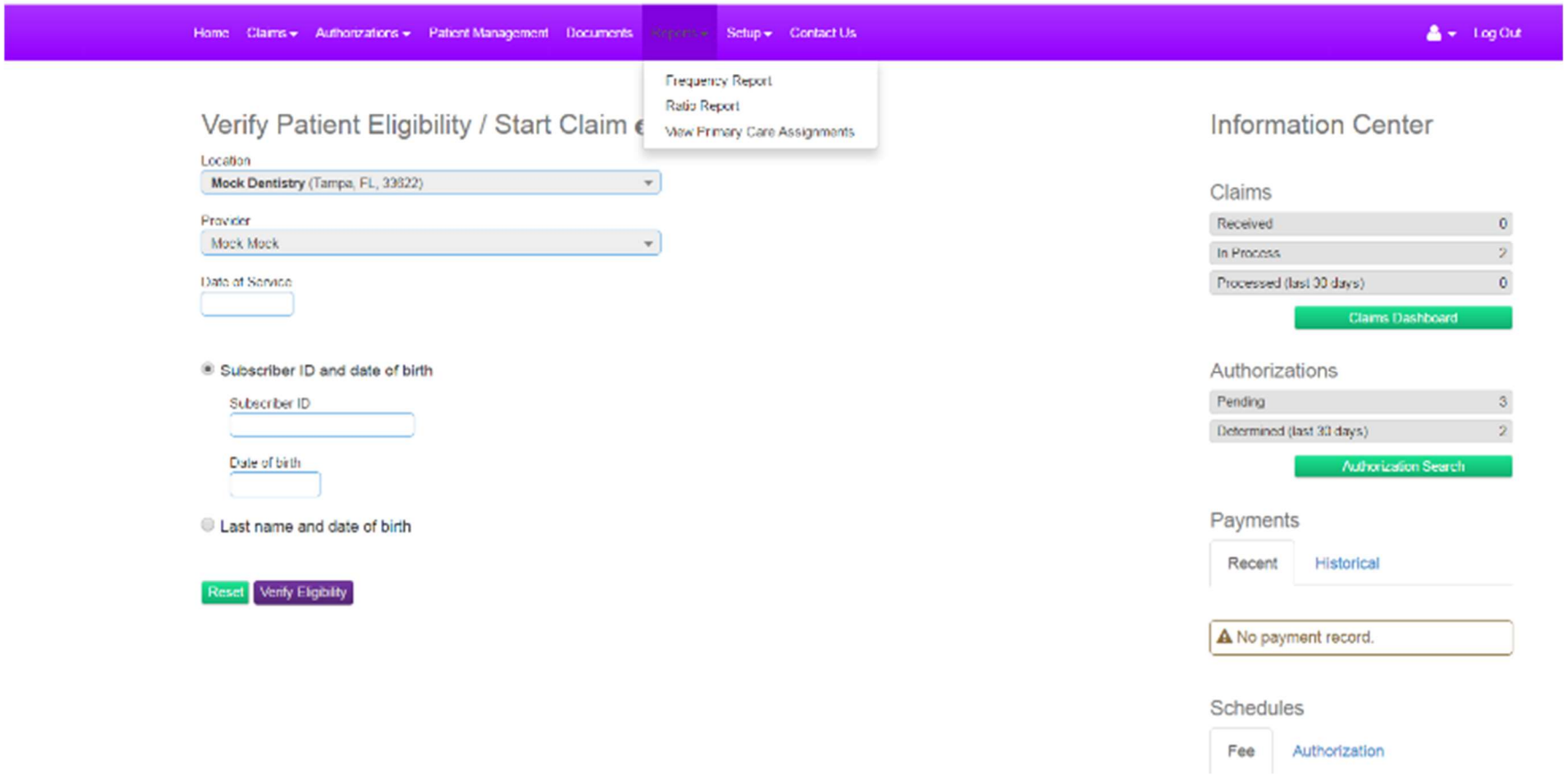
Documents

From the **Insurer Documents** tab, view a copy of the Envolve Dental Provider Manual.



Frequency and Ratios Reports

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



If you have questions about the Envolve Dental Provider Web Portal, please contact Provider Customer Service for assistance.

Envolve Dental Provider Manual for Medicare

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