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Quick Reference Guide

Provider Web Portal

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

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

Real-time eligibility

Authorizations – submit & view status

Claims – submit & view status

Clinical guidelines

Referral directories

Electronic remittance advice

Electronic Funds Transfer

Up-to-date provider manual

Access the Provider Web Portal by clicking this link:

https://pwp.envolvedental.com
# Contacts

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<td><a href="https://pwp.envolvedental.com">https://pwp.envolvedental.com</a></td>
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<td>Provider Services</td>
<td>855-434-9245</td>
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<tr>
<td>Sunflower Member Services (including translation and transportation assistance)</td>
<td>877-644-4623</td>
</tr>
<tr>
<td>Credentialing</td>
<td>844-847-9807 fax</td>
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<tr>
<td>Fraud, Waste &amp; Abuse</td>
<td>800-345-1642</td>
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| Authorization Address  | Envolve Dental  
|                        | Kansas Authorizations  
|                        | PO Box 25857  
|                        | Tampa, FL 33622-5857 |
| Paper Claim and Corrected Claim Address | Envolve Dental  
|                        | Kansas Claims  
|                        | PO Box 25857  
|                        | Tampa, FL 33622-5857 |
| Appeals Address        | Envolve Dental  
|                        | Kansas Appeals  
|                        | PO Box 25857  
|                        | Tampa, FL 33622-5857 |
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# Quick Reference Guide

## Claim Submission

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

Submit claims in one of the following formats:

- Envolve Dental Provider Web Portal at [https://pwp.envolvedental.com](https://pwp.envolvedental.com)
- Electronic claim submission through selected clearinghouses: Payer ID **46278**
- Alternate pre-arranged HIPAA-compliant electronic submissions
- Paper claims on a 2012 ADA claim form:
  Envolve Dental
  Kansas Claims
  PO Box 25857
  Tampa, FL 33622-5857

Electronic attachments with National Electronic Attachment (NEA) [http://www.neafast.com](http://www.neafast.com)

## Corrected Claim Submission

Providers who receive a claim denial and need to submit a corrected claim may send a paper claim or upload a corrected claim to the Provider Web Portal including ALL codes originally submitted, plus the corrected code with supporting documentation, within 365 calendar days of the denial to:

Envolve Dental
Kansas Corrected Claims
PO Box 25857
Tampa, FL 33622-5857

## Provider Reconsiderations/Appeals

Providers may request reconsideration of a claim within 123 calendar days from the original EOP or determination letter date. Providers may skip reconsideration and file an appeal within 63 calendar days from the NOA or EOP date.

To request a reconsideration of a claim:

- Call: 855-434-9245; or
- Write:
  Envolve Dental
  Kansas Reconsideration or Appeals
  PO Box 25857
  Tampa, FL 33622-5857

Provider appeals must be submitted in writing to the address above.
## Quick Reference Guide

### Provider Inquiries and Grievances

To make an inquiry or file a grievance:
- **Call:** 855-434-9245
- **Write:**
  - Envolve Dental
  - Kansas Grievances
  - PO Box 25857
  - Tampa, FL 33622-5857

Note: Providers must file a grievance within 180 calendar days of the event being grieved.

### Member Appeals and State Fair Hearing Requests

Members must submit appeals within 63 calendar days of the date of the Notice of Adverse Benefit Determination. For State Fair Hearing requests, members must file within 123 calendar days of the date on the Notice of Member Appeal Resolution.

Members may submit appeal or State Fair Hearing requests to:
- **Sunflower Health Plan Quality Department**
  - 8325 Lenexa Drive, Suite 200
  - Lenexa, KS 66214
  - Phone: 877-644-4623
  - (TTY: 711)
  - Fax: 888-453-4755

Note: A provider may file a member appeal on behalf of the member with written authorization from the member.

### Additional Provider Resources

For information about additional provider resources:
- **Call Provider Services:** 855-434-9245
- **Access the Provider Web Portal at [https://pwp.envolvedental.com](https://pwp.envolvedental.com)
- **Email Provider Services at providerrelations@envolvehealth.com**
Welcome

Welcome to the Envolve Dental provider network! We are pleased you joined our provider network, composed of the best providers in the state to deliver high quality dental healthcare. Envolve Dental, Inc., is a subsidiary of Envolve Benefit Options and Centene Corporation, a Fortune 100 company with more than 30 years of experience in Medicaid managed care programs.

In Kansas, Sunflower Health Plan is one of several managed care organizations (MCOs) contracted with two Kansas state agencies to provide comprehensive health care benefits for certain Medicaid-eligible residents (the Kansas Department of Health and Environment–KDHE, the Division of Health Care Finance–DHCF, and the Kansas Department for Aging and Disability Services–KDADS). Sunflower selected Envolve Dental to administer dental benefits beginning August 1, 2014 for Sunflower Health Plan’s members in the following benefit plans:

- Title 21 CHIP – Ages 0 to 18
- Title 19 Medicaid Children – Ages 0 to 20
- Title 19 Medicaid Adults – Ages 21 and Over
- HCBS Adults – Ages 65 and Over

This Envolve Dental provider manual supplies useful information about working with us. We strive to make information clear and user-friendly. If you have questions about specific portions of the manual or if you have suggestions for improvements, we welcome your input. Please contact Provider Services at 855-434-9245, Monday through Friday, 8:00 AM to 5:00 PM (CST).

Envolve Dental retains the right to modify items in this provider manual. Contracted providers must acknowledge this document and all other written materials produced by Envolve Dental as proprietary and confidential.
Provider Participation, Contracting and Credentialing

Provider Participation

Why participate? The Medicaid program is the nation’s largest health insurer, funding one sixth of total personal health care spending in the United States. Medicaid covers more than one in three children. Historically, providers cite low payment rates and administrative burdens as reasons for not participating in the Medicaid program. However, participating in the Envolve Dental provider network has many advantages. Among them are the following:

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

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

- Providers can choose a level of network participation based on their individual office needs. For example, providers can choose to:
  - accept only Sunflower members who are currently patients in their office;
  - accept new patients and be listed in a Sunflower Health Plan provider directory

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

---

1 Medicaid: A Primer, March 2013; The Kaiser Commission on Medicaid and the Uninsured
Contracting

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

- Call Provider Services at 855-434-9245. Our corporate-based representatives can send a packet or arrange for your local Envolve Dental network representative to deliver one personally.

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

If you have any questions about the contents of the Provider Agreement or how to apply, please call Provider Services at 855-434-9245.
Credentialing

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

Envolve Dental will honor claims from newly contracted providers for the first 90 days after plan commencement—as a grace period—to allow for document submission and review.

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

Step 2: Return to Envolve Dental:
- Completed Kansas credentialing data gathering form
- Copy of Drug Enforcement Agency (DEA) license
- Copy of malpractice insurance
- Completed Disclosure of Ownership (DOO) form

You can return documents by:
   Email: dentalcredentialing@envolvehealth.com
   Fax: 844-847-9807

Step 3: The Credentialing Committee reviews your application only when all documents have been received. Expect to receive a letter from Envolve Dental Credentialing if you need to submit missing documentation.

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

Databases Reviewed for Credentialing
- Office of Inspector General’s List of Excluded Individuals and Entities
- General Services Administration System for Award Management
- CMS/Medicare Exclusion Database
- State Board of Examiners
- National Practitioner Data Bank
- Health Integrity and Protection Databank
- State listings of excluded providers
<table>
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<th>Committee decision</th>
<th>What this means</th>
<th>What you can do</th>
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| 1. Accept application without restrictions | You are accepted to the Envolve Dental provider network when the Provider Agreement is signed and participating providers are fully credentialed. | Sign and return the Provider Agreement (if not done so previously).  
Register on the Envolve Dental Provider Web Portal.  
Start seeing members on the effective date. |
| 2. Accept application with restrictions | The Credentialing Committee will recommend to the Executive Subcommittee a specific action, which can be approved or denied.  
Examples: (1) A provider with sanctions may be accepted, but Cost Containment division will closely monitor claims for six months;  
(2) If a provider incurs additional sanctions after approval, Envolve Dental has the right to withdrawal credentialing acceptance and network participation. | Sign and return the Provider Agreement (if not done so previously).  
Register on the Envolve Dental Provider Web Portal.  
Start seeing members on the effective date.  
Cooperate with Cost Containment and Credentialing requests for new information.  
Advise Credentialing when external sanctions lifted. |
| 3. Table application               | The Credentialing Committee wants additional information about a questionable matter before making determination.  
OR  
The Credentialing Committee is waiting for a known external investigation to be concluded before making a final decision. | Provide as soon as possible any requested information to our Credentialing Specialists.  
Envolve Dental will reach out to request information.  
Provide up-to-date information to Envolve Dental Credentialing when the investigation concludes. |
| 4. Decline application             | The Credentialing Committee recommends denial to the Executive Subcommittee and it concurs.         | Providers can request a reconsideration of the initial denial by submitting new information. A second reconsideration is possible if denied twice. |
Envolve Dental and Sunflower Health have the exclusive right to decide which dentists it accepts as participating providers in the network. Envolve Dental does not discriminate based on age, race, ethnicity, gender, national origin, or religion in making credentialing determinations.

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

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

Reconsiderations for Adverse Credentialing Determinations

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

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

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

Contact Envolve Dental Credentialing at dentalcredentialing@envolvehealth.com if you have any questions or need further assistance with any credentialing details.
Electronic Funds Transfer (EFT)

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

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

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

- Mail: Envolve Dental
  P.O. Box 20808
  Tampa, FL 33622-0808
  Email: Envolve.DentalPDM@envolvehealth.com

**I – CHECK APPLICABLE REASON FOR SUBMISSION**

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

**II – PROVIDER/PAYEE INFORMATION**

Payee name: ________________________________

Tax Identification Number (TIN): (Designate SSN □ or EIN □) ________________________________

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

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

Your bank/depository name: ________________________________

Account type (check one):

☐ Checking  ☐ Savings

Depository routing transit number (Nine digits, include any leading zeroes):

Depository account number (Include any leading zeroes):

**IV – CONTACT INFORMATION**

Name of billing contact person: ________________________________

Phone number of billing contact: ________________________________

Email address of billing contact: ________________________________

**V – AUTHORIZATION**

I hereby authorize Envolve Dental to initiate credit entries and in accordance with 31 CFR part 210.4(g) initiate adjustments for any credit entries made in error to the account indicated above. I hereby authorize the financial institution/bank named above, hereafter called the DEPOSITORY, to credit the same to such account. This authorization agreement is effective as of the signature date below and is to remain in full force and effect until the CONTRACTOR has exercised written notification of its termination in such form as the CONTRACTOR and the DEPOSITORY may agree to. The CONTRACTOR may terminate this authorization agreement at any time and without notice if I fail to make payments to the CONTRACTOR within 10 days after the due date of such payments. Should I desire to change the DEPOSITORY for effecting the direct deposit, I agree to submit to the CONTRACTOR an authorization agreement to effect such change.

Signature of authorized billing contact: ________________________________ Date: ________________________________

© 2019 Envolve Dental, Inc. All rights reserved.
The following terms and conditions, as amended from time to time (“Agreement”) apply to all use of the Envolve Dental’s Electronic Funds Transfer Solutions (“EFT Services”). In this Agreement, the words “you,” “your,” “yours” means the individual(s) entity or entities identified on the attached Electronic Funds Transfer (EFT) Authorization Agreement, and the words “we,” “our,” “us,” “us” refers to Envolve Dental affiliates and designees. Your enrollment or use of the EFT Services signifies your agreement to be legally bound by the terms and conditions set forth herein. ACH and Wire Transfers. This Agreement is subject to Article 4A of the Uniform Commercial Code – Funds Transfers. By signing this Agreement, you authorize Envolve Dental, acting on your behalf or as the result of your breach of this Agreement, to create, issue, maintain and transfer electronic data, accounts, records, balance adjustments to your Accounts whenever a change is required. For example, if we make an error with respect to your Account, you agree that we may correct such error immediately and without notice to you. Such errors may include, but are not limited to, reversing an improper credit to your Account, making adjustments for returned items, and correcting calculation and input errors. Our right to make adjustments shall not be subject to any limitations or time constraints, except as required by law. Accounts. You represent and warrant that (a) you are the owner of each of the Accounts and (b) none of the Accounts is used primarily for personal, family or household purposes. Confidentiality. During the term of this Agreement, from time to time, we may disclose or make available to you, whether orally, electronically or in physical form, confidential or proprietary information concerning you and/or our business, products or services in connection with this Agreement (together, “Confidential Information”). Confidential Information includes, without limitation, business plans, health plan relationships, acquisition plans, systems architecture, information systems, technology, data, computer programs and codes, processes, methods, operational procedures, finances, budgets, policies and procedures, customer, employee, provider, member, patient and beneficiary information, claims information, vendor information (including agreements, software and products), product plans, projections, analyses, plans, results, and any other information which is normally and reasonably considered confidential. You agree that during the term of this Agreement and thereafter: (i) you will use Confidential Information solely for the purposes of this Agreement; (ii) you will take all reasonable precautions to ensure that you do not disclose Confidential Information belonging to us to any third party (other than to your employees, contractors and/or professional advisors on a need-to-know basis who are bound by obligations of nondisclosure and limited use precautions at least as stringent as those contained herein) without first obtaining our written consent. Confidentiality Exclusions. For purposes hereof, “Confidential Information” will not include any information that you can establish by convincing written evidence: (i) was independently developed by you Without use of or reference to any Confidential Information belonging to us; (ii) was acquired by you from a third party having the legal right to furnish same to the you without disclosure restrictions; or (iii) was at the time in question (whether at disclosure or thereafter) generally known by or available to the public (through no fault of you). Amendments and Termination. Envolve Dental may add, remove, change or otherwise modify any term of this Agreement at any time. We may also terminate or discontinue some or all of the EFT Services at any time without notice to you. Governing Law and Venue. The laws of the State of WI shall govern this Agreement and all disputes arising hereunder. You hereby consent that jurisdiction and venue are proper in the State of WI for the resolution of any dispute arising under this Agreement. Severability. If any provision of this document is found to be unenforceable according to its terms, all remaining provisions will continue in full force and effect. Headings in this document are for convenience or reference only and shall not govern the interpretation of the provisions. Construction. Except where it would be unreasonable or illogical to do so, words and phrases used in this document shall be construed so the singular includes the plural and the plural includes the singular. Cooperation. You agree to cooperate fully with us in furnishing any information, documentation or performing any action requested by us. You shall furnish us, upon forty-eight (48) hours notice, with true, accurate and complete copies of such records, documentation or any other information we or our authorized employees, representatives and any regulatory agencies may request; provided, however, that you shall not be required to divulge any records to the extent prohibited by applicable law. Ownership. Except as provided in this Agreement, Envolve Dental shall have and own all rights, title and interests in the EFT Services and any information arising from or in connection therewith. You hereby acknowledge the specific ownership interests of Envolve Dental as set forth herein and you shall not acquire any ownership rights by virtue of this Agreement. Assignment. You agree not to assign this Agreement, directly or indirectly, by operation of law or subcontracting, delegate or appoint any third-party agent to perform any or all of its duties obligations hereunder without our written consent, and any such attempted assignment, subcontracting, delegating or appointment without such consent shall be void. All written notices shall be delivered by registered or certified mail, return receipt requested, and shall be deemed effective seventy-two (72) hours after the same is mailed via certified mail as described above with postage prepaid. Notice sent by any other method shall be effective only upon actual receipt. As to whom notices shall be given pursuant to this Agreement: (a) to which party hereto or which party hereto or which party hereto or which party hereto to which notices may be sent or which party hereto to which notices may be sent or which party hereto to which notices may be sent or which party hereto to which notices may be sent or which party hereto. Force Majeure. Envolve Dental shall not be liable for a delay in performance or failure to perform any obligation under this Agreement to the extent such delay is due to causes beyond our control, including, but not limited to, governmental requests, regulations or orders, utility or communication failures, delays in transportation, national emergency, war, civil commotion or disturbance, war conditions, fires, floods, storms, earthquakes, tidal waves, failure or delay in receiving electronic data, equipment or systems failure or communication failures. WARRANTIES. Envolve Dental hereby disclaims all warranties with respect to the services and products provided herewith, whether express, implied, statutory or otherwise, including without limitation any warranty of merchantability or fitness for use for a particular purpose. Under no circumstances shall the financial responsibility of Envolve Dental for any failure of performance by us under this Agreement exceed the fees or charges paid by you to Envolve Dental for the transaction, or activity that is or was the subject of the alleged failure of performance. IN NO EVENT SHALL Envolve Dental, its parent, affiliates, subsidiaries, directors, officers, employees, agents or representatives be liable for special, incidental or consequential damages or claims by you or any third party relative to the transactions hereunder. Indemnification. You shall be liable to and shall indemnify, defend and hold Envolve Dental its directors, officers, employees, representatives, successors and permitted assigns harmless from and against any and all claims, demands by third parties, losses, liability, cost, damage and expense, including litigation expenses and reasonable attorneys’ fees and allocated costs for in-house legal services, to which Envolve Dental, its directors, officers, employees, representatives, successors and permitted assigns may be subjected or which it may incur in connection with any claims which arise out of or as a result of your breach of this Agreement; (b) your performance, duties and obligations under this Agreement; or (c) the negligence or willful misconduct of you, your directors, officers, employees, agents and affiliates in the performance of their duties and obligations under this Agreement. You shall bear all risk of loss of items, records, data and materials during transit from you to Envolve Dental’s location or that of Envolve Dental’s agents or sub-contractors. Waiver. No waiver or failure to exercise any option, right, or privilege under the terms of this Agreement on any occasion or occasions shall be construed to be a waiver of the same or any other right, privilege or any occasion on another occasion.
Provider Rights and Responsibilities

Consistent with Sunflower’s policies, Envolve Dental applies the following rights and responsibilities to all network providers.  

Provider Rights

Providers have the right to

- be treated with respect and dignity by members, other healthcare workers and Envolve Dental staff;
- expect that members will keep appointments and follow agreed-upon treatment plans;
- complete and accurate medical histories from members;
- expect that other network providers will work as partners in member treatment plans;
- receive accurate and timely authorization determinations and claims payments;
- access Envolve Dental quality improvement program information;
- make a grievance against a member, Sunflower Health Plan, or Envolve Dental; and
- file an appeal with Envolve Dental.

Provider Responsibilities

Providers are responsible for

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


2 Sunflower Health Plan Member Handbook and Sunflower Provider Office Manual
Member Rights and Responsibilities

Consistent with Sunflower Health Plan’s policies, Envolve Dental applies the following rights and responsibilities to all members.³

Member Rights

Members have the right to receive:

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

Members also have the right to:

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

Member Responsibilities

Members are responsible for

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

³ Sunflower Health Plan Member Handbook and Sunflower Provider Office Manual
Member Identification Card

Sunflower issues identification cards to members on a regular basis and members are responsible for presenting the card on the date of service.

Envolve Dental recommends each dental office make a photocopy of the member’s identification card and ensure it is current in the office’s records at each visit.

If a member reports a lost or missing card, please direct the member to call Sunflower Member Services at 877-644-4623 for a replacement. Note that possession of an identification card does not guarantee eligibility.

Eligibility Verification

The Kansas Department of Health and Environment, Division of Health Care Finance determines member eligibility and communicates data to Sunflower Health Plan and Envolve Dental. On each date of service, providers are responsible for verifying member eligibility on the Envolve Dental Provider Web Portal or by phone on our Interactive Voice Response (IVR) system.

You will need the following information to verify eligibility:

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

**Provider Details**
- Provider NPI number

When you have this information ready, choose to verify eligibility on the internet or via telephone, as follows.
## Member Eligibility, Services and Standards

<table>
<thead>
<tr>
<th>Provider Web Portal via Internet</th>
<th>IVR via Telephone</th>
</tr>
</thead>
<tbody>
<tr>
<td>Go to <a href="https://pwp.envolvedental.com">https://pwp.envolvedental.com</a>. Log in with your username and password.</td>
<td>Call 855-434-9245 for the Envolve Dental IVR system.</td>
</tr>
</tbody>
</table>

Go to the “Eligibility” tab. Enter the member’s information and date of service.

<table>
<thead>
<tr>
<th>• Provider ID number</th>
<th>• Provider ID number</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Enter Member ID</td>
<td>• Enter Member ID</td>
</tr>
<tr>
<td>• Press 1 to hear the information again</td>
<td>• Press 1 to hear the information again</td>
</tr>
<tr>
<td>• Press 2 to check the service history for the member</td>
<td>• Press 2 to check the service history for the member</td>
</tr>
<tr>
<td>• Press 3 to check eligibility and history for another member</td>
<td>• Press 3 to check eligibility and history for another member</td>
</tr>
<tr>
<td>• Press 9 to return to main menu</td>
<td>• Press 9 to return to main menu</td>
</tr>
<tr>
<td>• Press 0 to speak to a Provider Relations Representative</td>
<td>• Press 0 to speak to a Provider Relations Representative</td>
</tr>
</tbody>
</table>

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

### Member Transportation Services

Non-emergency transportation is covered by Sunflower Health Plan for medically necessary services. Members who need transportation assistance should contact Sunflower member services at 877-644-4623 at least three days in advance to schedule a ride. Sunflower will approve transportation for eligible members and will work directly with the transportation company on behalf of the member. If a member cancels an appointment, s/he must also cancel the pre-arranged transportation services.

### Member Translation and Hearing Impaired Services

Members requiring language assistance should contact Sunflower Health Plan member services at 877-644-4623 at least seven days prior to an appointment to schedule an interpreter to be present for services.

Hearing impaired members can call the Kansas Relay Service at 7-1-1 or 877-455-3323 and ask the operator to connect to 877-644-4623. Sunflower’s TTY is available by calling 711. Providers may also request translation services on behalf of our members.
Appointment Availability Standards

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

<table>
<thead>
<tr>
<th>Member calls for . . .</th>
<th>Appointment must be scheduled and services provided within . . .</th>
</tr>
</thead>
<tbody>
<tr>
<td>urgent care</td>
<td>forty-eight (48) hours</td>
</tr>
<tr>
<td>emergency care</td>
<td>immediately</td>
</tr>
</tbody>
</table>

On the appointment date, waiting time in the office must not exceed forty-five (45) minutes from the scheduled appointment time.

Envolve Dental will keep providers informed about appointment standards, monitor office adequacy, and take corrective action if warranted.

Referrals to Specialists

Envolve Dental does not require general or pediatric dentists to obtain an authorization or referral to dental specialists. If a specialist is needed, providers should recommend to members a specialist in the Envolve Dental network. Participating network specialists can be found on the Sunflower “Find a Provider” page at https://www.sunflowerhealthplan.com/find-a-doctor.html.

If the specialist requires a referral before he/she will schedule an appointment for the member, please consult directly with the specialist for that office’s referral requirements.
Missed Appointments

The Sunflower member manual includes instructions for members to cancel an appointment no less than 24 hours in advance if unable to keep it. Envolve Dental recommends that providers contact members by phone at least 24 hours prior to scheduled appointments to confirm the commitment and your office location. Please note:

- Providers can discontinue providing services to a member if he/she repeatedly misses appointments. Be sure to keep a record of occurrences in the member’s record, and refer the member to Sunflower at 877-644-4623 to identify a new dental provider.
- Your office’s missed appointment and dismissal policies for Sunflower members cannot be stricter than your private or commercial patient policies.
- Providers are not allowed to charge Sunflower members for missed appointments.

Balance Billing and Payment for Non-Covered Services

Envolve Dental network providers are contractually obligated to abide by billing requirements, which are established by Envolve Dental, Sunflower Health Plan, the Kansas Department of Health and Environment (KDHE), and the Centers for Medicare and Medicaid Services. These conditions include the following:

- Providers cannot bill members for any type of cost-sharing for covered dental services, including a co-payment, coinsurance, deductible, or deposit.
- Providers must accept the Envolve Dental payment as “payment in full,” and cannot balance bill members—that is, for the difference between the provider-billed amount and the Envolve Dental payment amount.

Providers may bill a member only for non-covered dental services, with the condition that the provider must inform the member in detail and obtain a signed, detailed agreement from the member (or his/her guardian) prior to services being rendered. Providers also agree to hold harmless Envolve Dental and Sunflower Health Plan for payment of non-covered services. The form with specific required wording for Sunflower follows.

Non-covered services vary by payor; refer to the Benefit Grids for details. For children receiving EPSDT services, any limits on services may be exceeded when medically necessary.
NON-COVERED SERVICES LIABILITY ACKNOWLEDGEMENT

Provider Name: __________________________
Provider NPI: __________________________
Member Name: __________________________
Member ID: __________________________
Health Plan: __________________________
Date of Service: ____________

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

<table>
<thead>
<tr>
<th>Description</th>
<th>Cost</th>
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<tbody>
<tr>
<td></td>
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</tr>
</tbody>
</table>

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

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

Date Signed ________________
Print Member Name __________________________
Member Signature __________________________
Name of Parent or Legal Guardian (if applicable) __________________________
Signature of Parent or Legal Guardian (if applicable) __________________________

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

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Member Information and HIPAA

The Health Insurance Portability and Accountability Act

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

Envolve Dental complies with HIPAA rules and expects network providers to adhere to HIPAA rules as well. Examples of important definitions and practical applications are listed in Table 2.

<table>
<thead>
<tr>
<th>Security Rule Requirement</th>
<th>Definition</th>
<th>Application Example</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Confidentiality</strong></td>
<td>Protected Health Information (PHI) and electronic PHI (e-PHI) is not disclosed or available to unauthorized persons.</td>
<td>Envolve Dental will ask callers for their name, Tax ID number, and/or NPI number to verify identity. Callers requesting patient information must also provide member name, date of birth, and member ID or social security number before Envolve Dental will share member-related information.</td>
</tr>
<tr>
<td><strong>Integrity</strong></td>
<td>E-PHI is not altered or destroyed in an unauthorized manner.</td>
<td>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.</td>
</tr>
<tr>
<td><strong>Availability</strong></td>
<td>The property that data or information is accessible and usable upon demand by an authorized person.</td>
<td>Envolve Dental enables only authorized, registered users to access the Provider Web Portal containing patient information. The portal is available 24 hours a day and seven days a week.</td>
</tr>
</tbody>
</table>
### Table 2. HIPAA Definitions and Applications

<table>
<thead>
<tr>
<th>Security Rule Requirement</th>
<th>Definition</th>
<th>Application Example</th>
</tr>
</thead>
<tbody>
<tr>
<td>Protect against threats or disclosures</td>
<td>Potential threats or disclosures to e-PHI that are reasonably anticipated must be identified and protected.</td>
<td>All email correspondence that includes patient name and personal health details must be sent via a secure email service. <em>Providers should never initiate to Envolve Dental an email that is not encrypted and contains patient details.</em> Envolve Dental can initiate a secure, encrypted email to providers who can then reply while maintaining the security of the email. Call Provider Services for details.</td>
</tr>
<tr>
<td>Staff compliance</td>
<td>People employed by provider offices and health plans (covered entities under HIPAA) adhere to rules.</td>
<td>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.</td>
</tr>
</tbody>
</table>

Source: Department of Health & Human Services @ [www.hhs.gov/ocr/privacy/index.html](http://www.hhs.gov/ocr/privacy/index.html)

For additional details about HIPAA, visit the U.S. Department of Health and Human Services’ website at [HHS.gov](https://www.hhs.gov).
Cultural Competency

Cultural competency is defined as the willingness and ability of a system to value the importance of culture in the delivery of services to all segments of the population. It is the use of a systems perspective which values differences and is responsive to diversity at all levels in an organization. Cultural Competency is developmental, community focused, and family oriented.

In particular, it is the promotion of quality services to understand racial/ethnic groups through the valuing of differences and integration of cultural attitudes, beliefs and practices into diagnostic and treatment methods and throughout the system to support the delivery of culturally relevant and competent care. 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. All services will be provided in a culturally competent manner, including services provided to members with limited English proficiency and diverse cultural and ethnic backgrounds.

Members are entitled to dignified, appropriate, and quality care. When healthcare services are delivered without regard for cultural differences, members are at risk for sub-optimal care. Members may be unable or unwilling to communicate their healthcare needs in an insensitive environment, reducing effectiveness of the entire healthcare process. Providers should note that the experience of a member begins at the front door. Failure to use culturally competent and linguistically competent practices could result in the following:

- Feelings of being insulted or treated rudely
- Reluctance and fear of making future contact with the office
- Confusion and misunderstanding
- Treatment non-compliance
- Feelings of being uncared for, looked down on, and devalued
- Parents resisting to seek help for their children
- Unfilled prescriptions
- Missed appointments
- Misdiagnosis due to lack of information sharing
- Wasted time
- Increased grievances or complaints

Envolve Dental will evaluate the cultural competency level of its network providers and provide access to training and tool kits to assist providers in developing culturally competent and culturally proficient practices. Network providers must ensure:
• Members understand that they have access to medical interpreters, signers, and TDD/TTY services to facilitate communication without cost to them

• Dental care is provided with consideration of the member’s race/ethnicity and language and its impact/influence on the member’s health or illness

• Office staff that routinely interact with members have access to and participate in cultural competency training and development

• Office staff responsible for data collection make reasonable attempts to collect race- and language-specific member information. Staff will also explain race/ethnicity categories to a member so that the member is able to identify the race/ethnicity of themselves and their children

• Treatment plans are developed 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, and other prevalent non-English languages required by the Kansas Medical Assistance Program.

The road to developing a culturally competent practice begins with the recognition and acceptance of the value of meeting the needs of your patients. Envolve Dental is committed to helping you reach this goal. Take into consideration the following as you provide care to Sunflower Health Plan members:

• What are your own cultural values and identity?

• How do or can cultural differences impact your relationship with your patients?

• How much do you know about your patient’s culture and language?

• Does your understanding of culture take into consideration values, communication styles, spirituality, language ability, literacy, and family definitions?

• Do you embrace differences as allies in your patients’ healing process?

The U.S Department of Health and Human Services' Office of Minority Health has published a suite of online educational programs to Advance Health Equity at Every Point of Contact through development and promotion of culturally and linguistically appropriate services. Visit Think Cultural Health at www.thinkculturalhealth.hhs.gov to access these free online resources.
Utilization Management & Review

Utilization Management

Utilization management aims to manage health care costs before services are rendered by specifically defining clinical criteria that are based on accepted dental practices. Envolve Dental considers all state-required benefits and applies clinical standards to them, explicitly outlining for providers what conditions must be present in order for the covered benefits to apply. Clinical criteria for Sunflower members should be used in conjunction with the benefit grids that include required documentation that substantiates the criteria.

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

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

Utilization Review

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

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

Practical Applications

Providers can facilitate good utilization management by

- Reviewing clinical criteria and comprehensively documenting member’s condition based on them;
- Maintaining accurate, up-to-date dental records and medical histories for each member, including perio-charting and treatment plans, even for routine cases;
- Ensuring x-rays are high quality for accurate diagnoses;
- Submitting all required documentation for authorizations and claims accurately and completely;
- Maintaining good communications with Envolve Dental by calling Provider Services with questions and concerns: 855-434-9245.
Patient Dental Records

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

Fraud, Abuse, and Waste

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

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

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

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

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

The primary difference between fraud and abuse is intention.

Waste: Providing medically unnecessary services.4,5

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

5 Medicare Fraud & Abuse: Prevention, Detection, and Reporting, Centers for Medicare & Medicaid Services, August 2014
Envolve Dental is obligated to report suspected fraud or abuse by members and health care providers. Members and providers also are expected to report possible incidents, which can be done so anonymously by calling a fraud and abuse hotline.

**Fraud and Abuse Hotlines**

Envolve Dental Hotline: 800-345-1642

Sunflower Fraud and Abuse Hotline: 866-685-8664

Federal Medicaid Office of Inspector General: 800-447-8477

Table 3 summarizes applicable federal laws pertaining to fraud and abuse. Additional details are available on the Centers for Medicare and Medicaid Services website: [www.cms.gov](http://www.cms.gov).

<table>
<thead>
<tr>
<th>Law or Regulation</th>
<th>Premise</th>
<th>Example and Penalty/Award</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>False Claim Act (FCA)</strong></td>
<td>Knowingly submitting a false or fraudulent claim to a federally funded government program.</td>
<td>A provider submits claims for a higher level of services than provided. Fines of $5,500 to $11,000 per false claim and up to three times the amount of damages sustained by the government.</td>
</tr>
<tr>
<td><strong>Qui Tam Provision (Whistleblower protection)</strong></td>
<td>Under the FCA, allows citizens with evidence of fraud to sue, on behalf of the government, to recover stolen funds.</td>
<td>Awards 15 to 25 percent of recovered funds to the informant and provides protection for those who may be discharged for taking reasonable action under the FCA.</td>
</tr>
<tr>
<td><strong>Physician Self-Referral Law (Stark Law)</strong></td>
<td>Prohibits health care providers from making a referral for certain health services when the provider (or a family member) has an ownership interest in the referral designation.</td>
<td>A provider refers a patient to another office or business where the provider has a financial interest. Penalties include fines, claim repayment, and potential exclusion from federal health care programs.</td>
</tr>
<tr>
<td><strong>Anti-Kickback Statute (AKS)</strong></td>
<td>Knowingly and willfully offering, paying, soliciting, or receiving remuneration to induce or reward referrals reimbursable by a federal health care program.</td>
<td>A provider receives cash or other benefits for referrals. Civil penalties can be up to three times the kickback amount.</td>
</tr>
</tbody>
</table>
## Table 3. Federal Laws for Medicaid Fraud and Abuse

<table>
<thead>
<tr>
<th>Law or Regulation</th>
<th>Premise</th>
<th>Example and Penalty/Award</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Criminal Health Care Fraud Statute</strong></td>
<td>Knowingly and willfully executing a scheme in connection with the delivery of or payment for health benefits or services to defraud the program or obtain under fraudulent pretenses any money from the program.</td>
<td>Several providers conspire to defraud the Medicaid program by coordinating a scheme for services that are not medically necessary. Penalties can include fines, imprisonment, or both.</td>
</tr>
</tbody>
</table>

Source: Centers for Medicare and Medicaid Services @ Medicare Fraud & Abuse
## Prior Authorization & Retrospective Review

Envolve Dental has specific clinical criteria and authorization processes to manage service utilization according to medical necessity and appropriateness of care. Please review the benefit descriptions and clinical criteria requirements for services listed in the Clinical Criteria section of this manual. Required documentation to support authorization requests are listed per code in the benefit grids in Appendix A. Providers should measure intended services to the clinical criteria before treatment begins to assure appropriateness of care. Authorization requests are considered according to the following:

<table>
<thead>
<tr>
<th>Authorization Type</th>
<th>Conditions</th>
<th>What to do</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prior Authorizations</td>
<td>Required prior to treatment for certain codes identified in the benefit grids.</td>
<td>Check the appropriate benefit grid for requirements for each code and submit at least 14 business days prior to scheduled service.</td>
</tr>
<tr>
<td>Urgent/Emergent Authorizations</td>
<td>Defined as situations involving severe pain, swelling, infection, uncontrolled hemorrhage, or traumatic injury.</td>
<td>Treat the member. Submit the completed claim and all required documentation as a Retrospective Review no later than 180 calendar days from service date. If you choose to receive prior authorization for urgent cases, call Provider Services at 855-434-9245 for options and directions about submission via a HIPAA-compliant secure e-mail. If you choose to receive prior authorization for urgent cases, call Provider Services at 855-434-9245 for options and directions about submission via a HIPAA-compliant secure e-mail.</td>
</tr>
<tr>
<td>Retrospective Reviews</td>
<td>Provider is confident that the member’s condition and the clinical criteria in this manual are equivalent, and codes are (1) consistent for appropriate treatment and (2) are covered benefits.</td>
<td>Submit claim with all required authorization documentation within 180 calendar days from the date of service. Note: Providers starting treatment before authorization approval are at financial risk and may not balance bill the member if the utilization management reviewer determines conditions were not met.</td>
</tr>
</tbody>
</table>

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

Submit prior authorization requests with complete documentation requirements to Envolve Dental at least 14 business days before a scheduled procedure that requires prior authorization.

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

Envolve Dental will make an authorization determination within 14 calendar days from the date the request is received, provided all information is complete. For urgent/expedited requests, where you indicate that the member’s ability to attain, maintain or regain maximum function would be compromised by waiting 14 days, contact Provider Services at 855-434-9245 to request an urgent review. Envolve Dental will make urgent determinations within 72 hours after receipt of request.

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

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

Peer-to-Peer Review

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

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

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

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

Envolve Dental
Kansas Authorizations
PO Box 25857
Tampa, FL 33622-5857

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or call Envolve Dental Provider Services at 855-434-9245. The request will be processed by Envolve Dental utilization management staff who will call the office within one business day to schedule a phone appointment between the requesting dentist and the Envolve dental consultant at a mutually agreed date and time.

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

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

Retrospective Review Authorizations

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

Providers starting treatment before authorization approval are at financial risk and may not balance bill the member if the utilization management reviewer determines conditions were not met.

Providers who choose to pursue prior authorization for urgent cases before treatment should call Provider Services at 855-434-9245 for directions about submission via a HIPAA-compliant secure e-mail initiated by an Envolve Dental representative.

Codes Requiring Authorization

Prior authorization is required for orthodontic services and non-emergent services provided out-of-state (which also requires a single case agreement for out-of-network). To facilitate proper processing and billing, Envolve Dental requires prior authorization for dental services that will be provided in a hospital or ambulatory surgical facility.

Other dental procedures require a medical review when claims are submitted. These are considered “retrospective” or “pre-payment” reviews. Codes requiring retrospective reviews are listed in the clinical criteria section and in the benefit grids in Appendix A.
Authorization Submission Procedures

Authorization requests must be received 14 calendar days in advance in one of the following formats:

1. Envolve Dental Provider Web Portal at https://pwp.envolvedental.com
2. Electronic clearinghouses, using Envolve Dental payer identification number 46278
3. Alternate HIPAA-compliant electronic files
4. Paper request on a completed ADA 2012 claim form by mail

Provider Web Portal Authorization Submissions

Providers can submit authorization requests directly to Envolve Dental on our Provider Web Portal, including attachment uploads. Submissions on the portal are quick and easy and facilitate faster processing and determinations. To submit, log on to https://pwp.envolvedental.com

A user guide is included in Appendix B in this manual. If you have questions about submitting authorization requests or accessing the Envolve Dental Provider Web Portal, call Provider Services at 855-434-9245 or email providerrelations@envolvehealth.com.

Clearinghouse Authorization Submissions

Providers can use their preferred clearinghouse for authorization requests.

Use Envolve Dental payer identification 46278 for all clearinghouses. As of this manual publication date, we currently work with the following:

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

Please use the Master ID number 463005 for ENVD KS Sunflower. Envolve Dental will receive the requests electronically and process them with our state-of-the-art authorization administration modules. Be sure to include all required documentation listed in the benefit grids when submitting on their portals, using a NEA FastAttach® tracking number in the remarks section. A Dental Review Specialist assigned to Sunflower Health will make the determination.

Electronic Attachments for Clearinghouse Submissions

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

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

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 FastAttach®, call NEA at 800-782-5150.

Alternate HIPAA-Compliant 837D File

Electronic authorization submissions must be HIPAA-compliant. Envolve Dental strongly recommends using our custom Provider Web Portal because we stay current with HIPAA regulations. If your office uses an alternative electronic system that requires direct integration using an 837D file, Envolve Dental will consider options to assist. To schedule an appointment with our technical specialist to discuss alternatives, please email us at providerrelations@envolvehealth.com or call 855-434-9245.

Paper Authorization Submission

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

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

For services requested, include:

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

Missing or incorrect information could result in an authorization denial or determination delay.

Mail paper authorization requests and all required documents with correct postage to:

Envolve Dental
Authorizations
PO Box 25857
Tampa, FL 33622-5857

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

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

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

GENERAL INSTRUCTIONS
A. The form is designed so that the name and address (item 3) of the third-party payer receiving the claim (insurer, company, dental benefit plan) is visible in a standard 10B window envelope (window to the left). Please fold the form using the guidelines printed in the margin.
B. Complete all items unless noted otherwise on the form or in the CDT manual's instructions.
C. Enter the full name of an individual or a full business name, address and zip code when a name and address field is required.
D. All dates must include the four-digit year.
E. If the number of procedures reported exceeds the number of lines available on one claim form, list the remaining procedures on a separate, fully completed claim form.

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

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

Item 29a – Diagnosis Code Pointer ("A" through "D" as applicable from item 34a)
Item 34 – Diagnosis Code List Qualifier (B for ICD-9-CM; AB for ICD-10-CM)
Item 34a – Diagnosis Code(s) / A, B, C, D (up to four with the primary adjacent to the letter "A")

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

11 = Office; 12 = Home; 21 = Inpatient Hospital; 22 = Outpatient Hospital; S1 = Skilled Nursing Facility; S2 = Nursing Facility

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

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

<table>
<thead>
<tr>
<th>Category / Description Code</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dentist</td>
<td>122300000X</td>
</tr>
<tr>
<td>A dentist is a person qualified by a doctorate in dental surgery (D.D.S.) or dental medicine (D.M.D.) licensed by the state to practice dentistry, and practicing within the scope of that license.</td>
<td></td>
</tr>
<tr>
<td>General Practice</td>
<td>122300001X</td>
</tr>
<tr>
<td>Dental Specialty (see following list)</td>
<td>Various</td>
</tr>
<tr>
<td>Dental Public Health</td>
<td>122300002X</td>
</tr>
<tr>
<td>Endodontics</td>
<td>122300003X</td>
</tr>
<tr>
<td>Orthodontics</td>
<td>122300004X</td>
</tr>
<tr>
<td>Pediatric Dentistry</td>
<td>122300005X</td>
</tr>
<tr>
<td>Periodontics</td>
<td>122300006X</td>
</tr>
<tr>
<td>Prosthodontics</td>
<td>122300007X</td>
</tr>
<tr>
<td>Oral &amp; Maxillofacial Pathology</td>
<td>122301006X</td>
</tr>
<tr>
<td>Oral &amp; Maxillofacial Radiology</td>
<td>122300008X</td>
</tr>
<tr>
<td>Oral &amp; Maxillofacial Surgery</td>
<td>122300112X</td>
</tr>
</tbody>
</table>

Provider taxonomy codes listed above are a subset of the full code set that is posted at "www.wpc-edl.com/codes/taxonomy"
Prior Authorization for Facility and Hospital Services

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

When submitting the authorization request to Envolve Dental, include the following:

1. Proposed Treatment Plan
2. X-rays (if available)
3. Provider Narrative that includes:
   a. Description of Medical Necessity (reason for request)
   b. Proposed Date of Service*
   c. Place of Service (i.e., facility name)*
4. All procedure codes, including D9420 for the facility
5. All required documentation per code, as listed in Appendix A

*In lieu of 3b and 3c, the provider may submit a completed Sunflower Outpatient Medicaid Prior Authorization Fax Form.

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

<table>
<thead>
<tr>
<th>Responses to Facility Authorization Requests</th>
</tr>
</thead>
<tbody>
<tr>
<td>Approved</td>
</tr>
<tr>
<td>• Envolve Dental will send an automated</td>
</tr>
<tr>
<td>fax approval letter to the requesting</td>
</tr>
<tr>
<td>dentist.</td>
</tr>
<tr>
<td>• The requesting provider calls the facility</td>
</tr>
<tr>
<td>to schedule the services.</td>
</tr>
<tr>
<td></td>
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<td></td>
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</tr>
</tbody>
</table>

A copy of the Facility Medical Necessity form and the Sunflower Outpatient Medicaid form follows.
Hospital / Outpatient Facility Medical Necessity Form
(Revised 2014)

Member name: 

Member DOB: 

Member ID number: 

Requesting Provider name and NPI: 

Contact person name: 

Contact person phone number: 

**Medically necessary:**
The use of Hospital / Outpatient facilities services during the delivery of dental services is considered **medically necessary** when submitted documentation (including narrative, radiographs, etc.) demonstrates the presence of any of the following circumstances:

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Young children requiring extensive operative procedures (such as multiple restorations, treatment of abscesses or oral surgical procedures), when in-office treatment (nitrous oxide, GA / IV sedation or oral sedation) is not appropriate or available and hospitalization is not solely based upon reducing, avoiding or controlling apprehension; or</td>
</tr>
<tr>
<td>2.</td>
<td>Individuals requiring extensive dental procedures and classified by the American Society of Anesthesiologists (ASA) as Class 3 or class 4; or</td>
</tr>
<tr>
<td>3.</td>
<td>Medically compromised patients whose medical history indicates that the monitoring of vital signs or the availability of resuscitative equipment is necessary during dental procedures; or</td>
</tr>
<tr>
<td>4.</td>
<td>Individuals requiring extensive dental procedures with a medical history of uncontrolled bleeding, severe cerebral palsy or other medical condition that renders in-office treatment not medically appropriate; or</td>
</tr>
<tr>
<td>5.</td>
<td>Individuals requiring extensive dental procedures who have documentation of significant behavioral health conditions or psychiatric disorders that require special treatment (e.g., severe panic disorder); or</td>
</tr>
<tr>
<td>6.</td>
<td>Cognitively disabled individuals requiring extensive procedures whose prior history indicates hospitalization is appropriate; or</td>
</tr>
<tr>
<td>7.</td>
<td>Hospitalized individuals who need extensive restorative or surgical procedures</td>
</tr>
</tbody>
</table>

* Diagnostic quality pre-operative radiographs / photos taken prior to admission into the OR (or in the OR before treatment begins) should be present in the patient’s chart. If documentation cannot validate retrospective review of treatment submitted recoupment of paid claims may occur.
Authorization Submission Procedures
Prior Authorization for Orthodontia

All Orthodontic services are covered benefits only when medically necessary. See Clinical Criteria requirements for complete coverage details.

Envolve Dental does not currently accept orthodontic models as documentation for authorization or claim submissions. If an orthodontic model is received, Envolve Dental will create a copy of all accompanying paperwork, process the authorization and return the orthodontic model to the dentist per plan guidelines.

Submit the following required documentation for consideration (as found in appendix A):

1. Panorex or full-mouth x-rays;
2. Cephalometric x-ray (with tracings)
3. Five to seven (5-7) diagnostic quality photos
4. Narrative of case
5. Treatment plan

Additional Information for Orthodontic Services

Orthodontic services are limited to eligible children with cases of severe orthodontic abnormality caused by genetic deformity (such as cleft lip or palate) or traumatic facial injury resulting in serious health impairment to the beneficiary at the present time.

Additional limitations and are as follows:

- Procedures are limited to members under age 21 whose handicapping malocclusion creates a disability and impairment to physical development.
- If the maxillary and mandibular arches are to be treated concurrently.
- Orthodontic treatment benefits do not include related extractions, oral surgery or orthognathic surgery, which must be billed separately.
- Orthodontic appliance procedure code D8080 includes appliance and retainer removal at the end of treatment.
- Procedure code D8999 may be used for reimbursement of debanding and retainers when appliances were placed with a different provider from an unaffiliated practice.
- Medicaid regulations prohibit reimbursement when the child misses an appointment, did not receive a service, or was ineligible for Medicaid.
Orthodontic Continuity of Care

Sunflower Health Plan members who started orthodontic treatment prior to joining Sunflower will be evaluated on a case-by-case basis to determine continuation of care specifics. The current orthodontic provider can continue providing services for at least the first 90 days of the member’s enrollment with Sunflower Health Plan. Envolve Dental will make best efforts to continue treatment at the recipient’s current orthodontic office until care is completed.

The current provider must submit the following information to Envolve Dental in order to start receiving reimbursement:

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

An Envolve Dental Appeals Specialist will coordinate the request with clinical reviewers to determine the remaining treatments allowed per the benefit plan. The Appeals Specialist will also determine if the treatment will be completed by the current provider (if out-of-network), or if the member can finish treatment successfully with an in-network provider. A written notice will be sent by the Appeals Specialist to the requesting orthodontic provider when the determination is made. In all cases, the member’s best possible outcome will be a significant determining factor.
Claim Submission Procedures

Submit claims and encounters electronically or by mail within 180 calendar days of the date of service by using one of the following options:

1. Envolve Dental Provider Web Portal at https://pwp.envolvedental.com
2. Electronic clearinghouses, using Envolve Dental payer identification number 46278
3. Alternate HIPAA-compliant electronic files
4. Paper claims on a completed ADA 2012 claim form by mail

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

Provider Web Portal Claim Submissions

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

To access the Envolve Dental provider web portal, go to

https://pwp.envolvedental.com

Log on with your username and password. If you have not yet registered for the web portal, or if you have questions about how to submit claims on it, call Provider Services at 855-434-9245 or send us an email at providerrelations@envolvehealth.com. See Appendix B for details on claim submissions.

Electronic Clearinghouse Claim Submission

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

Use Envolve Dental payer identification number 46278 for all clearinghouses. Please use the Master ID number 463005 for ENVD KS Sunflower. As of this manual publication date, we currently accept claims from the following:

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

If you use a different electronic clearinghouse and would like us to consider participating, please send your request to providerrelations@envolvehealth.com, 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 855-434-9245.

Paper Claim Submission

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

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

Be sure to include all required identifiers (quadrants, tooth numbers, and surfaces) as detailed in the benefit grids for each code (see Appendix A).

Mail paper claims with any required supporting documentation to:

Envolve Dental
Claims-KS
PO Box 25857
Tampa, FL 33622-5857

Postage due mail will be returned to sender.

Encounter Submission for FQHCs, CHCs and RHCs

Facilities such as Federally Qualified Health Centers (FQHCs), Community Health Centers (CHCs) and Rural Health Clinics (RHCs) are reimbursed through encounter payments. These providers can choose one of the four claim submission options to submit encounters. Note the following requirements:

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

Effective October 1, 2015, KMAP requires that dental providers submit International Classification of Diseases (ICD-10) diagnosis codes with claims for specific dental procedure codes. As of this manual publication date, the requirement applies to claims for oral and maxillofacial surgery CDT codes (D7000s) and anesthesia CDT codes (D9200s). Appendix A specifies the requirement in the “Additional Notes” box per code, when applicable.

The 2012 ADA Claim Form, or its electronic equivalent, must be used for all claim submissions. The Envolve Dental Provider Web Portal includes field entry spaces for ICD-10 diagnosis codes.

Resources to assist providers with ICD-10 use are as follows:

- **ICD-10 identification:** Dental codes are listed in Chapter 11 of the ICD-10 Tabular List document from the CMS.gov website. The navigation path is:
  - Click on download file “2016 Code Tables and Index [ZIP, 16MB]”
  - Click on the PDF file name “Tabular.”

- **ICD-10 on claim forms:** Fields 29a, 29b, 34 and 34a on the 2012 ADA Claim Form (“Diagnosis Code List Qualifier”) are the primary fields relating to the ICD-10 implementation. KMAP produced Attachment 1 with comprehensive instructions for completion. This document is available on the Envolve Dental Provider Web Portal under the “Documents” tab.

- **Proper ICD code use:** The American Dental Association produced *CDT 2015 Companion: Help Guide and Training Manual*, which includes a chapter on the CDT to ICD crosswalk to assist with claim submissions. It is available on their website at [http://ebusiness.ada.org](http://ebusiness.ada.org).

- **Clearinghouse use:** If you included an ICD code with your clearinghouse submission and the claim was rejected for a missing or invalid ICD code, call your clearinghouse and/or software vendor for details and then contact Envolve Dental for coordinating a solution.

Claims that include ICD codes which are not required by KMAP and are invalid (e.g., the diagnosis code is not appropriate for the procedure code), will be denied. Therefore, it is important to only include ICD codes for the required CDT codes.

Billing for Special Practice Visit Program for I/DD Members

Sunflower Health Plan and Envolve Dental offer a value-added dental benefit to Sunflower members who are eligible for I/DD service (enrolled through KanCare’s Intellectual or Developmentally Disabled [I/DD] program). The purpose of the benefit is to increase preventative dental visits by supporting members with I/DD to feel comfortable in the dental office setting. All Envolve Dental providers are eligible and encouraged to participate. The benefit should be billed with *D9430—Office visit for observation*, but it will be promoted to members as a “practice visit,” where members go to the dental office to simulate a full dental exam. The benefit may be utilized twice per year, per member. The process is:

1. Sunflower will market the benefit to eligible members, explaining how the program works.
2. Members with I/DD or their authorized representatives will call the dental provider to schedule a 30-minute practice visit.

3. Provider schedules appointment.

4. The Sunflower Care Manager will fax to the provider the “Dental Practice Visit Tracking Form” prepared for the member’s service date.

5. Member arrives on appointment date and completes as many of the skill steps as possible. Maximum time allowed for the visit is 30 minutes. If a full exam and cleaning are able to be completed, provider will bill D0120 and D1110 and not the D9430 for the practice visit.

6. Provider completes the skill step form and faxes it to Sunflower at the fax number indicated at the bottom of the tracking form. The same form is kept in the member’s record and updated at each visit (one date per column).

7. After the first practice visit, Sunflower Health Plan mails member an electric toothbrush for participating.

8. Provider submits claim to Envolve Dental for D9430—Office visit for observation, or D0120 and D1110 if the exam and cleaning were completed.

9. Envolve Dental pays provider $30.00 for D9430 or contracted rates for D0120 and D1110.

Billing for Orthodontia

Approved interceptive and comprehensive orthodontic treatment is reimbursed up to a maximum of $1,728 per member (D8050, D8060, D8070, or D8080). When submitting claims, use the banding date of service. The reimbursement amount includes all study charges. Once the member begins treatment, providers are responsible for continuing treatment to conclusion, even if the beneficiary becomes ineligible.

For denied orthodontic cases, reimbursement is made for the orthodontic exam and treatment plan (D8999). Only one initial orthodontic study is reimbursable every 18 months. A total of three studies are covered per member per lifetime.

Billing for Crowns and Dentures

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

Billing for Services Rendered Out-of-Office

Billing for all services should include the location code where services were rendered on the 2012 ADA claim form (Box #38-Place of Treatment) or on the appropriate section of an electronic claim submission. The code for treatment in an office setting is “11”. For services provided in an out-of-service setting, such as a school or nursing home, bill with the appropriate location code. The most common are “03” for
Claim Submission Procedures

school, “15” for mobile unit, “22” for outpatient hospital, “24” for ambulatory surgical center, “31” for skilled nursing facility, “32” for nursing facility and “99” for “other.” A comprehensive list of locations can be found on the Centers for Medicare and Medicaid Services website: CMS Place of Service Codes.

Electronic Attachments

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

NEA, through FastAttach®, enables providers to securely send attachments electronically—x-rays, EOBs, intraoral photographs, and more. To use the system, go to www.nea-fast.com, install the software, and follow the steps to begin using it. The steps are simple: a provider scans required documents, transmits them to NEA’s secure repository, selects Envolve Dental as the payer (ID#46278) and receives an NEA unique tracking number. The provider includes the NEA tracking number in the remarks section of authorization requests and claim submissions to Envolve Dental. Please use the Master ID number 463005 for ENVD KS Sunflower.

Images 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 FastAttach®, call NEA at 800-782-5150.

Billing Limitations

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

- **X-rays/Radiographs**: Maximum provider reimbursement per member per date of service is limited to the fee for a complete series. Limited x-rays may be billed by two different providers for the same member when one provider is a general dentist, the second is a dentist specializing in treating the member’s condition, and both providers do not share a common office location or billing practice.

- **Amalgams 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, except for allowable O-surface restorations. 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.

- **Out-of-office preventive services**: Providers must be able to provide all four preventive services when rendered out-of-office: exam, cleaning, fluoride and sealants. When submitting paper claims for out-of-office preventive services, insert the appropriate place of service code into box #38 on the ADA claim form, or in the appropriate box when filing electronically.
Claim Submission Procedures

- **Cost-sharing:** Providers cannot bill members for any type of cost-sharing for covered dental services, including a co-payment, coinsurance, deductible, spend-down or deposit. Spend-down payment amounts are deducted automatically from claims.

- **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.

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**Coordination of Benefits (COB)**

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

- Submit claims to the primary insurer first.
- After receiving the primary insurer’s Explanation of Benefits (EOB), submit a claim for any remaining balance to Envolve Dental with the EOB statement.

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.

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**Claims Adjudication, Editing and Payments**

Envolve Dental adjudicates all claims weekly with an automated processing system that imports the data, assesses it for completeness, and then analyzes it for correctness in terms of clinical criteria, coding, eligibility, and benefit limits, including frequency limitations. The system also evaluates claims requiring prior authorizations and automatically matches them to the appropriate member authorization records.

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

- EFT is the quickest means to receive payments.
- Electronic remittance statements are available in the “Documents” tab in your Envolve Dental Provider Web Portal account. Insert the date span for remittances you want to view.
- Clearinghouses will not transmit Envolve Dental remittance statements to providers.
- Remittance statements will remain available on the Envolve Dental web portal indefinitely.
- You can call Provider Services at 855-434-9245 with questions about claims and remittances.
Corrected Claim Processing

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 calendar days of the claim denial date. Claims are considered “corrected claims” if at least one code on the original submission was denied due to missing information such as a missing tooth number or surface identification, an incorrect member ID, an incorrect code or incorrect amount. To submit a corrected claim, providers may resubmit the claim directly through the Provider Web Portal or mail the corrected claim as follows:

Provider Web Portal Submission

Providers can now update and resubmit previously processed claims directly through the web portal to correct inaccurate data and add missing information. By eliminating the expense and inconvenience of filing and processing paper claim correction forms, direct electronic submission boosts the efficiency for the provider office. When a corrected claim is submitted, the original claim is automatically backed out of the system and a new updated claim takes its place. Claim and service adjustments are created to compensate for changes in paid amounts from the original claim, and patient responsibility amounts are rolled back and then reprocessed to ensure accurate benefit consumption.

For a claim that has already been corrected, users can view a list of associated claims and if applicable, correct the latest claim of the series. For claims eligible for correction (fully processed and not already resubmitted as a corrected claim), a single click loads the data into the Claim Entry page, ready for users to update and submit. After updating the claim data, users can select from a list of client-configurable reasons defining the nature of the correction, add notes for further detail, and submit their changes for processing.

For more information, see the Provider Web Portal section in the back of the manual.

Mail Submission

- Complete the 2012 ADA claim form with: ALL codes originally submitted, including accurate code(s) and the corrected code(s)
- ALL required documentation, even if previously submitted with an accurate code(s)

Mail with correct postage to:

Envolve Dental
Corrected Claims
PO Box 25857
Tampa, FL 33622-5857

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

Claim Denials

Claims submitted correctly but were denied can be submitted for reconsideration or appeal if sent to Envolve Dental within specified time frames after the denial was issued, or the non-payment notification was made, as indicated on the remittance advice. Please review the clinical criteria and benefit limitations in this manual when formulating a written reconsideration, citing why you believe the claim should be paid. To submit, mail an appeal with your name, NPI, contact details, and all supporting documentation to:
Grievances, Reconsiderations and Appeals

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

<table>
<thead>
<tr>
<th>Table 4: Distinguishing Grievances, Reconsiderations and Appeals</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Providers – Handled by Envolve Dental</strong></td>
</tr>
<tr>
<td><strong>Members – Handled by Sunflower Health Plan</strong></td>
</tr>
<tr>
<td><strong>Grievance</strong></td>
</tr>
<tr>
<td>An expression of dissatisfaction about any matter other than an adverse benefit determination or an action*, including but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the member's rights. Can be submitted verbally or in writing to Envolve Dental and must be filed within 180 calendar days of the date of the incident being grieved.</td>
</tr>
<tr>
<td><strong>Reconsideration</strong></td>
</tr>
<tr>
<td>Reconsideration is an optional, less formal process than an appeal and provides an opportunity to resolve claim payment concerns directly by calling, faxing, emailing or mailing Envolve Dental. Requests for reconsideration must be received within 123 calendar days of the date of the notice of action or Explanation of Payment (EOP). Providers have the right to terminate the reconsideration process and submit a provider appeal within 63 calendar days from the date of the notice of action or EOP. If providers do not submit an appeal within 63 calendar days, they must wait to receive the notice of reconsideration resolution. Providers have the right to submit a provider appeal after receipt of the</td>
</tr>
</tbody>
</table>
### Table 4: Distinguishing Grievances, Reconsiderations and Appeals

<table>
<thead>
<tr>
<th>Category</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Notice of Reconsideration Resolution</td>
<td>Within 63 calendar days from the date of the notice of action.</td>
</tr>
<tr>
<td>Appeal</td>
<td>A request by a provider for a managed care organization to review an action such as denial of payment to a provider for a service or a recoupment of claims previously paid to a provider.* Must be submitted within 63 calendar days from the date of the Notice of Action or EOP. The appeal step is required to proceed to a State Fair Hearing if the provider does not agree with the appeal determination.</td>
</tr>
<tr>
<td>Appeal</td>
<td>A request by a member or authorized representative for a managed care organization to review an adverse benefit determination, such as a denial of authorization for service.* Must be received within 63 calendar days of the Notice of Adverse Benefit Determination. The appeal step is required to proceed to a State Fair Hearing if the member does not agree with the appeal determination. A provider may represent a member with written consent or completed/signed ARD form.</td>
</tr>
<tr>
<td>State Fair Hearing</td>
<td>You should only file for a State Fair Hearing (SFH) after you have completed the appeal process with determinations received by Envolve Dental. If you disagree with the decision made in the dispute/appeal response, you may then submit a request to the Office of Administrative Hearings for a State Fair Hearing within 123 calendar days of the date of the notice of action. Providers must submit in writing.</td>
</tr>
<tr>
<td>State Fair Hearing</td>
<td>A request for a hearing made to the state about an appeal result that is not resolved to the member’s satisfaction. Must be filed within 123 calendar days of the date of the Notice of Member Appeal Resolution regarding their standard or expedited appeal.</td>
</tr>
</tbody>
</table>

*Action is defined as the denial, in whole or in part, of payment for a service to a provider.

### Provider Grievance, Reconsideration, and Appeal Procedures

Differences may develop between Envolve Dental and a network dentist concerning prior authorization decisions or payment for billed services. Differences can also result from misunderstanding of a processing policy, service coverage or payment levels. The following explains how to initiate a grievance or appeal.
The first level of managing a disagreement begins with a **Grievance**—defined as an expression of dissatisfaction about any matter other than an adverse benefit determination or an action received verbally or in writing about a policy, procedure, claim, contracting, or other function about working with Envolve Dental. Envolve Dental will acknowledge provider grievances in writing within 10 calendar days of receipt and resolve all provider grievances within 30 calendar days of the date the grievance was received. Providers must submit grievances within 180 calendar days of the event being grieved.

Call, email, or write with provider grievances to:

<table>
<thead>
<tr>
<th>855-434-9245 Provider Services</th>
<th><a href="mailto:providerrelations@envolvehealth.com">providerrelations@envolvehealth.com</a></th>
<th>Envolve Dental - KS Appeals</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>PO Box 25857</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Tampa, FL 33622-5857</td>
</tr>
</tbody>
</table>

Reconsideration is defined as a request by a provider for Envolve Dental to review the denial, in whole or in part, of payment for a service. The process for **Reconsideration** is an optional and less formal process than the appeals process and provides an opportunity to resolve claim payment concerns by working directly with the Envolve Dental team. Providers can request a reconsideration through a variety of methods including:

- Calling Provider Services at 855-434-9245
- Faxing the reconsideration request to Provider Services at 844-815-4448.
- Sending a secure email to Provider Services at providerrelations@envolvehealth.com
- Mailing the request to Envolve Dental – KS Reconsiderations, P.O. Box 25857, Tampa FL 33622-5857

Although the Provider Reconsideration & Appeal Form may be utilized and mailed when submitting a reconsideration request, it is not required. Reconsideration requests can be submitted verbally over the phone or by sending us the claim number along with any supporting documentation through faster methods like fax or secure email. Envolve Dental will reprocess the reconsideration based on the additional information provided and the decision will be included on a future remittance advice.

Reconsiderations must be requested within 123 calendar days of the date of the notice of action. Providers do not need to file a reconsideration in order to file an appeal. Providers may terminate the reconsideration process and submit an appeal within 60 calendar days from the date of the notice of action, plus three calendar days if the notice is mailed. If Providers do not file an appeal within 63 calendar days, they must wait to file an appeal after receiving the reconsideration notice. Envolve Dental will resolve your reconsideration within 30 calendar days from date of receipt.

A provider **Appeal** is defined as a request by a provider for a managed care organization such as Envolve Dental to review an action, such as denial of payment for a service to a provider or a recoupment of claims previously paid to a provider. Providers must file an appeal within 63 calendar days of the date of the initial Explanation of Payment or determination letter. Verbal appeals must be followed up with a written appeal. Envolve Dental will confirm receipt of the appeal within 10 calendar days of receipt, and will indicate if any additional information is required to consider the appeal request.
Please be sure to use the Provider Reconsiderations & Appeal Form, as noted on the following pages, and complete the form in its entirety, including a copy of the EOP with the claim number to be adjusted clearly circled. Mail it to the address listed above.

Envolve Dental will resolve each appeal and provide written notification of the decision within 30 calendar days following receipt of the appeal request. The written appeal determination will include:

- The Envolve Dental decision;
- The date of the decision;
- For appeal decisions not in favor of the provider, information about how a provider can pursue a State Fair Hearing

Providers may utilize the reconsideration process and must exhaust the appeals process prior to filing for a State Fair Hearing. If you disagree with the decision made in the reconsideration/appeal response, you may then appeal to the Office of Administrative Hearings and request a State Fair Hearing within 123 calendar days of the dispute/appeal response by contacting Envolve Dental, Sunflower Health Plan or the Office of Administrative Hearings directly at:

Office of Administrative Hearings
1020 Kansas Avenue
Topeka, KS 66612

You also may contact Envolve Dental at the Appeals address listed above. If Envolve Dental receives your request for a hearing, Envolve Dental must forward your request to the Office of Administrative Hearings within one business day.
# Provider Reconsideration & Appeal Form

Use this Provider Reconsideration and Appeal Form to request a review of a decision made by Envolve Dental. The process for reconsideration and appeal is the same for participating and non-participating providers. Please see the Provider Manual for details and requirements of the reconsideration and appeal processes.

If original claim submitted requires correction, such as a valid procedure code, location code or modifier, please submit the corrected claim following the "Corrected Claim" process in the Provider Manual. Please do not include this form with a corrected claim.

All boxes immediately below are required to be completed – Do not attach another copy of the claim.

<table>
<thead>
<tr>
<th>Provider Name</th>
<th>Provider Tax ID#</th>
</tr>
</thead>
<tbody>
<tr>
<td>Control/Claim Number (branch code)</td>
<td>Date(s) of Service</td>
</tr>
<tr>
<td>Member Name</td>
<td>Member ID Number</td>
</tr>
</tbody>
</table>

**Request Review Type** (must select one):
- [ ] Reconsideration (optional dates)
- [ ] Provider Appeal (required stop to proceed to State Fair Hearing)

**Reason for Dispute** (please check):
- [ ] Claim was denied for no authorization, but authorization was obtained.
- [ ] Claim was denied for no authorization, but no authorization is required for this service.
- [ ] Claim was paid to wrong provider.
- [ ] Claim was denied for untimely filing, or claim was paid for incorrect amount.
- [ ] Claim was paid for incorrect amount.
- [ ] Denied as duplicate in error.
- [ ] Denial of eligibility.
- [ ] Denial of benefits (please explain below).
- [ ] Client obligation/patient liability/spend down not applied correctly.
- [ ] Other (please explain below).

**Supporting comments/explanation:**

<table>
<thead>
<tr>
<th>Requestor Name</th>
<th>Requestor Phone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date of Request</td>
<td></td>
</tr>
</tbody>
</table>

**ATTACH** A copy of the EOB with the claim number to be reviewed clearly circled. Please complete required information above and do not attach a copy of the claim. Mail completed form(s) and attachments to:

Envolve Dental – KS Reconsiderations and Appeals  
P.O. Box 25957 
Tampa, FL 33622-25957

1-855-434-3246  
https://www.envolvadental.com  
KDEA Approved 04-04-18
Member Grievance, Appeal and Fair Hearing Procedures

A member Grievance is defined as an expression of dissatisfaction by a member about any matter other than an adverse benefit determination or an action, including but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the member's rights. An Adverse Benefit Determination is defined as:

1. The denial or limited authorization of a requested service, including the type or level of service;
2. The reduction, suspension, or termination of a previously authorized service;
3. The denial, in whole or in part, of payment for a service;
4. The failure to provide services in a timely manner, as defined by the State;
5. The failure of Envolve Dental to act within the mandated timeframes or,
6. The denial of a member’s request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other member financial liabilities.

Members or their designated representatives may file a grievance with Sunflower Health Plan about their dental or medical care any time after the event causing dissatisfaction occurred. Members may file a grievance either orally or in writing. In order for member to be represented by a provider, family member, attorney or other representative written consent by the member or a completed and signed Authorized Representative Designation (ARD) form must be submitted. Member grievances will be acknowledged in writing within 10 calendar days of receipt. Envolve Dental will support the Sunflower Health Plan Grievances Coordinator with information gathering that can assist in formulating a response to the member no later than 30 calendar days from the date the grievance is received.

Member grievances should be directed to:

Sunflower Health Plan Quality Department
8325 Lenexa Drive, Suite 200
Lenexa, KS 66214
Phone: 877-644-4623
(TDD/TTY: 888-282-6428)
Fax: 888-453-4755

A member Appeal is defined as a request by a member for a managed care organization such as Sunflower to review an adverse benefit determination (see definition above). The appeal step is required to proceed to a State Fair Hearing if the member does not agree with the adverse benefit determination. A provider may represent a member with written consent or completed/signed ARD form. Member appeals are preferred to be received in writing; however, it is not required. Within five calendar days of receiving an appeal from a member, Sunflower Health Plan will mail to the member an acknowledgement letter that includes a description of appeal and resolution timeframes. Appeal resolution will occur as expeditiously as the member's health condition requires, and no later than 30 calendar days from the date the appeal was received. A resolution letter will be mailed to the member and will include member's rights for further review if the member or member’s representative is not satisfied with appeal determination.

When a dental provider submits a request for prior authorization for services and the services are denied, limited, reduced or terminated, Envolve Dental mails to the member and provider (and faxes to the provider) a Notice of Adverse Benefit Determination. The member or authorized member representative has the option to appeal the decision to Sunflower within 63 calendar days from the date of the Notice of Adverse Benefit Determination. Sunflower will acknowledge receipt of an appeal in writing within five calendar days after receiving the appeal. Sunflower will resolve each appeal and provide
written notice of the resolution no more than 30 calendar days from receipt. Expedited appeals may be filed when the situation involves the potential loss of life, limb or the member’s ability to attain, maintain or regain function would be jeopardized. In such cases, appeals are resolved no later than 72 hours from the date the request is received.

Members can request a State Fair Hearing when an appeal is not resolved in the member’s favor. Members also may appoint someone to represent them in member appeals, to include their provider, attorney, or family member, or other designated person. The request must be submitted within 123 calendar days from the date of the notice of appeal resolution. It may be made to Sunflower or Envolve Dental, who will make a record of it and submit to the Office of Administrative Hearings. Or it may be made directly in writing by contacting:

Office of Administrative Hearings
1020 Kansas Avenue
Topeka, KS 66612

Members may contact Sunflower with their request for a State Fair Hearing, and Sunflower will forward the request to the Office of Administrative Hearings within 1 business day of receipt.

Non-HCBS Services:
Previously authorized services may be continued during the appeal if the request for continuation is made within 10 calendar days of mailing date on Notice of Adverse Benefit Determination or the intended effective date, whichever is later.

- If the final resolution is adverse to the member, then to the extent that the services were furnished while the appeal was pending, the member may be responsible for the cost of those previously authorized services that Envolve Dental’s action reduces, suspends or terminates.

Non-HCBS Services will end 10 calendar days following the mailing date of the Notice of Appeal Resolution, unless the member requests a State Fair Hearing and Continuation of Services within that 10 days.

- If the member/authorized representative requests State Fair Hearing and Continuation of Services within 10 calendar days, the services will be continued through the date of the decision in the SFH
- If the final resolution of the State Fair Hearing is adverse to the member, then to the extent that services were provided while the appeal/State Fair Hearing was pending, the member may be responsible for the cost of the services
- A provider may not request Continuation of Services on the member’s behalf, even if they are an Authorized Representative

HCBS Services:
Continuation of HCBS services will continue automatically without change until the appeal process is complete.

- If no appeal requested, services end 63 calendar days from mailing/sent date on notice of Adverse Benefit Determination
- If the final resolution is adverse to the member, then to the extent that the services were furnished while the appeal was pending, the member will NOT be responsible for the cost of those services
- A provider may not request Continuation of Services on the member’s behalf, even if they are an Authorized Representative

HCBS Services will end 123 calendar days following the mailing/sent date of the Notice of Appeal Resolution, unless the member requests a State Fair Hearing.
Appendix A: Benefit Plan Details

- If the member/authorized representative requests State Fair Hearing within 123 calendar days, the services will be continued through the date of the decision in the State Fair Hearing.
- If the final resolution of the State Fair Hearing is adverse to the member, then to the extent that services were provided while the appeal/State Fair Hearing was pending, the member will NOT be responsible for the cost of the services.

If you or the member do not know if the services related to the appeal are Home and Community Based Services (HCBS), please contact Member Services at 1-877-644-4623.

A KanCare Ombudsman is employed by the State of Kansas Depart for Aging and Disability Services (KDADs) and is available to assist KanCare members if they have not received culturally appropriate care. The Ombudsman can be reached at 855-643-8180, TTY 711 or by email at KanCare.Ombudsman@kdads.ks.gov.
Dental Health Guidelines Ages 0–18 Years

The American Academy of Pediatric Dentistry (AAPD) advocates clinical guidelines and policies to promote optimal oral health for children. One initiative outlines recommended timeframes for providing oral health assessments, preventive care, and anticipatory guidance to children from birth to age 18, and their parents. The following chart represents the specific AAPD guidance for children who are developing normally and do not have extenuating medical conditions. Providers should assess each child for his or her unique health needs and make appropriate adjustments intended to optimize the child’s health.

<table>
<thead>
<tr>
<th>Recommended Services</th>
<th>6 to 12 Months</th>
<th>12 to 24 Months</th>
<th>2 to 6 Years</th>
<th>6 to 12 Years</th>
<th>12+ Years</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical oral examination ¹</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Assess oral growth and development ²</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Caries-risk assessment ³</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Radiographic assessment</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Prophylaxis and topical fluoride ³,⁴</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Fluoride supplementation ⁵</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Anticipatory guidance/counseling ⁶</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Oral hygiene counseling ⁷</td>
<td>Parent</td>
<td>Parent</td>
<td>Patient/Parent</td>
<td>Patient/Parent</td>
<td>Patient</td>
</tr>
<tr>
<td>Dietary counseling ⁸</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Injury prevention counseling ⁹</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Counseling for nonnutritive habits ¹⁰</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Counseling for speech/language development</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Substance abuse counseling</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Counseling for intraoral/perioral piercing</td>
<td></td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Assessment and treatment of developing malocclusion</td>
<td></td>
<td></td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Assessment for pit and fissure sealants ¹¹</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Assessment and/or removal of third molars</td>
<td></td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Transition to adult dental care</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>X</td>
</tr>
</tbody>
</table>

¹ First examination at the eruption of the first tooth and no later than 12 months. Repeat every 6 months as indicated by child’s risk status/susceptibility to disease. Includes assessment of pathology and injuries.

² By clinical examination.

³ Must be repeated regularly and frequently to maximize effectiveness.

⁴ Timing, selection, and frequency determined by child’s history, clinical findings and susceptibility to oral disease.

⁵ Consider when systemic fluoride exposure is suboptimal. Up to at least 16 years.

⁶ Appropriate discussion and counseling should be an integral part of each visit for care.

⁷ Initially, responsibility of parent. As child matures, jointly with parent; then when indicated, only child.

⁸ At every appointment, initially discuss appropriate feeding practices, then the role of refined carbohydrates and frequency of snacking in caries development and childhood obesity.

⁹ Initially play objects, pacifiers, car seats. When learning to walk, then playing sports, include importance of mouth g

¹⁰ At first, discuss the need for additional sucking: digits vs pacifier, then the need to wean from the habit before malocclusion or skeletal dysplasia occurs. For school-aged children and adolescent patients, counsel regarding ex habits such as fingernail biting, clenching, or bruxism.

¹¹ For caries-susceptible primary molars, permanent molars, premolars, and anterior teeth with deep pits and fissures place as soon as possible after eruption.

Source: Adapted from the American Academy of Pediatric Dentists for Kansas
Benefits

Eligibility Categories by Plan

Plan Eligibility

Sunflower Health offers dental benefits through Envolve Dental providers for people eligible for and enrolled in the following plans:

- Title 21 CHIP – Ages 0 to 18
- Title 19 Medicaid Children – Ages 0 to 20
- Title 19 Medicaid Adults – Ages 21 and Over
- HCBS Adults – Ages 65 and Over

Refer to the appropriate benefit grids in Appendix A to view specific benefits, limitations, and authorization requirements for each plan.

Title 21 CHIP – Ages 0 to 18
KanCare covers periodic teeth cleaning, fluoride treatment, sealants, tooth restorations, radiographs, extractions and other dental services as determined medically necessary.

Title 19 Medicaid Children – Ages 0 to 20
KanCare covers periodic teeth cleaning, fluoride treatment, sealants, tooth restorations, radiographs, extractions and other dental services as determined medically necessary.

Title 19 Medicaid Adults – Ages 21 and Over
Sunflower Health Plan offers adult Medicaid members (ages 21 and over), dental cleaning every 6 months using code D1110 (prior approval not required).

KanCare covers extractions only when considered medically necessary. Exams and x-rays are only payable when performed with covered services or to make a diagnosis.

HCBS Adult – Ages 21 and Over PD, I/DD and TBI

Home and Community Based Services (HCBS) adult beneficiaries covered under all waiver programs are not eligible for selected dental services. Dental coverage for these beneficiaries is provided under the Title 19 adult benefit plan.

If the patient must be sedated and the procedure is performed in a hospital setting, please submit a Sunflower Health Plan Outpatient Facility Authorization form with a narrative of medical necessity and a treatment plan to Envolve Dental. If the sedation is not performed in a hospital setting, a retro authorization, along with a narrative of medical necessity and treatment plan is required.

HCB Adult – Ages 65 and Over
Appendix A: Benefit Plan Details

Refer to the Crisis Exception process table.

**Medically Needy (Spenddown)**
For some families and individuals, income exceeds the threshold to qualify for public assistance, but income levels cannot meet all medical expenses. The family group or individual is considered Medically Needy (MN) and must incur a state-specified amount of medical expenses before they are eligible for Medicaid benefits. This process is called “spenddown.” It is similar to an insurance deductible, where the person or family spends a certain amount of money on medical expenses, and then Medicaid pays for any medical costs for covered benefits that exceed the personal amount.

Providers should bill Envolve Dental for all dental claims for MN members. Providers should not reduce claim charges or the balance due by the spenddown amount. A reduction, if applicable, is made automatically during claim processing. If the member has not yet met the spenddown amount, the provider can then bill the member for denied fees.

Envolve Dental sends claim submission information to the state, which maintains a record of all medical spending and tabulates when the spenddown amount is met.

**Crisis Exception Process**

The Frail and Elderly Waiver population is comprised of the Home and Community Based Services (HCBS) which includes adults ages 65 and over.

Frail Elderly Waiver members are eligible for select oral health services above and beyond those dental services covered for all adult Medicaid members. These oral health services include accepted dental procedures, diagnostic, prophylactic and restorative care, and allow for the purchase, adjustment and repair of dentures. This includes anesthesia services provided in the dentist's office and billed by the dentist. These services do not include outpatient or inpatient facility care, orthodontic and implant services, or provision of oral health services for cosmetic services.

HCBS Frail and Elderly members’ additional oral health services are limited to the participant’s assessed level of service need, provided to the Adult T-19 members. However, additional benefits can be provided subject to a crisis exception process.

In addition to the documentation required for the requested service, include a narrative of medical necessity. The narrative should include at a minimum a documented assessment of the member’s oral health plus:

- Did the member have a treatment plan in place? If yes, what treatment remains in progress?
- Does the member require emergency treatment to resolve an oral health issue that is life threatening?
- How will non-treatment of the oral health issue impact the member?
  1. “Active Infection” soft tissue or bone that causes:
     a. Abscess
     b. Class 3 mobility–(non-restorable tooth)
  2. “Inflammation”
     a. Leading to infection (chronic)
     b. Hygienist treatment
  3. Cavity
     a. Infection possible (restore)
Appendix A: Benefit Plan Details

4. Chipped tooth/broken tooth - In addition, does the member have:
   a. Diabetes? (especially apply to questions 1 & 2)
   b. Only 3 to 4 teeth, lack of ability to eat and no dentures?
   c. A lack of infection but would rank above cavity/chipped tooth?
   d. Only a few remaining teeth and will risk maintaining good nutrition? Six (6) teeth on top and six (6) teeth on bottom could function depending on which teeth.
   e. A rate of inflammation to infection differs depending on specific circumstances?

Once the patient is determined to have a life-threatening condition, the dental consultant will review the clinical criteria for the requested services to determine if the requested service is in the best interest of the member.

Clinical Definitions

Teeth should be identified as follows:

<table>
<thead>
<tr>
<th>Teeth</th>
<th>Identified by</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary</td>
<td>Letters A through T</td>
</tr>
<tr>
<td>Permanent</td>
<td>Numbers 1 through 32</td>
</tr>
<tr>
<td>Supernumerary</td>
<td>Letters AS through TS*</td>
</tr>
<tr>
<td></td>
<td>Numbers 51 through 82*</td>
</tr>
</tbody>
</table>

*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.

Selected Benefit Reimbursement Limitations

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

- **X-rays/Radiographs:** Maximum provider reimbursement per member per date of service is limited to the fee for a complete series. Limited x-rays may be billed by two different providers for the same member when one provider is a general dentist, the second is a dentist specializing in treating the member’s condition, and both providers do not share a common office location or billing practice.

- **Amalgams 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, except for allowable O-surface restorations. 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.

- **Out-of-office preventive services:** Providers must be able to provide all four preventive services when rendered out-of-office: exam, cleaning, fluoride and sealants. When submitting paper claims for out-of-office preventive
services, insert the appropriate place of service code into box #38 on the ADA claim form, or in the appropriate box when filing electronically.

- **Sedation:** For all members, D9223 and D9243 are not billable services when only diagnostic services are provided on the same date of service. For IDD members, D9223 and D9243 are only billable when dental services are provided on the same date of service, regardless of whether or not the services are covered by the members’ benefit plans. If you do not believe that you can provide diagnostic only services without sedation due to the safety and well-being of the member or your office staff, you would need to file a prior authorization for sedation explaining exactly why this would be the case for Envolve Dental’s consideration.
Appendix B: Provider Web Portal User Guide

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

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

Access the Envolve Dental Provider Web Portal at:

https://pwp.envolvedental.com

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

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

A web browser, a valid user name, and a password are required for Provider Web Portal access. First-time users are required to register by calling Envolve Dental Provider Services at 1-855-434-9245 to obtain a unique Payee ID Number. Provider Services will verify your identity to ensure registration is completed and accessed only by an authorized user.

To register, complete the following steps:

1. Go to [https://pwp.envolvedental.com](https://pwp.envolvedental.com).
2. Click Register Now.
3. Call 1-855-434-9245 Monday through Friday, 8:00 AM to 5:00 PM to obtain your Payee ID Number.
4. On the **User Registration** pop-up screen, from the register drop-down, select **As a Payee**.

5. Add the Payee ID number from Provider Services.

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 **Submit**.

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

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

The subaccounts feature is available only for users who log in with "master" accounts. A "master" account is created when a user registers 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,

1. Log in to your Payee account.
2. From the Setup tab, click Entity Management.
3. Click on "+Add New User."

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User Account Security

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

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

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

- **Review Fee Schedules** – All fee schedules that are linked to your participation are listed on the Payee Dashboard.

- **Track Open/Processed Authorization Records** – Status and final disposition of all authorizations can be reviewed on the Provider Web Portal. The number of open and processed authorizations is listed on the Information Center to allow providers to track authorization progress. Individual authorizations can be reviewed down to the service level by clicking on the Authorization Search.

- **Track Open/Processed Claim Records** – Status and final disposition of all claims can be reviewed via the Provider Web Portal. The number of open and processed claims is listed on the Information Center to allow providers to track payment progress. Individual claims can be reviewed down the service level by clicking on the linked pictured above. The Provider Web Portal also has search functionality allowing a specific claim to be retrieved by clicking on Claims Dashboard.

- **Access Electronic Remittances** – PDF copies of all EOPs/remittances are archived on the Provider Web Portal and can be retrieved at any time.
Appendix B: Provider Web Portal User Guide

Eligibility Verification

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

1. Click the Home tab.

2. Choose Location and Provider. Enter projected date of service, member’s Subscriber ID, and date of birth.

3. Click “Verify Eligibility” and review the Eligibility Report detailing the member’s coverage.

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

<table>
<thead>
<tr>
<th>Patient Eligibility Report</th>
<th>Patient Eligibility Report</th>
</tr>
</thead>
<tbody>
<tr>
<td><em>This report is only accurate on the date and time it is rendered. The patient's information may have changed after it has been generated.</em></td>
<td><em>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.</em></td>
</tr>
<tr>
<td>This patient is eligible for services on 10/05/2016 from Mock Mock at Mock Dentistry.</td>
<td>This patient is NOT ELIGIBLE for services 10/05/2016.</td>
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</table>

### Patient Information

<table>
<thead>
<tr>
<th>Lauren Bicuspid</th>
<th>Lawrence Bicuspid</th>
</tr>
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<tbody>
<tr>
<td>1 Floss Way</td>
<td>Gene E Backey</td>
</tr>
<tr>
<td>Tampa, FL 33603</td>
<td>306 N Fremont Ave</td>
</tr>
<tr>
<td>Tampa, FL 33603</td>
<td>Tampa, FL 33606</td>
</tr>
<tr>
<td>(813)361-8319</td>
<td>(813)361-8319</td>
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<tr>
<td>Subscriber ID: 946458333</td>
<td>Subscriber ID: 7334351762</td>
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### Provider Information

<table>
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### Insurer Information

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<th>Dental Health &amp; Wellness, Inc. - Florida</th>
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<tr>
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### Eligibility Details

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<td>*Total Dollars Consumed:</td>
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</table>

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Appendix B: Provider Web Portal User Guide

Authorization Entry & Submission

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

Enter the “Authorizations” tab, provide applicable narratives and attach any required documentation using the Provider Web Portal’s Authorization Entry functionality.
1. Click the Authorizations tab.
2. Enter member ID and date of birth, then choose location and provider from the drop-down menus.
3. Click "Verify eligibility" to confirm member's coverage.
4. Use the check boxes inside the "Ancillary Authorization Information" box to notate service details, e.g., orthodontic treatment, accident-related, etc.
5. On the “Services” sub-tab, enter specific procedures by line, including tooth/surface/area information as required, projected date of service, quantity, and the billed rate.
6. Click on the “Remarks” sub-tab to add additional narratives, including an NEA number for attachment identification or other pertinent details.
7. Once submission data is entered, click the “Skip Review and Submit” button.
8. A pop-up window will open confirming that you want to submit the authorization.
Authorization Status

The “Authorization Search” functionality allows a search for a single authorization by authorization number or for batches of authorizations using various criteria.

- Searches can be made for “open,” “processed” or “all” authorizations.
- Batches of authorizations can be searched for 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
Appendix B: Provider Web Portal User Guide

Manage Roster

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

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

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

7. Enter procedures rendered for each line using CDT Codes, including tooth/surface/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” tab to add any additional narratives, such as NEA numbers or other pertinent details.

9. Click "Attachments" tab to attach x-rays or other documents that are required for payment.

10. If an EOB is present and primary payment information needs to be entered; be sure the “EOB Present” box on the top of the screen is checked to enter COB details.
Pre-Claim Estimate – Remaining Dental Benefit Amount

An important feature is the pre-claim estimate pop-up window, available on the claim entry tab. Once all fields have been entered, as above, click on the “View Estimate” button. A pre-claim estimate pop-up window will show the reimbursement amount a provider can expect to receive for the reported CDT codes.
Claims Status

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

- The claim status functionality allows a provider to search for a single claim by claim encounter ID number or for batches of claims.
- Searches can be for all, “received” or “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 (Electronic Fund Transfer) offer direct deposit into a bank account more quickly than payments made by check. To set up EFT, complete an EFT form (found in your contracting packet) or in the Provider Manual and send with a copy of a voided check for verification to Envolve.DentalPDM@envolvehealth.com or fax to 844-847-9807. Allow four to six weeks for your EFT application to take effect, as the banks must verify all information is accurate.

To view online remittances, go to the “Documents” tab, then select “My Documents” and choose the applicable remittance statement date.
A copy of the Envolve Dental Provider Manual can be found under the “Insurer Documents” tab.

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<thead>
<tr>
<th>Document Description</th>
<th>Document Type</th>
<th>Date</th>
</tr>
</thead>
<tbody>
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<tr>
<td>EFT Form</td>
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<td>FL Provider Manual</td>
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<tr>
<td>Provider Web Portal Enhancements/New Features</td>
<td>Other</td>
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</tr>
</tbody>
</table>
Frequency and Ratios Reports

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

If you have questions about the Envolve Dental Provider Web Portal, please contact Provider Services at 855-434-9245 for assistance.