IHCP WORKS ANNUAL SEMINAR

OCTOBER 2023

Welcome

DentaQuest

OUR MISSION: TO IMPROVE THE ORAL HEALTH OF ALL

*DentaQuest is an independent company providing dental benefit management services on behalf of the health plan.
MDwise is an independent company providing dental benefit management services on behalf of the health plan.
INBCBS-CD-040233-23 October 2023

Agenda

- Introductions
- What's New
- Eligibility
- Medicaid Dental Benefit Information
- Office Reference Manual Overview
- Key Things You Should Know
- Access and Availability
- FAQs
- Q&A

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DentaQuest* acts as the Dental Benefits Manager for Anthem Blue Cross and Blue Shield (Anthem) and MDWise*

Go Green Initiative

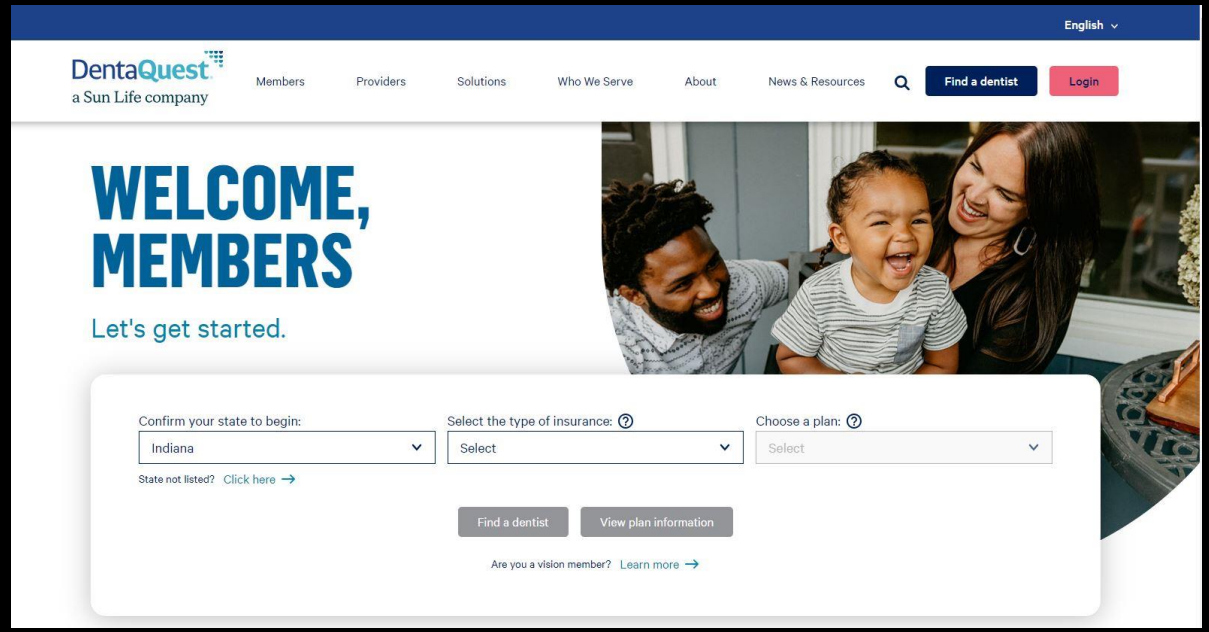
The Go Green Initiative includes:

- Explanation of Benefits (EOB) conversion on 04/30/2023 – go to the portal to see EOB.
- DentaQuest encourages offices to enroll in Electronic Funds Transfer (EFT) for quicker payments.

For instructions to enroll in EFT please reach out to your area Network Manager.

DentaQuest New Website

DentaQuest launched a new website at the end of June. The website helps members find a provider and helps providers navigate the plans DentaQuest offers.



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Member Eligibility Validation

- Eligibility should always be verified on the IHCP Provider Healthcare Portal. This portal is the source of truth for eligibility.
- Always check a member's eligibility prior to rendering services. Check it the same day of the appointment.
- Once the eligibility has been verified the provider can view the member's Service History on the Dentaquest provider portal.

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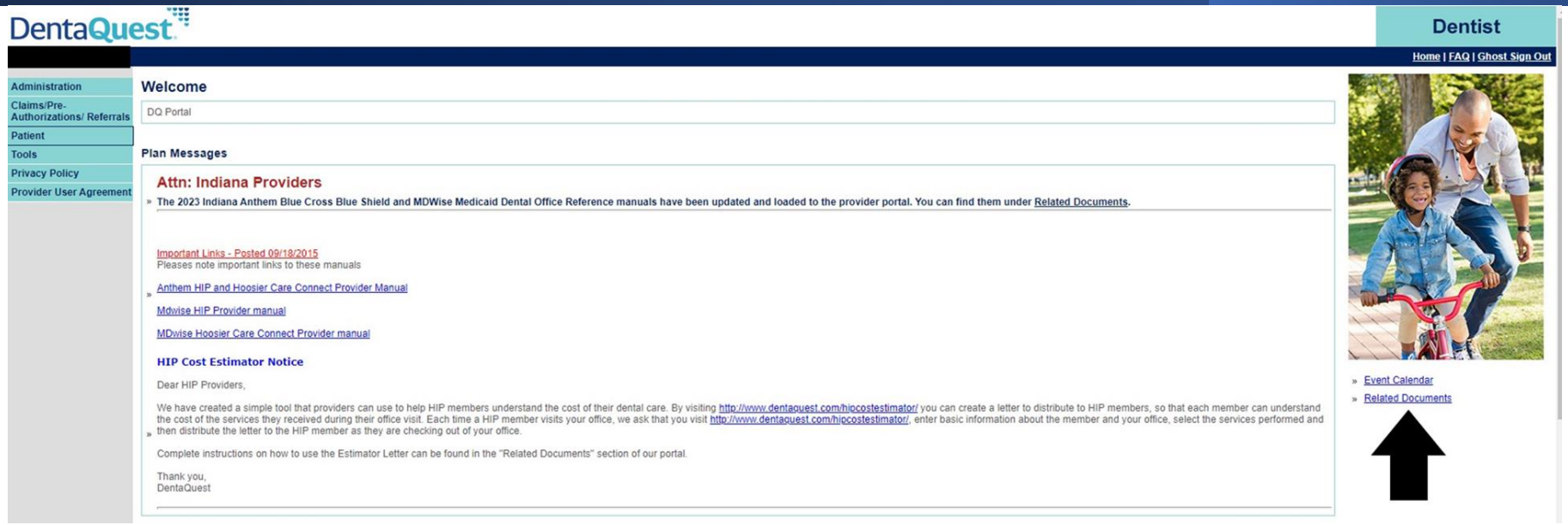
DentaQuest Provider Portal



Provider Web Portal Home Page

The portal has many self-service functions that can help alleviate the need for calling in when you can easily look up the answers in a matter of seconds and avoid frustrating wait times. The *Home Page* is a reference point of navigation for self service functions within the portal. On this page click *Related Documents*, to locate the Office References Manuals. On the opposite side of the *Home Page* you can perform various other self service functions. Let's explore some of the possibilities.

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Patient Eligibility

Member Eligibility List

This page displays the Members meeting the search criteria. You can conduct another search by clicking search again, view Member detail by clicking a Member name link, and print the results by using the Printer Friendly Format button.
Please note this information does not guarantee or imply payment and is contingent upon other factors, including but not limited to eligibility changes, covered services and benefit limitations.

Printer Friendly Format

Active

Order Entered	Service Date	Member Number	Date of Birth	Member Name		Plan	Benefit	Client Number	Network Name	Paid Through Date	Dentist/Office Name	Dentist Effective Date
1	07/07/2023	[redacted]			-	Anthem IN BCBS State Plan Medicaid - No CoPay	Usage	6001421051	IN - MD Wise/ Anthem - HIP - Medicaid			

Ineligible

Order Entered	Service Date	Member Number	Date of Birth	Member Name
No Results Found				

Note: If you wish to search again, the information you originally entered for these members will be retained allowing you to correct any information you previously entered.

Search Again

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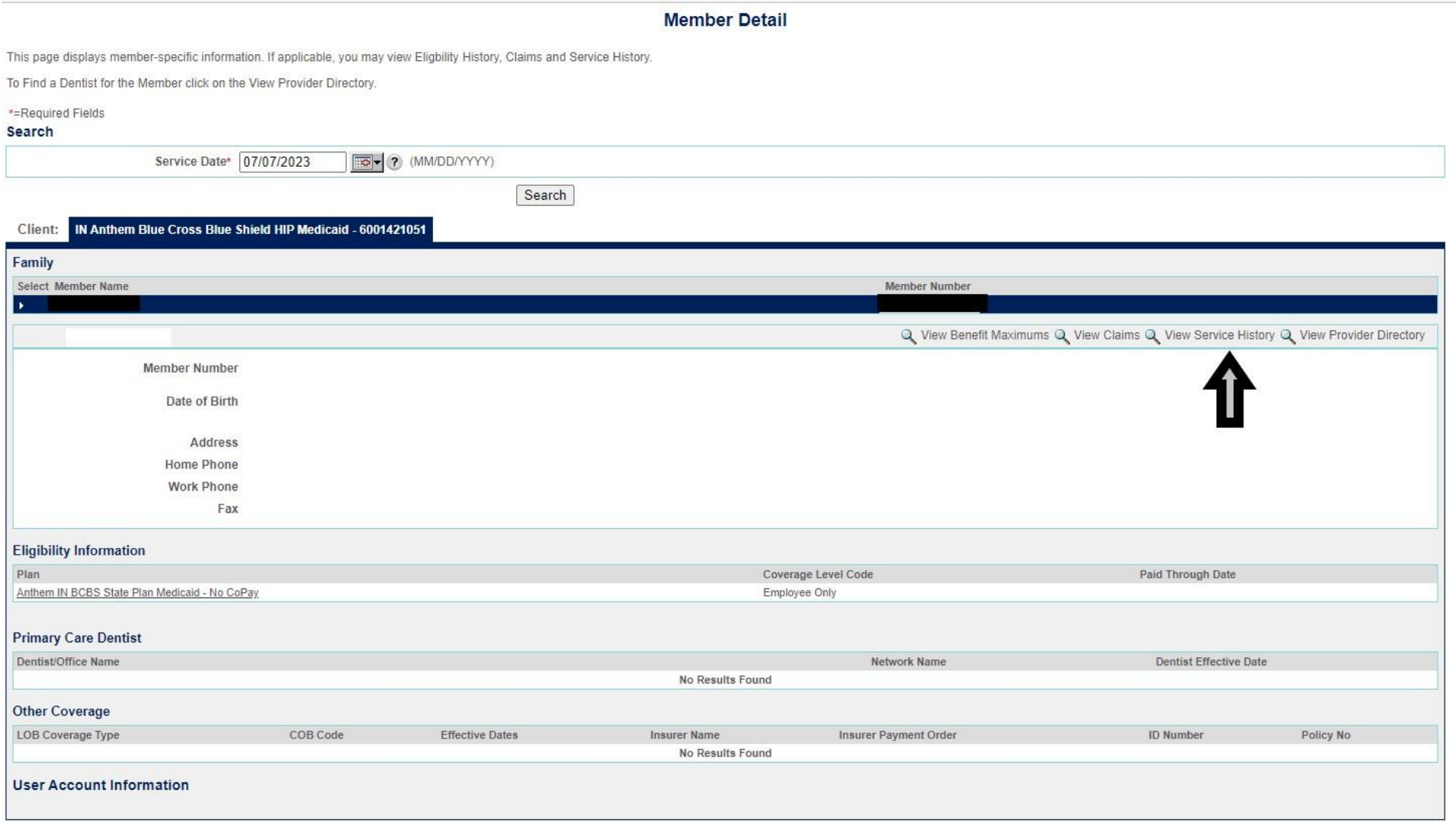
Patient Eligibility

Service History



Service History Page

Personal Health General Info

Member Information

Download File Printer Friendly Format

Member Name

Date of Birth

Member ID

Member Service History

Procedure Code	Procedure Code Description	Tooth/Quad/Arch	Place of Service	Service Date
D0274	bitewings - four radiographic images		Office	06/14/2023
D0140	limited oral evaluation-problem focused		Office	03/08/2023
D0140	limited oral evaluation-problem focused		Office	02/22/2023
D0220	intraoral - periapical first radiographic image	13	Office	02/22/2023
D2391	resin-based composite - one surface, posterior	28	Office	02/01/2023
D2394	resin-based composite - four or more surfaces, posterior	13	Office	02/01/2023
D0120	periodic oral evaluation - established patient		Office	01/12/2023
D1110	prophylaxis - adult		Office	01/12/2023
D0120	periodic oral evaluation - established patient		Office	05/19/2022
D0274	bitewings - four radiographic images		Office	05/19/2022
D1110	prophylaxis - adult		Office	05/19/2022
D0120	periodic oral evaluation - established patient		Office	09/23/2021
D1110	prophylaxis - adult		Office	09/23/2021
D2330	resin-based composite - one surface, anterior	8	Office	06/23/2021
D2330	resin-based composite - one surface, anterior	7	Office	06/23/2021
D2391	resin-based composite - one surface, posterior	5	Office	06/23/2021
D0120	periodic oral evaluation - established patient		Office	03/02/2021
D0274	bitewings - four radiographic images		Office	03/02/2021
D1110	prophylaxis - adult		Office	03/02/2021

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Member Detail

This page displays member-specific information. If applicable, you may view Eligbility History, Claims and Service History.

To Find a Dentist for the Member click on the View Provider Directory.

*=Required Fields

Search

Service Date* 07/07/2023 (MM/DD/YYYY)

Search

Client: **IN Anthem Blue Cross Blue Shield HIP Medicaid - 6001421051**

Family

Select	Member Name	Member Number
▸	[redacted]	[redacted]

View Benefit Maximums | View Claims | View Service History | View Provider Directory

Member Number

Date of Birth

Address

Home Phone

Work Phone

Fax

Eligibility Information

Plan	Coverage Level Code	Paid Through Date
Anthem IN BCBS State Plan Medicaid - No CoPay	Employee Only	

Primary Care

Dentist/Office Na	Network Name	Dentist Effective Date
No Results Found		

Other Coverage

LOB Coverage Type	COB Code	Effective Dates	Insurer Name	Insurer Payment Order	ID Number	Policy No
No Results Found						

User Account Information

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Benefit Plan Summary of Benefits

This page lists a summary benefits for a benefit plan.

Benefit Details

Printer Friendly Format

Description	Anthem IN BCBS State Plan Medicaid - No CoPay
Documents	
Group Information	
Group Name	Anthem IN BCBS State Plan Medicaid - No CoPay
Group Number	6001422954
Product	Adult Medicaid
Benefit Period	Calendar Year starting 1/1/2023
Dependent Coverage to Age	NONE
Diagnostic	
Comprehensive Evaluation. -- Subscriber Only	2 time(s) per 1 Years
Comprehensive Evaluation. All Networks. -- Subscriber Only	100%
Periodic Oral Exam. -- Subscriber Only	1 time(s) per 6 Months. Not allowed within 6 months of D0150 by the same provider.
Periodic Oral Exam. All Networks. -- Subscriber Only	100%
Full Mouth X-rays. -- Subscriber Only	1 time(s) per 36 Months
Full Mouth X-rays. All Networks. -- Subscriber Only	100%
Bitewing X-rays. -- Subscriber Only	4 time(s) per 12 Months. A total of four horizontal bitewing films in any combination of D0270, D0272, D0273, or D0274 per 12 Month(s) Per Provider. Not to be billed in the same 12 months as a D0277.
Bitewing X-rays. All Networks. -- Subscriber Only	100%
Single Tooth X-rays. -- Subscriber Only	1 time(s) per 12 Months per tooth
Single Tooth X-rays. All Networks. -- Subscriber Only	100%
Preventive	
Teeth Cleaning. -- Subscriber Only	1 time(s) per 6 Months
Teeth Cleaning. All Networks. -- Subscriber Only	100%
Fluoride Treatments. -- Subscriber Only	1 time(s) per 6 Months age 20 AND younger
Fluoride Treatments. All Networks. -- Subscriber Only	100%
Sealants. -- Subscriber Only	1 time(s) per 1 Lifetime. Occlusal surfaces only. Includes buccal and lingual grooves. Teeth must be caries free. Sealant will not be covered when placed over restorations.
Sealants. All Networks. -- Subscriber Only	100%
Restorative	
Silver Fillings. -- Subscriber Only	1 time(s) per 12 Months per surface per tooth
Silver Fillings. All Networks. -- Subscriber Only	100%
White Fillings (Front Teeth). -- Subscriber Only	1 time(s) per 12 Months per surface per tooth
White Fillings (Front Teeth). All Networks. -- Subscriber Only	100%
White Fillings (Back Teeth). -- Subscriber Only	1 time(s) per 12 Months
White Fillings (Back Teeth). All Networks. -- Subscriber Only	100%
Temporary Fillings. -- Subscriber Only	1 time(s) per 1 Lifetime per tooth
Temporary Fillings. All Networks. -- Subscriber Only	100%
Stainless Steel Crowns. -- Subscriber Only	1 time(s) per 1 Lifetime per tooth. Must encompass the complete clinical crown and should be utilized with the same criteria as for full crown construction.
Stainless Steel Crowns. All Networks. -- Subscriber Only	100%
Endodontics	
Root Canal Treatment. -- Subscriber Only	1 time(s) per 1 Lifetime per tooth
Root Canal Treatment. All Networks. -- Subscriber Only	100%
Root Canal - posterior. -- Subscriber Only	1 time(s) per 1 Lifetime per tooth
Root Canal - posterior. All Networks. -- Subscriber Only	100%
Vital Pulpotomy. All Networks. -- Subscriber Only	100%
Periodontics	
Periodontal Surgery. -- Subscriber Only	1 time(s) per 24 Months per quadrant

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Office Reference Manual (ORM) Overview

All manuals can be accessed through the portal from the home page under Related Documents

ORM's have a Table of Contents to help you quickly reference your question

ORM's have Exhibits that describe which benefits are covered under each plan

Each exhibit will illustrate Codes>Description>Teeth Covered> Authorization Required>Benefit Limitations>Documentation Required

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Office Reference Manual (ORM) Overview (cont.)

Frequently asked questions found in the ORM.

Timely Filing Limits 90 days from DOS
Secondary claims must be submitted with the primary EOB no later than 90 days from the date on the primary EOB

You may find some members have Dual Coverage under another DentaQuest administered plan; these claims will coordinate internally in our Claims Processing system. There is no need to wait for the Primary EOB

It is important to learn how to find information in the ORM.

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Refer to the ORM for codes that require Prior Auths

TRUE PRIOR AUTHORIZATION

SERVICE MUST BE SUBMITTED AND APPROVED PRIOR TO TREATMENT

FAILURE TO PRIOR AUTHORIZE WILL LEAD TO SYSTEM DENIAL OF CLAIM
"SERVICE REQUIRES PRIOR AUTHORIZATION. NO PRIOR AUTHORIZATION IS ON FILE."

APPROVED PRIOR AUTHORIZATION ON FILE WILL LEAD TO SYSTEM APPROVAL OF CLAIM

All standard claims submission requirements must be met in order for claim to pay

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PROVIDERS HAVE A CHOICE
SUBMIT NOW AS A PRIOR AUTH
OR LATER AS A CLAIM

IF THEY CHOOSE TO SUBMIT AS AN AUTH
CLINICAL REVIEW PROCESS WILL OCCUR
& IF APPROVED CLAIM WILL PAY

IF THEY CHOOSE TO SUBMIT AS A CLAIM
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All standard claims submission requirements must be met in order for claim to pay

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Key Things You Should Know: Prior Auth Submission

Prior Auth (PA) Submission

If a service you are rendering requires prior authorization and your initial submission has been denied, please DO NOT continuously resubmit the PA. As noted on the Provider Determination notice, you have 60 days from the denial to appeal. You should utilize this option if you are disputing the denial, or if by chance, you need to provide additional information, i.e., additional narrative, supporting documentation or forgotten x-rays.

What does the processing policy "Service not reviewed" mean?

This processing policy means the service/code is reviewed retrospectively (after the claim is submitted). The ORM details the clinical criteria. The plans' stance is the provider is to couple their clinical expertise and the criteria to determine if the member qualifies for the service. Ensure that all supporting documentation is included in the claim submission to support medical necessity.

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Key Things You Should Know: Provider Information Updates

Make sure your office information is up to date.

Each provider is contractually required to notify DentaQuest 60 days prior to termination (9(b)ii) from the DentaQuest Medicaid Network. Please ensure that the DentaQuest Provider Update Form is submitted 60 days prior with the effective date as the 60th day from the notice.

Each provider is responsible for notifying FSSA of a termination from a location.

If you need to make updates to your office information or add plans for which you would like to treat members, please utilize the Standard Update Request Form.

You may access this information via the DentaQuest provider portal.

https://govservices.dentaquest.com

Customer Service is available for immediate assistance. Please contact our customer service line at 1-855-453-5286.

Key Things You Should Know: Peer-to-Peer Request

Peer to Peer Request

What is a Peer to Peer?

A Peer to Peer is a meeting via telephone between a participating provider and a DentaQuest Dental Consultant. The intent of the Peer to Peer is to review edits, policies, procedures, and denial codes. The participating provider will have the opportunity to ask questions and gain clarity. The Peer to Peer is not an appeal process and no claims/authorizations will be overturned on a Peer to Peer. The claim/authorization is used as reference for the discussion only.

How do I make a Peer to Peer Request?

- Make the request on the DentaQuest Provider Portal under Tools/Contact DentaQuest/DDS Peer to Peer Call Request
- Must be submitted no earlier than 48 hours prior to the date/time requested call
- What to include in the request:
  - Caller name
  - Provider name
  - Reason for call: Peer to Peer Request
  - Authorization/Claim number
  - Claim line numbers Contact phone number for provider
  - Time zone
  - Time of day provider is available to receive the call

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Indiana Access and Availability to care for Medicaid Members

Your office is required to participate in the quarterly Access and Availability calls.
Please Note: These are not spam calls from DentaQuest.

To ensure that all members can access services in a timely manner for their dental needs, we ask our Dental Providers to work within the following appointment availability standards as determined by the MCE:

Anthem members

- **Emergency Appointments: within 24 hours**
  - *Emergency care appointments include, but are not limited to, a need to control bleeding, infection, imminent tooth loss, or treatments of injuries to teeth*
- **Urgent Appointments: within 24 hours**
  - *Urgent Appointments include, but are not limited to, a chipped tooth, sensitivity, and mild pain*
- **Routine Care: within 30 days**
  - *Routine care includes, but is not limited to, routine cleaning and check-up*

Follow-up appointments must be scheduled within 30 days of the present treatment date, as appropriate.

DentaQuest

Indiana Access and Availability to care for Indiana MDWise Medicaid Members

Your office is required to participate in the quarterly Access and Availability calls.
Please Note: These are not spam calls from DentaQuest.

To ensure that all members can access services in a timely manner for their dental needs, we ask our Dental Providers to work within the following appointment availability standards as determined by the MCE:

MDWise Members

- **Emergency Appointments: within 24 hours**
  - *Emergency care appointments include, but are not limited to, a need to control bleeding, infection, imminent tooth loss, or treatments of injuries to teeth*
- **Urgent Appointments: within 72 hours**
  - *Urgent Appointments include, but are not limited to, a chipped tooth, sensitivity, and mild pain*
- **Routine Care: within 60 days**
  - *Routine care includes, but is not limited to, routine cleaning and check-up*

Follow-up appointments must be scheduled within 30 days of the present treatment date, as appropriate.

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Your Frequently Asked Questions (Medicaid)

How to bill a member for non-covered service?

- Medicaid members must sign a comprehensive financial agreement (waiver) specific to the date of service, codes, descriptions of non-covered services, and fees for those services. A general "statement of responsibility form" or signed treatment notes are not sufficient documentation for billing for non-covered services.

What fee can I charge for a non-covered service?

- When you bill for a service code that is outside of the member's benefit limitation and the service code is noted on the Medicaid fee schedules, the fees on the Medicaid fee schedule should be used for non-covered services.
- When you bill for a service code and the ADA is absent from the fee schedule based on the child/adult benefit your normal usual & customary fees can be billed.

Can a member be balanced billed?

- Balanced bill means that members are billed for the difference between the Medicaid fee assigned and the usual & customary fees. Medicaid Members cannot be balanced billed.

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Your Frequently Asked Questions (Medicaid) (cont.)

What does it mean to "Hold Harmless"?

- In relation to Medicaid – a provision that stipulates that a covered person is not held liable for payment of covered services under these programs.

Can your office collect deductibles based on the members' primary insurance?

- No deductibles or copayments are permitted for Medicaid-covered services. A provider shall be permitted to charge an eligible Member for goods or services which are not covered only if the Member knowingly elects to receive the goods or services and enters into an agreement in writing to pay for such goods or services prior to receiving them.

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Questions and Answers

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