APPENDIX: PLAN SPECIFICS

MANAGED HEALTH SERVICES (MHS) INDIANA DENTAL BENEFITS

The provisions outlined in these Plan Specifics shall prevail over any provision in the Provider Manual that may conflict or appear inconsistent with any provision contained in this document.

Envolve Dental, doing business as Centene Dental Services, administers the dental benefit for MHS. Members are eligible for clinically indicated dental services within the scope of Indiana's Medicaid program as detailed below.

We provide dental services to the following Indiana Health Coverage Program (IHCP) member eligibility categories:

- Healthy Indiana Plan (HIP)
  - HIP Basic
  - HIP Plus
  - HIP State Plan (Basic, Plus, Plus Copay)
  - HIP Maternity
- Hoosier Care Connect
- Hoosier Healthwise

MEMBER BENEFIT AND ELIGIBILITY INFORMATION AVAILABLE 24/7

- For individual benefits and eligibility, access our Provider Web Portal (PWP) (centenedental.com/logon).
- You may also call 855-609-5157 to reach our automated member eligibility verification system.

COVERED DENTAL SERVICES

Dental coverage is consistent with Indiana Health Coverage Programs (IHCP) benefits, limits, and exclusions found in the IHCP Dental Services Module. For detailed coverage and coding information, please visit our Dental Code Search Tool (centenedental.com/cdt) and visit our Provider Web Portal (centenedental.com/logon).

MHS Indiana	Dental Benefit Summary (may include additional benefits)
HIP Basic *Age 19-64*	• Limited Accidental Dental Injury Benefits • Other Services (EPSDT members age 19-20 only)
HIP Plus *Age 19-64*	• 2 oral exams every 12 months (at least six months apart) • 2 cleanings every 12 months (at least six months apart) • 4 bitewing x-rays every 12 months • Comprehensive radiograph series (D0210, includes bitewings) or panoramic x-ray (D0330) once every 60 months • Minor restorative services (fillings) and extractions (combined four per calendar year) • Prefabricated crowns (one every calendar year) • Emergency dental services

HIP State Plan Basic **HIP State Plan Plus** **HIP State Plan Plus Copay** **HIP Maternity** *Age 19-64* **Hoosier Care Connect (HCC)** Full Package A *All Ages* **Hoosier Healthwise (HHW)** Package A *All Ages* Package C - CHIP *Age 0-18*	• 1 oral exam every 6 months • Members age 20 and under: 1 cleaning every 6 months • Members age 21 and over: 1 cleaning every 12 months • 1 fluoride treatment every 6 months for members age 20 and under • One bitewing x-ray series every 12 months • Comprehensive radiograph series (D0210, includes bitewings) or panoramic x-ray (D0330) once every 36 months • Sealants for members through age 20 (one per posterior tooth per lifetime) • Minor restorative services, such as fillings • Major restorative services, such as prefabricated crowns • Periodontal services including scaling and root planing • Dentures, partials, and repairs (with limits) • Oral surgery services including extractions • Orthodontia for members through age 20 (based on medical necessity) • Emergency dental services

DENTAL CLINICAL POLICIES

Centene Dental Services applies clinical standards to all covered benefits, outlining for providers what conditions must be present for plan coverage. Please review our clinical policies at centenedental.com/policies prior to providing services. These policies also include listings of required documentation to support services provided.

AUTHORIZATION REQUIREMENTS

Some services require prior authorization to be obtained prior to rendering treatment. Other services are subject to pre-payment review with claim submission. To view the requirements per covered code, visit the Dental Code Search Tool (centenedental.com/cdt).

When possible, authorization requests should be received at least 14 calendar days in advance of treatment via:

- Centene Dental Provider Web Portal (centenedental.com/logon**)**
- Electronic clearinghouses, using payor ID number 46278
- Alternate, pre-arranged, HIPAA-compliant electronic files
- Paper submissions mailed to the address listed in the *Provider Quick Reference* (last page)
    - Requests must be submitted on a current (2019 or later) ADA original claim form
    - Copies, handwritten or faxed forms are not accepted

For urgent requests, please mark your authorization request "Expedited Request" in the Provider Web Portal or on your clearinghouse or paper submission. Members may receive an expedited/fast decision when life, health or ability to regain function may be jeopardized. In an emergency, a provider should not wait for prior authorization to provide treatment to the member. For emergencies without prior authorization, please contact Customer Service for claim submission instructions within two business days of rendering emergency care.

Please note: Expedited requests not meeting urgent medical standards or lacking sufficient information for fast decision may be downgraded to standard processing times.

Prior authorization decisions for non-urgent services shall be made within five business days of receipt. An extension may be granted if the member, provider, or Centene Dental justifies the need for additional information and the extension is in the member's interest based on regulatory guidelines.

ORTHODONTIC CONTINUITY OF CARE

Members in previously authorized orthodontic treatment prior to joining MHS Indiana are eligible to receive services with the original orthodontist through treatment completion as long as the member remains eligible and enrolled. Members will be evaluated on a case-by-case basis to determine continuation of care specifics. Note that maximum Centene Dental benefit limits will apply.

In-Network Providers should submit a continuation of care prior authorization request to Centene Dental Utilization Management with the following**:**

- A copy of the prior health plan or carrier authorization;
- A copy of the provider's ledger showing reimbursement of all services provided to the member, including all remits/EOPs received; and
- A narrative detailing the remaining treatment plan and request for continuing care.

Out-of-Network Providers should email Centene Dental Case Management (dentalcaremanagement@centene.com) and provide the following:

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

Centene Dental will review the request to determine the remaining allowed coverage. A written notice will be sent to the requesting orthodontic provider when a determination is made.

OUTPATIENT HOSPITAL OR FACILITY AUTHORIZATION

Outpatient hospital or facility prior authorization requests must be made at the same time dental service authorization is requested. Providers must use a participating MHS facility and receive prior authorization. To obtain the most recent listing of hospitals in your area:

- Visit MHS Health Plan website: mhsindiana.com
- Call MHS Health Plan Provider Services: 877-647-4848

APPOINTMENT WAIT TIMES

If the member cannot be seen within one hour of their appointment time, the office shall advise the member and offer the option to reschedule the appointment. Wait times for scheduled appointments should not routinely exceed 60 minutes, including time spent in the waiting room and the examining room, unless the provider is

unavailable or delayed because of an emergency. If a provider is delayed, the member should be notified immediately. If a wait of more than 60 minutes is anticipated, the member should be offered a new appointment.

CLAIM SUBMISSION

Timely Filing Requirements

- Contracted Providers: 90 calendar days from date of service
- Non-Contracted Providers: 180 calendar days from date of service
- Claims with Primary Coverage (COB):
  - 365 calendar days from date of service; or
  - 60 days after primary carrier EOB date if primary carrier EOB is received greater than 365 days from date of service; or
- Corrected Claims: 60 calendar days from date printed on original EOP

Claims submitted beyond timely filing requirements are considered a provider liability, and members may not be billed. Services billed should include applicable arch, quadrant, and tooth identifiers.

Submit claims in one of these formats:

- Centene Dental Provider Web Portal at centenedental.com/logon
- Electronic claim submission through selected clearinghouses: Payor ID 46278
- Alternate pre-arranged HIPAA-compliant electronic submissions
- Paper claims mailed to the address listed in the Provider Quick Reference (last page)
  - Must be submitted on a current (2019 or later preferred) ADA original claim form
  - Copies, handwritten or faxed forms are not accepted

Billing for Crowns, Dentures and Root Canals

The billed date of service for crowns is the final cementation date; for dentures, the insertion date; and for root canals, the final fill date.

PROVIDER CLAIM APPEALS & GRIEVANCES

Claim Appeals must be filed within 60 calendar days from the date of notification of payment or denial. All provider appeals and grievances will be resolved within 30 calendar days.

To file an appeal or grievance, providers may:

- Call 855-609-5157 for information
- Email dentalhwappeals@centene.com or dentalgrievances@centene.com, as applicable
- Write to the address listed in the *Provider Quick Reference* (last page)

PRIOR AUTHORIZATION APPEALS

Members or authorized representatives must submit prior authorization appeals directly to MHS within 60 calendar days of receipt of the denial letter to:

MHS Appeals
PO Box 441567
Indianapolis, IN 42644

Final determination regarding member appeals must be made by MHS within 20 business days of the date of receipt of the appeal request. MHS may request more time to review the appeal, in writing, on or before the end of the 20th business day, or the appeal will be approved.

CENTENE™
DENTAL SERVICES

mhs

MHS Indiana Dental Benefits
Provider Quick Reference

Provider Web Portal (PWP)
centenedental.com/logon
	• Verify member benefits and eligibility
	• File claims and review claim status
	• Download, research and reprint EOPs
	• Request/submit secure, HIPAA compliant prior authorization
	• Access important provider information
	  ○ Covered dental codes and details
	  ○ Clinical policies
	  ○ Provider manuals, training, bulletins

Website
centenedental.com
	• View member ID card examples
	• Update provider forms, including:
	  ○ Electronic Funds Transfers (EFT)
	  ○ Disclosure of Ownership (DOO)
	• Credentialing documents
	• Read timely provider news and newsletters

Electronic Clearinghouse Authorizations and Claims	Centene Dental Payor ID Number 46278 NEA: 463026 ENVD IN MHS - HP Basic (19-20 yrs. old) 463027 ENVD IN MHS - HP Plus 463028 ENVD IN MHS - HIP Basic, Plus, Pregnancy 463029 ENVD IN MHS - Hoosier Care Connect 463031 ENVD IN MHS - Hoosier Healthwise Package A 463032 ENVD IN MHS - Hoosier Healthwise Package C
Paper Authorizations, Claims, Provider Claim Appeals	Centene Dental Services PO Box 20847 Tampa, FL 33622-0847
Automated Member Eligibility Verification System 24 hours/7 days a week **Customer Service Phone Number** Monday through Friday 8 am – 8 pm local time	855-609-5157
Provider Relations *(for questions not related to member benefits/eligibility)*	Email Provider Relations (dentalproviderrelations@centene.com)
Member ID Card	Please visit our website to view health plan ID card examples (centenedental.com/mystate).