CENTENE™

DENTAL SERVICES

# 2025 Provider Manual

# Contents

# WELCOME

Welcome to Centene Dental! Thank you for being part of our network of dentists and oral healthcare professionals. We look forward to working with you to improve the health of our community.

## About Centene Dental

Envolve Dental, doing business as Centene Dental, is a wholly owned subsidiary of Envolve Benefit Options, Inc. and Centene Corporation, Inc.

We are a dental benefits manager committed to improving the oral health of the community one smile at a time, which leads to improved overall health of individuals. Our provider education programs, personal attention and support teams create a comprehensive dental care system that reduces administrative burden for providers and offers quality dental services for our clients' members.

## About This Manual

This manual contains helpful information about our operations, policies and procedures. The most updated version can be viewed on our Provider Web Portal (PWP) at centenedental.com/logon.

This provider manual supplies useful information about working with us. We strive to make information clear and user-friendly. If you have questions or suggestions about a topic in the manual, please email Provider Relations at dentalproviderrelations@centene.com. Our state-based phone lines are staffed Monday through Friday, 8 a.m. to 5 p.m. local time in most markets, unless otherwise indicated in the plan specifics.

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

## Common Links

| | |
|---|---|
| Website Home Page | centenedental.com |
| Secure Provider Web Portal | centenedental.com/logon |
| Online CDT Code Search Tool | centenedental.com/cdt |
| Dental Clinical Policies | centenedental.com/policies |
| ID Card Copies and Phone Numbers | centenedental.com/mystate |
| Online Medicare Benefit Summary | centenedental.com/benefits |
| Find A Dentist Page | centenedental.com/fap |
| Electronic Funds Transfer (EFT) | centenedental.com/eft |

## CONTRACTING

Dentists must sign a provider agreement and apply for network participation by completing credentialing documentation. Provider agreements are available by emailing our network development team; please refer to the Plan Specifics for the most updated contact information.

Providers must ensure that any contracted downstream entity, subcontractor or related entity assumes the same obligations as the provider 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 our Customer Service department, which will be glad to assist you.

## CREDENTIALING

To become a participating provider, all applicants must be fully credentialed and approved by our Credentialing Committee. The credentialing and re-credentialing process helps maintain a high-quality healthcare delivery system by validating the professional competency and conduct of providers. This includes verifying licensure, board certification, education, and identification of adverse actions, including malpractice or negligence claims, through the applicable state and federal agencies and the National Practitioner Data Bank. Participating providers must meet the criteria established by each health plan, as well as government regulations and standards of accrediting bodies.

We perform this process for most of our network providers; however, some states (including GA, IL, MS and OH) contract with a vendor to provide a centralized credentialing verification process. This section is specific to the Centene Dental credentialing and re-credentialing process; please refer to your state's documentation for those states who perform this process separately.

Centene Dental requires re-credentialing at least every three years in accordance with the National Committee of Quality Assurance (NCQA) regulations. It is essential that we maintain current provider professional information. This information is also critical for the health plan's members, who depend on the accuracy of the information in its provider directory.

Note: To maintain a current provider profile, providers are required to notify us of any relevant changes to their credentialing information in a timely manner.

Centene Dental has the exclusive right to decide which dentists it accepts as participating providers in the network. We do not discriminate based on age, race, ethnicity, gender, national origin, or religion when making credentialing determinations.

When a provider incurs a sanction or disciplinary action, we notify the provider, health plan and state (as applicable) and the provider is evaluated for continued participation in the network. Other important credentialing details include:

- Each provider must be credentialed, but only one application per provider is required, whether they practice at one or multiple locations.
- We send the provider a letter by U.S. mail to the provider's office address alerting them to an updated credentialing application. 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 before the three-year re-credentialing timetable, the provider must submit updated copies to us as soon as they are received from the issuing organization.
- The Disclosure of Ownership (DOO) statement must be updated and submitted at least every three years unless there is a change in ownership. A new disclosure form must be completed if changes to existing ownership occur.

## Right to Review and Correct Information

All providers participating within our network have the right to review information used to evaluate providers' credentialing and/or re-credentialing applications. This includes information obtained from any outside primary source such as the National Practitioner Data Bank, malpractice insurance carriers and state licensing agencies. This does not allow a provider to assess peer review-protected information such as references, personal recommendations, or other information.

Should a provider identify any erroneous information used in the credentialing/re-credentialing process, or should any information gathered as part of the primary source verification process differ from that submitted by the provider, the provider has the right to correct any erroneous information submitted by another party. The provider has 30 days to make the necessary corrections and submit them to the Centene Dental Credentialing Department. To request release of such information, a provider must submit a written request to our Credentialing Department. Upon receipt of this information, the provider has 14 days to provide a written explanation detailing the error or the difference in information. The Centene Dental Credentialing Committee then includes the information as part of the credentialing/re-credentialing process.

## Right to Be Informed of Application Status

All providers who have applied to join Centene Dental have the right to be informed of the status of their application, upon request. Providers also have the right to know what information can be shared with them and the process we take for responding to requests for application status. To obtain application status, please contact Network Development.

### Reconsiderations for Adverse Credentialing Determinations

We may decline an existing provider applicant's continued participation for reasons such as quality of care or liability claims issues. In such cases, the provider has the right to request reconsideration in writing within 30 days of formal notice of denial. All written requests should include additional documentation supporting the applicant's reconsideration for participation in our network. The Credentialing Committee reviews the reconsideration request at its next regularly scheduled meeting, but in no case later than 60 days from the receipt of the additional documentation. Centene Dental sends a written response to the provider's reconsideration request within 10 business days of the final decision.

### Re-credentialing

To comply with NCQA standards, we re-credential providers at least every 36 months from the date of the initial credentialing decision. Please refer to Plan Specifics under Provider Credentialing, as applicable. This process identifies changes in the practitioner's licensure, sanctions, certification, competence, or health status that may affect the ability to perform services the provider is under contract to provide. This process includes all providers, primary care providers, specialists and ancillary providers/facilities currently credentialed to practice within our network.

In between credentialing cycles, we conduct ongoing monitoring activities on all network providers. This includes an inquiry to the appropriate state licensing agency to identify newly disciplined providers and providers with a negative change in their current licensure status. This monthly inquiry helps ensure certain providers maintain a current, active, unrestricted license to practice in between credentialing cycles. Additionally, we review monthly reports released by the Office of Inspector General and other sources, such as VerifPoint, to identify network providers who have been newly sanctioned or excluded from participation in federal and state programs.

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

## MEMBER ELIGIBILITY AND SERVICES

### Member Eligibility

We offer three methods to verify member eligibility:

1. **Log on to our PWP.** Our secure provider website (centenedental.com/logon) lets you search by date of service and either the member's name and date of birth, or member's ID and date of birth. Our PWP helps you access a list of eligible members who have selected their services or were assigned to them. The patient roster is reflective of all demographic changes made within the last 24 hours.

2. **Call our automated member eligibility IVR system.** Call Customer Service from any touch-tone phone and follow the appropriate menu options to reach our automated member eligibility-verification system 24 hours a day, seven days a week. The system prompts you to enter the member ID and the month of service to check eligibility.
3. **Call our Customer Service team.** If you cannot confirm a member's eligibility using the methods above, call Customer Service. Follow the menu prompts to speak to a Customer Service representative to verify eligibility before rendering services. Customer Service will need the member's name, member's ID, and date of birth to verify eligibility.

Eligibility changes can occur throughout the month, and the patient roster does not prove eligibility for benefits or guarantee coverage. Use one of the above methods to verify member eligibility on the date of service. Verification of eligibility is not a guarantee of payment. Payment can be made only after the claim has been received and reviewed in light of eligibility, dental necessity and other limitations or exclusions. Additional rules may apply to some benefit plans.

### Member ID Cards

Each health plan issues member identification (ID) cards to members on a regular basis. Members are responsible for presenting the card on the date of service. We recommend each dental office photocopy the member's ID card and ensure it is current in the office records at each visit. Possession of an identification card does not guarantee eligibility. For examples of each health plan's member ID cards, please visit the applicable state page on our website.

### Language Assistance

Health plan members are eligible for complimentary language assistance and interpretation services, including sign language. Members should call the health plan's phone number on the back of their member ID card to determine eligibility at least several days prior to an appointment.

### Transportation Services

Depending on health plan benefits, some health plan members are eligible for complimentary non-emergency transportation services to and from healthcare appointments when they do not have other options available. Members should call the health plan's phone number on the back of their member ID card to determine eligibility and schedule a ride at least three days before the appointment date.

## PROVIDER GUIDELINES

### Member Confidentiality and HIPAA

The Health Insurance Portability and Accountability Act of 1996, commonly known as HIPAA, includes

a privacy rule to protect individually identifiable health information and a security rule that specifies administrative, physical, and technical safeguards to ensure the confidentiality, integrity, and availability of electronic-protected health information. A major goal of these rules is to allow the flow of health information to promote high quality healthcare while properly protecting individual health information.

Centene Dental complies with all federal and state laws and regulations relating to HIPAA and expects network providers to adhere to HIPAA rules as well. We require all contracted practitioners' offices to maintain and follow appropriate policies and procedures to ensure the confidentiality of member records and information. For additional details about HIPAA, visit the U.S. Department of Health and Human Services' website.

### *HIPAA Security Rules and Applications*

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

> Centene Dental asks provider office 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 we share member-related information.

**Integrity:** e-PHI is not altered or destroyed in an unauthorized manner.

> Patient data should be backed up to prevent loss in case of system crashes. Controls should be in place to identify data changes due to human error or electronic failures. Clinical notes cannot be modified or deleted, but addendums can be added. Patients have the right to ask for a change in their medical records.

**Availability:** Data or information is accessible and usable upon demand by an authorized person.

> Centene Dental enables only authorized, registered users to access the PWP containing patient information. The portal is available 24/7.

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

> All email correspondence that includes patient name and personal health details must be sent via secure email. **Providers should always encrypt emails containing patient details when initiating an email to us.** Centene Dental can initiate a secure, encrypted email to providers who can then reply while maintaining the security of the email. Call Customer Service for details.

In addition, the email subject line should not contain member name or ID. That information should be included only within the body of the email that is sent securely. Remember to employ the minimum necessary rule when submitting member data. This means using only the specific data required when submitting documents and other information to us. Please ensure that any supporting documentation you submit has been redacted to include only the minimum necessary. For example, if submitting an Explanation of Payment (EOP) as evidence for an appeal, please be sure to only include the information for the member in question and redact any other member data.

**Staff compliance:** People employed by provider offices and health plans (covered entities under HIPAA) adhere to rules.

At least one staff person must be designated as a security official responsible for implementing HIPAA requirements, ensuring training is completed by all staff upon hiring and annually, overseeing compliance, and carrying out appropriate sanctions for violations.

*Source: Department of Health & Human Services.*

## 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 promotes 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 appropriate and relevant competent care. Cultural competency 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 services are delivered in a culturally competent manner.

Centene Dental is committed to the development, strengthening, and sustaining of healthy provider and member relationships. Members are entitled to be treated with dignity and receive appropriate and quality healthcare. 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. The member experience begins at the front door. Failure to use culturally 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.

Centene Dental evaluates 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 they have access to medical interpreters, signers, and 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 who 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 members also explain race/ethnicity categories to a member so the member can 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 state.

The road to developing a culturally competent practice begins with the recognition and acceptance of the value of meeting the needs of your patients. We are committed to helping you reach this goal. Take into consideration the following as you provide care to health plan members:

- What are your own cultural values and identity?
- How do/can cultural differences affect 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?

Centene Dental has adopted the Culturally and Linguistically Appropriate Services Standards, as developed by the Department of Health and Human Services, Office of Minority Health, which serves as a key resource in providing culturally sensitive services. **We encourage our participating providers to complete the U.S. Department of Health and Human Services Physician Practical Guide to Culturally Competent Care**, which equips healthcare professionals with the skills necessary to better treat the diverse populations that they serve. This accredited educational program is available online and is free of charge. For registration information, please visit cccm.thinkculturalhealth.hhs.gov.

## Non-Discrimination

Envolve Dental, Inc. dba Centene Dental Services and its subsidiaries (collectively "Dental Services"), complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex (including pregnancy, sexual orientation, and gender identity). Dental Services does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex (including pregnancy, sexual orientation, and gender identity).

Dental Services:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
    - Qualified sign language interpreters.
    - Written information in other formats (large print, audio, accessible electronic formats, and other formats).
- Provides free language services to people whose primary language is not English, such as:
    - Qualified interpreters.
    - Information written in other languages.
    - If you need these services, contact the Dental Services' Provider Services Department at 855-735-4395.

If you believe that Dental Services has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex (including pregnancy, sexual orientation, and gender identity), you can file a grievance with:

1557 Coordinator
PO Box 31384
Tampa, FL 33631
855-577-8234
TTY: 711
FAX: 866-388-1769
SM_Section1557Coord@centene.com.

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, our

1557 Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW, Room 509F, HHH Building
Washington, D.C. 20201
800-368-1019 or 800-537-7697 (TDD)

Complaint forms are available at the Office for Civil Rights website.

This notice is available on the Dental Services website.

## Referrals to Specialists

**Centene Dental does not require general or pediatric dentists to obtain a referral to dental specialists.** If a specialist is needed, providers should recommend to members a specialist in our network. Participating network specialists can be found on our website Find A Dentist page or the health plan's Find a Provider site.

Some specialists may have an office policy requiring a referral before they schedule an appointment for a member. Please consult directly with the specialist for office-specific referral requirements.

## Appointments and Access to Care

### *Appointment Accessibility Standards*

Centene Dental follows the accessibility requirements set forth by applicable regulatory and accrediting agencies and monitors compliance with these standards on an annual basis. We use the results of appointment standards monitoring to ensure adequate appointment availability and reduce unnecessary emergency room utilization. Please refer to the Plan Specifics for more details.

### *Appointment Wait Times*

If a member cannot be seen for their scheduled appointment within a timely manner (typically within 30 minutes of the appointment time), the provider office should contact the member and offer the option to reschedule the appointment. Please refer to the Plan Specifics for more details.

### *24-Hour Access*

Centene Dental providers are required to maintain sufficient access to facilities and personnel to

provide covered services and ensure those services are accessible to members as needed 24 hours a day, 365 days a year as follows:

- A provider's office phone must be answered during normal business hours.
- After hours, a provider must arrange one of the following:
    - Access to a covering provider.
    - An answering service.
    - Triage service.
    - A voice message that provides a second phone number that is answered.
    - Any recorded message must be provided in English and Spanish, if the provider's practice includes a large population of Spanish-speaking members.

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

- The provider's office telephone number is only answered during office hours.
- The provider's office telephone is answered after hours by a recording telling patients to leave a message.
- The provider's office telephone is answered after hours by a recording directing patients to go to an emergency room for any services needed.
- A clinician returning after-hours calls outside 20 minutes for urgent calls or one hour for non-urgent calls.

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

Centene Dental monitors provider offices' after-hour coverage through surveys and mystery shopper calls conducted by our staff.

### *Access to Care*

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

Centene Dental prohibits all providers from intentionally segregating members from fair treatment, covered services and appointment availability provided to other members.

### *Telephone Arrangements*

Providers must:

- Answer the member's telephone inquiries on a timely basis.
- Prioritize appointments.
- Schedule a series of appointments and follow-up appointments as needed by a member.
- Identify and, when possible, reschedule broken and no-show appointments.
- Identify special member needs while scheduling an appointment (for example, wheelchair and interpretive linguistic needs, non-compliant individuals, or those people with cognitive impairments).
- Adhere to the following response time for telephone call-back waiting times:
    - After-hours telephone care for emergent, symptomatic issues within 20 minutes and non-emergent, symptomatic issues within one hour.
    - Same day for non-symptomatic concerns.
    - Schedule continuous availability and accessibility of professional, allied, and supportive personnel to provide covered services within normal working hours. Protocols shall be in place to provide coverage in the event of a provider's absence.

After-hours calls should be documented in a written format in either an after-hours call log or some other method, and then transferred to the member's dental record.

### *Missed Appointments*

The health plan member manual includes instructions for members to keep appointments or cancel and reschedule if unable to keep them. We recommend providers call members 48 hours prior to scheduled appointments to confirm the commitment and the location where services will be rendered. Please note:

- Providers can discontinue providing services if a member repeatedly misses appointments. Be sure to keep a record of occurrences in the member's file and refer the member to the health plan to identify a new dental provider.
- Your office's missed appointment and dismissal policies for health plan members cannot be stricter than your private or commercial patient policies.
- Providers may not charge health plan members for missed appointments.

## Patient Dental Records

All participating providers are subject to periodic chart audits and other record requests. Providers must comply with these requests; audits may take place in the provider's 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 Participating Provider Agreement and the American Dental Association Dental Records policy.

## Transfer of Dental Records

We expect participating providers to transfer a copy of all requested member dental files to other participating dentists as designated by us or as requested by the member. Providers also must provide a copy of a member's dental record upon their reasonable request at no charge, in addition to facilitating the member's medical record transfer to another provider at the member's request. Your office shall cooperate with Centene Dental in maintaining the confidentiality of member dental records at all times, in accordance with state and federal laws.

### Provider Office Information Updates

When there are demographic changes within your office, you must notify us at least 10 calendar days prior to the effective date of the change. This supports accurate claims processing as well as helps to make sure that our Find A Dentist website page and provider directories are up-to-date. Requests must be made in writing with corresponding and/or backup documentation. Please complete the Provider Data Request Form found on our website or contact our customer service team. Please also notify the state Department of Medicaid, as applicable.

### Office Conditions

Your dental office must meet applicable American Dental Association (ADA) and Occupational Safety & Health Administration (OSHA) standards. We require an attestation for each dental office location that the physical office meets ADA standards or describes how accommodation for those standards is made, and that dental recordkeeping practices conform with our standards.

### EPSDT

Providers should submit diagnoses that demonstrate medical necessity under Dental Services clinical policies or relevant clinical documentation with services they believe are medically necessary under applicable Early and Periodic Screening, Diagnostic, and Treatment requirements.

### Dental Health Guidelines and Periodicity for Ages 0-20

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. Please refer to AAPD website for the most recent guidance for children who are developing normally and do not have extenuating medical conditions or special needs. Providers should assess each child for his or her unique health needs and make appropriate adjustments intended to optimize the child's health.

## UTILIZATION MANAGEMENT

### Utilization Management Review

The Centene Dental Utilization Management (UM) program seeks to optimize a member's oral health status and access to quality dental care by providing services that are covered benefits, medically necessary, appropriate to the patient's condition, rendered in the appropriate setting and meeting professionally recognized standards of care.

The treating dental provider, in conjunction with the member, is ultimately responsible for making all clinical decisions regarding dental treatment. We inform this process by making benefit decisions based on the member's plan of covered services and established clinical policy guidelines. Payment may be denied for failure to obtain authorization for services that require plan approval or for rendering services outside Centene Dental clinical guidelines. All participating providers must hold the beneficiary harmless for remaining or denied charges when services are denied for these reasons.

## Centene Dental Affirmative Statement

Centene Dental does not reward practitioners, providers, or employees who perform reviews for issuing denials of coverage or care. Utilization Management decision-making is based only on appropriateness of care, service, and existence of coverage. UM decision-makers are not given financial incentives to make decisions resulting in underutilization. Coverage denials are based on lack of medical necessity or lack of covered benefit.

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

## Clinical Policy Guidelines

Centene Dental uses objective clinical policy guidelines founded upon evidence-based dentistry to determine medical necessity when making utilization decisions. We take individual circumstances and the local delivery system into account when determining the medical appropriateness of dental services. All clinical policy guidelines and the procedures for applying criteria are developed, adopted, and evaluated annually by dental directors through a formal process. A UM Committee reviews and approves the clinical policy guidelines and procedures for applying criteria.

Current clinical policies are published on our public website at centenedental.com/policies. To request paper or electronic copies of clinical policy guidelines, please contact our Customer Service team (see Plan Specifics for the most up-to-date contact information).

## Retrospective Review

Retrospective review considers practice standards and patterns based on claims data history, in comparison to other providers in the same geographic area. Centene Dental conducts utilization reviews to analyze variations in treatment patterns that may be significantly different among

providers in the same area. General dentists are not compared to specialty dentists.

If significant differences are evident, we may notify providers if their practice patterns are not in keeping with their peers. If deviations occur over time, we may initiate an audit of member records to determine the practice's appropriateness of care.

## Medical Necessity

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

- Appropriate and consistent with the diagnosis of the treating provider and the omission of which could adversely affect the eligible member's medical condition.
- Compatible with the standards of acceptable medical practice in the community.
- Provided in a safe, appropriate, and cost-effective setting given the nature of the diagnosis and severity of the symptoms.
- Not provided solely for the convenience of the member or the convenience of the healthcare provider or hospital.
- Not primarily custodial care unless custodial care is a covered service or benefit under the members evidence of coverage.

There must be no other effective and more conservative or substantially less costly treatment, service and setting available. In no instance shall Centene Dental cover experimental, investigational or cosmetic procedures. Determination of medical necessity for covered care and services, whether made on a prior authorization, pre-payment/retrospective review, or exception basis, must be documented in writing. The determination is based on dental information provided by the member, the member's authorized representative which may include family/caretaker and the dental provider, as well as any other programs or agencies that have evaluated the member.

All such determinations must be made by qualified and trained dental care providers.

## Authorization Requests

Centene Dental considers all state-required benefits and applies clinical standards to them, explicitly outlining for providers what conditions must be present for the covered benefits to apply. Please refer to the clinical policy guidelines posted on the PWP for more information. Providers should measure intended services to the clinical policy guidelines before treatment begins to assure appropriateness of care.

The prior authorization and pre-payment review processes are 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 may be

monitored via pre-payment review. That is, as long as the clinical policy guidelines for a service are met and the required documentation supports the criteria, the service will be approved, and the claim will be paid. (See the next section for specific details about prior authorizations and pre-payment reviews and submission options for each.)

## Prior Authorization

Failure to obtain the required approval or prior authorization may result in a denied claim(s). All services are subject to benefit coverage, limitations, and exclusions as described in applicable plan coverage guidelines. Centene Dental providers are contractually prohibited from holding any member financially liable for any service administratively denied by us for failure of the provider to obtain timely authorization.

Prior authorization requires the provider or practitioner to make a formal medical necessity determination request to Centene Dental prior to the service being rendered. Upon receipt, the prior authorization request is screened for eligibility and benefit coverage and assessed for medical necessity and appropriateness of the oral health services proposed, including the setting in which the proposed care will take place.

An approved prior authorization is not a guarantee of payment. Prior authorizations address medical necessity criteria and appropriateness of care. Payment is ultimately based upon the member's eligibility on the date of service, documentation, and any policy limitations on the date of service.

## Procedures for Requesting a Prior Authorization

When possible, please submit prior authorization requests with complete documentation requirements to us at least 14 calendar days before the scheduled procedure.

Determinations are made based upon covered benefits, state- or plan-specific criteria, Centene Dental clinical policy, medical necessity criteria, and commonly accepted dental standards. We reserve the right to determine if a less costly service may adequately meet the member's needs.

An extension for prior authorization determination 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. Our staff attempts to contact the provider's office to obtain missing or incomplete clinical information required for determination. Providers may also visit the PWP for electronically submitted requests to view notifications related to missing or incomplete clinical information. Additional clinical information can be submitted via fax to 855-609-5171 or emailed to dentalauthorizations@centene.com. Please attach the member ID or assigned authorization number to your communication so requests can be processed within the decision deadline.

Urgent/expedited review is available when the treating provider indicates and/or Centene Dental determines the member's life, health, or ability to regain function may be jeopardized. The provider can indicate "Urgent" or "Expedited" on their prior authorization submission. Authorizations that do not meet urgent/expedited criteria are subject to routine processing under normal authorization timelines. In cases of emergency where required prior authorization is not possible, services are to be rendered but are subject to pre-payment review for all medical necessity criteria. We may deny claims that upon pre-payment review do not meet emergency criteria.

Centene Dental notifies providers of approval or denial of prior authorization as allowed or required by plan guidelines. Notifications include the authorization number for tracking purposes. Be certain your fax number, email, and physical address are always current to ensure accurate notification delivery. Authorization determinations are also visible on the PWP.

- Your office should contact members to schedule appointments when you receive an approved authorization.
- Prior authorizations are valid for the time span indicated upon the approval notification; however, an approved authorization does not guarantee payment. The member must be eligible at the time services are provided and all other payment criteria must be met. Providers are responsible for verifying eligibility on the service date.
- Providers are not allowed to bill the member, health plan, or us if services begin before authorization is determined and authorization is subsequently denied.

## Peer-to-Peer Review – Prior Authorization Denials

Utilization Management staff utilize Centene Dental clinical policy, ADA® coding guidance, and state and federal regulations to determine medical necessity of a requested service. When determinations are made, we send a notice of the outcome to the provider. The determination is also viewable on the provider's account on the Provider Web Portal.

Where the requesting provider believes additional clinical information exists which could modify an initial medical necessity denial decision, the provider may request a peer-to-peer phone call review. The Centene Dental clinical consultant who reviewed is the primary peer-to-peer dentist for the call. If the initial adverse determination dental consultant is not available for the peer-to-peer call, then another dentist of the same or similar specialty is selected to complete the call. Information from the denial will be made available to any dentist completing the peer-to-peer call. All Centene Dental consultants maintain active and current unrestricted dental licenses.

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

Offices may request a peer-to-peer review by phone by calling Provider Customer Service. The request will be processed by Centene Dental Utilization Management staff who will call the office

within one business day to schedule a phone appointment between the requesting dentist and the Centene Dental consultant at a mutually agreeable date and time.

The peer-to-peer discussion includes, at a minimum, the clinical basis for our 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 Centene Dental system, where the provider can access details in their Provider Web Portal account. The decision is also mailed to the requesting provider via U.S. Postal Service.

Peer-to-peer review is not a part of the formal 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.

## Pre-payment/Retrospective Review Authorizations

Pre-payment and retrospective review address the need for review of documentation after services have been provided to the member but prior to payment. Certain procedure codes may be subject to pre-payment review and require clinical documentation to be submitted with the claim. Alternatively, providers may also be placed on pre-payment review as part of an audit outcome. Retrospective review is available when prior authorization was not able to be obtained due to extenuating circumstances (for example, member was unconscious at presentation, urgent/emergent care was required, etc.). Requests for retrospective review must be submitted promptly and before claims for these instances are filed.

Where the treating provider indicates and/or we determine that the member's life, health, or ability to regain function would be compromised, prior authorization requirements may be replaced with retrospective review. Dental providers are encouraged to treat the member, call us within two business days and to record the incident in the member's dental record. After these steps and within timely filing standards, submit the completed retrospective authorization by mail with all required authorization documents on a current ADA claim form. All urgent/emergent review requests are evaluated by the dental director, 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 emergency conditions were not met.

## Time Frames for Prior Authorization Requests and Notifications

Centene Dental makes decisions as expeditiously as the member's health condition requires. Providers must obtain authorization prior to delivery of certain elective and scheduled services. Please refer to the Plan Specifics for authorization determination time frames for each state and health plan product.

| Service Type | Authorization Type | Conditions | Action | Authorization Request Time Frame |
|---|---|---|---|---|
| Standard | Prior Authorization | Required prior to treatment for certain codes identified in the Plan Specifics and corresponding dental codes | Check the Plan Specifics and corresponding dental codes for requirements | At least 14 calendar days before scheduled procedure |
| Urgent/ Emergent | Retrospective Review | Situations involving severe pain, swelling, infection, uncontrolled hemorrhage, or traumatic injury. Provider is confident the member's condition and the clinical criteria in this manual are equivalent, and codes are consistent for appropriate treatment and are covered benefits. | Treat the member. Call us within two business days to report the urgent service in the member's Centene Dental record. Submit the completed retrospective authorization and all required documentation. Claims should not be filed until approval notice is received. | Within two business days post-event. |

## Authorization Submission Procedures

When possible, authorization requests should be received at least 14 calendar days in advance of services being rendered. These may be submitted via our PWP at centenedental.com/logon or:

- Electronic clearinghouses, using payor ID number 46278.
- Alternative pre-arranged HIPAA-compliant electronic files.
- Paper request typed on a current ADA original claim form (copies and handwritten or faxed forms are not accepted)

For urgent requests, submit your authorization request and notate "Expedited Request" in the Provider Web Portal or on your clearinghouse or paper submission. Our secure provider portal is the preferred method for submitting authorizations. The provider must be a registered user on the portal. If the provider is not already a registered user on the portal and needs assistance or training on submitting prior authorizations, the provider should contact their Provider Relations

representative.

We use the same electronic and paper formats to process authorization requests as well as claims. Please refer to the Claims and Billing section for more details on using these formats to submit authorization requests, including imaging requirements.

# CLAIMS AND BILLING

## General Billing Guidelines

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

It is important that providers ensure we have accurate billing information on file. We reject claims when billing information does not match the information in our files or a claim is missing required information. The provider is notified of the rejection. Incomplete claims cannot be entered into the system for processing.

To avoid payment delays, we recommend that providers notify us in advance of any changes to billing information by submitting an updated W-9 form to Provider Relations. Changes to a provider's Tax ID Number and/or address will not be processed from a claim form.

Clean claims that are eligible for payment must meet the following requirements:

- The member is eligible on the date of service.
- The service is a covered benefit on the date of service.
- Prior authorization processes were followed, as applicable.
- Claims must contain the provider's NPI (Type 1) in box 54.
- If you are a part of a group practice, include the group's NPI (Type 2) in box 49.

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

## Encounters vs. Claims

You are required to submit either an encounter or a claim for each service that you render to a health plan member.

Most facilities such as Federally Qualified Health Centers (FQHCs), Community Health Centers (CHCs), and Rural Health Clinics (RHCs) are reimbursed through encounter payments. It is mandatory to submit encounter data per state and federal guidelines. These providers can choose one of the four claim submission options to submit encounters. Note the following requirements:

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

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

### *Clean Claim Definition*

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

### *Non-clean Claim Definition*

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

### *Timely Filing Requirements*

For payment consideration, all claims must be received within timely filing standards that begin the date the service was provided. Claims received after this time frame are denied for failure to file timely. Please refer to the dental plan specifications for specific deadlines for the applicable state and health plan product.

## Claims Submission Information

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

### Required Information on Claim Form

A current original dental ADA claim form must be submitted for payment of services rendered. One claim form should be used for each patient and the claim should reflect only one treating dentist for services rendered. The claims must also have all necessary fields completed as outlined below:

### Header Information

Indicate the type of transaction by checking the appropriate box: Statement of Actual Services.

### Subscriber Information

- Name (last, first and middle initial)
- Address (street, city, state, ZIP code)
- Date of birth
- Gender
- Subscriber ID number

### Patient Information

- Name (last, first and middle initial)
- Address (street, city, state, ZIP code)
- Date of birth
- Gender
- Patient ID number

### Primary Payer Information

- Record the name, address, city, state and ZIP code of the carrier.

### Other Coverage

- If the patient has other insurance coverage, completing the “Other Coverage” section of the form with the name, address, city, state and ZIP code of the carrier is required. You will need to indicate if the “other insurance” is the primary insurance. You must provide documentation from the primary insurance carrier, including amounts paid for specific services.

### Other Insured's Information (If Other Coverage Exists)

If the patient has other coverage, provide the following information:

- Name of subscriber/policy holder (last, first and middle initial)
- Date of birth
- Gender
- Subscriber ID number
- Relationship to the member

### Billing Dentist or Dental Entity

Indicate the provider or entity responsible for billing, including the following:

- Name
- Address (street, city, state, ZIP code)
- License number
- Social Security number (SSN) or tax identification number (TIN)
- Phone number
- National provider identifier (NPI)

### Treating Dentist and Treatment Location

List the following information regarding the dentist that provided treatment:

- Certification — Signature of dentist and the date the form was signed
- Name (use name provided on the Practitioner Application)
- License number
- TIN (or SSN)
- Address (street, city, state, ZIP code)

- Phone number
- NPI

## Electronic Claims Submission

### *Provider Web Portal (PWP)*

The PWP (centenedental.com/logon) is user-friendly and the fastest way for claims to be processed and paid. Our secure 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 corresponding dental codes to ensure you include all required information before submitting. Providers who bill electronically must monitor their error reports and Explanation of Payments (EOPs) to ensure all submitted claims and encounters appear on the reports. Providers are responsible for correcting any errors and resubmitting the affiliated claims and encounters within your state or product-specified timeframe.

### *Electronic Clearinghouse and Attachments*

We work with selected electronic clearinghouses to facilitate dental offices that use one electronic source for all their insurance providers. Please check with your preferred vendor so that your software is up to date and confirm your first submission 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 payor ID number 46278 for all clearinghouses.
- 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, Explanation of Benefits, intraoral photographs, perio charts, and more. To use the system, go to Vyne Dental (formerly nea-fast) 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 Centene Dental as the payor (ID 46278), and receives a unique NEA tracking number. Next, include the NEA tracking number in the remarks section of all authorization requests and claims submissions
- Please use the product identifiers found in the Plan Specifics when submitting electronic files.
- Images you transmit are stored for three years in NEA's repository and can only be viewed by your office and us. Data and images remain secure with HIPAA-compliant standards. You should only give your office's NEA account login and password to authorized users. If you have questions about using FastAttach, please call NEA.

If you use a different electronic clearinghouse and would like us to consider participating, please

send your request to Customer Service. Include your practice name, technical contact details and average monthly claim volume.

### *Alternate HIPAA-Compliant Electronic Submission*

Electronic claim submissions must be HIPAA-compliant. We strongly recommend using our custom PWP 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, we will consider options to assist. To schedule an appointment with our technical specialists to discuss alternatives, please call or email Customer Service.

## Paper Claims

The following information must be included on a current ADA original claim form for timely claims processing:

- Member name
- Member ID number
- Member date of birth
- Provider name
- Provider location and service setting
- Billing location
- NPI and Tax ID 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). Mail paper claims with any required supporting documentation to us. **Please refer to *Claims Submission Information* section for more information on what information needs to be included when submitting a claim.**

## Claims Imaging Requirements

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

### *Do*

- Do send claims to the P.O. box designated in the applicable plan specific.
- Do submit all claims in a 9-by-12-inch or larger envelope.
- Do type all fields completely and correctly.

- Do submit on a current ADA original claim form.

*Don't*

- Don't submit handwritten claim forms *or they will be rejected.*
- Don't circle any data on claim forms.
- Don't add extraneous information to any claim form field.
- Don't use highlighter on any claim form field.
- Don't submit photocopied claim forms.
- Don't submit carbon copied claim forms.
- Don't submit claim forms via fax.

## Claims Adjudication, Editing, and Payments

We adjudicate all claims at least weekly with an automated processing system that imports the data, assesses it for completeness, and then analyzes it for correctness in terms of clinical policy guidelines, 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.

Claims are adjudicated (finalized as paid or denied) at the following levels:

- Clean claims within state guidelines of claim receipt.
- Non-clean claims within 30 business days from the date of the original submission or electronic claim receipt.

Once editing is complete, our system updates individual claim history, calculates claim payment amounts — including copays and deductible accumulations, if applicable — and generates a remittance statement and corresponding payment amount. Most clean claims are paid within 10 days of submission. Payments are made to the provider's Electronic Funds Transfer (EFT) account or to a check printer that delivers the paper check and remittance statement by U.S. mail.

Please remember:

- EFT is the quickest means to receive payments.
- Electronic remittance statements are available on the PWP. Insert the date span for remittances you want to view.
- Clearinghouses will not transmit Centene Dental remittance statements to providers.
- Remittance statements remain available on the PWP indefinitely.
- You can call Customer Service with questions about claims and remittances.
- All our EFT payments are no-fee. 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 the email address indicated. 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 PWP for all providers active with EFT. Visit our website for more information, including a link to the EFT form.

### *Provider Corrected (Resubmitted) Claims*

Providers who receive a claim denial due to incorrect or missing information can submit a "corrected claim" (also known as a claim adjustment) on a current ADA original claim form **within the timeline allowed per your state guidelines**. 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 and/or an incorrect code. If a service was denied for clinical reasons or medical necessity, do not submit a corrected claim; please refer to your plan-specific document for how to appeal clinical and medical necessity denials.

**To submit a corrected claim, providers may mail the corrected claim as follows:**

Complete a current ADA original claim form with:

- ALL codes originally submitted, including accurate code(s) and the corrected code(s), even if previously paid.
- ALL required documentation only for the corrected, unpaid codes.
- "CORRECTED CLAIM" typed on the top of the form, with the original claim number.

Corrections must be indicated on a current ADA original claim form as follows:

- Make the correction on the service line that was in error (for example, cross through the error and write in correct information).
- In the "Remarks" section of the form (box 35), write in the details of the correction (for example, add a tooth number, change to accurate service date, code, etc.).
- Do NOT highlight any items on the form. Doing so prevents our scanners from importing the information.
- Mail with correct postage to the address listed in the Plan Specifics.

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

### *Claim Adjustment*

When a provider can substantiate that additional reimbursement is appropriate, the provider may adjust and resubmit a claim. The provider has the option to submit the written request, Explanation of Payment, and all claims related documentation either electronically or by U.S. mail. The

adjustment request must include sufficient documentation to identify each claim. Please follow the same steps above for a corrected claim, instead typing “ADJUSTED CLAIM” at the top of the form. Incomplete requests are returned without further action. Mail with correct postage to the address listed in the Plan Specifics.

If overpayment errors occur, we need your cooperation in correcting the error and recovering any overpayment. If you identify a refund due to us, please mail your refund with the overpaid claim Explanation of Payment (EOP) along with an explanation. If we identify an overpayment, a notification of overpayment will be sent following the provider’s receipt of the overpayment. The notification will explain the reason for the refund.

A provider office may dispute the claim of overpayment and has the right to appeal the overpayment request. All appeals must be received per state guidelines from the date of Notification of Overpayment. The appeal must be in writing, explain why the provider’s office believes recoupment is not warranted, and contain any supporting documentation to be considered for review.

Refund checks and overpayment request appeals may be mailed to the PO box listed in the Plan Specific.

## Third-party Liability/Coordination of Benefits

Third-party liability refers to any other health insurance plan or carrier (for example, individual, group, employer-related, self-insured or self-funded, or commercial carrier, automobile insurance, or worker’s compensation) or program that is or may be liable to pay all or part of the healthcare expenses of the member. Medicare is always primary to Medicaid coverage.

Centene Dental providers shall make reasonable efforts to determine the legal liability of third parties to pay for services furnished to health plan members. Providers must submit the claim to the primary insurance for consideration and submit a copy of the Explanation of Benefits (EOB) or Explanation of Payment (EOP), or rejection letter from the other insurance when the claim is filed. If this information is not sent with an initial claim filed for a member, the claim will pend and/or deny until this information is received.

After receiving the primary insurer’s Explanation of Benefits (EOB), submit a claim for any remaining balance with the Explanation of Benefits (EOB) statement within the regulatory guidelines for the applicable state and product.

For PWP submissions, indicate the primary carrier information in the Other Insurance fields and once complete, then coordinate each service line in the Capture Other Insurance Information pop-up box from the claims entry page. Please attach a copy of the Primary Carrier Explanation of Benefits (EOB).

For EDI submissions, indicate the Primary Carrier information along with the Other Carrier payment amounts per service line. Please attach a copy of the Primary Carrier Explanation of Benefits (EOB).

Payments to providers will not exceed the contracted rate in the provider agreement. Claims are considered paid in full when the primary insurer's payment meets or exceeds the contracted rate.

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

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

If we are aware of other coverage information which is primary coverage, we will deny any claim submitted without the accompany Explanation of Benefits (EOB) from the primary payer. The provider may resubmit their claim within the applicable state guidelines according to the process above after the primary payer has processed the claim.

## Coordination of Benefits (COB) Timely Filing

Claims originally filed timely with a third-party carrier must be received within the regulatory guidelines for the applicable state and product.

## Continuity of Care

To assure members' medically necessary treatment, we honor authorizations from the member's prior dental benefit administrator through their expiration date. While health plans may differ in their continuity of care regulations, Centene Dental providers can always submit a request for authorization with the prior approval attached at any time following the member's transition to us to assure there is no gap in treatment.

## Billing the Member/Member Acknowledgement Form

Centene Dental reimburses only services that are medically necessary and covered through the health plan program. Providers are not allowed to "balance bill" for covered services if the provider's usual and customary charge for covered services is greater than our fee schedule, unless otherwise allowed by state or federal law.

Providers may bill members for services NOT covered by either the health plan or Centene Dental or for applicable copays, deductibles or coinsurance as defined by the state.

To bill a member for services not covered under the health plan program, or if the service limitations have been exceeded, be sure to obtain a completed and signed Non-Covered Services Liability Acknowledgement form that acknowledges the member's responsibility for payment of non-covered services. The form can be found on the PWP.

### Tips For Successful Claims Resolution

- Do not let claim issues grow or go unresolved.
- Call Customer Service if you can't verify a claim is on file.
- Do not resubmit validated claims on file unless submitting a corrected claim with the required indicators.
- File adjustment requests and claims disputes within contractual time requirements.
- If you must exceed the maximum daily frequency for a procedure, submit the medical records justifying medical necessity. If you have questions, call Customer Service.
- Medicaid is the payor of last resort. This means you must bill and get an Explanation of Benefits (EOB) from other insurance or source of health care coverage before billing us. Secondary claims must be received per state guidelines from the date of service, even if the primary carrier has not made payment.
- When submitting appeal or reconsiderations requests, follow the instructions in the *Claim Adjustment* section.

## RIGHTS AND RESPONSIBILITIES

### Member Rights

Centene Dental expects its providers to respect and honor health plan members' rights. Members have the right to:

- Have all their personal information, including their dental records, kept private.
- Be given choices about their healthcare.
- Know all their options.
- Never worry about someone forcing them to do something because it makes their job easier.
- Talk with their provider about their medical records; ask for and receive a copy of their medical records; ask for a summary of their record; request that their medical records be changed or corrected; and have their records kept private.

- Be able to request information on the Quality Assessment Performance Improvement Program (QAPI). The QAPI program assures that all members receive quality care and appropriate care. The QAPI program focuses on improving clinical care and non-clinical care that will result in positive health outcomes.
- File a complaint against a provider about the service/care they received. If they file a complaint, no one can stop them from continuing to get services.
- File an appeal when they are unhappy about the outcome of a complaint or decision.
- Know how to file an administrative review for a decision not to pay for a service or limit coverage.
- Know that they or their provider will not be penalized for filing a complaint or administrative review.
- Not pay if the health plan runs out of money to pay their bills.
- Have medical services available to them under their health plan in accordance with 42 CFR 438.20 through 438.210, which are the federal QAPI access standards.
- Be free from any health plan debts in the event of insolvency and liability for covered services in which the state does not pay the health plan.
- Never pay more than what the health plan would charge if the health plan must have someone else manage their care.
- Only have a small co-payment and/or deductible, as allowed by state laws and regulations as described in the Member Handbook.
- Only be billed by a provider if they have agreed to the following:
    - They signed a Member Acknowledgement Statement which makes them responsible for services not covered by the health plan.
    - They agreed ahead of time to pay for services that are not covered by the health plan.
    - They agreed ahead of time to pay for services from a provider who is not in the network and/or did not receive a prior authorization ahead of time and requested the service anyway.
- Be free from receiving bills from providers for medically needed services that were authorized or covered by the health plan.
- Be treated with dignity, respect, and privacy by health plan staff, providers, and their office staff.
- Choose a health plan provider and be told which hospitals to use.
- Change their provider without a reason.
- Know about other providers who can help them with treatment.
- Know their rights and responsibilities with the health plan and to call if they have questions or comments or want to make recommendations about the member rights and responsibilities policy.
- Get information about the health plan’s organization and services, providers, hospitals, policies and procedures, their rights and responsibilities and any changes made.

- Get a second opinion.
- Know about all the services they will get. This includes:
    - Hours of operation.
    - How to get emergency care after hours.
    - How to get services if they are out of town.
    - What may not be covered.
    - What has limited coverage.
- Be told if their services change.
- Be told if we cancel a service.
- Be told if their provider is no longer available.
- Tell us and their provider if they need help talking to their provider. They will not have to pay if they are hearing impaired or if they do not speak English.
- Tell their provider what they like and don't like about their care.
- Speak with their provider about decisions related to their healthcare, including the right to refuse medical or surgical treatment to the extent of the law and to refuse to take part in medical research.
- Help set treatment plans with their provider, talk to their provider openly and understand their healthcare options, regardless of cost or benefit coverage.
- Understand their health problems and to speak with their provider about their treatment plans which they and their provider agree.
- Decide ahead of time the kind of care they want if they become sick, injured or seriously ill by making a living will or advance directive.
- Decide ahead of time the person they want to make decisions about their care if they are not able to by making a durable power of attorney.
- Be free from any form of restraint or seclusion as a means of force, discipline, convenience, or revenge.
- Exercise these rights. Also, to know if they do, it will not change how they are treated by the plan and its providers.

## Member Responsibilities

Health plan members have the following responsibilities to:

- Give information about themselves to the health plan organization, providers, and hospitals to help set treatment goals.
- Give information about their health to their provider.
- Understand their health problems and how to take their medicines the right way.
- Ask questions about their healthcare.
- Follow their instructions for care agreed upon by them and their physician or hospital.
- Help set treatment goals with their provider.

- Read the Member Handbook to understand how the health plan works.
- Call the health plan and ask questions when they don't understand.
- Always carry their health plan Member ID card.
- Show their ID cards to each provider.
- Schedule appointments for care with their provider.
- Go to the emergency room when they have an emergency.
- Notify the health plan as soon as possible if they go to the emergency room.
- Cooperate with people providing their healthcare.
- Be on time for appointments.
- Notify the provider's office if they need to cancel an appointment.
- Notify the provider's office if they need to change their appointment time.
- Respect the rights of all providers.
- Respect the property of all providers.
- Respect the rights of other patients.
- Not be disruptive in their provider's office.
- Keep all their appointments. To be on time and cancel within 24 hours if they cannot make it.
- Treat their provider with dignity and respect.

## Provider Rights

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

- Be treated by their patients and other healthcare workers with dignity and respect.
- Receive accurate and complete information and medical or oral health histories for members' care.
- Have their patients act in a way that supports the care given to other patients and that helps keep the provider's office, hospital, or other offices running smoothly.
- Expect other network providers to act as partners in members' treatment plans.
- Expect members to follow their directions.
- Make a complaint or file an appeal against Centene Dental, the health plan and/or a member.
- File a grievance with Centene Dental or the health plan on behalf of a member, with the member's consent.
- Have access to information about Centene Dental or the health plan quality improvement programs, including program goals, processes, and outcomes that relate to member care and services.
- Contact Centene Dental Customer Service with any questions, comments, or problems.
- Collaborate with other healthcare professionals who are involved in the care of members.

## Provider Responsibilities

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

- Help members or advocate for members to make decisions within their scope of practice about their relevant and/or medically necessary care and treatment, including the right to:
    - Recommend new treatments.
        - Provide information regarding the nature of treatment options.
        - Provide information about the availability of alternative treatment options, therapies, consultations, and/or tests, including those that may be self-administered.
        - Be informed of the risks and consequences as well as the benefits associated with each treatment option.
- Treat members with fairness, dignity, and respect.
- Not discriminate against members based on race, color, national origin, disability, age, religion, mental or physical disability, or limited English proficiency.
- Maintain the confidentiality of members' personal health information, including medical records and histories, and adhere to state and federal laws and regulations regarding confidentiality.
- Give members a notice that clearly explains their privacy rights and responsibilities as it relates to the provider's practice/office/facility.
- Provide members with an accounting of the use and disclosure of their personal health information in accordance with HIPAA.
- Allow members to request restriction on the use and disclosure of their personal health information.
- Provide members, upon request, access to inspect and receive a copy of their personal health information, including medical records.
- Provide clear and complete information to members, in a language they can understand, about their health condition and treatment, regardless of cost or benefit coverage, and allow the member to participate in the decision-making process.
- Allow a member who refuses or requests to stop treatment the right to do so, if the member understands refusing or stopping treatment may worsen the condition or be fatal.
- Respect members' advance directives and include these documents in the members' medical record.
- Allow members to appoint a parent, guardian, family member, or other representative if they can't fully participate in their treatment decisions.
- Allow members to obtain a second opinion, and answer members' questions about how to access healthcare services appropriately.
- Follow all state and federal laws and regulations related to patient care and patient rights.
- Participate in Centene Dental data collection initiatives, such as HEDIS®[1] and other contractual or regulatory programs.

[1] HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

- Review clinical practice guidelines distributed by Centene Dental.
- Comply with the Centene Dental Utilization Management program as outlined in this handbook.
- Disclose overpayments or improper payments to Centene Dental.
- Provide members, upon request, with information regarding the provider's professional qualifications, such as specialty, education, residency, and board certification status.
- Obtain and report to Centene Dental information regarding other insurance coverage.
- Notify Centene Dental in writing if the provider is leaving or closing a practice.
- Contact Centene Dental to verify member eligibility or coverage for services, if appropriate.
- Invite member participation, to the extent possible, in understanding any medical or behavioral health problems they may have and to develop mutually agreed upon treatment goals, to the extent possible.
- Provide members, upon request, with information regarding office location, hours of operation, accessibility, and languages, including the ability to communicate with sign language.
- Office hours of operation offered to members will be no less than those offered to commercial members.
- Not be excluded, penalized, or terminated from participating with Centene Dental for having developed or accumulated a substantial number of patients in the health plan network with high-cost medical conditions.
- Coordinate and cooperate with other service providers who serve members such as Head Start Programs, Healthy Start Programs, Nurse Family Partnerships and school-based programs as appropriate.
- Object to providing relevant or medically necessary services on the provider's moral or religious beliefs or other similar grounds.
- Disclose to Centene Dental, on an annual basis, any physician incentive plan (PIP) or risk arrangements the provider or provider group may have with physicians either within its group practice or other physicians not associated with the group practice even if there is no substantial financial risk between Centene Dental and the physician or physician group.

# COMPLAINT AND GRIEVANCE PROCESS

## Provider Complaints and Appeals

Differences may develop between Centene 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 provider complaint or appeal.

### *Complaints*

The first level of managing a disagreement begins when a provider contacts us with a complaint. A complaint is defined as an expression of dissatisfaction received verbally or in writing about a policy, procedure, contracting, or other function about working with Centene Dental. We will acknowledge the complaint as applicable and respond in writing within 30 calendar days of the date of receipt. Call, email, or write with complaints using the contact information listed in the Plan Specifics.

### *Appeals*

An appeal is the mechanism for which providers may request a review of a decision that denied a payment or benefit,or if the provider is aggrieved by any rule, policy or decision made by us. Please refer to the Plan Specifics for the state and product for provider appeal details.

### Member Grievances and Appeals

A member, or member-authorized representative or a member's provider (with written consent from the member), may file an appeal for payment issues and/or utilization management or general grievance either verbally or in writing.

The health plan gives members reasonable assistance in completing all forms and taking other procedural steps of the appeal and grievance process, including, but not limited to, providing translation services, communication in alternative languages and toll-free numbers with TTY and interpreter capability.

We value our providers and will not take punitive action, including and up to termination of a provider agreement or other contractual arrangements, for providers who file an appeal or grievance on a member's behalf. The health plan helps both members and providers with filing an appeal or grievance by contacting the health plan directly.

Please refer to the Plan Specifics for more information. You may also refer to the health plan's member handbook or Evidence of Coverage for more information on member grievances and appeals.

## FRAUD, WASTE AND ABUSE (FWA)

Centene Dental takes the detection, investigation, and prosecution of fraud, waste and abuse very seriously. CMS definitions for FWA are defined as follows:

**Fraud:** Intentional deception, misrepresentation or omission made by someone with knowledge that it may result in benefit or financial gain. Examples of fraud:

- The health plan 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 ID card.

**Waste:** Providing medically unnecessary services.[2,3] Includes any practice that results in unnecessary use or consumption of financial or medical resources due to inefficiency. Example of waste:

- Providers who submit duplicate claims/services without allowing time for claim to be completed.

**Abuse:** A practice inconsistent with accepted business or medical practices or standards that results in unnecessary costs. Examples of abuse may include:

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

The primary difference between fraud and abuse is intention.

We perform ongoing claims audits that may result in taking actions against those providers who, individually or as a practice, commit waste, abuse, and/or fraud. These actions include but are not limited to:

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

## Fraud, Waste and Abuse Training

Centene Dental expects all providers and staff who provide services to complete FWA Training within 30 days of hire and annually thereafter. Training is available through the Centene Dental website, or a comparable training will be accepted. Providers should be prepared to provide

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

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

evidence of training completion if requested for auditing purposes. We expect all providers and staff to comply with applicable laws and regulations, including but not limited to the following:

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

## Reporting Fraud, Waste and Abuse

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

If a provider suspects another provider is inappropriately billing us or if a member is receiving unnecessary services, please contact Centene Dental's FWA hotline as indicated below. Centene Dental takes all reports of potential FWA seriously and investigates all reported issues.

Providers are required to cooperate with the investigation of suspected fraud and abuse by our Special Investigations Unit (SIU) department, state and federal government agencies, and local law enforcement agencies. If you suspect fraud and abuse by us, a member, or a provider, it is your responsibility to report this immediately.

You may report suspected cases of fraud and abuse anonymously. You may also report confidentially without fear of retaliation.

- Centene Dental Special Investigation Unit Email: CDVSIU@centenedental.com
- Centene Dental FWA Hotline: 866-685-8664

# QUALITY MANAGEMENT

The Quality Improvement Program provides an effective, systemwide, measurable plan for monitoring, evaluating and improving the quality of care and services in a cost-effective and efficient manner for our members. To this end, our aim is to produce better oral health outcomes at lower costs for our members while enhancing the patient experience and lowering the total cost of care.

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

- Continuity and coordination of care.
- Member and provider complaint/grievance system.
    - Member and provider satisfaction.
- Quality management.
- Timeliness and clinical appropriateness of care as required per state guidelines. If not otherwise specified, the standards below apply:
    - Provider appointment accessibility/availability.
    - Available member scheduling for urgent care within 24 hours.
    - Available member scheduling for routine/preventive dental appointments within 30 days of request, unless member requested otherwise.
- Provider network adequacy and capacity.
    - Network performance.
- Patient safety.
- Credentialing and re-credentialing of practitioners and providers.
    - Compliance with state, federal, and professional standards and guidelines. Providers should be able to produce documentation of compliance at the request of Centene Dental.
- Utilization management, including under and over-utilization.
- Denials and administrative reviews.
- Provider services.
- Quality management.

A copy of the Quality Improvement program is available to all participating providers upon request.

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

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

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

- Provide and build quality into all aspects of Centene Dental's organizational structure and processes and continuously strive for improvement in the delivery of care and patient safety to all members.
- Provide a formal process for the continuous and systematic monitoring, evaluation, intervention for improvement, and reassessment of the adequacy and appropriateness of clinical and administrative services provided us to members, practitioners, and other internal and external customers.
- Develop appropriate quality guidelines and standards for implementation by the QI Committee and subcommittees, departments, and personnel involved in quality issues including providers and their staff.
- Plan services will meet industry-accepted standards of performance.
- Facilitate culturally sensitive and linguistically appropriate services.
- Fragmentation and/or duplication of services will be minimized through integration of quality improvement activities across organization functional areas.
- Continuously assess the overall effectiveness of the guidelines and standards in all levels of service and care with appropriate measurements.
- Take corrective action when quality guidelines and standards are not followed or met.
- Make best efforts to adapt and modify guidelines and standards, at least annually, in accordance with the most recent state and federal regulations (including HIPAA) and the most up-to-date clinical/medical studies and practice guidelines.
- Support a high level of satisfaction as it pertains to the services provided by us to

members, providers and clients.

- Ensure key performance metrics are monitored such that any benchmarks not being met will be included for Quality Improvement initiatives.

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

## REVISION HISTORY

| Version | Revision Information | Date |
|---|---|---|
| 2.00 | ***Originating from the 2024 Provider Manual:***<br>• Updated language, URLs, formatting to reflect Centene Dental brand<br>• Added new sections:<br>  ○ Member ID Cards<br>  ○ Language Assistance<br>  ○ Transportation Services<br>  ○ Appointment Wait Times<br>  ○ Access to Care<br>  ○ Patient Dental Records<br>  ○ Transfer of Dental Records<br>  ○ Provider Office Information Updates<br>  ○ Office Conditions<br>  ○ EPSDT<br>  ○ Dental Health Guidelines and Periodicity for Ages 0-20<br>  ○ Tips for Successful Claims Resolution<br>  ○ Revision History<br>• Updated credentialing language to reflect states that perform their own credentialing<br>• Updated non discrimination language<br>• Clarified billing the member verbiage<br>• Clarified verbiage regarding complaint acknowledgement timeline<br>• Updated information on Fraud, Waste and Abuse<br>• Expanded on Quality Improvement details | 1/1/2025 |

Centene Dental Provider Manual

We welcome your input for future editions: cdvcommunications@centene.com