

IHCP WORKS  
ANNUAL  
SEMINAR

OCTOBER 2023

# Welcome



**OUR MISSION: TO IMPROVE THE ORAL HEALTH OF ALL**

\*DentaQuest is an independent company providing dental benefit management services on behalf of the health plan.

MDwise is an independent company providing dental benefit management services on behalf of the health plan.

INBCBS-CD-040233-23 October 2023

# Agenda

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

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



# Go Green Initiative



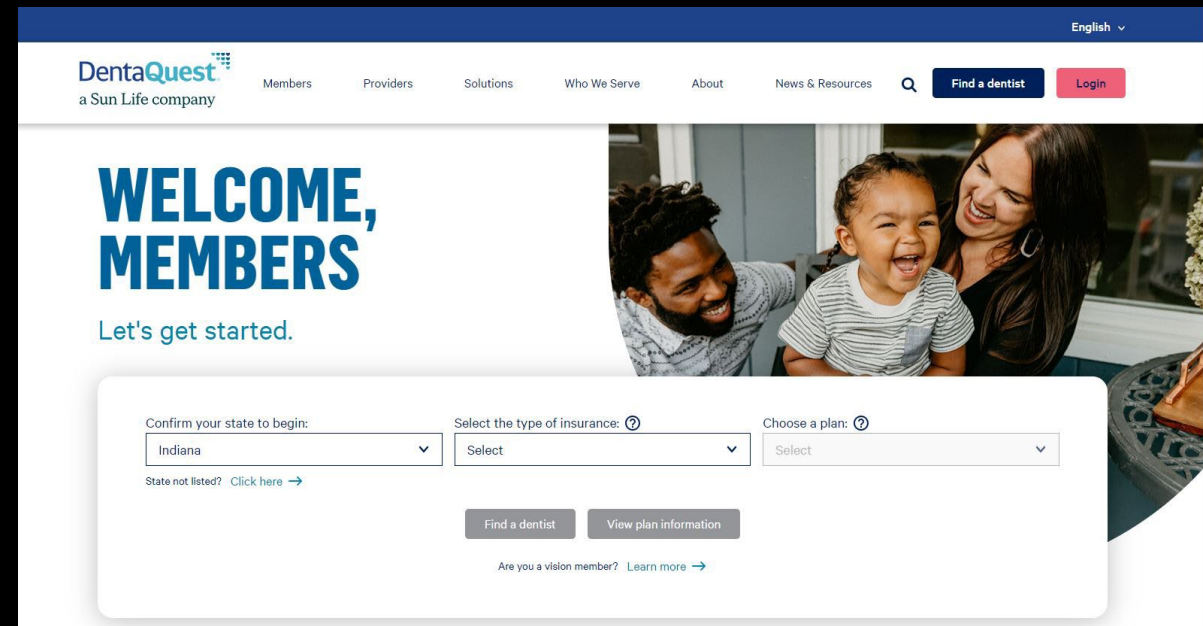
The Go Green Initiative includes:

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

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

# DentaQuest New Website

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



# Member Eligibility Validation

INDIANA MEDICAID for Providers

Home | Contact Us | FAQs | Login

Home | Friday 07/07/2023 12:12 PM EST

**Login**

\*User ID  
  
**Log In**  
[Forgot User ID?](#)  
[Register Now](#)  
[Where do I enter my password?](#)

**Broadcast Messages**

ATTENTION PROVIDERS: Beginning 7/1/2023, all PA requests will be processed by Kepro. Please send all PA-related documents, including clinical information, to Kepro effective 7/1/2023. This includes any communication about existing PAs that were submitted prior to 7/1/2023. Effective 7/1/2023, please also direct all PA-UM administrative review requests to Kepro.

Effective 7/1/2023, Kepro will also be the Right Choices Program (RCP) administrator for IHCP fee-for-service members, effective 07/01/2023. The RCP referral process will not change, and will continue to be submitted through the IHCP Provider Portal. However, RCP questions can be directed to the Kepro phone number listed below.

Effective 7/1/2023, Kepro's contact information is as follows: fax: 1-800-261-2774; mail: 6802 Paragon Place, Suite 440, Richmond, VA 23230; Kepro's toll-free telephone number: (866) 725-9991; or through the Atrrezzo Provider portal: <https://portal.kepro.com/>

**WHAT CAN YOU DO IN THE PROVIDER HEALTHCARE PORTAL?**

Through the Indiana Health Coverage Programs (IHCP) secure and easy-to-use internet portal, healthcare providers can:

- Submit claims
- Check on the status of their claims
- Inquire on a patient's eligibility
- View their Remittance Advices
- Request prior authorization

Managed Care Entities can:

- Enroll, disenroll, and update primary medical providers
- Review their encounter claims
- Inquire on a managed care member's eligibility

In addition, the Portal provides access to a wide variety of IHCP information and resources.

[Website Requirements](#)  
[Notify Me](#)

© 2023 Indiana Medicaid | R4.2 | Privacy Policy | Medicaid Provider Home Page

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

# DentaQuest Provider Portal

The screenshot shows the DentaQuest Provider Portal interface. At the top left is the DentaQuest logo. A navigation menu on the left includes: Administration, Claims/Pre-Authorizations/ Referrals, Patient, Tools, Privacy Policy, and Provider User Agreement. The top right corner shows the user role 'Dentist' and links for 'Home | FAQ | Ghost Sign Out'. The main content area is titled 'Welcome' and 'DQ Portal'. Below this is a 'Plan Messages' section with a message titled 'Attn: Indiana Providers' stating that 2023 manuals have been updated and are available under 'Related Documents'. There are links for 'Important Links - Posted 09/18/2015' and several manual links: 'Anthem HIP and Hoosier Care Connect Provider Manual', 'MDwise HIP Provider manual', and 'MDwise Hoosier Care Connect Provider manual'. A 'HIP Cost Estimator Notice' follows, explaining a tool for understanding dental care costs. On the right side, there is a photo of a man and a child, and two links: 'Event Calendar' and 'Related Documents'. A large black arrow points to the 'Related Documents' link.

## Provider Web Portal Home Page

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

# Patient Eligibility

## Member Eligibility List

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

 Printer Friendly Format

### Active

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

### Ineligible

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

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

# Patient Eligibility

# Service History

## Member Detail

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

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

\*=Required Fields

### Search

Service Date\*    (MM/DD/YYYY)


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

### Family

Select	Member Name	Member Number
▶	[REDACTED]	[REDACTED]

[View Benefit Maximums](#) [View Claims](#) [View Service History](#) [View Provider Directory](#)

Member Number
Date of Birth
Address
Home Phone
Work Phone
Fax



### Eligibility Information

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

### Primary Care Dentist

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

### Other Coverage

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


### User Account Information



# Service History Page

## Personal Health General Info

### Member Information

 Download File  Printer Friendly Format

Member Name

Date of Birth

Member ID

### Member Service History

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

## Member Detail

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

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

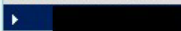

\*=Required Fields

### Search

Service Date\*    (MM/DD/YYYY)

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

### Family

Select Member Name	Member Number
	
<a href="#">View Benefit Maximums</a> <a href="#">View Claims</a> <a href="#">View Service History</a> <a href="#">View Provider Directory</a>	
Member Number	
Date of Birth	
Address	
Home Phone	
Work Phone	
Fax	

### Eligibility Information

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

### Primary Care

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


### Other Coverage

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

### User Account Information

## Benefit Plan Summary of Benefits

This page lists a summary benefits for a benefit plan.

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

# Office Reference Manual (ORM) Overview



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

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

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

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

# Office Reference Manual (ORM) Overview



Frequently asked questions found in the ORM.



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



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



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

# **TRUE PRIOR AUTHORIZATION**



**SERVICE MUST BE SUBMITTED AND APPROVED PRIOR TO TREATMENT**



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

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





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

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

**IF THEY CHOOSE TO SUBMIT AS A CLAIM  
CLINICAL REVIEW PROCESS WILL OCCUR  
& IF APPROVED CLAIM WILL PAY**



# Key Things You Should Know: Prior Auth Submission

## Prior Auth (PA) Submission

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

### **What does the processing policy “Service not reviewed” mean?**

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



# Key Things You Should Know: Provider Information Updates

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## **Make sure your office information is up to date.**

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

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

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

**You may access this information via the DentaQuest provider portal.**

**<https://govservices.dentaquest.com>**

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

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

## Peer to Peer Request

### What is a Peer to Peer?

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

### How do I make a Peer to Peer Request?

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

# Indiana Access and Availability to care for Medicaid Members

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

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

## **Anthem members**

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

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

# Indiana Access and Availability to care for Indiana MDWise Medicaid Members

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

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

## **MDWise Members**

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

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

# Your Frequently Asked Questions (Medicaid)

## **How to bill a member for non-covered service?**

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

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

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

## **Can a member be balanced billed?**

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

# Your Frequently Asked Questions (Medicaid)

## **What does it mean to “Hold Harmless”?**

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

## **Can your office collect deductibles based on the members’ primary insurance?**

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

# Questions and Answers

