HEALTH FIRST COLORADO (COLORADO'S MEDICAID DENTAL PROGRAM) – FREQUENTLY ASKED QUESTIONS

Q: What should I be aware of under DentaQuest's administration of the Health First Colorado benefits program?
A: Under DentaQuest's administration, providers can expect advantages including an easy-to-use provider portal, which is available 24/7 for your convenience, for electronic claims submissions, claims payment status and more; limited services that require a Prior Authorization Review (PAR); and availability of Pre-Payment Review (PPR), allowing you to treat members without need for a PAR. You will also have access to responsive provider contact center representatives, trained on the Colorado Medicaid program, as well as the availability of local, regionally-based provider relations representatives.

Q: Why is it necessary that I contact DentaQuest to verify my contact and payment information is correct? Isn't that information already on file?
A: We want to ensure accuracy of information for all Medicaid dental providers which allows us to ensure you receive prompt payment. To ensure your EFT and contact information are correct, we request that you contact DentaQuest at 855.225.1731 to verify your information. To protect your privacy, the state of Colorado is not able to share your EFT information with any Third Parties.

Application/Credentialing

Q: How does a new provider apply to participate as a Health First Colorado provider? (Reference ORM section 10.00)
A: The Colorado Department of Health Care Policy and Finance will continue to credential and enroll Providers. The online enrollment applications are available on the Department's website located at (https://colorado-provider-portal.xco.dcs-usps.com/hcp_v500/provider/Home). For instructions click on the "How to become a provider (enroll)" button.
If you have questions regarding your Medicaid provider enrollment or revalidation application, please contact

Colorado Medicaid Enrollment and Revalidation Information Center
800-237-0757, option 5.
Available Monday through Friday from 8:00 a.m. to 5:00 p.m.
Closed between 12:00 p.m. to 1:00 p.m.

EFT (Direct Deposit) (Reference ORM section 4.02)

Q: How do I enroll in EFT (Electronic Funds Transfer) or Direct Deposit with DentaQuest?

A: To protect your privacy, the state of Colorado is not able to share your EFT information with any Third Parties. This means providers will need to submit a separate EFT application to DentaQuest. To ensure your EFT and contact information are correct, please contact DentaQuest at 855.225.1731 to verify your information. You can also visit www.dentaquest.com for instructions on how to set up EFT with DentaQuest, simply go to the DentaQuest website please click on Dentists, select Colorado, click on Health First Colorado Provider Page, and then click on Electronic Funds Transfer (EFT).

Q: Does an office have to use EFT or can payment be received by mailed check?
A: No. The use of EFT is a preferred vehicle for payment however it is not required, and payment can be received via a mailed check.

Q. Will a breakdown of all weekly payments be available?
A. Yes. Providers will receive paper remittance statements also known as an Explanation of Benefits. Providers enrolled in the Direct Deposit Program will have access to their remittance statements/ EOB's online and will not receive paper remittance statements.

Claims (Reference ORM section 4.00)

Q. What different ways can a provider submit a claim?

A. DentaQuest is able to accept dental claims in any of the following four different methods:

- Electronic claims via DentaQuest's website (www.dentaquest.com)
- Electronic submission via clearinghouses.
- HIPAA Compliant 837D File
- Paper claims may be submitted by mail or fax.
    - Our claims mailing address is DentaQuest – CO, P.O. Box 2906, Milwaukee, WI 53201-2906
    - Our claims fax number is 262-834-3589

Q. How long do providers have to submit an initial claim?

A. Providers have 120 days from the date of service to submit their claim to DentaQuest.

Q. Do providers have access to reports of claims paid or denied?

A. Yes. Each DentaQuest Provider office will receive an Explanation of Benefit (EOB) report with their remittance. This report includes patient information and an allowable fee by date of service for each service rendered.

Q. When members have another dental insurance plan, do providers need to attach a Primary Insurance's Explanation of Benefits (EOB) statement to a claim?

A. Yes**.** When members have other insurance, that other insurance plan is always the primary payer. DentaQuest needs a copy of the primary insurance carrier's EOB to process the claim as the member's secondary insurance carrier.

Q. Can an office sign up for National Electronic Attachment (NEA)? (Reference ORM section 2.02)

A. Yes. To sign up for FastAttach, visit www.nea-fast.com or call NEA at 800-782-5150

Q. Are Pre-Authorizations required? (Reference ORM section 2.00)

A. Some dental codes do require an approved authorization for reimbursement. Approved authorizations should be obtained before providers submit a claim for processing. An authorization is a utilization tool that requires participating providers to submit "documentation" associated with certain dental services for a member which support the medical necessity of the service.

Reimbursement/Payment Timing

Q. Do reimbursements/fees change? Where can I find the fee schedule?

A. Fees can change. The State Medical Assistance Dental Program (Medicaid) is over seen by the State Legislature who annually appropriates or "budgets" the amount of dollars available for reimbursement to the providers as well as the fees for each procedure. Since there is usually no patient co-payment, these dollars represent all the reimbursement available to the provider. These "budgeted" dollars, being limited in nature, make the fair and appropriate distribution to the providers of crucial importance. There are some program elements that DentaQuest must implement as directed by the State of Colorado and the Department of Health Care Policy and Finance, and this includes the fee schedule for dental rates. The fee schedules for the Health First Colorado dental plans are available for your reference on our or website www.dentaquest.com and our on-line Provider Portal.

Q. Can a patient be billed for services not covered or denied? (Reference ORM section 4.10)

A. Colorado law prohibits providers from billing Health First Colorado Dental Program Members or the estates of deceased Members for services that are covered benefits. Providers may bill a member for non-covered services if the provider has obtained a written acknowledgment of financial responsibility from the member prior to rendering such services.

Q. Do members have co-pays?
A. Some members are responsible for a co-payment. By federal law, providers may not refuse services if the client cannot pay a co-payment when services are rendered. Clients may be billed for unpaid co-payments.

Q. Can a provider be reimbursed for missed appointments? (Reference ORM section 4.10)
A. Providers may not bill DentaQuest for missed appointments, telephone calls, completion of claim forms, or completion of medication refill approvals.

Eligibility/Benefits (Reference ORM section 1.04)

Q. How do providers check member eligibility?
A. Participating providers have access to member eligibility information through DentaQuest's Interactive Voice Response (IVR) System, and through DentaQuest's website located at www.dentaquest.com. To access the IVR, simply call DentaQuest's Customer Service Department at 855.398.8411 and press 1 for eligibility. Providers can also verify member eligibility via the Colorado Department of Health Care Policy and Financing Provider Portal www.colorado.gov .

Q. Should providers check member eligibility on the date of service?
A. Yes**.** Participating providers are responsible for verifying that members are eligible on the date that services are rendered and to determine if recipients have other health insurance.

Q. Are there limitations on services, procedures or age?
A. Some codes do have set limits. Please refer to our online ORM in the Exhibit A, Benefits table for a comprehensive list, found on our website www.dentaquest.com .

Q. How often do providers receive claim statements/ Evidence of Benefits (EOB)?
A. Each DentaQuest provider office receives an "explanation of benefit" report with their remittance. This report includes patient information and an allowable fee by date of service for each service rendered. Statements and EOB's are generated weekly when there is claim activity.

Q. Will members receive an EOB via mail? (Reference ORM pg. 4)
A. Yes. All members have a right to receive pertinent written and up-to-date information about DentaQuest, the managed care services DentaQuest provides, the participating providers and dental offices, as well as members rights and responsibilities.

Payment Authorization Review (PAR) (Reference ORM section 4.03)

Q: How do I submit a Prior Authorization Review (PAR)?
A: As of July 1, 2014, PARs need to be submitted directly to DentaQuest via either the online provider portal or paper submission for review.

Q. What services require prior authorization?
A. Many services such as Orthodontic care and all hospital or surgery center dental care require prior authorization. Please refer to the benefit grids available in our ORM, for a comprehensive list of codes which includes prior authorization requirements. Providers should ensure they have an authorization determination before providing any non-emergency service that requires authorization.

Q. What if I'm confident a service is medically necessary, do I have to request a Prior Authorization Review?
A. In this program Prior Authorization Review (PAR) of certain services is required to ascertain medical necessity prior to the provider proceeding with medically necessary treatment. In an effort to allow greater freedom to the provider to appropriately treat a patient in a timely manner, DentaQuest allows a Pre-Payment Review (PPR) process for some codes. PPR allows the provider to bypass the PAR process when they are confident that the PAR

will be approved. Utilizing PPR, providers can treat the patient and submit the required documentation for review after the services have been performed, when requesting payment for the services, and using the same clinical criteria as PAR. This eliminates the need for a two-step process for payment. In this way, providers can pursue PAR or PPR, using the same criteria for both processes. Once providers are comfortable with the clinical criteria and documentation requirements listed in the ORM, many find the PPR process more acceptable. The only exceptions to the PPR process is orthodontic services and services provided in a hospital, both of which require PAR. Please refer to our online ORM in the Exhibit A, Benefits table for a comprehensive list of codes that are eligible for the PPR process, our ORM can be found on our website www.dentaquest.com and Provider Portal.

Q. Does a referral to a specialist require a Prior Authorization Review? (Reference ORM section 1.06)
A. No. Patients requiring a referral to a dental specialist can be referred directly to any specialist contracted with DentaQuest, without authorization from DentaQuest.

Q. What is the turnaround time for a Prior Authorization Review?
A. Two business days. An authorization number will be provided within two business days from the date the authorization review request documentation is received. The authorization number will be issued to the submitting office by mail and must be submitted with the other required claim information after the treatment is rendered.

Provider Web Portal

Q: How do I sign up for or access the online provider portal?
A: Our free easy-to-use, online provider portal can be accessed at your convenience, 24/7, at http://www.dentaquest.com/dentists/self-registration-page/. The portal can be used to submit electronic claims submissions, view claims payment status, and much more.

Q. How many users can be on the Web Portal?
A. 10

Q. If sharing a login, can more than one person be logged in at one time?
A. To protect patient and provider security DentaQuest encourages Dental Offices to provide each user with a separate login.

Q. Where can I access the ORM?
A. Our Office Reference Manual is available to providers on our web page www.dentaquest.com and Provider Web Portal.

Members

Q: Where can I direct my patients for more information on DentaQuest and the Health First Colorado dental benefits program?
A: Providers can direct Health First Colorado members to our website located at www.dentaquest.com or to our toll-free member service line at 1-(855)-225-1729.

Additional Questions

Q: I have additional questions. Where can I go for more information?
A: DentaQuest offers many resources to our Health First Colorado dental providers:
• DentaQuest website – www.dentaquest.com/colorado
• Providers can call our information line – 1-(855)-225-1731. Our offices are open 7:30 am-5pm MDT, Monday to Friday.
• Participating Health First Colorado Providers can also utilize our online provider portal - http://www.dentaquest.com/dentists/self-registration-page/. The Provider Portal is available at your convenience, 24 hours a day, seven days a week.

• Providers can utilize self-service assistance via our Interactive Voice Response system, available 24 hours, 7 days a week

Non-Citizen Immigrants and Emergency Dental Services (Reference ORM sec 1.05)
Dental services for non-citizens are limited to emergency treatment of the oral cavity (refer to section 5.01 – Emergency Treatment for Oral Cavity Conditions Adults). No other dental services are a benefit for non-citizens under any circumstances. Coverage does not include follow-up care. An unsupervised dental hygienist cannot provide and bill dental services for a Health First Colorado non-citizen Member of any age.

Member Eligibility in the DentaQuest Web Portal
To look up member eligibility on the DentaQuest Provider Portal, an accurate Date of Birth (DOB) and a member ID is needed. If you verified a member's eligible on the Colorado Department of Health Care Policy and Financing's Provider Portal and see that the DentaQuest Provider Portal is not showing the member to be eligible, a guarantee number generated on the Date of Service (DOS) through an Eligibility Response from the Colorado Department of Health Care Policy and Financing's Provider Portal can be used.