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KanCare | sunflower health plan

APPENDIX: PLAN SPECIFICS

SUNFLOWER HEALTH PLAN MEDICAID DENTAL BENEFITS

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

Envolve Dental administers the dental benefit for Sunflower Health Plan. Sunflower Medicaid members are eligible for clinically indicated dental services within the scope of the Kansas Medical Assistance Program (KMAP) as detailed below. In addition to standard Medicaid dental benefits Sunflower provides adults 21 and older a value-added benefit of one dental checkup every six months and eligible I/DD members the option of a dental practice visit.

We provide dental services to the following KanCare Medicaid member eligibility categories:

- Children, Title 19 (ages 0-20) and Title 21 CHIP (ages 0-18)
- Adults, Title 19 (ages 21+) (includes eligible HCBS waiver adults not listed below)
- Home and Community Based Services (HCBS) Adults in Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID) (ages 21+)
- Home and Community Based Services (HCBS) Adults with Frail Elderly (FE) Waiver (ages 65+)

MEMBER BENEFIT AND ELIGIBILITY INFORMATION AVAILABLE 24/7

- For specific individual member benefits and eligibility, access Envolve Dental's Provider Web Portal (envolvedental.com/logon)
- You may also call 855-434-9245 to reach Envolve Dental's automated member eligibility-verification system

COVERED DENTAL SERVICES AND CODES

Envolve Dental provides dental services for KanCare covered Medicaid members. Dental coverage is consistent with KanCare benefits, limits, and exclusions: https://www.kancare.ks.gov/home. For detailed coverage and coding information, please visit Envolve Dental's Provider Web Portal: envolvedental.com/logon and search using the online grid tool.

Sunflower Health Plan Medicaid Plans	Dental Benefit Summary (may include additional benefits) *Review Envolve Dental's clinical policy guidelines on the Provider Web Portal prior to providing services
Children, Title 19 *(ages 0-20)* **Children, Title 21 CHIP** *(ages 0-18)*	• 1 periodic oral exam twice per calendar year • 1 cleaning twice per calendar year • 1 bitewing code per date of service, per beneficiary, per provider or provider billing group • Full-mouth radiograph series (D0210 includes bitewings) or panoramic x-rays (D0330) once every 36 months • Periodontal services including scaling and root planing • Sealants for members up to age 20 (one per tooth, per 12 months) • Minor restorative services, such as fillings • Major restorative services, such as crowns • Tooth extractions (based on medical necessity)

	• Orthodontia for members through age 20 (based on medical necessity) • Dentures, partials, and denture repairs (with limits) • Other dental surgery (with limits)
Adults, Title 19 (includes HCBS waiver adults not listed below) *(ages 21+)*	• 1 periodic oral exam twice per calendar year* • 1 cleaning twice per calendar year* • 1 bitewing code per date of service, per beneficiary, per provider or provider billing group • Tooth extractions (based on medical necessity) • Other dental surgery (with limits) • Limited denture services (PD Waiver only)** • Office visit for observation (I/DD Waiver only)***
HCBS Adults ICF/IID *(ages 21+)* **HCBS Adults FE Waiver+** *(ages 65+)*	• 1 periodic oral exam twice per calendar year • 1 cleaning twice per calendar year • 1 bitewing code per date of service, per beneficiary, per provider or provider billing group • Full-mouth radiograph series (D0210 includes bitewings) or panoramic x-rays (D0330) once every 36 months • Periodontal services including scaling and root planing • Minor restorative services, such as fillings • Major restorative services, such as crowns • Tooth extractions (based on medical necessity) • Dentures, partials, and denture repairs (with limits) • Dental surgery (with limits) • Office visit for observation (I/DD Waiver only)***

VALUE-ADDED SERVICE: ADULT DENTAL VISITS*
Sunflower Health and Envolve Dental offer a value-added dental benefit to adults 21 and older of two dental visits (cleanings, exams) for adults 21 and older every year, as reflected in the summary above.

VALUE-ADDED SERVICE: PHYSICAL DISABILITY (PD) WAIVER MEMBER DENTURES**
Dentures are covered for eligible members with PD Waiver benefits. Eligibility is based on medical necessity. Authorization is required.

VALUE-ADDED SERVICE: I/DD MEMBERS SPECIAL PRACTICE VISIT PROGRAM ***
As indicated in the summary above, Sunflower Health Plan and Envolve Dental offer a value-added dental benefit to Sunflower members who are eligible for I/DD service (enrolled through KSADS Intellectual or Developmentally Disabled [I/DD] program). The purpose of the benefit is to increase preventive dental visits by supporting members with I/DD to feel comfortable in the dental office setting. All Envolve Dental providers are eligible and encouraged to participate.

The benefit should be billed with *D9430—Office visit for observation*, but it will be promoted to members as a "practice visit," where members go to the dental office to simulate a full dental exam. The benefit may be utilized twice per year, per member:

1. Sunflower will market the benefit to eligible members, explaining how the program works.

2. Members with I/DD or their authorized representatives will call the dental provider to schedule a 30-minute practice visit.
3. Provider schedules appointment.
4. The Sunflower Care Manager will fax to the provider the "Dental Practice Visit Tracking Form" prepared for the member's service date.
5. Member arrives on appointment date and completes as many of the skill steps as possible. Maximum time allowed for the visit is 30 minutes. If a full exam and cleaning are able to be completed, provider will bill D0120 and D1110 and *not* the D9430 for the practice visit.
6. Provider completes the skill step form and faxes it to Sunflower at the fax number indicated at the bottom of the tracking form. The same form is kept in the member's record and updated at each visit (one date per column).
7. After the first practice visit, Sunflower Health Plan mails member an electric toothbrush for participating.
8. Provider submits claim to Envolve Dental for D9430—Office visit for observation, *or* D0120 and D1110 if the exam and cleaning were completed.
9. Envolve Dental pays provider $30.00 for D9430 or contracted rates for D0120 and D1110.

HCBS FE WAIVER CRISIS EXEMPTION+

Members under the HCBS Frail Elderly (FE) Waiver are eligible for select oral health services with an approved crisis exemption. Authorizations for services for these members must include medical necessity and documentation demonstrating the following:
(1) Does the participant require emergency treatment to resolve an oral health issue that is life threatening?
(2) How will non-treatment of the oral health issue impact the participants health?
(3) Did the member have a treatment plan in place? If yes, what treatment remains in progress?

Services are reviewed for medical necessity based on this information.

AUTHORIZATION REQUIREMENTS

Some services require prior authorization to be obtained prior to rendering treatment. Other services are subject to pre-payment review with claim submission. To view the requirements per covered code, visit envolvedental.com/logon and search using the online grid tool. Please maintain documentation in the member's file of the necessity of services provided.

Members may receive an expedited/fast decision when life, health or ability to regain function may be jeopardized. In an emergency, a provider should not wait for prior authorization to provide treatment to the member. When possible, standard authorization requests should be received at least 14 calendar days in advance via:

- Envolve Dental Provider Web Portal at envolvedental.com/logon
- Electronic clearinghouses, using Envolve Dental payor ID number 46278
- Alternate, pre-arranged, HIPAA-compliant electronic files
- Paper request on a current, completed ADA claim form by mail
- For urgent requests, submit your authorization request and call Customer Service at 855-434-9245

Prior authorization decisions for non-urgent services shall be made within 14 calendar days from receipt of request. An extension may be granted if the member, provider, or Envolve Dental justifies the need for additional information and the extension is in the member's interest based on regulatory guidelines.

Orthodontic Continuity of Care
Sunflower Health Plan members who started orthodontic treatment prior to joining Sunflower will be evaluated on a case-by-case basis to determine continuation of care specifics. The current orthodontic provider can continue providing services for at least the first 90 days of the member's enrollment with Sunflower Health Plan. Envolve Dental will make best efforts to continue treatment at the recipient's current orthodontic office until care is completed.

The current provider must submit the following information to Envolve Dental in order to start receiving reimbursement:

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

An Envolve Dental Appeals Specialist will coordinate the request with clinical reviewers to determine the remaining treatments allowed per the benefit plan. The Appeals Specialist will also determine if the treatment will be completed by the current provider (if out-of-network), or if the member can finish treatment successfully with an in-network provider. A written notice will be sent by the Appeals Specialist to the requesting orthodontic provider when the determination is made. In all cases, the member's best possible outcome will be a significant determining factor.

Hospital or Facility Authorizations
Hospital or facility prior authorization requests must be made at the same time that the dental service authorization is requested. Providers must use a participating Sunflower Health Plan facility and receive prior authorization. To obtain the most recent listing of facilities in your area:

- Visit Sunflower Health Plan website: https://www.sunflowerhealthplan.com/
- Call Sunflower Health Plan Provider Services: 877-644-4623

CLAIM SUBMISSION
The timely filing requirement is 180 calendar days from the date of service for standard claims or 365 calendar days from the date of payment notification for corrected claims. No reimbursement will be made for claims received beyond this date. Claims received after the timely filing deadline will be considered a provider liability and members may not be billed for services. Include applicable diagnosis code, arch, quadrant or tooth identifiers as applicable when billing for dental services. Clean claims will be processed within state guidelines of receipt. Claims with retrospective review requirements may take additional processing time. Submit claims in one of these formats:

- Envolve Dental Provider Web Portal at: envolvedental.com/logon
- Electronic claim submission through selected clearinghouses: Payor ID 46278
- Alternate pre-arranged HIPAA-compliant electronic submissions
- Paper claims must be submitted on a current (2012 or later) ADA red or blue original claim form (copies and handwritten or faxed forms are not accepted) and mailed to:

Envolve Dental Claims
PO Box 25857
Tampa, FL 33622-5857

Billing for Crowns and Dentures
For crowns, the date of service must be billed according to the cementation date. For dentures, the billed date of service must be the “seat date”/date of insertion.

APPEALS & GRIEVANCES
Claim reconsideration (optional at provider’s request) must be requested within 120 calendar days of the Notice of Action date. Provider appeal requests must be filed in writing within 60 calendar days of the date of the notice action. Three additional calendar days will be allowed for mailing time. Reconsiderations and appeals will be resolved within 30 calendar days from the date of receipt.

To file a provider appeal or grievance, providers may:

- Call 855-434-9245 for information
- Email dentalappeals@envolvehealth.com or dentalgrievances@envolvehealth.com as applicable
- Write:

Envolve Dental Appeals and Grievances
PO Box 25857
Tampa, FL 33622-5857

Members (or providers on behalf of members) must submit prior authorization appeals within 63 calendar days from the Notice of Adverse Benefit Determination date to:

Sunflower Health Plan
Attn: Appeals Department
8325 Lenexa Dr., Suite 410
Lenexa, Kansas 66214
Fax: 1-888-453-4755
For Expedited Member Appeals Call: 1-877-644-4623

Member appeals will be resolved within 30 calendar days of filing, with possible extension of 14 calendar days if needed for information gathering.

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Sunflower Health Plan Medicaid Dental Benefits Envolve Dental Provider Quick Reference	

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

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

Electronic Clearinghouse Authorizations and Claims	• Envolve Dental Payor ID Number 46278 463005 ENVD KS Sunflower Medicaid 463060 ENVD KS Sunflower Ambetter (HIM) 463062 ENVD KS Sunflower Medicare
Paper Authorizations, Claims, Provider Appeals	Envolve Dental PO Box 25857 Tampa, FL 33622-5857
Automated Member Eligibility Verification System 24 hours/7 days a week **Customer Service Phone Number** Monday through Friday 8 am – 5 pm local time	855-434-9245
Customer Service Email Address	providerrelations@envolvehealth.com

MEDICAID MEMBER ID CARD: EXAMPLE ONLY