Welcome To Ambetter Sunflower Health Plan

Your Partner In Better Healthcare

2025 Provider Review

AGENDA

WHAT YOU NEED TO KNOW

- Our Networks
- Key Contact Information
- Provider Manual
- Support from Health Plan Departments
- Public Website and Secure Portal
- Verification of Eligibility, Benefits and Cost Shares
- Referrals
- Prior Authorization
- Claims, Billing and Payments
- Complaints, Grievances and Appeals
- Specialty Companies and Vendors

QUESTIONS & ANSWERS

2025 Provider Review

OUR NETWORKS

OUR NETWORKS

PREMIER*: The Ambetter core network – our broadest network of healthcare providers and hospitals offering affordable care to individuals or families that need to purchase healthcare coverage on their own. Referrals are not required.

Bronze	Silver	Gold
Elite Bronze	Clear Silver	Elite Gold
Everyday Bronze	Focused Silver	Everyday Gold
Standard Expanded Bronze	Standard Silver	Standard Gold

Clear Silver plan does not have vision and dental offering.

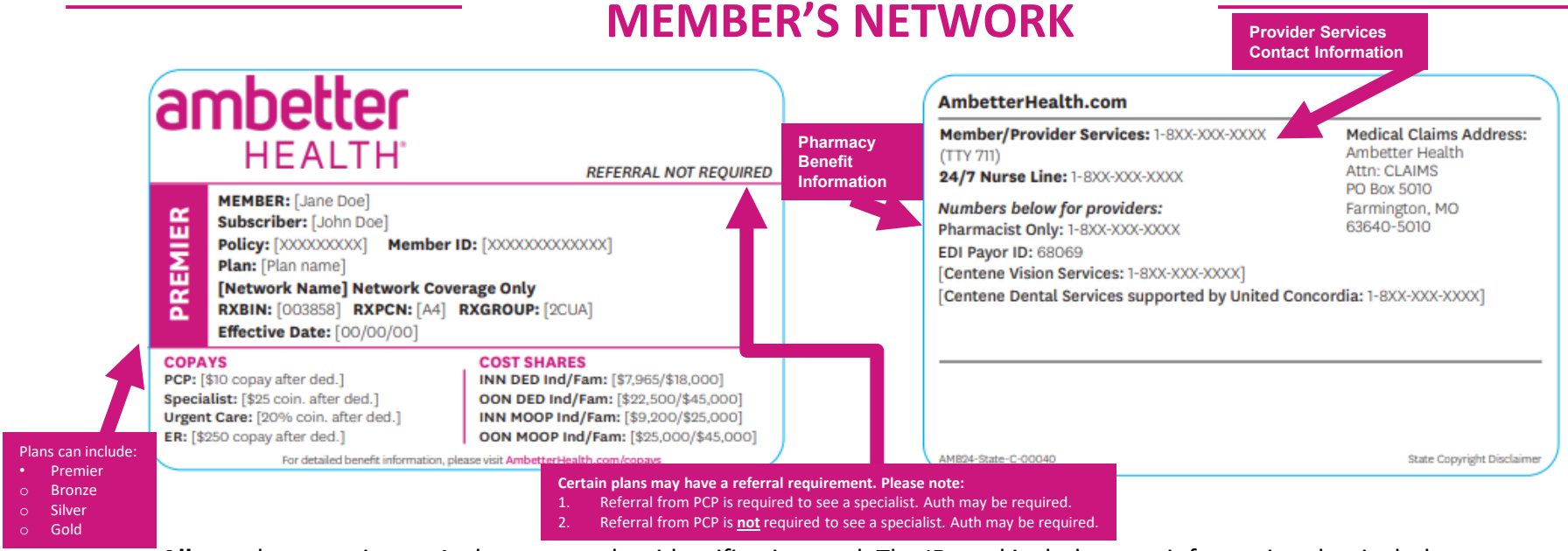
Premier formerly known as Bronze | Silver | Gold portfolio (Core).

Each Ambetter Health network is designed to offer members a unique type of coverage option specific to their state. This means that member plans and benefits can vary, and there may be referral requirements for certain types of care to be covered. As a provider, it is important you confirm which network and plan a member is in before extending care. This information is located on the member's ID card and can also be confirmed when verifying the member's eligibility.

**Network availability varies by state.*

Our Innovative Networks

HOW TO IDENTIFY A MEMBER'S NETWORK



All members receive an Ambetter member identification card. The ID card includes new information that includes:

- The **Ambetter Plan** the member has selected
- The **Provider Network** the member belongs to
- **Referral requirements** based on the member's plan selection.

Note: *Presentation of a member ID card is not a guarantee of eligibility. Providers must verify eligibility on the same day services are rendered.*

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WHAT YOU NEED TO KNOW

KEY CONTACT INFORMATION

Ambetter from Sunflower Health Plan

PHONE
1-844-518-9505

TTY
711

WEB
ambetterhealth.com/en/ks/

PORTAL
provider.sunflowerhealthplan.com

AMBETTER PROVIDER MANUAL

THE PROVIDER MANUAL IS YOUR COMPREHENSIVE GUIDE TO DOING BUSINESS WITH AMBETTER FROM SUNFLOWER HEALTH PLAN.

The manual includes a wide-range of important information relevant to providers doing business with Ambetter. Key information includes:

- Network information
- Billing guidelines
- Claims information
- Regulatory information
- Key contact list
- Quality initiatives

The Provider Manual can be found in the Provider section of the Ambetter from Sunflower Health Plan website at **ambetterhealth.com/en/ks/.**

Health Plan Notifications

HOSPITAL RESPONSIBILITIES

Hospitals must:

- Notify the PCP immediately or no later than the close of the next business day after the member's emergency room visit.
- Obtain authorizations for all inpatient and selected outpatient services listed in the Pre-Auth Needed tool available at **ambetterhealth.com/en/ks/**, except for emergency stabilization services;
- Notify the Medical Management department by either calling or sending an electronic file of the ER admission within **one business day**; the information required includes the member's name, member ID, presenting symptoms/diagnosis, date of service, and member's phone number.
- Notify the Medical Management department of all admissions via the ER within **one business day**.
- Notify the Medical Management department of all newborn deliveries within **one day of the delivery**; notification may occur by our Secure Provider Portal, fax, or by phone; and
- Adhere to the standards set in the Timeframes for Prior Authorization Requests and Notifications table in the Medical Management section of this manual.

Health Plan Notifications

Notification of Pregnancy

Providers should notify the health plans immediately of any member who is expecting.
This notification allows member to take advantage of the Start Smart for your Baby program.

Notification of Pregnancy Surrogacy

Providers should notify the health plan immediately of any member intending to come into a contractual agreement or is expecting because of surrogacy. All pregnancy related services provided to a surrogate mother are not covered, including but not limited to charges related to the baby's birth, hospitalization, or care because of surrogacy. Please see the Ambetter Evidence of Coverage for additional details.

Adding a Newborn or an Adopted Child

Coverage applicable for children will be provided for a newborn child or adopted child of an Ambetter member from the moment of birth or moment of placement for adoptions if the eligible child is enrolled timely as specified in the member's Evidence of Coverage.

Appointment Availability

PRIMARY CARE & PEDIATRIC

Urgent Care: Within 24 hours of member's call
Non-Urgent/Sick Care: Within 48 hours of member's call
Routine: Within 15 business days of request

OBGYN

Urgent Care: Within 24 hours of member's call
Routine: Within 30 business days of request

SPECIALIST

Urgent Care: Within 24 hours of member's call
Routine: Within 30 business days

BEHAVIORAL HEALTH

Non-Life-Threatening Psychiatric Emergency: Within 6 hours
Urgent: Within 48 hours
Routine (Initial Assessment): Within 10 business days
Routine Follow Up Care: Within 10 business days

After Hours Accessibility

Members must be able to access their providers 24-hours a day, 365 days a year

- Provider's office phones must be answered during normal business hours
- Messages left during normal business hours should be returned the same day

Members must be able to access their provider after normal business hours and on weekends by either

- Answering service or system that will page physician
- Answering system with option to page physician
- Advice nurse with access to physician
- Answering service that will page the physician after message is left

Unacceptable after-hours coverage include, but not limited to:

- A recording telling callers to leave a message
- A recording telling callers to go to an emergency department
- Calls not returned within 30 minutes

Sunflower will monitor providers' offices through scheduled and unscheduled visits and audits. It is recommended to record the message banner in English & Spanish.

PROVIDER SERVICES

The **Ambetter from Sunflower Health Plan** Provider Services team includes trained staff available to respond quickly and efficiently to all provider inquiries, or requests, including:

- Credentialing/network status
- Claims
- Request for adding/deleting physicians to an existing group

By calling **Ambetter from Sunflower Health Plan**. Provider Services at **1-844-518-9505**, providers can access real time assistance for all their service needs.

PROVIDER NETWORK OPERATIONS

- Providers should submit updates to demographic data to sunflowerstatehealth@centene.com within 30 days of the data change becoming effective.
- Forms to add new practitioners can be found on our website and should be submitted along with all credentialing documentation to sunflowerstatehealth@centene.com
- Enrollments are effective 30 days from the date all clean documents are received by Ambetter.

Please send the following items to sunflowerstatehealth@centene.com:

- **Contract clarification**
- **Demographic information updates**
- **Initiate credentialing of a new practitioner**
- **Inquiries related to the status of a new practitioner or Join Our Network request**

PROVIDER ENGAGEMENT

- As an **Ambetter from Sunflower Health Plan** provider, you will have a team of Provider Engagement Account Managers to assist you.
- Our Provider Engagement Specialists serve as the primary liaisons between our health plan and the provider network.
- Your Provider Engagement Account Manager is here to help your practice and address needs, such as:

- **Inquiries related to administrative policies, procedures, and operational issues**
- **Contract clarification**
- **Membership/provider roster questions**
- **Secure Portal registration and PaySpan**
- **Provider education**

Contact Us at Ambetter_KS_PR@sunflowerhealthplan.com

QUALITY PRACTICE CONSULTANT

- As an **Ambetter from Sunflower Health Plan** provider, you will have a team of Quality Practice Consultants available to assist you
- Our Quality Practice Consultants serve as the primary liaisons between our health plan and the provider network
- Your Quality Practice Consultants is here to help your practice and address needs, such as:

- **Performance pattern monitoring**
- **Provider education**
- **HEDIS/care gap reviews**
- **Financial analysis**
- **EHR utilization**

Contact Us at providerengagement@sunflowerhealthplan.com

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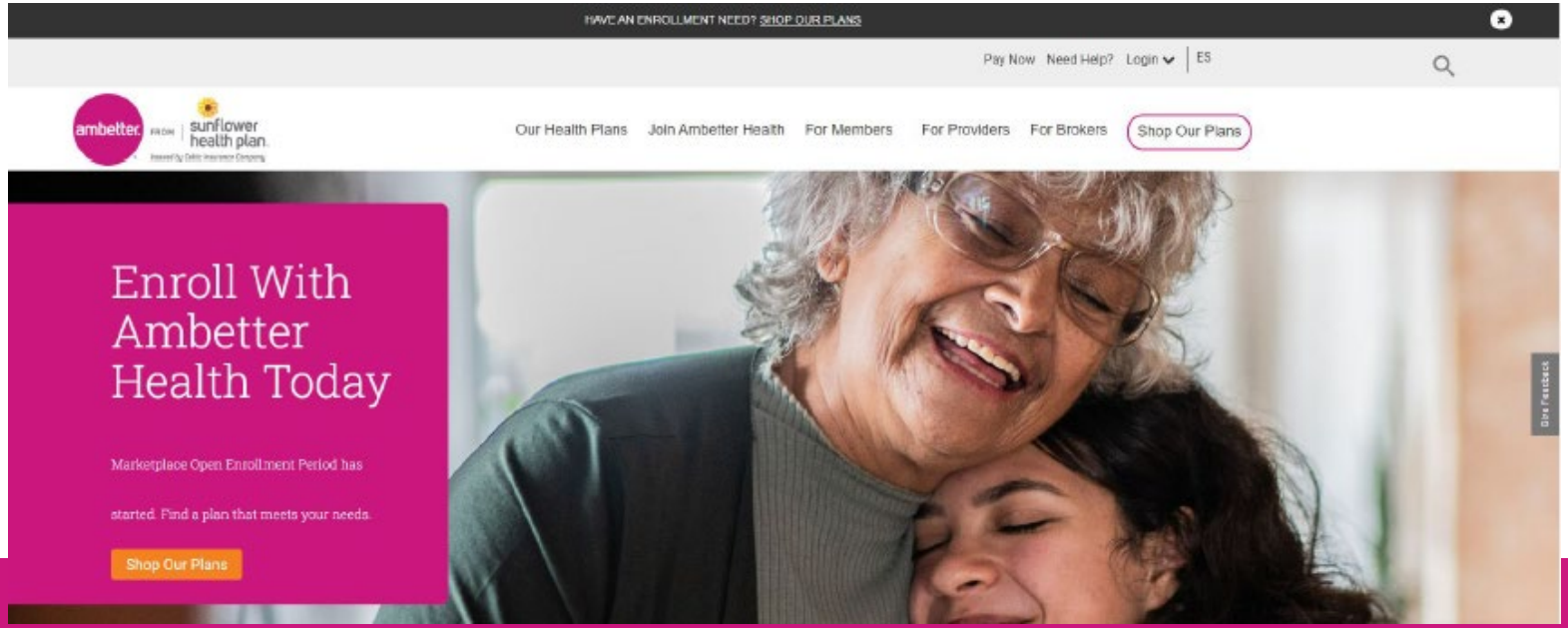
PUBLIC WEBSITE AND SECURE PORTAL

AMBETTER PUBLIC WEBSITE

ambetterhealth.com/en/ks/



Ambetter Public Website

AMBETTER PUBLIC WEBSITE

WHAT'S ON THE PUBLIC WEBSITE?

- Provider Manual
- Quick Reference Guides
- Important Forms (Notification of Pregnancy, Prior Authorization Fax forms, etc.)
- The Pre-Auth Needed Tool
- The Pharmacy Preferred Drug Listing

Ambetter Public Website

Clinical & Payment Policies

- Clinical policies are one set of guidelines used to assist in administering health plan benefits, either by prior authorization or payment rules.
- Claims payment policies are guidelines used to assist in administering payment rules based on generally accepted principles of correct coding. **ambetterhealth.com/en/ks/provider-resources/clinical-payment-policies**

Health Plan Policies

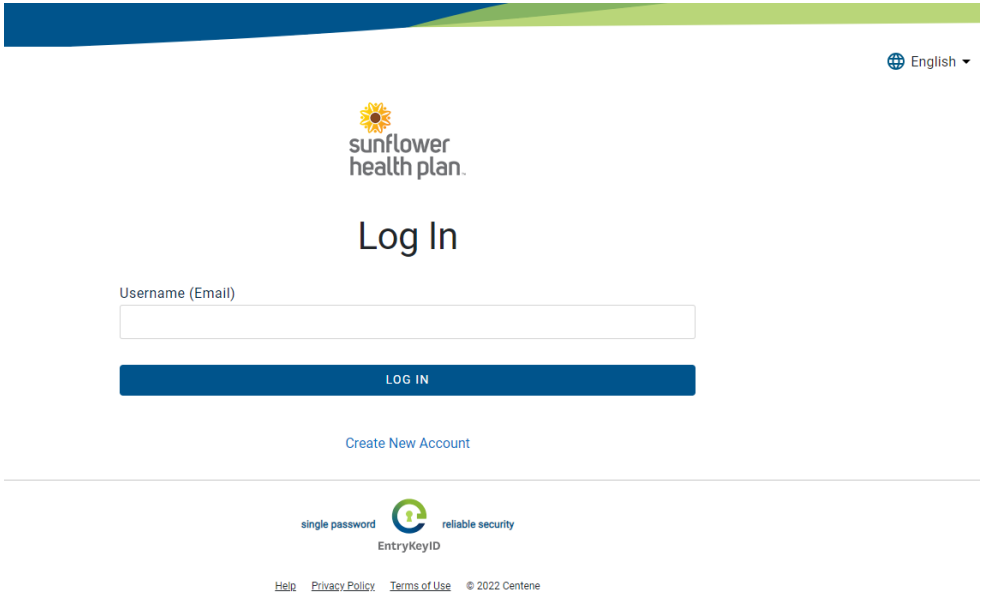
AMBETTER PAYMENT POLICIES

POLICY #	TITLE
CC.PP.007	Maximum Units (PDF)
CC.PP.008	Cerumen Removal (PDF)
CC.PP.009	Unlisted Procedure Codes (PDF)
CC.PP.010	EM Bundling Edits (PDF)
CC.PP.011	Coding Overview (PDF)
CC.PP.012	IV Hydration (PDF)
CC.PP.013	Modifier -25 clinical validation (PDF)
CC.PP.014	Modifier -59 clinical validation (PDF)

SECURE PROVIDER PORTAL

REGISTRATION IS FREE AND EASY!

Contact Ambetter_KS_PR@sunflowerhealthplan.com to get started!



Secure Provider Portal

SECURE PROVIDER PORTAL

WHAT'S ON THE SECURE PROVIDER PORTAL?

- Member eligibility and patient listings
- Health records and care gap information
- Authorizations
- Claims submissions and status
- Corrected claims and adjustments
- Payment history
- Monthly PCP cost reports
- Provider analytics reports
- PCP Referrals for Value plans

SECURE PROVIDER PORTAL

INSIGHTFUL REPORTS

PCP reports available on **Ambetter** Secure Provider Portal are generated monthly and can be exported into a PDF or Excel format.

PCP REPORTS INCLUDE:

- Patient List with HEDIS Care Gaps
- Emergency Room Utilization
- Rx Claims Report
- High-Cost Claims

AVAILITY ESSENTIALS

Ambetter has chosen Availity Essentials as its new, secure provider portal. Providers can validate eligibility and benefits, submit claims, check claim status, submit authorizations, and access payer resources, via Availity Essentials. A phased rollout schedule by state goes through early 2025.

- Our current secure portal is still available for other functions that providers use today. For providers new to Availity Essentials, getting their Essentials account is the first step toward working on Availity.
- The provider organization's designated Availity administrator is the person responsible for registering their practice in Essentials, managing user accounts, and should have legal authority to sign agreements for their organization.
- Administrators can register with Availity Essentials here:
  - **www.Availity.com/documents/learning/LP_AP_GetStarted**
  - Providers needing additional assistance with registration can call Availity Client Services at **1-800-AVAILITY (282-4548),** Monday through Friday, 7 a.m. – 7 p.m. CT.
- For general questions, providers can reach out to their health plan Provider Engagement representative.

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VERIFICATION OF ELIGIBILITY, BENEFITS AND COST SHARES

ELIGIBILITY, BENEFITS AND COST SHARE

PROVIDER MUST VERIFY MEMBER ELIGIBILITY

- Every time a member schedules an appointment
- When the member arrives for the appointment

PANEL STATUS

- PCPs should confirm that a member is assigned to their patient panel. This can be done via our Secure Provider Portal.
- PCPs can still administer service if the member is not on their panel and they wish to have the member assigned to them for future care

Verification of Eligibility, Benefits and Cost Share

ELIGIBILITY, BENEFITS AND COST SHARE

ELIGIBILITY, BENEFITS AND COST SHARES CAN BE VERIFIED IN THREE WAYS:

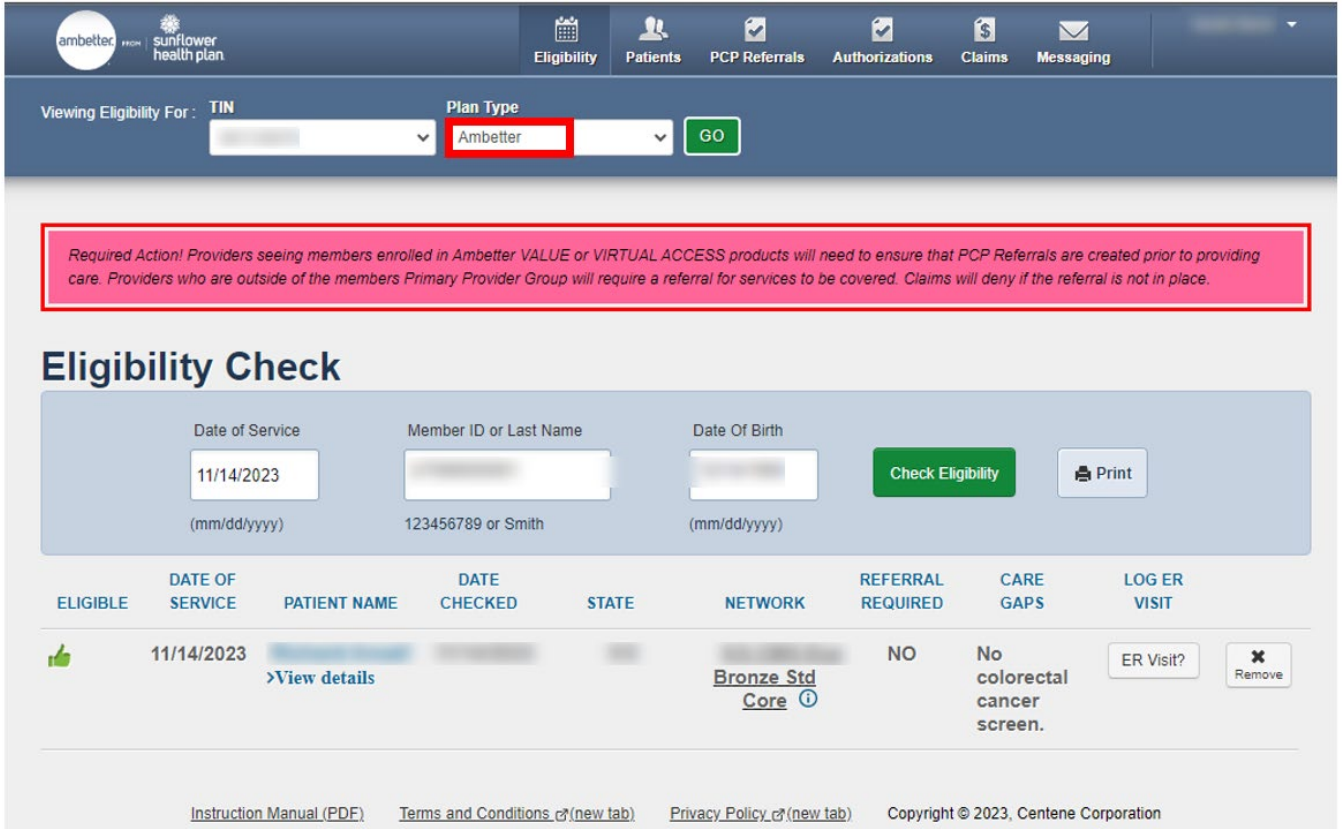
- **The Ambetter Secure Portal:** provider.sunflowerhealthplan.com
  If you are already a registered user of the Ambetter of Sunflower Health Plan secure portal, you do NOT need a separate registration!

- **24/7 Interactive Voice Response System**
  Enter the Member ID Number and the month of service to check eligibility

Contact Provider Services: 1-844-518-9505

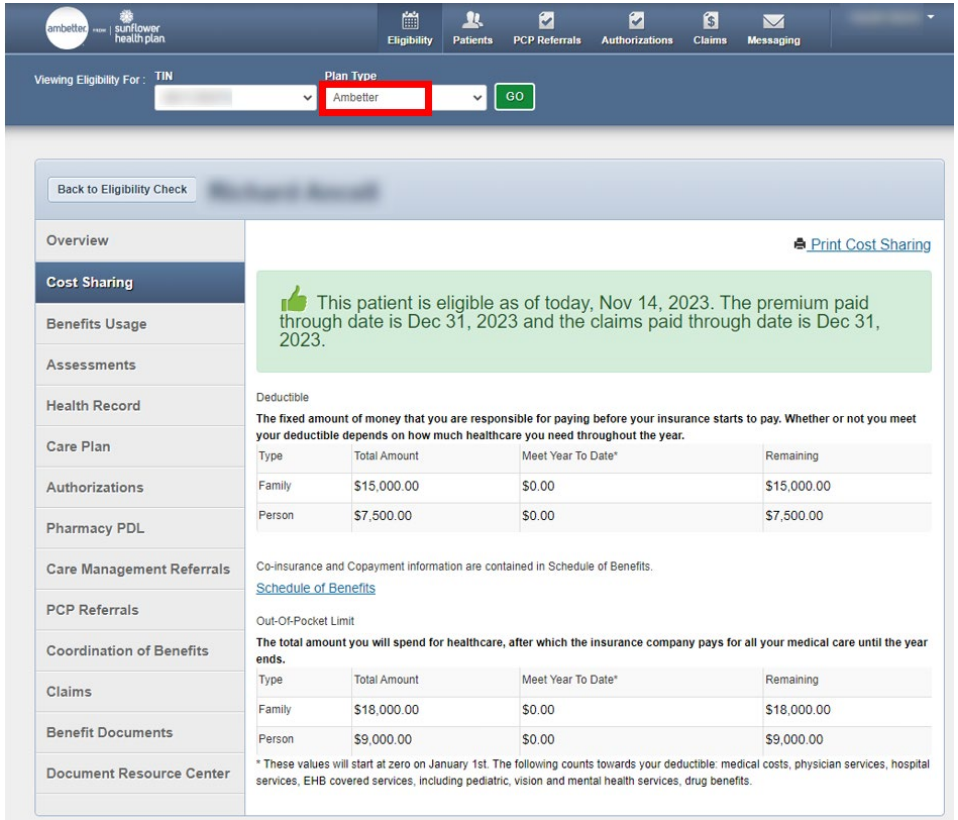
Verification of Eligibility, Benefits and Cost Share

VERIFICATION OF ELIGIBILITY ON THE PORTAL



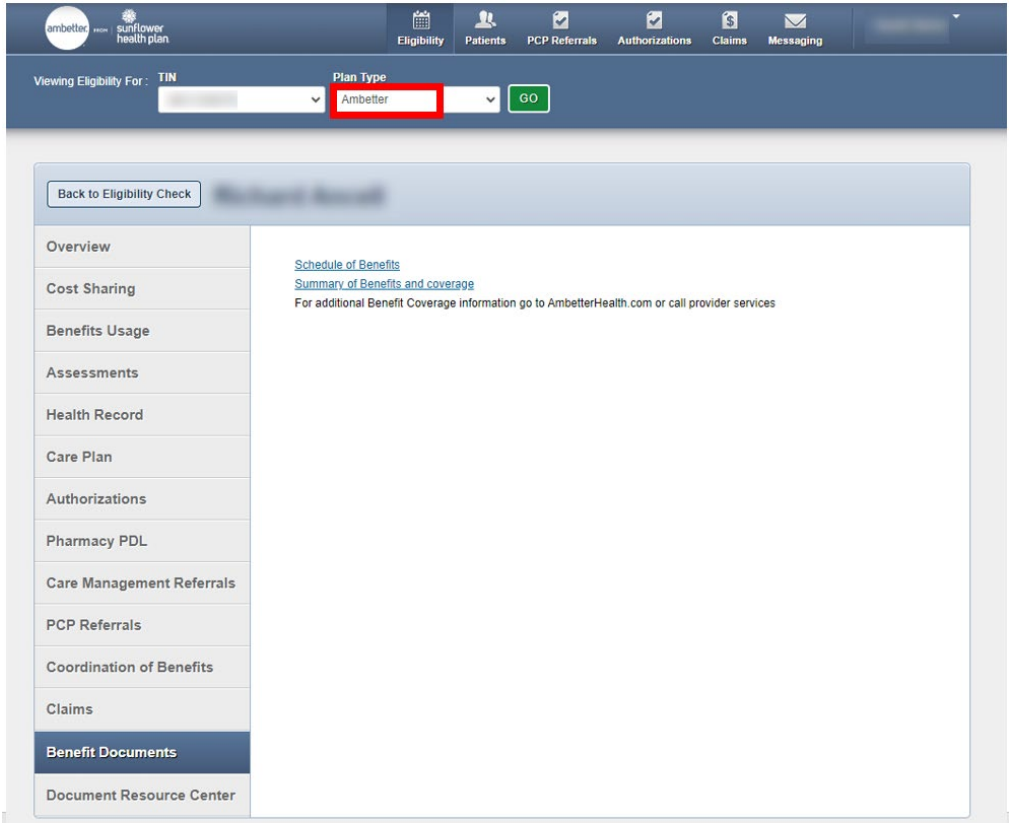
*Be sure the Plan Type is set to Ambetter.

VERIFICATION OF COST SHARES ON THE PORTAL



*Be sure the Plan Type is set to Ambetter.

VERIFICATION OF BENEFITS ON THE PORTAL



*Be sure the Plan Type is set to Ambetter.

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REFERRALS

AMBETTER PCP REFERRAL REQUIREMENTS

- Some Ambetter plans have referral requirements.
- For services to be covered under these plans, they must be provided by or referred by a PCP.
- If a referral is not initiated, services performed outside of the member's assigned provider or primary care group will be denied.
- Prior authorization requirements will also apply, as necessary.
- Referral requirements are reiterated throughout the Ambetter Guide and member plan materials to ensure members understand the rules associated with their plan.
- Referrals are not the same as Prior Authorizations. Services may require one or both.
- Referring providers can use our Secure Provider Portal to initiate referrals on behalf of members.

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PRIOR AUTHORIZATION

HOW TO SECURE A PRIOR AUTHORIZATION

NEED PRIOR AUTHORIZATION?

It can be requested in the following ways:

- Secure Web Portal (This is the preferred and fastest method.)
  https://provider.sunflowerhealthplan.com

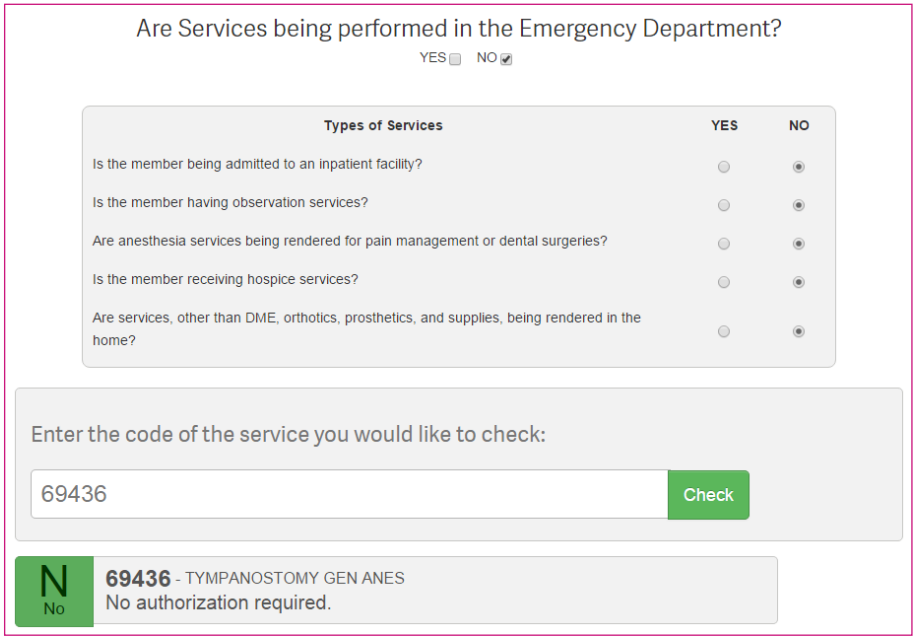
- Phone
  1-844-518-9505

- Fax
  1-844-474-7115

After normal business hours and on holidays, calls are directed to the plan's 24-hour nurse advice line. Notification of authorization will be returned via phone, fax, or web.

IS PRIOR AUTHORIZATION NEEDED?

- Use the **Pre-Auth Needed Tool** to quickly determine if a service or procedure requires prior authorization.
- Available on the provider section of the Ambetter from Sunflower Health Plan website at ambetterhealth.com/en/ks/.



REQUIREMENTS

PROCEDURES / SERVICES THAT NEED PRIOR AUTHORIZATION INCLUDE*:

- Potentially cosmetic
- Experimental or investigational
- High-tech imaging (e.g. CT, MRI, PET)
- Infertility
- Pain Management
- Inpatient Elective Surgical Procedures

**This list is not all-inclusive. Use the Pre-Auth Needed Tool to check if a specific service or procedure requires prior authorization.*

Prior Authorization Requirements

REQUIREMENTS

INPATIENT AUTHORIZATION IS NEEDED FOR THE FOLLOWING*:

- All elective/scheduled admission notifications requested at least 5 days prior to the scheduled date of admit including:
  - All services performed in out-of-network facilities
  - Behavioral health/substance use
  - Hospice care
  - Rehabilitation facilities
  - Transplants, including evaluation
- Observation stays more than 23 hours require Inpatient Authorization
- Urgent/Emergent Admissions
- Partial Inpatient, PRTF and/or Intensive Outpatient Programs (IOP)

**This list is not all-inclusive. Use the Pre-Auth Needed Tool to check if a specific service or procedure requires prior authorization.*

Prior Authorization Requirements

REQUIREMENTS

ANCILLARY SERVICES THAT NEED PRIOR AUTHORIZATION INCLUDE*:

- Air ambulance transport (non-emergent fixed-wing airplane)
- Durable medical equipment (DME)
- Home health care services, including:
  - Home infusion
  - Skilled nursing
  - Therapy
  - Private duty nursing
  - Adult medical day care
  - Hospice
  - Furnished medical supplies and DME

**This list is not all-inclusive. Use the Pre-Auth Needed Tool to check if a specific service or procedure requires prior authorization.*

Prior Authorization Requirements

TIMEFRAMES

Service Type	Timeframe
Scheduled admissions	Prior Authorization required 5 days prior to the scheduled admission date
Elective outpatient services	Prior Authorization required 5 days prior to the elective outpatient admission date
Emergent inpatient admissions	Notification within one (1) business day
Observation – 48 hours or less	Notification within one (1) business day for non-participating providers
Observation – greater than 48 hours	Requires inpatient prior authorization within one (1) business day
Emergency room and post stabilization, urgent care and crisis intervention	Notification within one (1) day
Maternity admissions	Notification within one (1) day
Newborn admissions	Notification within one (1) day
Neonatal Intensive Care Unit (NICU) admissions	Notification within one (1) day
Outpatient Dialysis	Notification within one (1) day

Prior Authorization Timeframes

TIMEFRAMES

Type	Timeframe
Prospective/Urgent	Three (3) calendar days
Prospective/Non-Urgent	Fifteen (15) calendar days
Emergency services	60 minutes (1 hour)
Concurrent/Urgent	Twenty-four (24) hours (1 calendar day)
Retrospective	Thirty (30) calendar days

Utilization Determination Timeframes

CORRECT CODING

PRIOR AUTHORIZATION WILL BE GRANTED AT THE CPT CODE LEVEL

- If a claim is submitted that contains CPT codes that were not authorized, the services will be denied.
- If additional procedures are performed during the procedure, the provider **must** contact the health plan to update the authorization in order to avoid a claim denial.
- It is recommended that this be done within 72 hours of the procedure. However, it **must** be done prior to claim submission or the claim will deny.
- Ambetter will update authorizations but will **not** retro-authorize services.
  - The claim will deny for lack of authorization.
  - If there are extenuating circumstances that led to the lack of authorization, the claim may be appealed.

CORRECT CODING FOR PRIOR AUTHORIZATION

Admissions

Admissions, Census Reports or Face Sheets should be faxed to **1-844-546-2334**.

- Notify the Medical Management department by either calling or sending an electronic file of the ER admission within one business day. The information required includes the member's name, member ID, presenting symptoms/diagnosis, date of service and member's phone number;
- Notify the Medical Management department of all admissions via the ER within one business day;
- Notify the Medical Management department of all newborn deliveries within one day of the delivery; notification may occur by our Secure Provider Portal, fax or by phone.

NOTICE OF ADMISSIONS

2025 Provider Review

CLAIMS, BILLING AND PAYMENTS

HOW TO SUBMIT A CLAIM

The timely filing deadline for initial claims is 180* days from the date of service, or date of primary payment, when Ambetter is secondary.

CLAIMS MAY BE SUBMITTED IN THREE WAYS:

1. **The Secure Provider Portal**
   https://provider.sunflowerhealthplan.com
2. **Electronic Clearinghouse**
   Payor ID 68069
   Sunflower Health Plan uses Availity Clearinghouse
3. **Mail**
   Ambetter
   P.O. Box 5010
   Farmington, MO 64640-5010

* PAR providers have 180 days, non-PAR provider have 90 days

CLAIM RECONSIDERATIONS AND DISPUTES

CLAIM RECONSIDERATIONS

- For reconsideration requests, providers can use the **Dispute – Option 2** button on the Claim Details screen within the Secure Provider Portal
- A written request from a provider about a disagreement in the manner in which a claim was processed. Use the ***Provider Request for Reconsideration and Claim Dispute Form*** at ambetterhealth.com/en/ks/provider-resources/manuals-and-forms
- Must be submitted within 180 days of the Explanation of Payment.
- Mail claim reconsiderations to:

Ambetter
Attn Reconsiderations
P.O. Box 5010
Farmington, MO 63640-5010

CLAIM DISPUTES

- Must be submitted within 180 days of the Explanation of Payment
- A Claim Dispute form can be found on our website at ambetterhealth.com/en/ks/provider-resources/manuals-and-forms
- Mail completed Claim Dispute form to:

Ambetter
Attn Claim Dispute
P.O Box 5000
Farmington, MO 63640-5000

CLAIM SUBMISSION SUSPENDED STATUS

WHAT IF A MEMBER IS IN SUSPENDED STATUS?

- After the first 30 days, the member is placed in a suspended status. The Explanation of Payment will indicate LZ Pend: Non-Payment of Premium
- A provision of the ACA allows members who are receiving Advanced Premium Tax Credits (APTCs) a three-month grace period for paying claims
- While the member is in a suspended status, claims will be pended
- When the premium is paid by the member, the claims will be released and adjudicated
- If the member does not pay the premium, the claims will be released, and the provider may bill the member directly for services

CLAIM SUBMISSION SUSPENDED STATUS

EXAMPLE TIMELINE OF A MEMBER IN SUSPENDED STATUS

- **January 1**
  Member pays premium
- **February 1**
  Premium due – member does not pay
- **March 1**
  Member placed in suspended status
- **April 1**
  Member remains in suspended status
- **May 1**
  If premium remains unpaid, member is terminated.
  Provider may bill member directly for services rendered.

Claims for members in a suspended status are not considered "clean claims."

HELPFUL INFORMATION ABOUT CLAIMS

MAKE SURE TO INCLUDE THE RENDERING TAXONOMY CODE!

- Claims **must** be submitted with the rendering provider's taxonomy code
- The claim will deny if the taxonomy code is not present
- This is necessary in order to accurately adjudicate the claim

REMINDER: DO NOT FORGET THE CLIA NUMBER!

- If the claim contains CLIA-certified or CLIA-waived services, the CLIA number **must** be entered in **Box 23** of a paper claim form or in the appropriate loop for EDI claims
- Claims will be rejected if the CLIA number is not on the claim

BILLING THE MEMBER

COPAYS, CO-INSURANCE AND DEDUCTIBLES

- Copays, co-insurance and any unpaid portion of the deductible may be collected at the time of service
- Deductible information, including the amount that has been paid toward the deductible so far, can be accessed via the Secure Provider Portal at https://provider.sunflowerhealthplan.com
- If the amount collected from the member is higher than the actual amount owed upon claim adjudication, the provider must reimburse the member within 45 days

CLAIMS PAYMENTS

PAYSPAN®: A FASTER, EASIER WAY TO GET PAID

- Ambetter offers PaySpan® Health, a free solution that helps providers transition into electronic payments and automatic reconciliation

- If you currently use PaySpan®, you will need to register specifically for Ambetter

- **Set up your PaySpan® account:**
  ~ Visit **www.payspanhealth.com** and click Register
  ~ You may need your National Provider Identifier (NPI) and Provider Tax ID Number (TIN) or Employer Identification Number (EIN)

  See the Guide for How to Register for PaySpan® Health on our website.

ELECTRONIC FUNDS TRANSFER

2025 Provider Review

COMPLAINTS, GRIEVANCES AND APPEALS

COMPLAINTS, GRIEVANCES AND APPEALS

CLAIMS

- A provider must exhaust the claims reconsideration and claims dispute process before filing a complaint/grievance or appeal

COMPLAINT/GRIEVANCE

- Must be filed within 30 days of the Notice of Action
- Upon receipt of complete information to evaluate the request, Ambetter will provide a written response within 5 days
- Ambetter will resolve the grievance within 30 days

COMPLAINTS, GRIEVANCES AND APPEALS

APPEALS

- For Claims, the Claims Reconsideration, Claims Dispute and Complaint/Grievances process must be exhausted prior to filing an appeal

MEDICAL NECESSITY

- Must be filed within 180 days from the Notice of Action.
- Ambetter shall acknowledge receipt within 5 days of receiving the appeal.
- Ambetter shall resolve each appeal and provide written notice as expeditiously as the member's health condition requires but not to exceed 30 days.
- Expedited appeals may be filed if the time expended in a standard appeal could seriously jeopardize the member's life or health. The timeframe for a decision for an expedited appeal will not exceed 72 hours.

COMPLAINTS, GRIEVANCES AND APPEALS

MEMBER REPRESENTATIVES

- Members may designate a provider to act as their representative for filing appeals related to medical necessity
  - ~ Ambetter requires that this designation by the member be made in writing and provided to Ambetter
- No punitive action will be taken against a provider by Ambetter for acting as a member's representative

NEED MORE INFORMATION?

- Full details of the claim reconsideration, claim dispute, complaints/grievances and appeals processes can be found in our Provider Manual, located on our website at **ambetterhealth.com/en/ks/**

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SPECIALTY SERVICES & VENDORS

SPECIALTY COMPANIES AND VENDORS

Service	Specialty Company/Vendor	Contact Information
High Tech Imaging Services	Evolent	1-800-424-4801 www.radmd.com
Vision Services	Centene Vision Services	1-844-344-9232 www.envolvevision.com
Dental Services	Centene Dental Services	1-833-246-8839 www.envolvedental.com
Pharmacy Services	Express Scripts	1-833-750-2290

OUR SPECIALTY COMPANIES AND VENDORS

Training

- Annual Cultural Competency Training available On Demand.
  www.sunflowerhealthplan.com/providers/resources/provider-training/cultural-competency-traiing.html
- Project ECHO offers free continuing education credit quarterly
  www.sunflowerhealthplan.com/providers/project-echo.html
- Office Hours offers an opportunity for guidance on navigating the health plan. See our website for session dates.
  www.sunflowerhealthplan.com/providers/resources/provider-training.html

Sign up for Email Alerts to be notified of policy changes, check run updates and upcoming training sessions.

www.sunflowerhealthplan.com/providers/resources.html

Provider Training Opportunities

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Quality Improvement

2025 Ambetter HEDIS Measures

AAB - Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis	CRE - Cardiac Rehabilitation	LBP - Use of Imaging Studies for Low Back Pain
AAP - Adults' Access to Preventive/Ambulatory Health Services	CWP - Appropriate Testing for Pharyngitis	MSC - Medical Assistance With Smoking and Tobacco Use Cessation
ADD-E - Follow-Up Care for Children Prescribed ADHD Medication	DBM-E - Documented Assessment After Mammogram	PBH - Persistence of Beta-Blocker Treatment After a Heart Attack
AHU - Acute Hospital Utilization	DMH - Diagnosed Mental Health Disorders	PCE - Pharmacotherapy Management of COPD Exacerbation
AIS-E - Adult Immunization Status	DMS-E - Utilization of the PHQ-9 to Monitor Depression Symptoms for Adolescents and Adults	PCR - Plan All Cause Readmissions
AMR - Asthma Medication Ratio	DRR-E - Depression Remission or Response for Adolescents and Adults	PDS-E - Postpartum Depression Screening and Follow-Up
APM-E - Metabolic Monitoring for Children and Adolescents on Antipsychotics	DSF-E - Depression Screening and Follow-Up for Adolescents and Adults	PND-E - Prenatal Depression Screening and Follow-Up
APP - Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics	DSU - Diagnosed Substance Use Disorders	POD - Pharmacotherapy for Opioid Use Disorder
ASF-E - Unhealthy Alcohol Use Screening and Follow-Up	EDU - Emergency Department Utilization	PPC - Prenatal and Postpartum Care
AXR - Antibiotic Utilization for Respiratory Conditions	EED - Eye Exam for Patients with Diabetes	PRS-E - Prenatal Immunization Status
BPC-E - Blood Pressure Control for Patients With Hypertension	FMA-E - Follow-Up After Abnormal Mammogram Assessment	SAA - Adherence to Antipsychotic Medications for Individuals with Schizophrenia
BPD - Blood Pressure Control for Patients with Diabetes	FUA - Follow Up After Emergency Department Visit for Substance Use	SNS-E - Social Need Screening and Intervention
BSC-E - Breast Cancer Screening	FUH - Follow Up After Hospitalization for Mental Illness	SPC - Statin Therapy for Patients With Cardiovascular Disease
CBP - Controlling High Blood Pressure	FUI - Follow-Up After High-Intensity Care for Substance Use Disorder	SPD - Statin Therapy for Patients With Diabetes
CCS-E - Cervical Cancer Screening	FUM - Follow Up After Emergency Department Visit for Mental Illness	UOP - Use of Opioids From Multiple Providers
CHL - Chlamydia Screening in Females	GSD - Glycemic Status Assessment for Patients With Diabetes	URI - Appropriate Treatment for Upper Respiratory Infection
CIS-E - Childhood Immunization Status	HDO - Use of Opioids at High Dosage	W30 - Well Child Visits in the First 30 Months of Life
COL-E - Colorectal Cancer Screening	IET - Initiation and Engagement of Substance Use Disorder Treatment	WCC - Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents
COU - Risk of Continued Opioid Use	IMA-E - Immunizations for Adolescents	WCV - Child and Adolescent Well Care Visits
CPA - CAHPS Health Plan Survey 5.1H, Adult Version	KED - Kidney Health Evaluation for Patients with Diabetes	

Quality Improvement

Medical Record Requests

You may receive a request from Sunflower's Medical Management, Quality, Auditing department, etc. We would like to remind you that Medical Records are required by contract for:

- All covered members (including those dual eligible where Sunflower was not payer of service provided)
- Contractual reasons for record requests
- To conduct utilization or quality review of member care
- Regulatory audits, monitoring, or reviews by the state, federal government or MCO
- To meet document requests required by accrediting organizations
- Public official requests

www.sunflowerhealthplan.com/content/dam/centene/sunflower/pdfs/Sunflower-Chasing-the-Chart-Provider-Info.pdf

Questions & Answers

Training Questions – provider_training@sunflowerhealthplan.com

General Support – Ambetter_KS_PR@sunflowerhealthplan.com