
# Medicaid New Provider Orientation

2025

KDHE Approved 03/12/2025

# Agenda

- Who We Are
- Provider Data
- Ongoing Training Opportunities
- Website Resources
- All About the Member
- Prior Authorizations
- Billing for Your Services
- Secure Provider Portal
- Quality
- Finding Support

# Who We Are

## Our Purpose

- Transforming the health of the communities we serve, one person at a time.

## Our Approach

- Sunflower strives to provide improved health status, successful outcomes, and member and provider satisfaction in an environment focused on coordination of care.



# Who We Are

Our Mission

- Ensure access to primary and preventive care services in accordance with the Kansas Department of Health and Environment - DHCF and KDADS standards;
- Ensure care is delivered in the best setting to achieve optimal outcomes;
- Improve access to necessary specialty services;
- Encourage quality, continuity, and appropriateness of medical care;
- Provide medical coverage in a cost-effective manner

Recommendations

- Ask if the patient is receiving services elsewhere;
- Reach out to those other providers of care;
- Discuss test results and follow-up actions with the patient;
- Document all discussion topics in the patient's medical record, sign & date at the time of service – If it isn't documented, it didn't happen.

# Who We Are

## Lines of Business

**KanCare**
**Kansas Medicaid**

**Wellcare By Allwell**
**Medicare plans**

**Ambetter - Marketplace**
**(Affordable Care Act)**

## Organizational Structure

- **Care Management**
- **Medical Management**
- **Claims**
- **Network**
- **Provider Relations**

# Social Determinants of Health

What does “social determinants of health” mean?

- Conditions of the environments in which people live, learn, work, play, worship and age that affect a wide range of health, functioning and quality-of-life outcomes and risks.

Goal of “social determinants of health.”

- Create social and physical environments that promote good health for all.

Employment

Housing

Food Insecurity

Social Integration

# Provider-Member Communication

Why is communication important?

- Affects patients' perception of the care they are receiving.

Why could a patient not understand what their healthcare provider is telling them?

- The patient's social and/or economic status
- The patient's education level
- The complexity of the treatment and instructions
- Health system variables

Here are some ways to encourage better communication with patients:

- Build rapport with the patient
- Do not interrupt the patient
- Ask open-ended questions
- Empower the patient

# KMAP Provider Enrollment

History

- December 2018 the KMAP Provider Enrollment Wizard became available for use.
- July 2019 KMAP Provider Enrollment now required for Sunflower to pay claims to providers for Medicaid services, including the TIN, NPI, type and specialty.
- For additional information go to KMAP Provider Enrollment www.kmap-state-ks.us/Public/Provider.asp

# Medicaid Credentialing and Contracting Details

- Initial enrollment is completed on the KMAP Provider Enrollment Wizard.
- Approved KMAP Provider Enrollment is forwarded to Sunflower if selected in the application submitted.
- Upon receipt of approved KMAP Provider Enrollment, Sunflower begins to complete necessary contracting (50 days) and/or credentialing (45 days) steps, including applicable provider data loading (7 days).
- Contracting, credentialing and system loading with Sunflower must be completed before provider claims will successfully process and pay to the provider.
- All Medicaid providers are subject to recredentialing every three years.

To check on the status or ask questions regarding credentialing or contracting please email sunflowerstatehealth@centene.com.

# Provider Enrollment Updates

- KMAP is the Kansas Medicaid provider source of truth.
- Demographic updates, provider changes and revalidation follow applicable KMAP provider instructions, i.e., bulletins, manuals. Begin the process at www.kmap-state-ks.us/Public/Enrollment%20Application.asp
- Providers should direct all changes to their provider record to KMAP. Updates are sent to the Managed Care Organizations from KMAP. This includes practitioners leaving or joining the practice.
- For more information, please view KMAP Bulletins page using keyword ‘enrollment’ or ‘revalidation’.

# K-TRACS Pharmacy Reporting

Medicaid providers must check the **Kansas Prescription Drug Monitoring Program (called K-TRACS)** for an enrollee's prescription history before prescribing controlled substances to a Medicaid beneficiary or member.

A prescription drug monitoring program (PDMP) is an electronic database that tracks controlled substance prescriptions. Information from PDMPs can help clinicians identify patients who may be at risk for overdose and provide potentially life-saving information and interventions.

**Website** – K-TRACS Login

**When does a provider have to check K-TRACS:**

- New patient visit: Check K-TRACS prior to writing/e-scribing a controlled substance.
- Current patient visit: Recheck K-TRACS every 180 days or when there are any changes to the patient's controlled substance prescriptions.
- Prescribers may not be required to check K-TRACS for all beneficiaries/members. All exceptions can be found in the 2024 Sunflower Provider Bulletin at Sunflower K-TRACS Pharmacy Reporting Bulletin.

**Annual Attestation**

- Every provider must submit an annual attestation form by January 1st of each year acknowledging their awareness of and compliance with our PDMP policies. The State and MCO will post reminder bulletins on their websites.
- Should a provider not submit an attestation form that acknowledges said compliance with PDMP policies, by the annual due date, this will be considered as provider non-compliance.

# HCBS Background Check Policy

KDADS Policy Number E2019-010

Definitions

- Applicant: an individual who applies for paid or unpaid employment with a center, facility, hospital or provider of HCBS services or applies to work for an employment agency or as an independent contractor that provides staff to a center, facility, hospital or a provider of HCBS services.
- Background Check: includes the criminal record check, license verification check, state and national registries.
- Prohibited Offense: any conviction listed in K.S.A 39-2009
- Provisional Employment: a one-time basis of 60 calendar days prior to the licensee obtaining background check results for the employee/volunteer from KDADS.

# HCBS Background Check Policy

KDADS Policy Number E2019-010

- An applicant shall not provide services to an HCBS waiver participant prior to receiving a clear background check.
- No Medicaid funds shall be used to pay a person prior to confirmation of a clear background check in accordance with the approved 1915 (c) HCBS waivers.
- No employer of HCBS services shall employ, paid or unpaid, a person who has adverse findings and/or a prohibited offense on their background check pursuant to K.S.A. 39-2009.
- After hire, any employee, paid or unpaid, shall immediately disclose any and all arrests to the employer.
- All HCBS providers shall receive a background check every two years after the commencement of paid or unpaid employment.

# HCBS Background Check Policy

KDADS Policy Number E2019-010

1. The employer shall complete the following requirements prior to the start of provisional employment:
   a. Request a criminal record check through HOC; and
   b. Request a Child ANE and Adult ANE check through DCF; and
   c. Complete a license verification status check to the applicable credentialing entity; and
   d. Complete a Driver's License check through Kansas Department of Revenue (KDOR) or MVR; and
   e. Complete an online database search for excluded individuals through the OIG; and
   f. The employer shall retain documentation showing that the background check has been requested or completed in the paid or unpaid employee's file before provisional employment can begin.

In the event an individual has a prohibited offense and/or an adverse finding, provisional employment to provide HCBS services shall terminate immediately.

Documentation of the outcome of the applicable background checks listed above must be retained in the paid or unpaid employee's file prior to providing HCBS services to a HCBS waiver participant.

# Fraud, Waste & Abuse (FWA)

Some of the most common FWA practices include:

- Unbundling of codes
- Upcoding services
- Add-on codes billed without primary CPT
- Claims for services not rendered
- Use of exclusion codes
- Diagnosis and/or procedure code not consistent with the member's age/gender
- Excessive use of units
- Misuse of benefits

**Ways to Report Potential Fraud, Waste and Abuse**

- Call the **Sunflower FWA Hotline** at 1-866-685-8664. You do not need to give your name.
- Contact Sunflower at Sunflower Health Plan Program Integrity, 8325 Lenexa Dr., Ste 410, Lenexa, KS 66214.
- You can also report suspected provider fraud, waste and abuse to the Kansas Medicaid Fraud and Abuse Division. Contact Kansas Attorney General's Office Medicaid Fraud & Abuse Division - 120 SW 10th Ave., 2nd Floor, Topeka, KS 66612-1597 Phone: 866-551-6328 or 785-368-6220

# Cultural Competency

## OUR COMMITMENT

- Providing quality health care services regardless of race, color, national origin, sex, sexual orientation, gender identity, age, or disability.
- Developing, strengthening, and sustaining healthy provider/member relationships.

## OUR PLAN

- Our staff complete annual Cultural Competency and sensitivity training.
- Offer information, resources and quarterly training to our providers.
- For additional information and resources on Sunflower's Cultural Competency program, please go to www.sunflowerhealthplan.com

# Annual Cultural Competency Training Requirements

- Verification of Cultural Competency Training
- Why? We are required to collect information on whether providers have completed Cultural Competency training and to display that in our provider directory and Find a Provider tool.
- What are the training requirement options? Choose one of the following:

| Sunflower | HHS | Continuing Education | Organizational Training |
|---|---|---|---|
| Offered On Demand | Complete HHS Think Cultural Health online session | Complete continuing education on cultural competency | If the provider organization offers in house cultural competency training |
| www.sunflowerhealthplan.com/providers/resources/provider-training.html | thinkculturalhealth.hhs.gov/education | | |
| Submit Verification of Completed training via Web Form: www.sunflowerhealthplan.com/providers/resources/provider-training/cultural-competency-traiing.html | | | |

# Provider Training

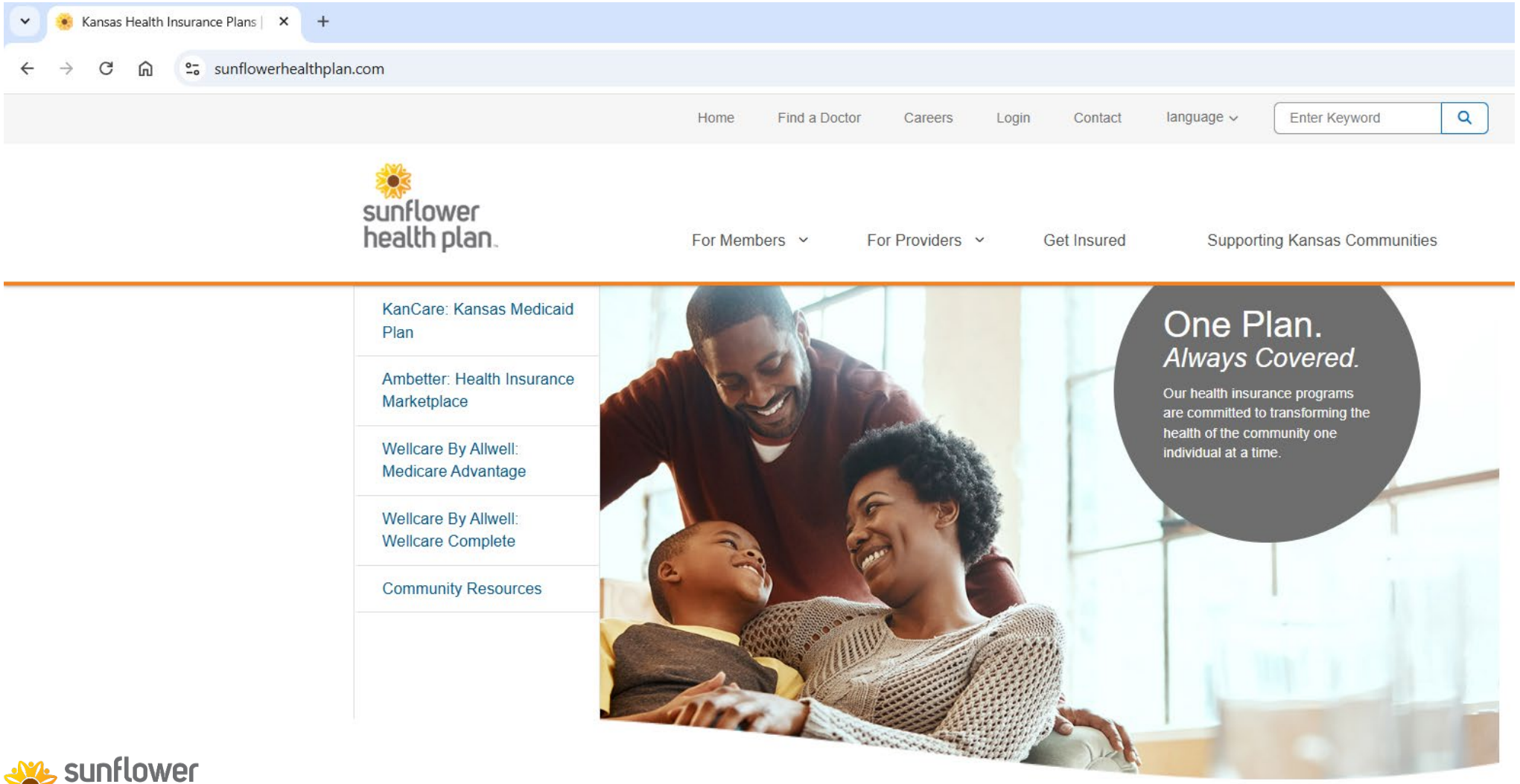

**Project ECHO** (Sunflower Project ECHO webpage):

- Project ECHO® (Extension for Community Healthcare Outcomes) is a self-paced lifelong learning and guided practice model that revolutionizes medical education and exponentially increases workforce capacity to provide best-practice specialty care and reduce health disparities.
- Quarterly Topics
- Free Continuing Education credits for licensed clinicians through the University of Missouri and certificate of completion for social workers & therapists.

**Provider Office Hours**

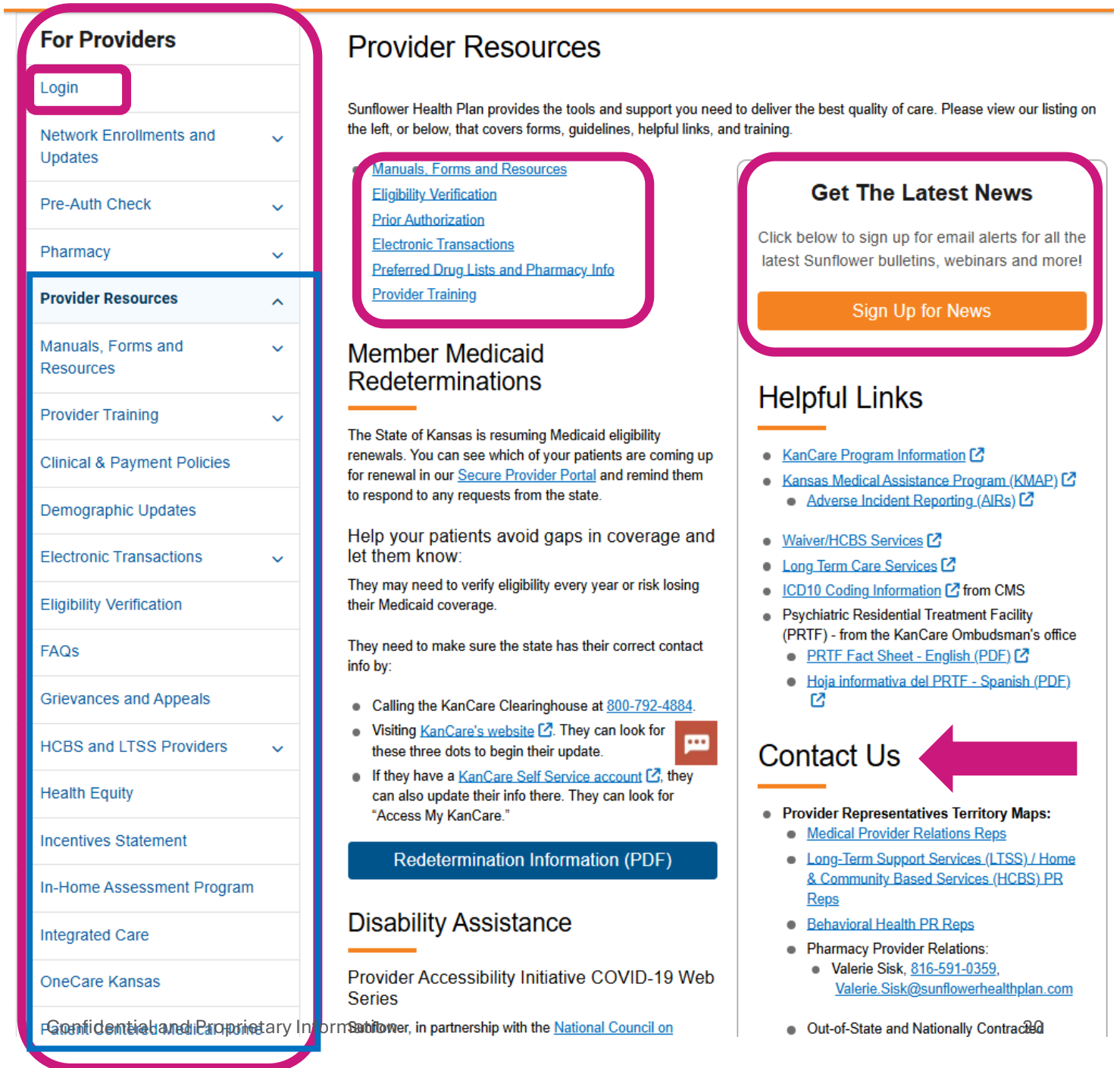
- Guidance on navigating the KMAP website or Sunflower website, how to reach Provider Relations, how to navigate the Secure Provider Portal and more. Registration is not required. See our Sunflower Provider Training webpage for session dates, additional training opportunities and upcoming events.

# Our Website: SunflowerHealthPlan.com



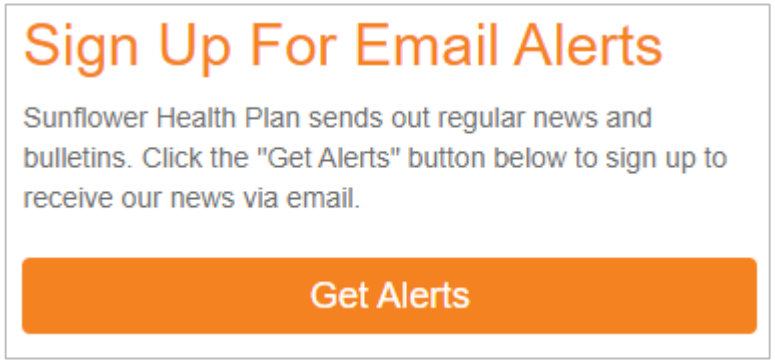

Kansas Health Insurance Plans from Sunflower Health Plan

# Provider Resources



# Sign Up Provider Bulletins

- Sign up for Provider Bulletins at www.sunflowerhealthplan.com/providers/resources.html
- Bulletins include:
  - State and Health Plan Policy Changes
  - Training Webinars
  - Holiday Check Run Updates



# Appointment Availability & Access Standards

### PRIMARY CARE & PEDIATRIC

- **Urgent Care**: Within 48 hours of member's call
- **Routine**: Within 21 calendar days of request

### SPECIALIST

- **Urgent Care**: Within 48 hours of member's call
- **Routine**: Within 30 calendar days

### OBGYN

- **Urgent Care**: Within 48 hours of member's call
- **Routine**: Within 15 calendar days of request
- **First Trimester**: Within 3 weeks
- **Second Trimester**: Within 2 weeks
- **Third Trimester**: Within 1 week

### Wait Time Standards for All Provider Types

- Office waiting time for scheduled appointments not to exceed 45 minutes. If a provider is delayed, patients shall be notified immediately. If the wait is anticipated to be more than 90 minutes, the patient shall be offered a new appointment.

### SUBSTANCE USE DISORDER (SUD)

- **Urgent Substance Use Disorder:** Assessed within 24 hours of request; services delivered within 24 hours of the assessment.
- **Routine SUD:** Assessed within 10 business days of the request.
- **Pregnant SUD and Person who Injects Drugs (PWID):** Provide services within 24 hours of assessment or 48 hours of initial contact to include prenatal care.
- **Person who Injects Drugs (PWID):** Assessment and admitted to treatment no later than 10 business days of request.

### BEHAVIORAL HEALTH

- **Non-Life-Threatening Behavioral Health Emergency:** Within 6 hours
- **Urgent:** Within 72 hours
- **Routine (Initial Assessment):** Within 10 business days
- **Routine (Follow-Up):** Within 10 business days

# 24-Hour Access to Providers

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
- Message 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
- Answering system provides phone number to access physician live or answering service

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

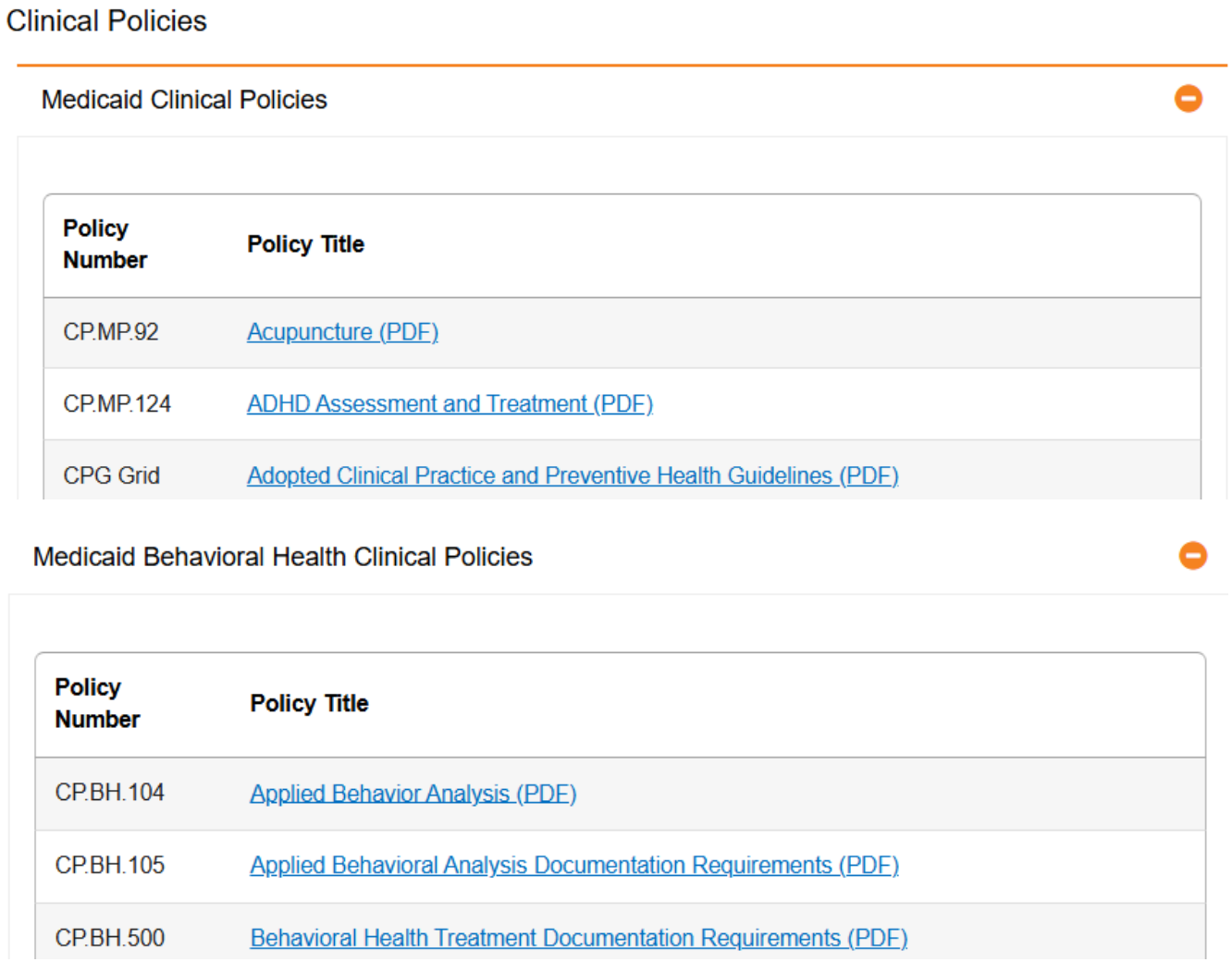
- A recording telling callers to leave a message
- A recording telling callers to go to an emergency department
- Calls not returned within 30 minutes

Sunflower will monitor providers' offices through scheduled and unscheduled visits and audits. It is recommended to record the message banner in English & Spanish. All pre-recorded messages must be high-quality, informative, and provide callers with certainty that they have reached the practice whose number they dialed. A member should, at minimum, have a means for leaving a message and should be told when to expect a return call.

# Clinical and Payment Policies

- Clinical policies are one set of guidelines used to assist in administering health plan benefits, either by prior authorization or payment rules.
- Health care claims payment policies are guidelines used to assist in administering payment rules based on generally accepted principles of correct coding.

www.sunflowerhealthplan.com/providers/resources/clinical-payment-policies.html



Clinical Policies

Medicaid Clinical Policies

| Policy Number | Policy Title |
|---|---|
| CP.MP.92 | Acupuncture (PDF) |
| CP.MP.124 | ADHD Assessment and Treatment (PDF) |
| CPG Grid | Adopted Clinical Practice and Preventive Health Guidelines (PDF) |

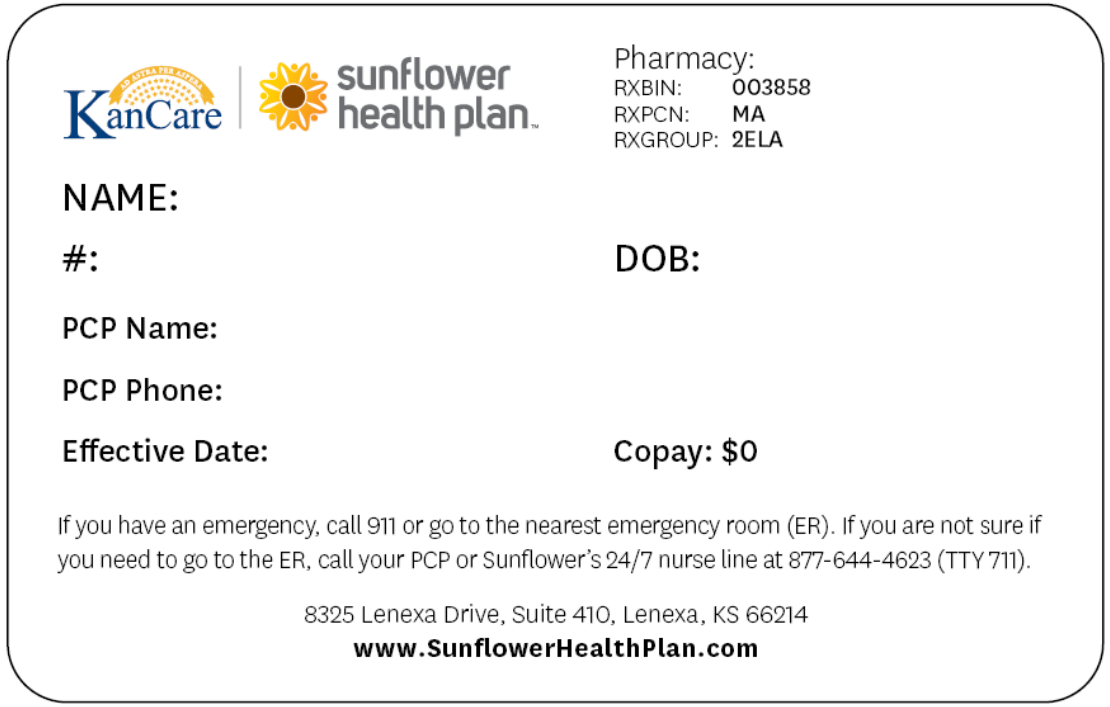
Medicaid Behavioral Health Clinical Policies

| Policy Number | Policy Title |
|---|---|
| CP.BH.104 | Applied Behavior Analysis (PDF) |
| CP.BH.105 | Applied Behavioral Analysis Documentation Requirements (PDF) |
| CP.BH.500 | Behavioral Health Treatment Documentation Requirements (PDF) |

# Notice of Admissions

- Admissions, Census Reports or Face Sheets should be reported by calling 1-877-644-4623 or by fax to 1-866-965-5433
- Hospitals should:
  - Notify the member's PCP immediately or no later than the close of the next business day after the member's emergency room visit.
  - Notify Sunflower's Population Health Department of all inpatient admissions within one business day following the admission. Clinical information must be submitted with the admission to support medical necessity criteria.
  - Partner with Sunflower's Population Health department by providing discharge dispositions or additional documentation on admissions where Sunflower may not be the primary payer.
  - Notify Sunflower's Population Health Department of all admissions via the ER within one business day.
  - Notify Sunflower's Population Health Department of all newborn deliveries within one day of the delivery.

# Member ID Card




# Verifying Member Eligibility

When to verify?

- When scheduling an appointment for a Sunflower member.
- When a Sunflower member is seen for an appointment.

How to verify?

- KMAP Secure Website: portal.kmap-state-ks.us/PublicPage/Public/Login
- Provider portal: provider.sunflowerhealthplan.com/
- Customer service & Interactive Voice Response (IVR)  1-877-644-4623 (TTY 711)

Possession of an ID card is not a guarantee of eligibility and benefits.

# PCP Selection

- Each new member is assigned a primary care provider (PCP) once they are enrolled with Sunflower Health Plan.
- Members may change their PCP at any time through our member portal, by calling Customer Service or by returning a completed PCP change form located on our website.
- Members do not need a referral before seeing another network physician or specialist.

# What is a Grievance?

A grievance is defined as any expression of dissatisfaction about any matter, other than an adverse benefit determination or an action that would be resolved through the appeals process.

- Providers have 180 calendar days to request a grievance from the date of the matter being grieved.

Grievances may include, but are not limited to:

- Quality of care or services provided
- Aspects of interpersonal relationships such as rudeness of a provider or employee
- Failure to respect the member's rights
- Access to care – unable to get an appointment
- Quality of care – no prescription given at appointment and member ended up in ER
- Attitude or service, Health Plan – rudeness of plan staff to member
- Attitude or service, Provider – provider rudeness
- Quality of practitioner office site – provider office is dirty

For more information regarding filing a grievance, please see the Sunflower Provider Manual.

# What is a Member Appeal?

- An appeal is a request for review of an adverse benefit determination
- An adverse benefit determination is the denial or limited authorization of a requested service, which can include any of the following:
  - The denial or limited authorization of a requested service, including the type or level of service
  - The reduction, suspension, or termination of a previously authorized service
  - The denial, in whole or part of payment for a service
  - The failure to provide services in a timely manner
  - The failure of plan to act within the timeframes to resolve grievances and appeals
  - For a member residing in a rural area with only one MCO, the denial of member's request to obtain services outside the network
  - The denial of member's request to dispute a financial liability
- Report to any health plan employee is valid and starts process
- For more information regarding filing an appeal, please see the Sunflower Provider Manual.

# 2025 Value Added Benefits for Members - New

| Benefit | Description |
|---|---|
| **Enhanced Transportation Benefits** | Twelve roundtrips per year for things like food, housing, pharmacy employment supports, support groups or health-education programs. (Expanded from social transportation VAB.) |
| **Car Seats** | Members in our Start Smart for Your Baby program can get a safety-certified car seat or booster seat for getting key prenatal care. |
| **First Year of Life** | Educational materials and support from maternal/childcare coordinators to schedule well-child visits and access resources. (Ages 0-15 months.) |
| **Pyx Health** | Pyx is a mobile application tool used to reduce loneliness using an empathetic chatbot, Pyxir, and is open to all members |
| **Mobile Clinics** | Quarterly mobile clinics in rural areas of Kansas focusing on dental and vision screenings. |
| **Value-Added Benefits for Members on Waivers and Other Special Groups** | |
| **Practice Dental Visits** (I/DD) | Up to two practice dental visits through member's dental provider's office. |
| **Healthy Living** (Harvey County) | Diabetes education classes for members living in Harvey County, KS. |
| **Traditional Healing** (American Indian & Alaska Native/AIAN) | Up to $200 per year for holistic treatments performed by traditional healing practitioners for American Indian and Alaska Native (AIAN) members. |

# 2025 Value Added Benefits for Members

Value-Added Benefits for All Members Who Qualify

| Benefit | Description |
|---|---|
| **My Health Pays® Rewards** | Members rewards for certain health-plan identified activities. (Updated activities and dollar amounts. Rewards can now be spent at Hy-Vee.) |
| **Cell Phones** | Sunflower supports members' access to phones, voice, text and data services. |
| **Start Smart® for Your Baby** | Program for pregnant members, babies and their families. Start Smart features no-cost nursing support, education and gifts. |
| **Community Programs for Children** | • $50 credit per year for youth programs (Ages 5-18)<br>• Sunny's Kids Club (Ages 0-12)<br>• Strong Youth Strong Communities Program™ (SYSC). |
| **Teladoc Digital Mental Health** | An eLearning resource for well-being and mental health. (Formerly myStrength) |
| **Farmers' Market Vouchers** | $10 vouchers to spend at participating farmers markets. |
| **Healthy Solutions for Life** | Healthy Solutions for Life offers multiple health coaching programs. (Small updates) |
| **Caregiving Collaborations®** | Caregivers are supported through various channels in the Caregiving Collaborations program. This benefit is available to one primary, informal support caregiver per member. |
| **Employment Support & Transportation** | GROW (GED, Rides, Opportunities, Work) is an employment support resource program. |

# 2025 Value Added Benefits for Members

Value-Added Benefits for Members on Waivers and Other Special Groups

| Benefit | Description |
|---|---|
| **Respite Care** (FE & PD Waivers) | Up to 60 hours of respite care per year for non-paid caregivers. |
| **Transition Services** | Welcome Home Program helps members leaving jail or nursing facilities (who are not receiving other transition supports) to return home. (Added members leaving incarceration.) |
| **Home Delivered Meals** (FE Waiver) | Up to two home-delivered meals per day for seven days for FE waiver members returning home from a nursing home or inpatient stay. |
| **Peer Support Program** | In-person and virtual training for waiver members. (Updated program.) |
| **Hospital Companionship** | Up to 16 hours of hospital companionship. (Now for members in all waivers.) |
| **Behavioral Health and Foster Care Training & Support Programs** | Peer-support calls for foster & adoptive families. Training resources for families and providers. |

# Member Assistance

- Non-emergent Medical Transportation (NEMT) is available to members when they do not have a way to get to their medical or behavioral health appointments. To schedule transportation, call three days before the appointment SafeRide 1-877-917-8162.
- Centauri Health Solutions can help members apply for Social Security Disability Insurance (SSDI) or Supplemental Security Income (SSI) if criteria is met.

Interpreter Services

- We offer access to interpreters for members who do not speak English or do not feel comfortable speaking it.  It is important that our providers and members can talk about medical and behavioral health concerns in a way both can understand.
- Our interpreter services are provided at no cost and is available for many different languages including sign language.  For members that are blind or visually impaired we will provide an oral interpretation.
- To arrange interpreter services, call Customer Service at 1-877-644-4623, TTY 711.

Sunflower Value Added Benefits

# Care Management

The Sunflower case management/care coordination program is designed to help members obtain needed services. Focusing on the whole person by partnering with our trusted providers to ensure members receive the right services, in the right place, at the right time. These services are implemented through:

- Care Coordination
- Complex / Intensive Case Management
- Disease Management

Some of the benefits of care management are:

- Working with members to develop a care plan
- Speaking with members at scheduled times
- Interacting with members doctors'
- Helping connect members with community programs and services
- Coordination and assistance with appointment scheduling

Providers can refer members for care management

  - Customer Service 1-877-644-4623
  - Secure Provider Portal

# Care Coordination

- Care coordination involves deliberately organizing patient care activities and sharing information among all the participants (providers) concerned with a patient's care to achieve safer and more effective care.
- The main goal of care coordination is to meet patients' needs and preferences in the delivery of high-quality, high-value health care.

**Improved health outcomes.**

# Care Coordination

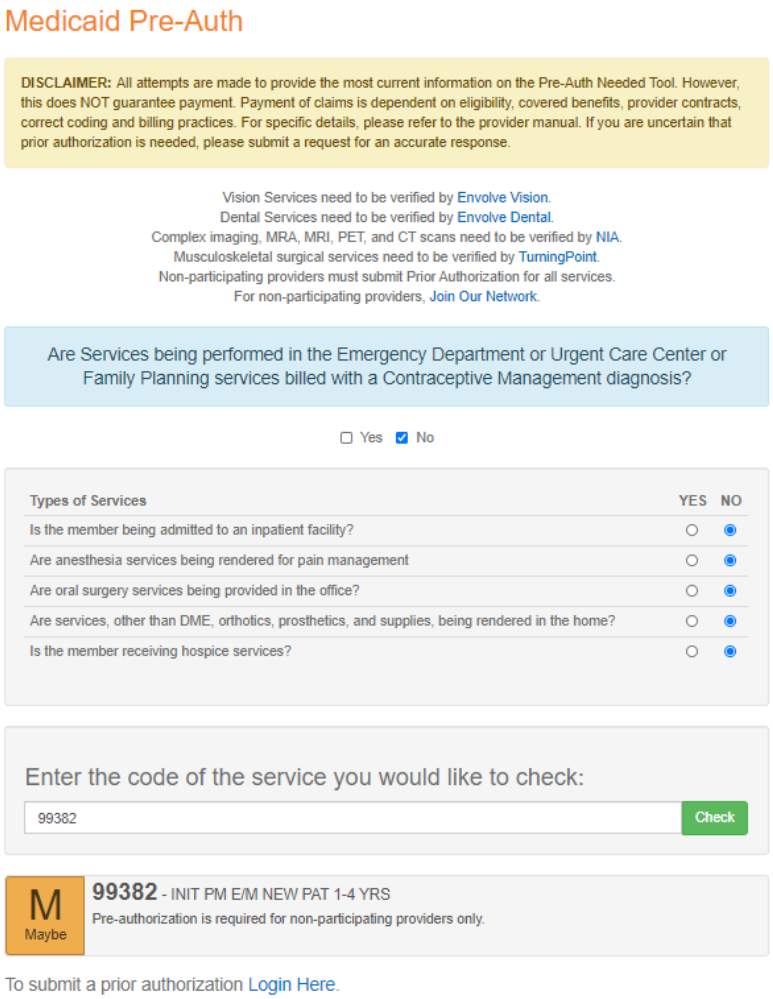
How can providers facilitate Coordination of Care?

- By making referrals and following up on those referrals to other healthcare providers.
- Talking with members about the healthcare services they are receiving.
- Establish a communication plan with the member and other healthcare providers which may include obtaining signed releases by the member.
- Documenting the communication of services being provided by other healthcare providers in the medical record including the initiation of services, ongoing and completion of the services.

# Advance Directives

- An advance directive is a legal document in which a person specifies what actions should be taken for their health if they are no longer able to make decisions for themselves because of illness or incapacity.
- A living will allow individuals to document their wishes concerning medical treatments at the end of life.
- A medical power of attorney (or healthcare proxy) allows an individual to appoint a person they trust as a healthcare agent (or surrogate decision maker), who is authorized to make medical decisions on their behalf. Before a medical power of attorney goes into effect a person's physician must conclude that they are unable to make their own medical decisions.
- Refer to www.sunflowerhealthplan.com for additional details regarding Advance Directives.

# Prior Authorization




**How to request Prior-Auth**

- Complete Prior-Auth request on Secure Provider Portal
- Call Customer Service to request 1-877-644-4623 (TTY 711)
- Submit completed Prior-Auth fax form

**Vendor Management**
www.sunflowerhealthplan.com/providers/resources/vendors.html

- Outpatient Therapy (PT, OT, ST)
- Radiology (i.e.., CT, PET, MRI)
- Musculoskeletal surgical services
- Oncology

**State Systems**

- Some HCBS services use AuthentiCare www.kdads.ks.gov/provider-home/home-and-community-based-services-provider-information/authenticare-kansas-information
- SUD use KDADS process www.kdads.ks.gov/provider-home/providers/policies-and-regulations

# Prior Authorization Reminders

- Submit all necessary clinical information when requesting an authorization.  Failure to do so could result in a denial of authorization.
- Request authorization timely or the request will result in a denial for late notification.
- If a service requires prior authorization and an authorization is not obtained, if a claim is submitted the claim will deny for no authorization.
- When a member obtains eligibility retroactively follow the process outlined in the provider manual for retro-eligibility to request authorization and the impact of claims.
- Submit attachments in PDF format.

# Prior Authorization Timelines

| Type of Services | | Provider Timeframe Request | Authorization Determination Timelines |
|---|---|---|---|
| **Outpatient** | Procedures, testing or interventions, home care services, hospice, genetic testing, pain management, DME, behavioral health | Request at least **5** business days before the scheduled service delivery date or as soon as the need for service is identified, keeping in mind a 7-day turnaround time. | For standard prior authorizations, the decision and notification will be made within **7** calendar days from receipt of the request. For expedited prior authorization requests or concurrent IP requests, a decision and notification is made within **72** hours of the receipt. |
| **Inpatient** | Hospital stays, skilled nursing facilities, LTAC, acute rehab, sub-acute, swing bed | All observation stays **>48** hours require prior authorization. Urgent/emergent admission require notification within one business day following date of admission. | |
| **PRTF** | Psychiatric Residential Treatment Facility | Guardian must request PRTF services for the child from the MCO. The MCO can then request a preauthorization review (PAR) and/or Community Based Services Team review (CBST review). The provider has seven days from the date of MCO request to return the clinical information to the MCO. | The MCO has **14** calendar days from the date the guardian requested PRTF services to make a Medical Necessity decision. |

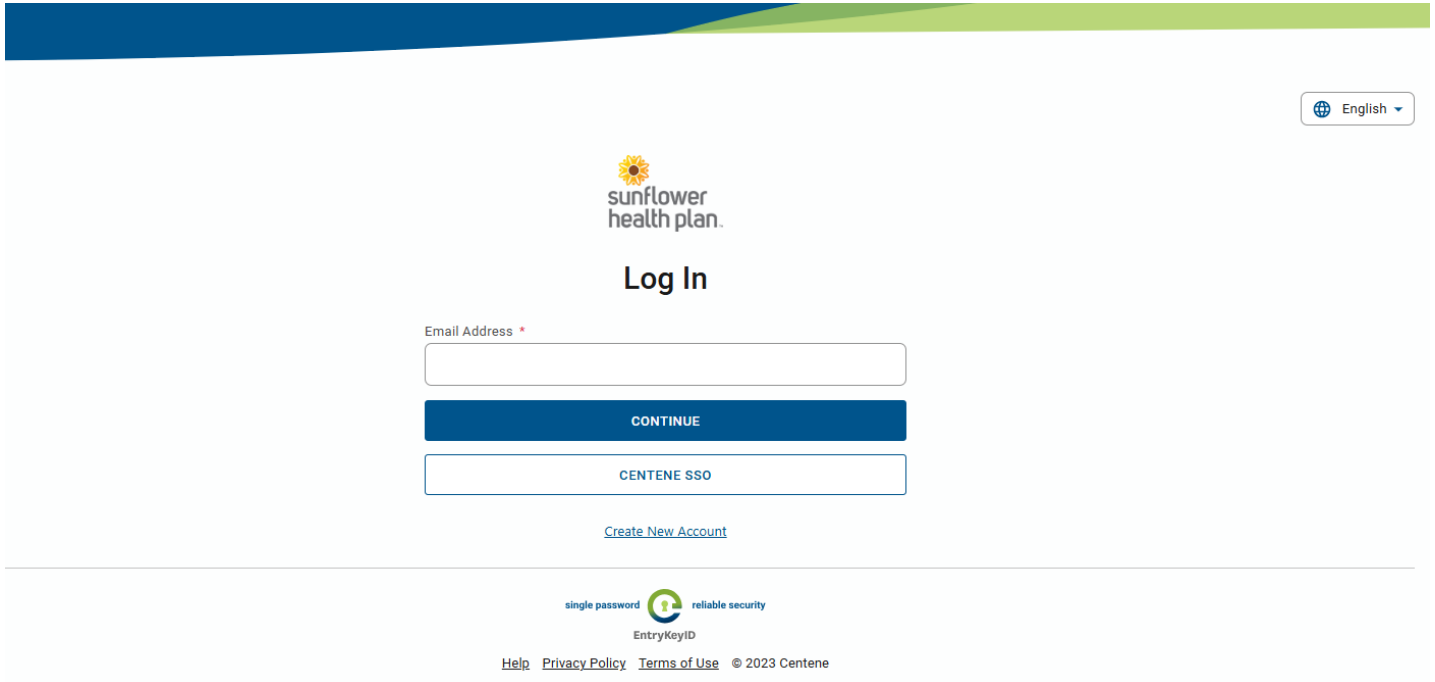
# Prior Authorization Notification

- When a service is approved notification of approval is sent to the provider and the member.
- When a service is denied a notice of adverse benefit determination (NOA) is sent to the provider and the member.
- Authorization status is available to review on the Secure Provider Portal.

# Secure Provider Portal

## REGISTRATION IS FREE & EASY!

**Contact your Practice Account Manager or Provider Relations to get started!**



# 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 the provider.sunflowerhealthplan.com 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

For additional support with these reports, contact providerengagement@sunflowerhealthplan.com

# Availity Essentials

- Sunflower 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.
- 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.

# Prior Authorization Denial

Notice of Adverse Benefit Determination (NOA)

- Providers are sent the NOA when a service is denied.
- Providers, on behalf of a member and with the members written consent, may appeal the decision.
- Follow the steps outlined in the NOA regarding timeline to submit, how to submit, where to submit an appeal to a denial.
- The resolution process includes Adverse Benefit Determination (ABD) issued to a member for a request for new health care services, appeal, External Independent Third-Party Review (EITPR) and State Fair Hearing.

# Vendor Affiliates

**Centene Vision Services**
1-877-865-1834
www.envolvevision.com

**Centene Dental Services**
1-855-434-9245
www.envolvedental.com

**Express Scripts**
1-877-644-4623
www.sunflowerhealthplan.com/providers/pharmacy.html

**Musculoskeletal Surgical Svcs - Evolent**
1-877-644-4623
www.RadMD.com

**CoverMyMeds for Prior Authorizations**
1-866-452-5017
www.covermymeds.com

**Oncology & medication** – members > 21 - **Evolent**
1-888-999-7713 | my.newcenturyhealth.com/

**Radiology – Evolent**
1-877-644-4623
www.RadMD.com

**Outpatient Therapy (PT) – Evolent**
1-877-644-4623
www.RadMD.com

For additional details go to www.sunflowerhealthplan.com/providers/resources/vendors.html

# Claims 101

Who can file a claim?

- All providers – whether in-network or out-of-network – who have rendered services to Sunflower members can file claims.

How can claims be filed?

- Electronic
  - EDI direct submission completed via Provider Portal
  - EDI submission completed via a clearinghouse
- Provider Portal
- Paper claims can be mailed

Coordination of Benefits (COB) & Third-Party Liability (TPL)

- Sunflower is always the payer of last resort.
- Bill the primary coverage first, unless the services are on the KMAP TPL non-covered list.
- Tertiary medical claims must be billed on paper claim forms and mailed.

Go to www.sunflowerhealthplan.com for additional details.

# Billing Definitions

Billing the Member

- Providers may not bill, charge, collect a deposit from, seek compensation, remuneration, or reimbursement from, or have any recourse against members for covered services in the event, including but not limited to, non-payment by Sunflower, health plan insolvency, or breach of the agreement between Sunflower and the provider.

Clean Claim

- A claim that can be processed without obtaining additional information from the provider of services or from a third party.

Non-Clean Claim

- Defined as a submitted claim that requires further investigation or development beyond the information contained in the claim. The errors or omissions in the claim may result in:
  - A request for additional information from the provider or other external sources to resolve or correct data omitted from the claim;
  - A need for review of additional medical records; or
  - A need for other information necessary to resolve discrepancies.
  - May involve issues regarding medical necessity and include claims not submitted within the filing deadlines.

# Advance Beneficiary Notice for Fee-for-Service Medicaid Program

- The KMAP beneficiary can be held responsible for payment of common services and situations. Beneficiaries can be billed only when program requirements have been met, and the provider has informed the beneficiary in advance and in writing. The provider must notify the beneficiaries in advance if a service will not be covered. To ensure the beneficiary is aware of his or her responsibility, the provider has the option of obtaining a signed Advanced Beneficiary Notice (ABN) from the beneficiary prior to providing services. A verbal notice is not acceptable. Posting the ABN in the office is not acceptable.
- For services where there is normally no face-to-face contact between the beneficiary and the provider (examples are lab and radiology services), the written ABN signed annually by the beneficiaries with the referring provider is an appropriate notification of responsibility for payment of noncovered charges.
- Providers are not to charge a KMAP beneficiary for services denied for payment by KMAP because the provider has failed to meet a program requirement including PA.
- Providers shall not bill beneficiaries for missed appointments. Missed appointments are not a distinct reimbursable service but a part of the providers' overall cost of doing business.
- For additional details, please refer to the KMAP General Benefits Provider Manual portal.kmap-state-ks.us/PublicPage/Public/ProviderManuals

# Claims Payments: Electronic Funds Transfer

Payspan: A Faster, Easier Way to Get Paid

- Sunflower 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 Sunflower

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.

# Claim Timely Filing and Processing

| Claim Submission Timely Filing | |
|---|---|
| 180 Days | From the date of service (DOS) |
| | From the date of eligibility determination |
| | When the member has other insurance, from the date on the primary payer's EOP |
| 60 Days | To refund overpayments or establish a payment plan |
| 365 Days | To submit corrected claims |

| Sunflower Claim Turn Around Timeframe | |
|---|---|
| 30 Days | To pay or deny clean claims |
| | To pay claims before interest begins to apply |
| | To pay or deny corrected claims |
| 90 Days | To pay or deny non-clean claims |

# Claim Resolution Process

| | Reconsideration (This step is optional) | Appeal | External Independent Third-Party Review (EITPR) | State Fair Hearing |
|---|---|---|---|---|
| **Deadline to Submit** | Within **120*** calendar days from the date of the EOP. | Within **60*** calendar days from date of the EOP. | Within **60*** calendar days from the date of the notice of appeal resolution. | Within **120*** calendar days from the date of the notice of appeal resolution. |
| **How to submit** | Call Customer Service: 1-877-644-4623<br><br>Mail: Address listed in EOP<br><br>Provider Portal: Claim detail submit Claim Reconsideration | Completed Claim Appeal form<br><br>Mail: Address listed in EOP<br><br>Provider Portal: Claim detail submit Claim Appeal | Completed EITPR Request Form<br><br>Mail: Sunflower Health Plan Appeals Dept., 8325 Lenexa Dr., Ste. 410, Lenexa, KS 66214<br><br>Fax: 1-888-453-4755 | Phone: 1-785-296-2433<br><br>Mail: Office of Administrative Hearings (OAH) 1020 Kansas Ave., Topeka, KS 66612 |
| **Resolution Details** | Notification Type: Revised or unrevised EOP (for same claim number).<br><br>Timeline: Will be resolved within 30 calendar days of receipt. | Notification Type: Written Provider Appeal Resolution Notice<br><br>Within 10 calendar days, provider will receive a written acknowledgment of their appeal request.<br>Within 30 calendar days from date of receipt, a resolution decision | Notification Type: Written resolution notice from Sunflower Health Plan. | Notification Type: Written communication from OAH<br><br>Timeline: Varies at discretion of OAH |

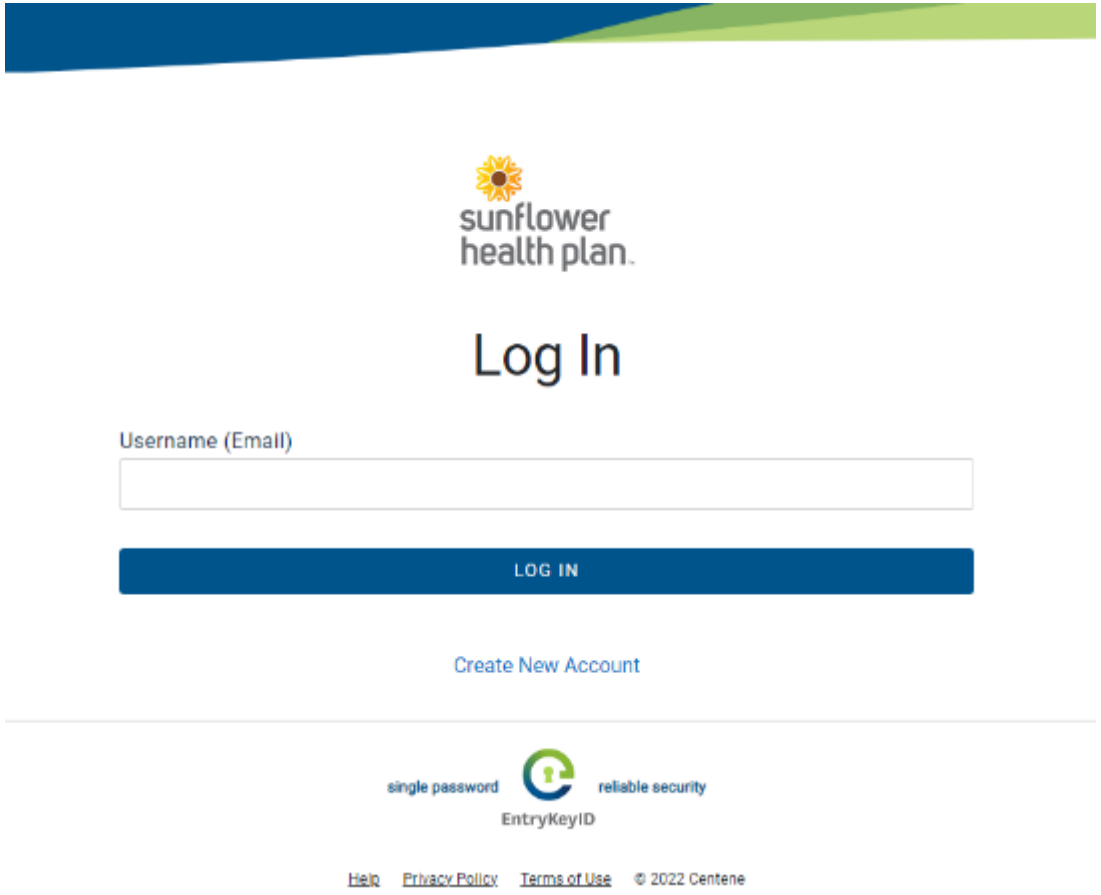
*Three additional calendar days will be allowed for mailing time. For additional information please see Provider Manual, EOP or resolution decision letter.

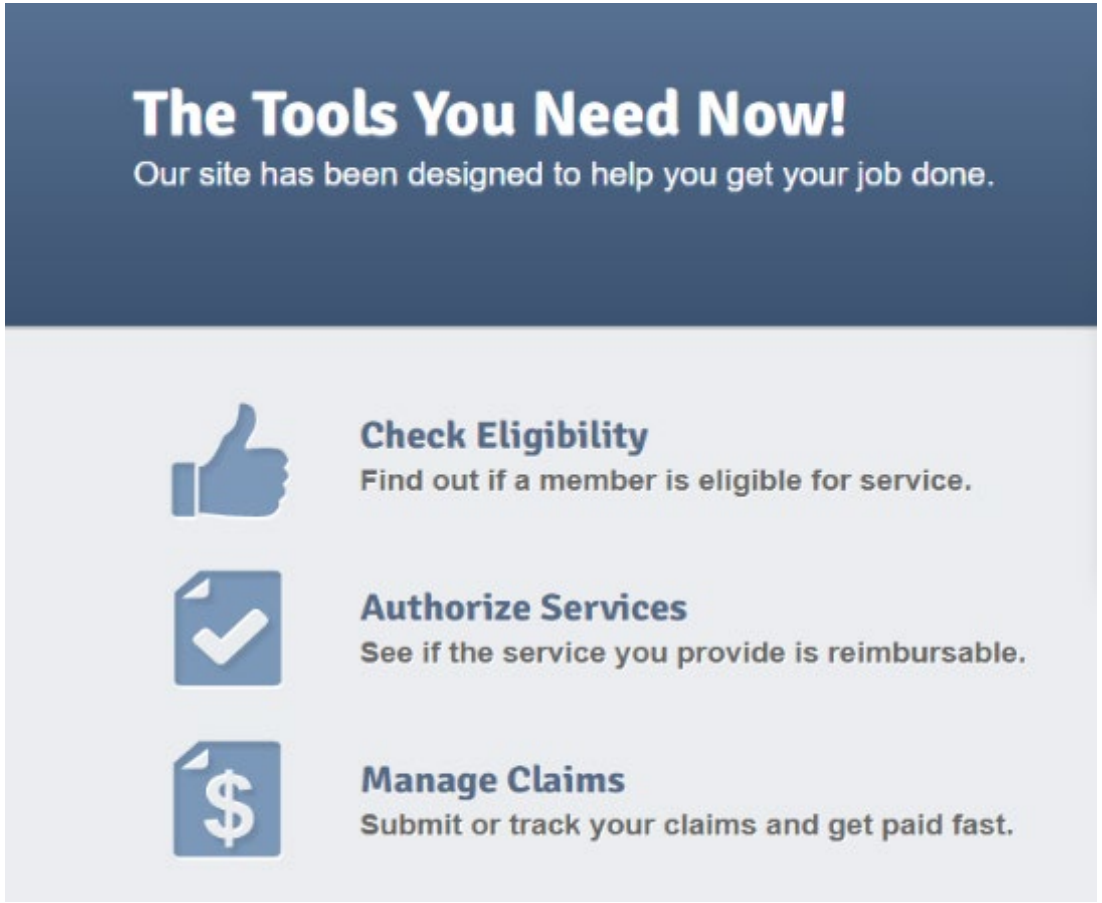
# Availity Essentials

Sunflower chose Availity Essentials as its new, secure provider portal in October 2024.

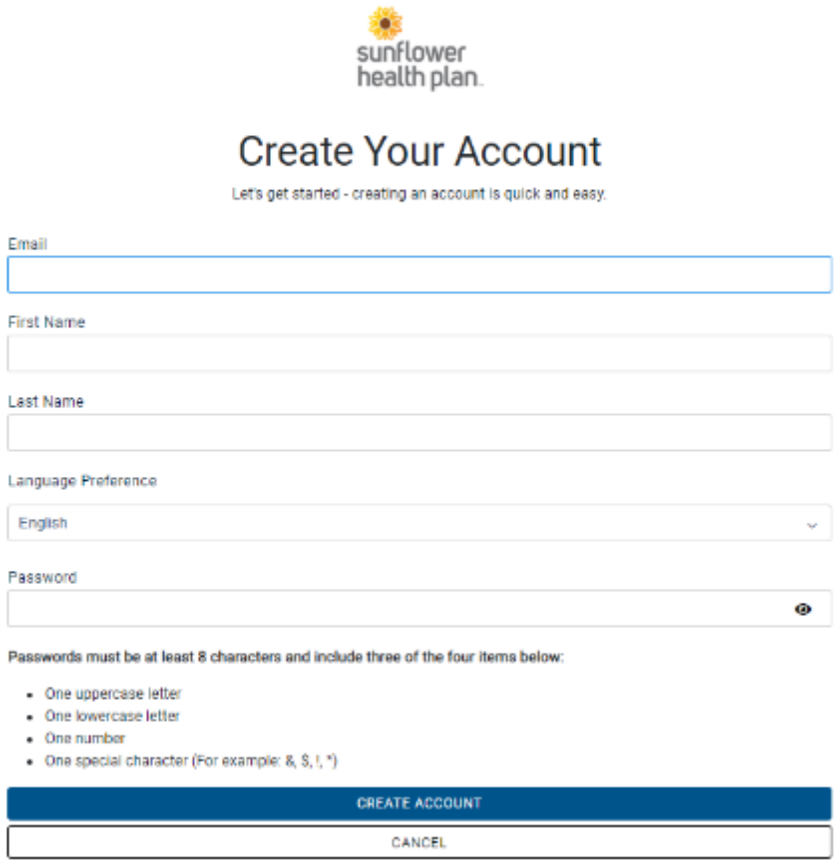
- If you are already working in Essentials, you can log in to your existing Essentials account to enjoy these benefits for Sunflower members:
  - Use Availity Essentials to verify member eligibility and benefits, submit claims, check claim status, submit authorizations, and more.
  - Look for additional functionality in Sunflower's payer space on Essentials and use the heart icon to add apps to My Favorites in the top navigation bar.
  - Access Manage My Organization – Providers to save provider information. You can then auto-populate that information repeatedly to eliminate repetitive data entry and reduce errors.
  - If you are new to Availity Essentials, getting your Essentials account is the first step toward working with Sunflower on Availity.

# Secure Provider Portal



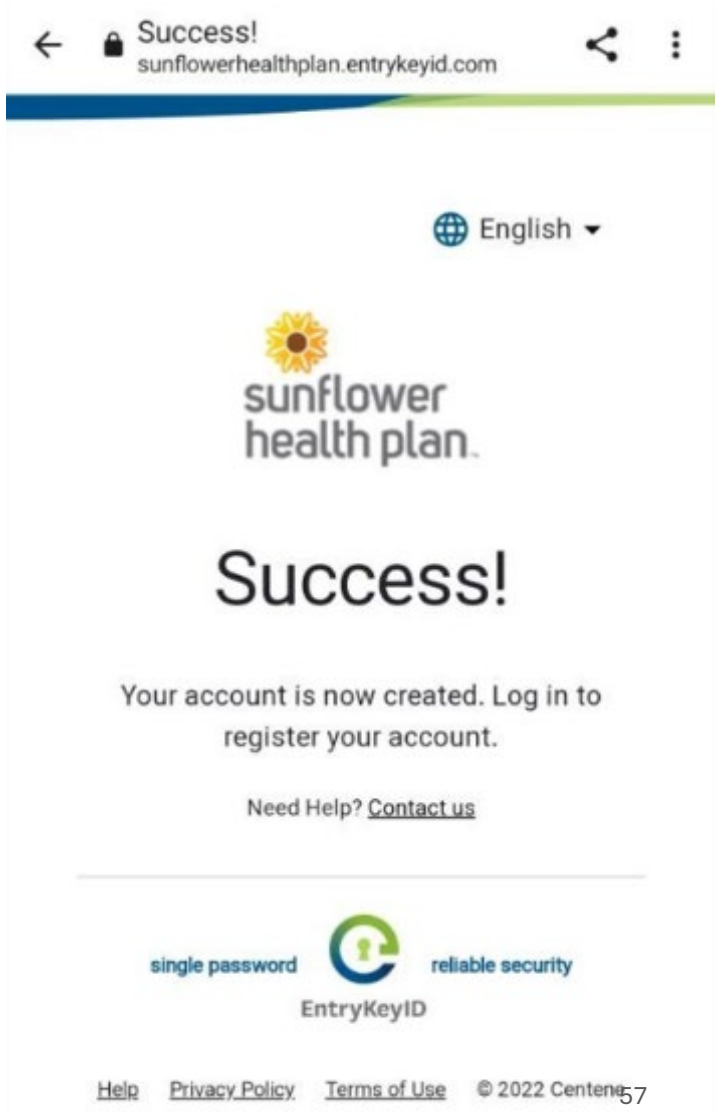



# New Portal Users – Create Your Account




Once you have clicked the Create Account button, you should receive this **Success!** response.

Before you can access the portal, your account will then need to be verified by the Account Manager at your practice or by the health plan. Contact your Provider Relations rep to verify your account.

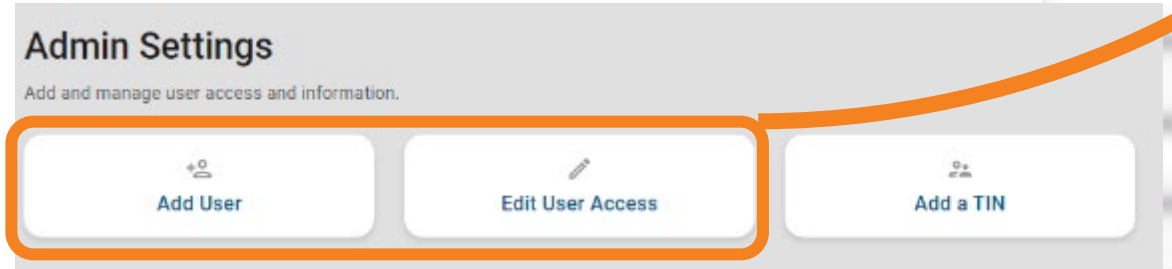


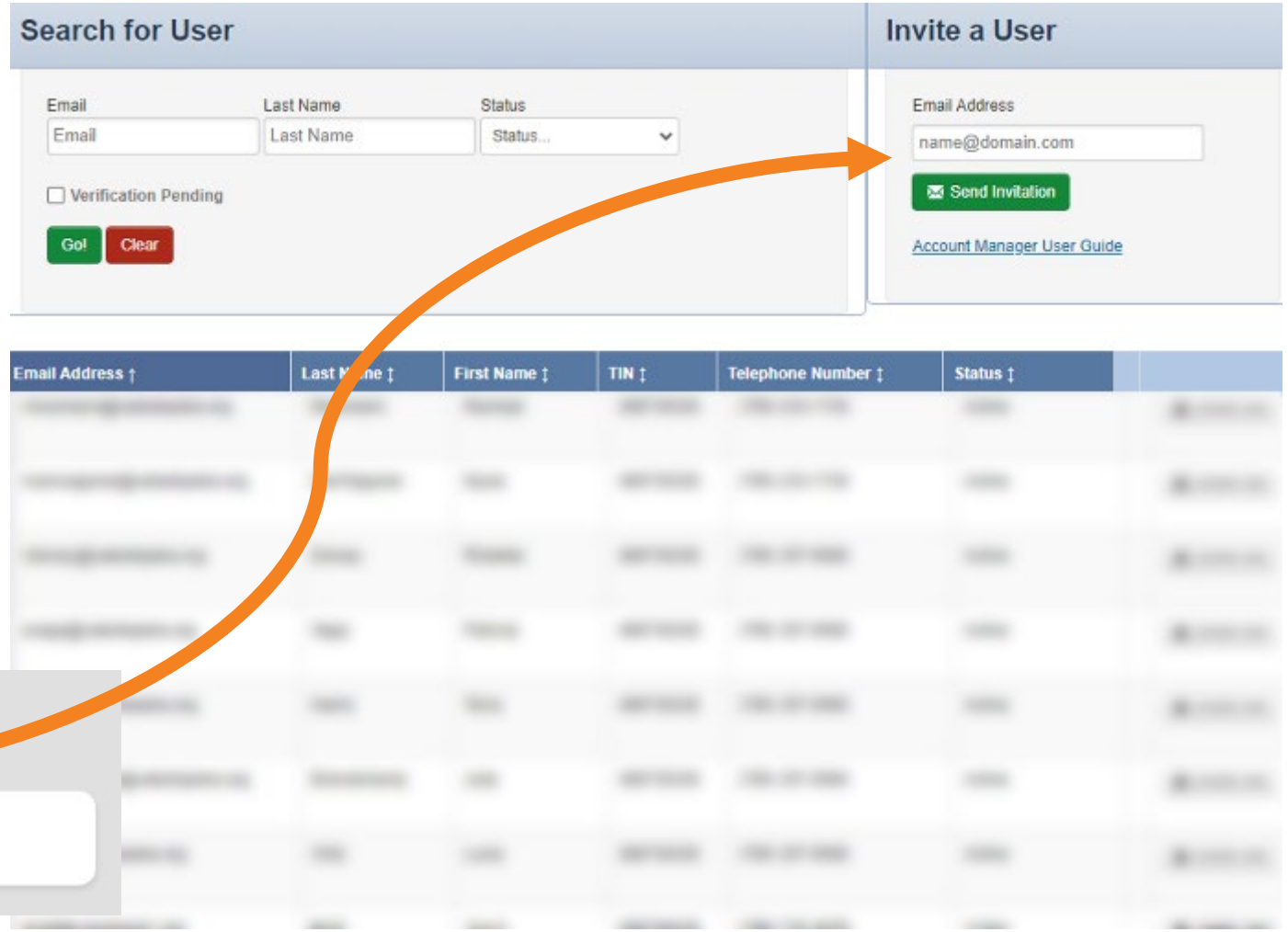
# Secure Provider Portal – Account Manager

**Role:** The primary point of contact between the provider's office and the health plan.

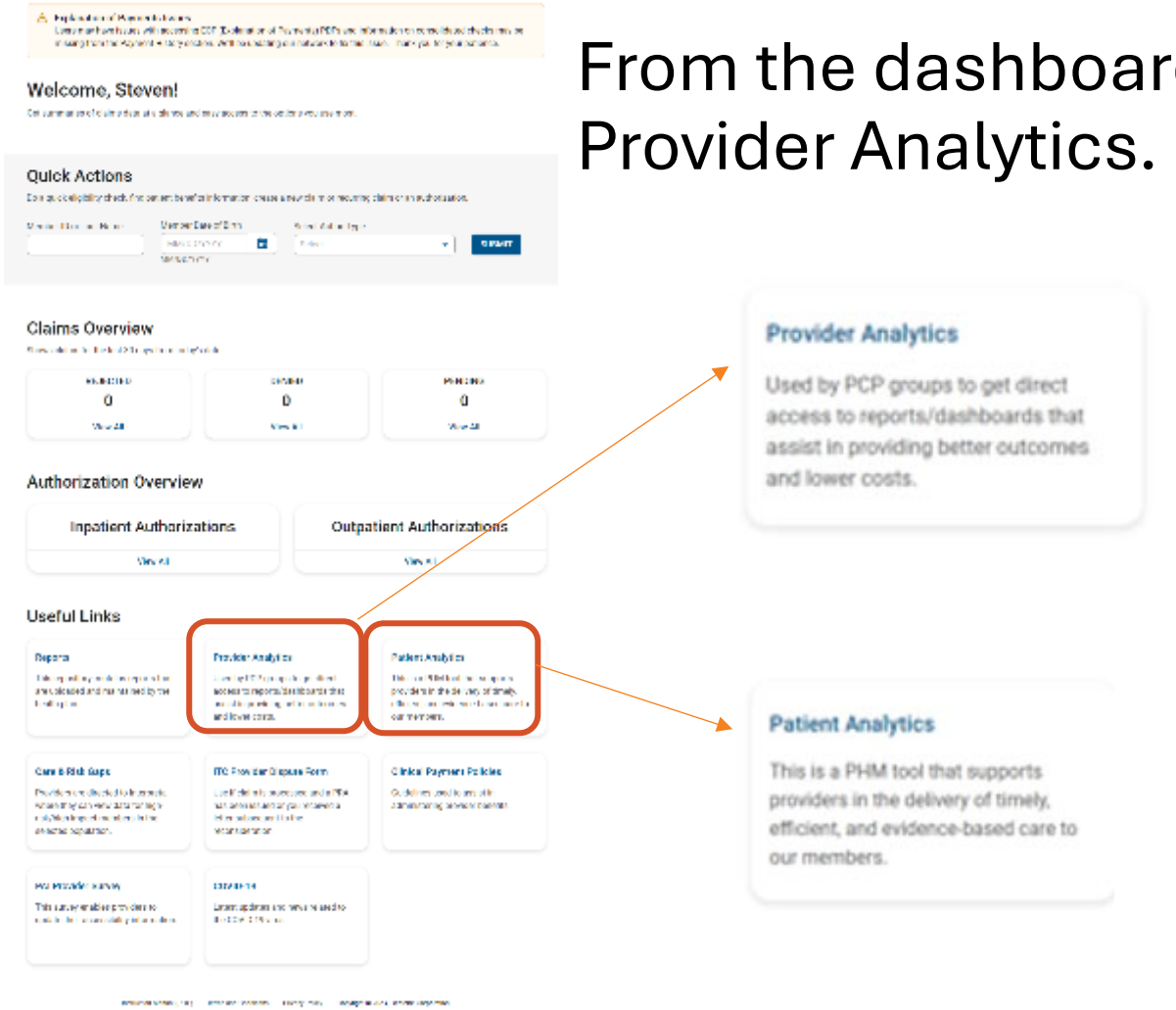
**Responsibility:** At a practice is responsible for the day-to-day support of all the other user accounts registered for the same Tax Identification Number (TIN).

- Verify new users for their TIN
- Enable or disable access to the portal for existing users
- Change the permissions of all users under their TIN



# Secure Provider Portal – Reporting Access




From the dashboard select Patient Analytics or Provider Analytics.

**Patient Analytics**

- Detailed Patient Listing
- Detailed Reports – Quality Measures, Management

**Provider Analytics**

- Supplemental Reports – COVID-19 Detail, Daily IP & Discharge, Weekly Medical and Rx Claims
- P4Q and Quality Reporting – Quality and P4Q Appointment Agenda
- Dashboard Reports – Summary and Cost Utilization/Services

Questions about reporting please send an email to providerengagement@sunflowerhealthplan.com

# Quality Improvement Program

## GOAL OF QUALITY PROGRAM

- Is to improve members' health status through a variety of meaningful quality improvement activities implemented across all care settings and aimed at improving quality of care and services delivered.
- Patient safety is integrated throughout many activities across the plan, but primarily through identification of potential and/or actual quality of care events.

## QUALITY OF CARE ISSUES

- Require investigation of the factors surrounding the event to make a determination of their severity and need for corrective action, up to and including review by the Peer Review Committee as indicated.
- Received in the QI department are tracked and monitored for trends in occurrence, regardless of their outcome or severity level.

# Performance Improvement Plan

- Adopts traditional quality/risk/utilization management approaches to identify problems, issues, and trends with the objective of developing improvement opportunities.
- Initiatives are selected based on data that indicates the need for improvement in a particular clinical or nonclinical area and includes targeted interventions that have the greatest potential for improving health outcomes or service standards.

# Care Gaps

## Pregnancy

- We want to ensure our pregnant members get the proper prenatal care, high-risk services and any additional care they may need.
- Please help us identify Sunflower members who have these needs so we may communicate all available benefits to them.

## Women between 21-64 Years of Age

- Have they had an appointment in the last year? Women in this age group should have regular exams for Cervical Cancer Screening with frequency based on their individual risk factors and history.
- Please assist in educating and scheduling these appointments.

## Members under 2 Years

- When was the child's last well child visit? Are they up to date on immunizations?
- Please assist in providing and educating on these services and their importance related to proper development and to prevent disease.

## Diabetes

- When was the member's last doctor's appointment to assess their diabetes? How about their last retinal eye exam? A1C testing? Diabetic foot exam? Nephropathy testing? Blood pressure check?
- Please help ensure these members are getting all the necessary exams and labs to assess their diabetes and progression of disease and ensure effectiveness of treatment.

# HealthCare Effective Data Information Set (HEDIS)

- HEDIS is a set of standardized performance measures developed by the National Committee for Quality Assurance (NCQA) that allows comparison across health plans. It gives purchasers and consumers the ability to distinguish between health plans based on comparative quality instead of simply cost differences.
- HEDIS Scores – Physician-specific scores are used to measure PCP practice's preventive care efforts.
- How Can Providers Improve Their HEDIS Scores?

**Knowledge & Understanding of HEDIS Measures**

**Submit Claims Including CPT II & Encounter Claims**

**Chart Documentation Reflects Services Provided**

**Provide Medical Records When Requested**

# 2025 Medicaid HEDIS Measures

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

For additional HEDIS information www.sunflowerhealthplan.com/providers/quality-improvement/hedis.html

# Why Did We Receive a Request for Medical Records?

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

# Medical Record Requests & Review for Quality

Provider Responsibilities:

- Documentation needs to fully meet request (read request document carefully and include all items in request)
- Timely submission (all requests will include a deadline and a contact number for questions, to discuss delivery, or if an extension is available)
- Submit documents in a secure, useable format (email, fax, upload to portal or mail)
- Specialists are to provide reports back to the member's PCP on a regular basis for coordination of care
    - Always submit medical records in PDF format

# Medical Record Documentation

Provider Responsibilities:

- To maintain clinical and medical records in a manner that is current, detailed and organized.
- Retain medical records for 10 years with additional details explained for extending the record retention timeframe noted in the provider manual.
- Maintain the confidentiality of clinical and medical record information and release the information in the following manner:
- All clinical and medical records of members shall be confidential and shall only be released in compliance with HIPAA and other applicable record-protection laws.
- Written consent of the member is only required for the transmission of the clinical and medical record information of a former enrolled member for “sensitive conditions” or as otherwise specified by HIPAA and other applicable protection laws.
- Authorization is not required when the provider is transitioning care to another KanCare provider.
- The extent of clinical or medical record information to be released in each instance shall be based upon tests of medical necessity and a “need to know” on the part of the practitioner or a facility requesting the information.
- All releases of information for SUD specific clinical or medical records must meet federal guidelines at 42 CFR Part 2.

# Quality Resources

## Providers

- Quality Care Pointers for Providers (PDF reference resource) - Helping your Sunflower patients achieve a Healthier Today, Better Tomorrow.
- Preventative and Disease Management Practice Guidelines
- State's Immunization Registry – Learn more about KANPHIX
- Reporting
  - > Secure Provider Portal
  - > www.availity.com

## Members

### Office Visit Checklist

- > English
- > Spanish

### Changing assigned PCP - Member PCP Change Request

- > English
- > Spanish

### Health and Wellness Tools

- Krames Health Library
- myStrength
- On.Target
- Health Books

# Satisfaction Surveys – We want you to be completely satisfied

- Provider Satisfaction Survey includes questions to evaluate provider satisfaction with our services such as:
  - Claims
  - Communications
  - Utilization Management
  - Customer Service
- Member Satisfaction Survey provides information on the experiences of members with:
  - Health plan
  - Practitioner services

# Medicaid Key Contacts

- Member eligibility or liability concerns - call KanCare Clearinghouse 1-800-792-4884
- Issues with AuthentiCare - call 1-800-441-4667 or email authenticare.support@fiserv.com
- Kansas Dept of Aging & Disability Services – call 1-785-296-4986
- Kansas Dept of Health & Environment - call 1-785-296-1500
- HCBS Authorization concerns – email HCBSAuthorizations@sunflowerhealthplan.com
- Sunflower Provider Services – call 1-877-644-4623 (TTY 711)
- Contracting & credentialing questions – email sunflowerstatehealth@centene.com
- Physical Health Provider Relations Map www.sunflowerhealthplan.com/providers/resources/provider-relations-territory-map.html
- HCBS/LTSS Provider Relations Map www.sunflowerhealthplan.com/providers/resources/pr-ltss-hcbs-map.html
- Behavioral Health Provider Relations Map www.sunflowerhealthplan.com/providers/resources/provider-relations-territory-map2.html
- Case Management Territory Map www.sunflowerhealthplan.com/providers/resources/care-manager-map.html

# How to Reach Us

| Resource | Sunflower - Medicaid | Ambetter - Marketplace | Wellcare - Medicare Advantage | Wellcare Complete |
|---|---|---|---|---|
| **Website - Provider Resources** | www.sunflowerhealthplan.com/providers/resources.html | ambetter.sunflowerhealthplan.com/provider-resources/manuals-and-forms.html | www.sunflowerhealthplan.com/providers/allwell-provider.html | www.wellcarecomplete.com/providers/provider-resources.html |
| **Customer Service** | 1-877-644-4623<br>TTY: 711 | 1-844-518-9505<br>TTY: 844-546-9713 | 1-800-977-7522<br>DSNP 1-877-796-6811<br>TTY: 711 | 1-800-977-7522<br>TTY: 711 |
| **Secure Provider Portal** | www.sunflowerhealthplan.com/login.html | | | provider.wellcarecomplete.com |
| **Contact Us Submission** | www.sunflowerhealthplan.com/contact-us.html | ambetter.sunflowerhealthplan.com/contact-us.html | wellcare.sunflowerhealthplan.com/contact-us.html | www.wellcarecomplete.com/contact-us.html |
| **Medicaid Provider Representative Territory Maps** | Physical Health – www.sunflowerhealthplan.com/providers/resources/provider-relations-territory-map.html<br>HCBS & LTSS – www.sunflowerhealthplan.com/providers/resources/pr-ltss-hcbs-map.html<br>Behavioral Health - www.sunflowerhealthplan.com/providers/resources/provider-relations-territory-map2.html | | | |
| **Contracting & Credentialling Status Inquiries** | sunflowerstatehealth@centene.com | | | |

# Questions?

Training Feedback
www.sunflowerhealthplan.com/providers/resources/provider-training/feedback.html

Provider Training Questions
Provider_Training@sunflowerhealthplan.com

General Questions
providerrelations@sunflowerhealthplan.com

# Thank You.

sunflower health plan