Regional Provider Workshop

Welcome!

KDHE approved 2/17/17

Sunflower Health Plan Earns Prestigious Commendable Accreditation Status

Date: 10/10/16

Commendable Status

Sunflower Health Plan, a subsidiary of Centene Corporation, has achieved national health plan accreditation with a commendable status from the National Committee for Quality Assurance (NCQA). The NCQA evaluates how well a health plan manages all parts of its delivery system – physicians, hospitals, other providers, and administrative services in order to continuously improve the quality of care and services provided to its members.

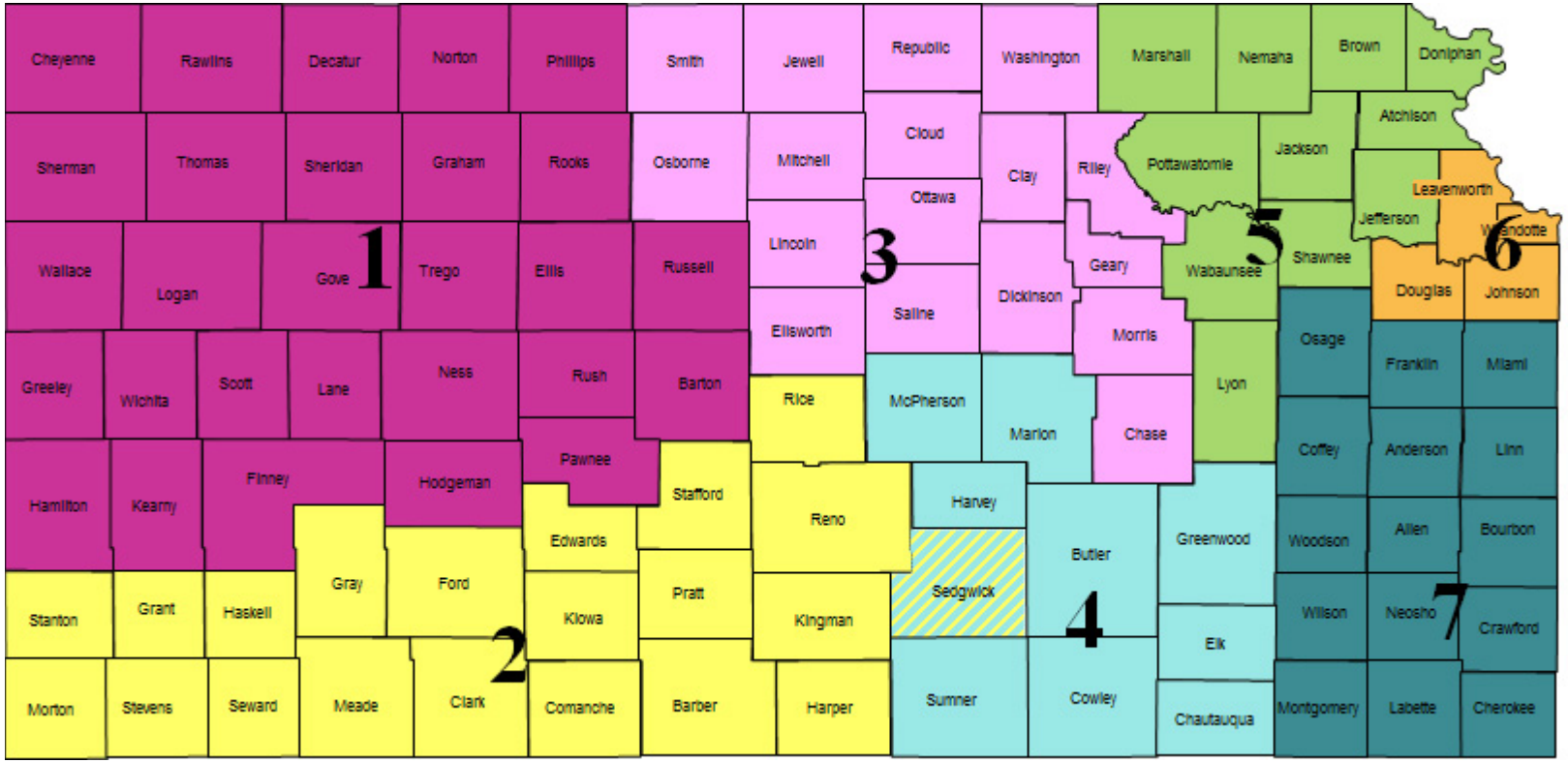
Sunflower Health Plan was first awarded NCQA accreditation in 2014, and today's announcement of Commendable status demonstrates the health plan's continuous improvement in quality measures.

"Achieving an accreditation status of Commendable from NCQA is a sign that a health plan is serious about quality," said Margaret E. O'Kane, president, NCQA. "It is awarded to plans whose service and clinical quality meet or exceed NCQA's rigorous requirements for consumer protection and quality improvement."

Sunflower Health Plan serves approximately 145,000 Kansas Medicaid beneficiaries in the state's KanCare program, which covers eligible pregnant women, children, the frail and elderly, as well as people with disabilities. Sunflower has improved health and wellness outcomes for its members, such as controlling diabetes, increasing immunizations and enhancing employment opportunities.

Meet Your Network Specialist

sunflower health plan



KanCare

KDHE approved 2/17/17

Meet Your Network Specialist

sunflower health plan

REGION	NAME	PHONE	EMAIL
1	DAVE VOSS	785-250-5532	davoss@sunflowerhealthplan.com
2	EMILY GAGNEBIN	316-218-2019	egagnebin@sunflowerhealthplan.com
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4	MARC MADDEN	316-680-8968	mmadden@sunflowerhealthplan.com
5	TAMMY ADAMS	785-207-4926	tamadams@sunflowerhealthplan.com
6	MICHELLE SWAIN	913-305-7654	mswain@sunflowerhealthplan.com
7	LAURA BLACK-JOHNSON	620-212-8802	lbjohnson@sunflowerhealthplan.com
I/DD Provider Rep	ALANA DOTSON	316-249-2172	adotson@sunflowerhealthplan.com

KanCare

Claims

Agenda & Objectives

- Corrected Claims
  - What is a Corrected Claim?
  - How to Submit a Corrected Claim
  - Common Corrected Claim Errors
- Top Denied Claim Reasons & How to Prevent Them
  - Resubmit Under the Newborn's Medicaid ID#, Name and Date of Birth *for Inpatient Hospitals*
  - Provider Must Use HCPC CPT for Correct Pricing *for Outpatient Hospitals*
  - Diagnosis Cannot Be Used as Primary Diagnosis, Please Resubmit *for multiple providers*
  - Name of Drug, NDC Number and Quantity is Required to Process Claim *for Medical Services*
  - **Preventable** Top Claim Denials
- Medicare Cross Over Claims
  - General Billing Requirements
  - Top Billing Error that results in Inpatient Hospital claim denials
  - State Bulletins and Policies

Corrected Claims

What is a Corrected Claim?

- A claim that has been submitted with incorrect or missing information, e.g.,:
  - Attending Provider Name and NPI (box 76 on a CMS UB-04 claim form)
  - Ordering, Referring or Prescribing Provider Name and NPI (box 17b on a CMS1500)
    - ***Note:** *Claims missing or denied for Attending, Ordering, Referring or Prescribing Provider may not be corrected using Sunflower Health Plan's Secure Provider Portal.*
  - Diagnosis Codes (boxes 21 and 24E of the CMS-1500 or boxes 66, 67, 67A-Q on a CMS UB-04 claim form)
  - CPT, HCPCS or Revenue Codes (box 24D of the CMS-1500 or boxes 42 and 44 on a CMS UB-04 claim form, for inpatient and outpatient hospital services respectively)
  - Unit Values are Changed
  - Late Charges are added to an inpatient facility claim

What is a Corrected Claim?

- A claim that has been submitted with incorrect or missing information, e.g.,:
  - EOP from the Primary/Other Insurer *or* the EOP's from the Primary and Secondary Other Insurers (when the member has tertiary coverage)
    - Providers not making changes to an original claim are allowed to resubmit the Sunflower EOB with a copy of the primary payer's EOB attached.
    - If a new primary EOB is submitted and that EOB does not match the original claim, submit a Corrected Claim and primary payer EOB using one of the following methods.
  - Consent forms
  - M.S.R.P. Invoices
  - Medical Records (when a claim contains a Not Otherwise Classified (NOC) or Unlisted Procedure Code)

How to Submit a Corrected Claim

Correction of Electronic (EDI) Claims

Submit corrected claims electronically via your clearinghouse using the values specified for the fields below:

- CMS 1500 / Professional Claims:
  - FIELD CLM05-3 = 7
  - REF*F8 = Must contain the original claim number from the Explanation of Payment (EOP)
- UB / Institutional Claims:
  - FIELD CLM05-3 = 7
  - REF*F8 = Must contain the original claim number from the Explanation of Payment (EOP)

How to Submit a Corrected Claim

Correction of Paper Claims

All paper claims submissions should be free of handwritten verbiage and submitted on a standard red-and-white UB-04 or CMS1500 claim form. Any UB-04 or CMS1500 forms received that do not meet the Centers for Medicare and Medicaid Services (CMS) printing requirements will be rejected and sent back to the provider or facility upon receipt.

In addition to submitting corrected claims on a standard red-and-white form, the previous claim number should be referenced as outlined in the National Uniform Claim Committee (NUCC) guidelines, http://www.nucc.org/.

Mail Corrected Paper Claims to:

Sunflower Health Plan
Attn: Corrected Claims
P.O. Box 4070
Farmington, MO 63640-3833

How to Submit a Corrected Claim

Correction of Paper Claims

CMS 1500 / Professional Claims:

- Box 22 - Medicaid Resubmission Code =
  - 7 for Replacement / Corrected
- Original Ref No. = Must contain the original MCO claim number from the Explanation of Payment (EOP)

UB / Institutional Claims:

- Box 4 = Must contain a Bill Type that indicates a correction, e.g., 0XX7
- Box 64 = Must contain the original claim number

How to Submit a Corrected Claim

Correct Claims via **Sunflower's Secure Provider Portal**

1. Click **Claims** at the top of the screen.
2. Select an individual paid claim to see the details.
3. The claim displays for you to correct as needed. Click **Correct Claim**.
4. Proceed through the claims screens correcting the information that you may have omitted when the claim was originally submitted.
5. Continue clicking **Next** to move through the screens required to resubmit.
6. Review the claim information you have corrected before clicking **Submit**.
7. You receive a success message confirming your submittal.

NOTE: Claim Corrections are not available if the provider data on the first submission is different than the corrected claim submission. The term provider data includes the billing, performing, ordering, referring, attending, and prescriber information.

Common Corrected Claim Errors

EX18 – DENY: DUPLICATE CLAIM SERVICE

Common Denial Reason(s):

- The claim is an exact duplicate of another claim that has already paid or denied.
- On a CMS UB-04 claim form, the claim is missing Bill Type ‘0XX7’ and the original claim ID (ICN) in box 64 to indicate it was a Corrected Claim.
- On a CMS-1500 claim form, the claim is missing Resubmission Code ‘7’ and the original claim ID (ICN) in box 22 to indicate it was a Corrected Claim.
- MCO’s have **30 days** to process and provide a response on a claim. Submitting the same claim multiple times results in duplicate claim denials, can contribute to delays in Sunflower claims processing time, may inflate outstanding A/R balances which can increase time spent by billing offices in posting accounts receivables.

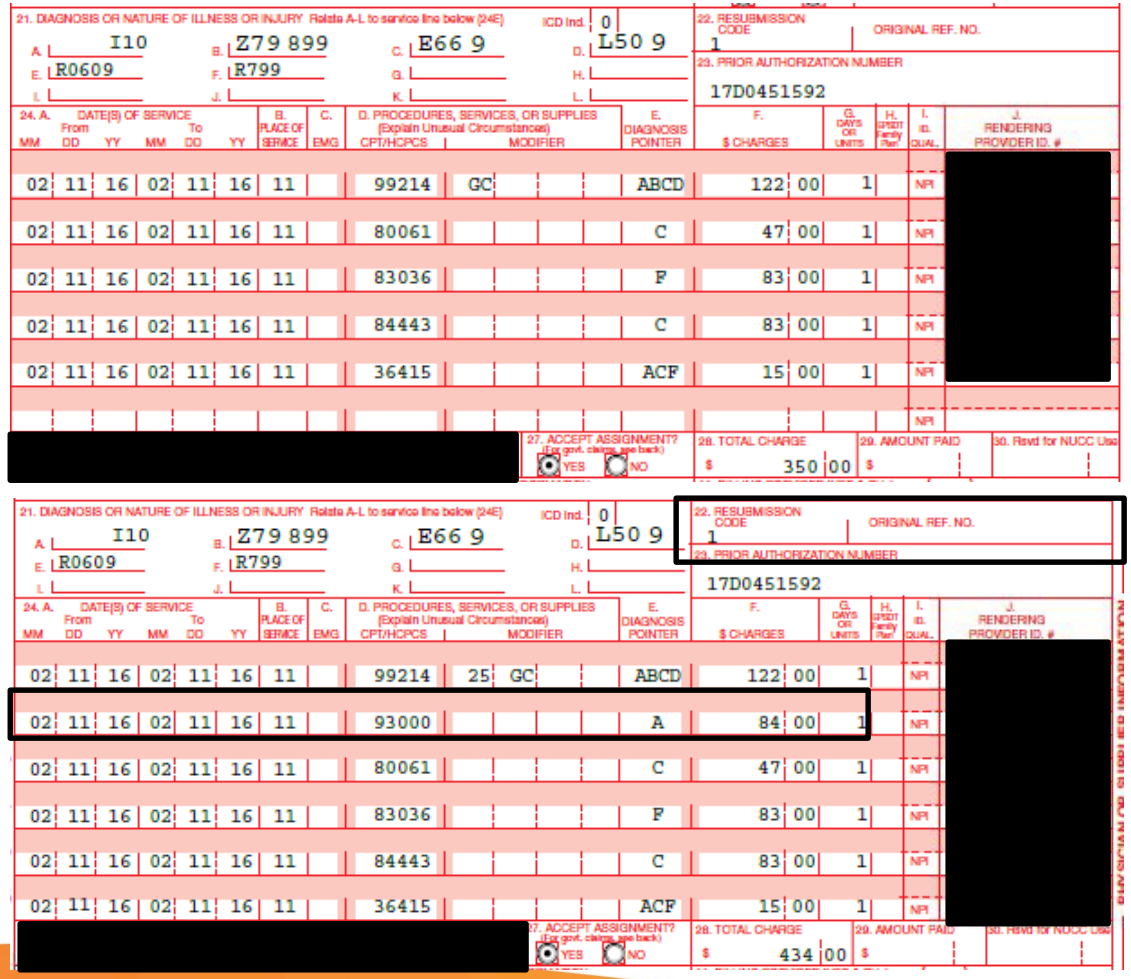
Top Denied Claim Reasons

EX*1 – DENY: HEALTHPLAN GUIDELINES FOR SUBMITTING A CORRECTED CLAIM WERE NOT FOLLOWED

Common Denial Reason(s):

- A claim was billed as a first time claim, but was suspected as a duplicate to another similar claim in the member's history (e.g., same member, date of service and provider; but field values were added or different).
- A UB-04 claim was billed with a Type of Bill '0XX7' and the original claim number in box 64 was missing or invalid.
- A CMS 1500 claim was billed with an Resubmission Code of 7 and the original claim number in box 22 was missing or invalid.

*EX*1 – DENY: HEALTHPLAN GUIDELINES FOR SUBMITTING A CORRECTED CLAIM WERE NOT FOLLOWED*



21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) — ICD Ind. 0
A. I10 B. Z79 899 C. E66 9 D. L50 9
E. R0609 F. R799 G. H. I. J. K. L.

22. RESUBMISSION CODE: 1 ORIGINAL REF. NO.
23. PRIOR AUTHORIZATION NUMBER: 17D0451592

24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
02	11	16	02	11	16	11		99214	GC	ABCD	122 00	1		NPI	[redacted]
02	11	16	02	11	16	11		80061		C	47 00	1		NPI	
02	11	16	02	11	16	11		83036		F	83 00	1		NPI	
02	11	16	02	11	16	11		84443		C	83 00	1		NPI	
02	11	16	02	11	16	11		36415		ACF	15 00	1		NPI	
														NPI	

[redacted] 27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO — 28. TOTAL CHARGE $ 350 00 — 29. AMOUNT PAID $ — 30. Rsvd for NUCC Use

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) — ICD Ind. 0
A. I10 B. Z79 899 C. E66 9 D. L50 9
E. R0609 F. R799 G. H. I. J. K. L.

22. RESUBMISSION CODE: 1 ORIGINAL REF. NO.
23. PRIOR AUTHORIZATION NUMBER: 17D0451592

24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
02	11	16	02	11	16	11		99214	25 GC	ABCD	122 00	1		NPI	[redacted]
02	11	16	02	11	16	11		93000		A	84 00	1		NPI	
02	11	16	02	11	16	11		80061		C	47 00	1		NPI	
02	11	16	02	11	16	11		83036		F	83 00	1		NPI	
02	11	16	02	11	16	11		84443		C	83 00	1		NPI	
02	11	16	02	11	16	11		36415		ACF	15 00	1		NPI	

[redacted] 27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO — 28. TOTAL CHARGE $ 434 00 — 29. AMOUNT PAID $

The first submission has charges totaling $350.00

The second submission has an additional service line (2) with CPT 93000 and $84.00 in charges, but does not include a Resubmission Code of 7 or the Original ICN in box 22.

KDHE approved 2/17/17

Top Denied Claim Reasons
&
How to Prevent Them

Top Denied Claim Reasons

Inpatient Hospital

EXnB – DENY: RESUBMIT UNDER THE NEWBORNS MEDICAID ID#, NAME AND DATE OF BIRTH

Common Denial Reason(s):

- The newborn became eligible and an ID number was provided within 45 days from the date of birth but was not submitted on the claim.
- Sunflower Provider Bulletins on billing OB Delivery and Newborn Claims:
  - SHPBN-2016-025 Newborn Claims Processing Changes
  - SHPBN-2016-086 OB Deliveries & Newborn Claims Billing Clarification

When the Mother is Assigned to Sunflower Health Plan:

Delivery and Newborn Claims

- Maternity admissions without delivery complications require notification and information on the delivery outcome within one business day of delivery and must include birth outcomes, including Ballard score or equivalent.
- NICU admissions require notification within one business day (by 5 p.m. CT) of admission. All NICU admissions are subject to concurrent review for continued stay.

For the Mom's Claim:

- **Medicaid ID:** Use the beneficiary's (*the mom's*) Medicaid ID
  Name: Use the mom's name
  Date of Birth: Use the mom's date of birth
  Diagnosis Code: Use the appropriate ICD10 diagnosis code, for example, *Z37 - Outcome of Delivery**
  Room & Board Revenue Code: Use the appropriate Med/Surg/Gyn/OB revenue code

**Note: Z37 ICD10 codes are not for use on the newborn claim*

Top Denied Claim Reasons

Inpatient Hospital

EXnB – DENY: RESUBMIT UNDER THE NEWBORNS MEDICAID ID#, NAME AND DATE OF BIRTH

When billing for a newborn <u>who does not</u> have a Medicaid ID number:

For the Baby's Claim:

- **Medicaid ID:** Use the mom's Medicaid ID
- **Name:** "Newborn," "BabyGirl," or "Baby Boy"
- **Date of Birth:** Use the newborn's date or birth
- **Diagnosis Code:** Use the appropriate ICD10 diagnosis code, for example, *Z38 - Live born Infants according to place of birth and type of delivery***
- **Room & Board Revenue Code:** must be a nursery room and board revenue code 170-179

***Note: Z38 ICD10 codes are not for use on the mother's claim*

- Effective with dates of service beginning January 1, 2015 claims for newborn services billed under the mother's beneficiary ID will be pended for 45 days pending receipt of the newborn's beneficiary ID number.
- If a newborn ID is received, the claim will be denied "EXnB – Deny: Rebill with Newborn Medicaid ID#, Name and DOB" notifying the provider they must submit a corrected claim **using the newborn's ID number**, name, and DOB.
- If no newborn ID is received and the date of service is within 45 days of the newborn's date of birth, the claim may be paid using the mother's ID number. If the date of service is not within 45 days of the newborn's date of birth, the claim will be denied.

Top Denied Claim Reasons

Inpatient Hospital

EXnB – DENY: RESUBMIT UNDER THE NEWBORNS MEDICAID ID#, NAME AND DATE OF BIRTH

Billing Reminders When Using the Mother's Beneficiary ID Number

Newborn services are considered procedure codes which specifically state "newborn" in the code description according to the CPT® manual or revenue codes 170-179. These services must be billed with a newborn diagnosis code in order to receive payment.

When billing newborn services for a newborn that does not have a beneficiary ID number, use "Newborn," "Baby Girl," or "Baby Boy" in the first name field and enter the last name. Use the newborn's date of birth and the mother's beneficiary ID number.

Top Denied Claim Reasons

Inpatient Hospital

EXnB – DENY: RESUBMIT UNDER THE NEWBORNS MEDICAID ID#, NAME AND DATE OF BIRTH

When the Mother is SOBRA or not assigned to Sunflower Health Plan: Newborn Claims

When a newborn delivery occurs and the mother is not assigned to an MCO or the mother is SOBRA, hospitals should refer to the *Kansas Medical Assistance Program Fee-for-Service Hospital Provider Manual* for guidance on billing for **Emergency Medical Services for Aliens (SOBRA)**. Claims for normal newborn births born to SOBRA Mothers would be considered to be retro-eligible and do not require notification, unless the newborn is in a NICU level of care. When the newborn is retro-eligible, they would be assigned their own Medicaid ID, and should be billed as follows:

For the Newborn Claim born to a SOBRA Mother:

- **Medicaid ID:** Use the Newborn's Medicaid ID
- **Name:** Use the Newborn's first and last name as shown in KMAP or on the ID Card
- **Date of Birth:** Use the newborn's date or birth
- **Diagnosis Code:** Use the appropriate ICD10 diagnosis code, for example, *Z38 - Live born Infants according to place of birth and type of delivery***
- **Room & Board Revenue Code:** must be a nursery room and board revenue code 170-179

***Note: Z38 ICD10 codes are not for use on the mother's claim*

Top Denied Claim Reasons

Inpatient Hospital

EXnB – DENY: RESUBMIT UNDER THE NEWBORNS MEDICAID ID#, NAME AND DATE OF BIRTH

When billing for a newborn <u>who has</u> their own Medicaid ID number:

For the Baby's Claim:

- **Medicaid ID:** Use the Newborn's Medicaid ID
- **Name:** Use the newborn's first and last name as shown in KMAP or on the ID card
- **Date of Birth:** Use the newborn's date or birth
- **Diagnosis Code:** Use the appropriate ICD10 diagnosis code, for example, *Z38 - Live born Infants according to place of birth and type of delivery***
- **Room & Board Revenue Code:** must be a nursery room and board revenue code 170-179

***Note: Z38 ICD10 codes are not for use on the mother's claim*

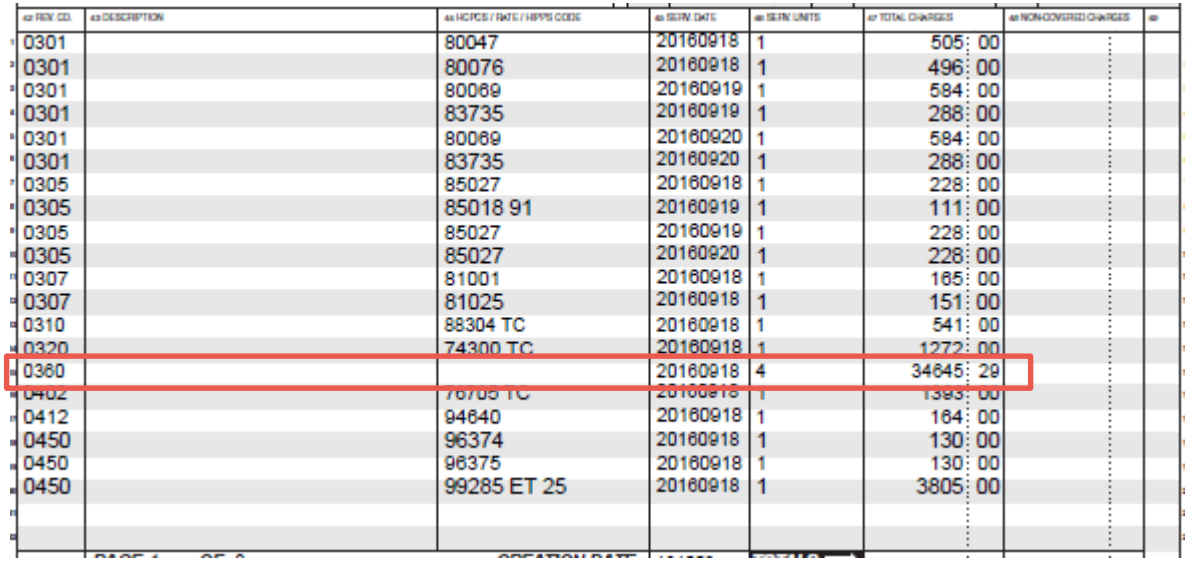
Top Denied Claim Reasons

Outpatient Hospital

EXH1 – DENY: PROVIDER MUST USE HCPCS CPT FOR CORRECT PRICING

Common Denial Reason(s):

- Use appropriate CPT and/or HCPCS codes for billing. Revenue codes are not required for any outpatient service.
- CPT and/or HCPCS codes are required for reimbursement of Hospital Outpatient services.



REV. CD.	DESCRIPTION	HCPCS / RATE / HIPPS CODE	SERV. DATE	SERV. UNITS	TOTAL CHARGES	NON-COVERED CHARGES	
0301		80047	20160918	1	505 00		
0301		80076	20160918	1	496 00		
0301		80069	20160919	1	584 00		
0301		83735	20160919	1	288 00		
0301		80069	20160920	1	584 00		
0301		83735	20160920	1	288 00		
0305		85027	20160918	1	228 00		
0305		85018 91	20160919	1	111 00		
0305		85027	20160919	1	228 00		
0305		85027	20160920	1	228 00		
0307		81001	20160918	1	165 00		
0307		81025	20160918	1	151 00		
0310		88304 TC	20160918	1	541 00		
0320		74300 TC	20160918	1	1272 00		
0360			20160918	4	34645 29		
0402		76705 TC	20160918	1	1393 00		
0412		94640	20160918	1	164 00		
0450		96374	20160918	1	130 00		
0450		96375	20160918	1	130 00		
0450		99285 ET 25	20160918	1	3805 00		

Revenue Code 360 – Operating Room Services, requires a surgical CPT and/or HCPCS code for reimbursement.

Sunflower Health Plan considers the following revenue codes Contractual Write Offs:

- 25x
- 27x
- 370
- 637
- 710

Top Denied Claim Reasons

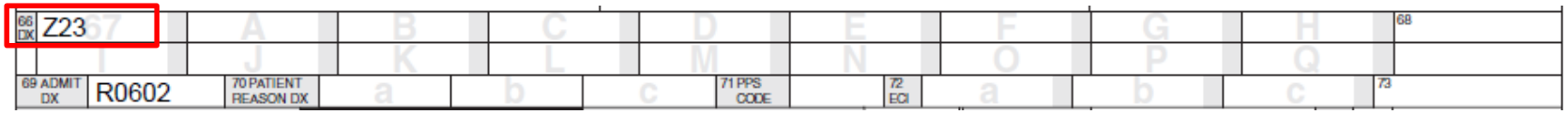
Hospitals

EXEC – DENY: DIAGNOSIS CANNOT BE USED AS PRIMARY DIAGNOSIS,

PLEASE RESUBMIT

Common Denial Reasons:

- The primary diagnosis code listed on the claim is identified as a Manifestation code and are not allowed to be reported as a principal or first-listed diagnosis code (e.g., 29410 or F0280 – Dementia).
- The primary diagnosis code listed on the claim is identified in ICD-9/ICD-10 as an Unacceptable Primary Diagnosis (PDx) code.



- Z23 – Encounter for immunization
- 2016 ICD-10-CM indicates the following, *"Code first any routine childhood examination"*

Top Diagnosis Codes denied by Hospital Place of Service

Inpatient (POS 21)

- Z23 - ENCOUNTER FOR IMMUNIZATION 65%
- J918 - PLEURAL EFF OTH COND CLASS ELSW 5%

Outpatient (POS 22)

- D631 - ANEMIA IN CHRONIC KIDNEY DISEASE 15%
- F0281 - DEMENTIA OTH DISEASE W/BEHAVRL DIST 13%

Emergency Room (POS 23)

- R5081 - FEVER PRESENTING W/COND CLASS 7%
- H673 - OTITIS MEDIA DZ CLASS ELSW BIL 1%

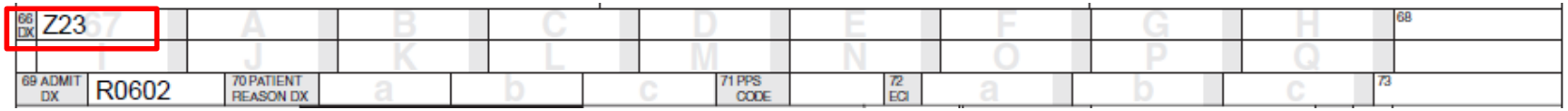
Top Denied Claim Reasons

Nursing Facilities

EXEC – DENY: DIAGNOSIS CANNOT BE USED AS PRIMARY DIAGNOSIS, PLEASE RESUBMIT

Common Denial Reasons:

- The primary diagnosis code listed on the claim is identified as a Manifestation code and are not allowed to be reported as a principal or first-listed diagnosis code (e.g., 29410 or F0280 – Dementia).
- The primary diagnosis code listed on the claim is identified in ICD-9/ICD-10 as an Unacceptable Primary Diagnosis (PDx) code.



- Z23 – Encounter for immunization
- 2016 ICD-10-CM indicates the following, *"Code first any routine childhood examination"*
- *Z23 makes up for 51% of all denied claims for Nursing Facilities for this reason*

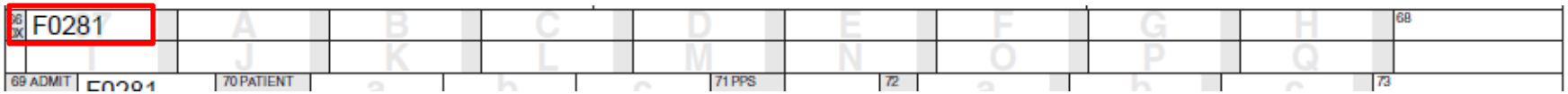
Top Denied Claim Reasons

Nursing Facilities

EXEC – DENY: DIAGNOSIS CANNOT BE USED AS PRIMARY DIAGNOSIS, PLEASE RESUBMIT

Common Denial Reasons:

- The primary diagnosis code listed on the claim is identified as a Manifestation code and are not allowed to be reported as a principal or first-listed diagnosis code (e.g., 29410 or F0280 – Dementia).
- The primary diagnosis code listed on the claim is identified in ICD-9/ICD-10 as an Unacceptable Primary Diagnosis (PDx) code.



- F028.1 – *Dementia in other diseases classified elsewhere*
- 2016 ICD-10-CM indicates the following*:*

Manifestation Codes - These codes appear in italic type, with a blue color bar over the title. A manifestation code cannot be reported as a first-listed or principal diagnosis. By definition, a manifestation code represents a demonstration of some aspect of an underlying disease, which is separately classifiable. In the alphabetic index, these codes are listed as the secondary code in brackets. The underlying disease code is listed first.

- *F0281 makes up for 11% of all denied claims for Nursing Facilities for this reason*
- *CMHCs also experience the highest volume of this denial with this diagnosis code*

Top Denied Claim Reasons

Professional Claims

EXEC – DENY: DIAGNOSIS CANNOT BE USED AS PRIMARY DIAGNOSIS, PLEASE RESUBMIT

Common Denial Reasons:

- The primary diagnosis code listed on the claim is identified as a Manifestation code and are not allowed to be reported as a principal or first-listed diagnosis code (e.g., 29410 or F0280 – Dementia).
- The primary diagnosis code listed on the claim is identified in ICD-9/ICD-10 as an Unacceptable Primary Diagnosis (PDx) code.

Top Diagnosis Codes denied by Place of Service POS 11 (Office)

- D631 – 33%
- R5081 – 19%

Common Corrected Claim Errors

EXN5 – DENY: NAME OF DRUG, NDC NUMBER AND QUANTITY IS REQUIRED TO PROCESS CLAIM

Common Denial Reason(s):

- Use appropriate NDC Code, Name of Drug and Quantity for billing. Revenue codes are not required for any outpatient service
- If billing a service with a NDC, include all of the required information in this field. The N4 qualifier must be present before the NDC number, followed by the unit/basis of measurement and number of units.
- Example: N412345678901UN1234.567

KMAP General Bulletin 14027

Published February 2014

NDC Billing Requirements

When billing a service with a national drug code (NDC) on the CMS-1500 claim, the provider must include all of the required information in the shaded area just above the detail line associated with the procedure requiring an NDC. The N4 qualifier must be present before the NDC number, followed by the unit/basis of measurement and number of units.
Example: N459148001665 UN1

The following qualifiers are accepted for the NDC unit/basis of measurement:

- F2 – International Unit
- GR – Gram
- ME – Milligram
- ML – Milliliter
- UN – Unit

Additional information is available in the *NUCC CMS 1500 Claim Form Reference Instruction Manual* on the NUCC website.

Common Corrected Claim Errors

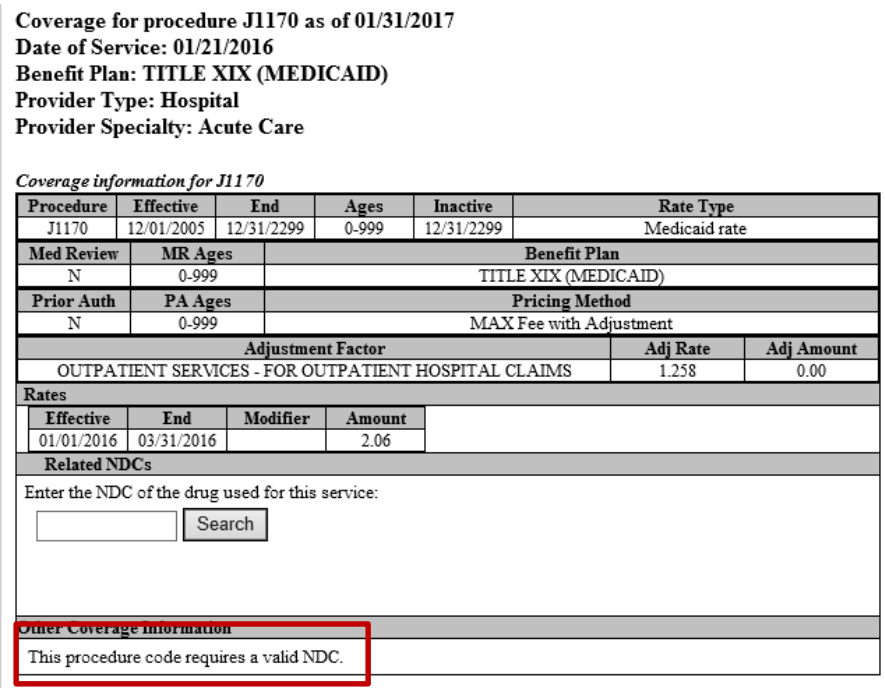
EXN5 – DENY: NAME OF DRUG, NDC NUMBER AND QUANTITY IS REQUIRED TO PROCESS CLAIM

Common Denial Reason(s):

- Use appropriate NDC Code, Name of Drug and Quantity for billing. Revenue codes are not required for any outpatient service
- If billing a service with a NDC, include all of the required information in this field. The N4 qualifier must be present before the NDC number, followed by the unit/basis of measurement and number of units.
- Example: N412345678901UN1234.567

J1170 is a service shown here and billed without an NDC, but is required for reimbursement

As shown in KMAP under Providers \ Reference Codes \ Search by Procedure \ HCPCS Code Detail



Coverage for procedure J1170 as of 01/31/2017
Date of Service: 01/21/2016
Benefit Plan: TITLE XIX (MEDICAID)
Provider Type: Hospital
Provider Specialty: Acute Care

Coverage information for J1170

Procedure	Effective	End	Ages	Inactive	Rate Type
J1170	12/01/2005	12/31/2299	0-999	12/31/2299	Medicaid rate

Med Review	MR Ages	Benefit Plan
N	0-999	TITLE XIX (MEDICAID)

Prior Auth	PA Ages	Pricing Method
N	0-999	MAX Fee with Adjustment

Adjustment Factor	Adj Rate	Adj Amount
OUTPATIENT SERVICES - FOR OUTPATIENT HOSPITAL CLAIMS	1.258	0.00

Rates

Effective	End	Modifier	Amount
01/01/2016	03/31/2016		2.06

Related NDCs

Enter the NDC of the drug used for this service:

Search

Other Coverage Information

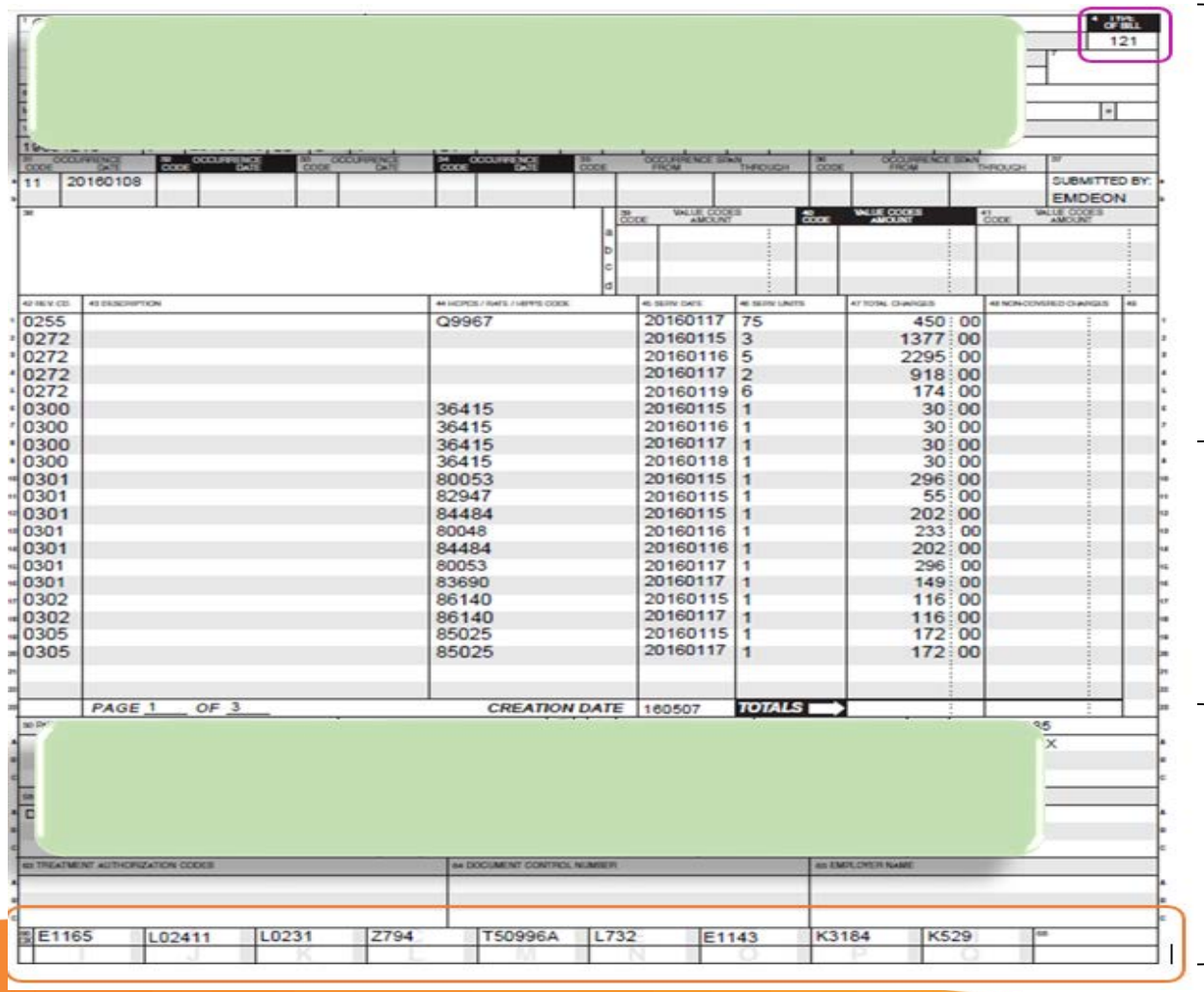
This procedure code requires a valid NDC.

Preventable *Top Claim Denials*

Sunflower continues to see these denials in the Top 10 across various provider types

1. Duplicate Claims Sunflower Health Plan has **30 days** to process your claim – duplicate claims require you to work each submission or duplicate claim when posting your A/R
2. Bill Primary Insurer 1st, Resubmit with EOB Other Insurance information is available to you! Use KMAP in conjunction with the *Sunflower Secure Provider Portal* to find the Primary Insurer's Policy information
3. The Time Limit for Filing a Claim has Expired **Know Your Numbers!** Check out our *Regional Provider Workshop Presentation* and Sunflower's Provider Bulletins link at www.sunflowerhealthplan.com
4. No Authorization on File that matches Service(s) Billed
    a. Use Sunflower's Retro Eligibility Notification Process Update
    b. Ensure services, modifiers and units authorized match the claim submission
5. Missing or Invalid Present on Admission (POA) Indicators
    a. Ensure Medicare Part B only claims are billed to Medicare correctly
    b. Verify the latest POA requirements on Sunflower's website https://www.sunflowerhealthplan.com/newsroom/shpbn-2016-087.html or the CMS website https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalAcqCond/Coding.html

Review Scenarios that Cause Claim Denials



										4 TYPE OF BILL	121
11	20160108									SUBMITTED BY:	EMDEON
0255			Q9967	20160117	75	450	00				
0272				20160115	3	1377	00				
0272				20160116	5	2295	00				
0272				20160117	2	918	00				
0272				20160119	6	174	00				
0300			36415	20160115	1	30	00				
0300			36415	20160116	1	30	00				
0300			36415	20160117	1	30	00				
0300			36415	20160118	1	30	00				
0301			80053	20160115	1	296	00				
0301			82947	20160115	1	55	00				
0301			84484	20160115	1	202	00				
0301			80048	20160116	1	233	00				
0301			84484	20160116	1	202	00				
0301			80053	20160117	1	296	00				
0301			83690	20160117	1	149	00				
0302			86140	20160115	1	116	00				
0302			86140	20160117	1	116	00				
0305			85025	20160115	1	172	00				
0305			85025	20160117	1	172	00				
PAGE 1 OF 3			CREATION DATE	160507	TOTALS						

E1165	L02411	L0231	Z794	T50996A	L732	E1143	K3184	K529	

Claim submitted with *Type of Bill* 121, indicating inpatient part B services

All inpatient claims must be submitted with appropriate room and board line and Present On Admission (POA) indicators

KDHE approved 2/17/17

Medical Record Requests and Review

- **4.1. Records.** Each Contracted Provider shall maintain medical, financial and administrative records related to items or services provided to Covered Persons, including but not limited to a complete and accurate permanent medical record for each such Covered Person, in such form and detail as are required by applicable Regulatory Requirements and consistent with generally accepted medical standards.
- **4.2. Access.** Provider and each Contracted Provider shall provide access to their respective books and records to each of the following, including any delegate or duly authorized agent thereof, subject to applicable Regulatory Requirements: (i) Company and Payor, during regular business hours and upon prior notice; (ii) appropriate State and federal authorities, to the extent such access is necessary to comply with Regulatory Requirements; and (iii) accreditation organizations. Provider and each Contracted Provider shall provide copies of such records at no expense to any of the foregoing that may make such request. Each Contracted Provider also shall obtain any authorization or consent that may be required from a Covered Person in order to release medical records and information to Company or Payor or any of their delegates. Provider and each Contracted Provider shall cooperate in and allow on-site inspections of its, his or her facilities and records by any Company, Payor, their delegates, any authorized government officials, and accreditation organizations. Provider and each Contracted Provider shall compile information necessary for the expeditious completion of such on-site inspection in a timely manner.
- **4.3. Record Transfer.** Subject to applicable Regulatory Requirements, each Contracted Provider shall cooperate in the timely transfer of Covered Persons' medical records to any other health care provider, at no charge and when required.

Medicare Crossover Claims

Medicare Billing Requirements

- When a patient is eligible for Medicare payment, providers must submit claims to Medicare first (unless the claim is for Medicare exempt services). To identify Medicare non-covered procedure codes, refer to the most current Third-Party Liability Noncovered Procedure Code List on the KMAP website.
- If a patient is 65 or over, has chronic renal disease, or is blind or disabled, an effort must be made to determine Medicare eligibility.
- When providers allow a Medicare claim to cross over to Sunflower, they are agreeing to accept Sunflower's payment as payment in full. In many cases, the claim will result in a zero payment because Medicare's payment is greater than the Medicaid allowed amount.
- Providers cannot seek to collect from the Medicaid beneficiary, or any financially responsible relative or representative of that individual, the difference between the Medicare/Medicaid allowable and the provider's billed charges (S.S.A.§1902(a)(25)(C).

Medicare Billing Requirements

- Providers should bill Medicare non-covered and Medicare-covered services separately to ensure proper reimbursement. Medicare-covered services should be billed to Medicare and automatically crossed over. Services non-covered by Medicare should not be billed to Medicare but instead directly to Sunflower Health Plan or the other primary payer.
- When Medicare is primary, Providers are required to follow the billing requirements of Medicare, even if this results in a claim denial from Sunflower. Providers will need to correct claims with Sunflower and include the Medicare EOB for the appropriate processing of the claim.

Claims Not Considered Crossover Claims

- Services non-covered by Medicare are not considered crossover and should not be billed to Medicare but instead should be billed directly to Sunflower Health Plan or the other primary payer.
- Inpatient Part B Only Claims
  - Web Submission Process (Medicare): Providers must use an insurance type other than Medicare in the Insurance Type drop-down box, e.g., “CI-Commercial Insurance”
  - EDI Submission Process (Medicare): Providers should submit with something other than MB or MA, for example: “CI- Commercial Insurance” in the SBR09 segment
- If a provider wants to pursue third parties after the Medicare payment but before filing with Sunflower Health Plan
  - Notify KMAP that you do not want any Medicare claims to cross over
  - Providers should pursue payment from Medicare and any other insurer prior to seeking reimbursement from Sunflower. In these instances, claims should not crossover to the other insurance and Sunflower simultaneously
  - When Sunflower is the Tertiary payer, claims with the attached primary and secondary EOBs must be billed on a paper claim and mailed to Sunflower

Claims Considered Crossover Claims

- If the provider does file the claim as a crossover simultaneously to the other insurance and Sunflower, once a response from the other insurance has been received, the provider will need to correct any Sunflower paid claims by dropping the claim to paper and submitting both EOBs

- Claims with Medicare-covered services
- Web and electronic claims for patients with a Medicare replacement plan (Medicare Part C, Medicare Advantage Plan)
- LTC Claims
  - Web Submission Process (Medicare): Providers must use an insurance type with the appropriate Medicare insurance type selected in the Insurance Type drop-down box.
  - EDI Submission Process (Medicare): Providers should submit the appropriate MA or MB indicator in the SBR09 segment

Recent State Crossover Claim Bulletins

sunflower health plan

Medicare Crossover Claim Processing Changes – January 2017

"To comply with the Centers for Medicare & Medicaid Services (CMS) Managed Care regulations at Federal Register § 438.3(t), States that use the automated crossover process must require managed care organizations (MCOs) to enter into a Coordination of Benefits Agreement (COBA) with Medicare and be able to accept and process automated crossover claims."

"Effective on and after January 1, 2018, all crossover claim files will be sent from the COBC directly to the applicable MCO. The routing of the affected claims will be determined by the member's assignment dates with the MCO or Kansas Medical Assistance Program (KMAP). Providers will not need to change the way crossover claims are billed. COBC will route the claim to the appropriate payer."

More about this and other provider resources can be found on the Kansas Department of Health and Environment (KDHE) website at https://www.kmap-state-ks.us/Public/homepage.asp under *Providers* and then, *Bulletins*

KanCare

Quality

Quality Assessment and Performance Improvement (QAPI)

- Goal – Sunflower's primary QAPI Program goal 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.
- Quality of Care – Patient safety is a key focus of the Sunflower QAPI Program. Monitoring and promoting patient safety is integrated throughout many activities across the plan but primarily through identification of potential and/or actual quality-of-care events.
- Investigation – Potential quality-of-care issues require investigation of the factors surrounding the event in order to make a determination of their severity and need for corrective action up to and including review by the Peer Review Committee as indicated.
- Monitoring – Potential quality-of-care issues received in the QI department are tracked and monitored for trends in occurrence, regardless of their outcome or severity level.

HEDIS and Provider Satisfaction

- What is it? **Healthcare Effectiveness Data and 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 also used to measure your practice's preventive care efforts. Your practice's HEDIS score determines your rates for physician incentive programs that pay you an increased premium—for example Pay For Performance or Quality Bonus Funds.
- Provider Satisfaction Surveys – Sunflower conducts an annual provider satisfaction survey, which includes questions to evaluate provider satisfaction with our services such as claims, communications, utilization management, and customer service. Behavioral health providers receive a provider survey specific to the provision of behavioral health services in the Sunflower network.

For more information please refer to the HEDIS FAQ guide at SunflowerHealthPlan.com

Immunization and Care Gaps

It is important that Sunflower and its participating providers work together to ensure our members are seen regularly for well child visits, diabetic care and prenatal care.

Not sure how you can help? Begin by asking yourself the following questions regarding these targeted member groups:

- **Members under 2 Years** – When was their 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.
- **Pre-Teen** – Has this [11, 12 or 13] year-old had a checkup in the past 12 months? Do they need immunizations to keep them healthy and in school? Help getting them scheduled for these services to help ensure their development is on track and for prevention of 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.
- **Pregnancy** – What an exciting time! 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.

Immunization and Care Gaps

- Does your patient need transportation to appointments? If your Sunflower patient doesn't have transportation, Sunflower Customer Service can help coordinate transportation to and from appointments.
- Quality Care Pointers for Providers (PDF reference resource) - Helping your Sunflower patients achieve a Healthier Today, Better Tomorrow.
- Immunization Registry – Are you a part of the State's Immunization Registry? Sign up to use WebIZ, Kansas' statewide immunization information system. It's a secure, web-based quality-assurance tracking tool used by public and private sites in efforts to communicate the immunization status of members. Learn more about WebIZ at https://kanphix.kdhe.state.ks.us/.

Claim Appeals

Provider Claim Appeals Process - The provider post-service appeal process is a two-step process. The post-service appeal process includes Reconsideration and Claim Dispute/Appeal. Provider appeals can only be initiated by the provider. Contracted providers must exhaust the Sunflower provider appeal process prior to accessing the State Fair Hearing process.

- Overall Claim Appeal Timeline:

  Step 1: Provider files Reconsideration by calling Customer Service or by sending a letter to Sunflower

  Step 2: Sunflower reviews the Reconsideration on request and submits a revised EOP to provider

  Step 3: If provider is not satisfied with response, provider submits Claims Dispute form to Sunflower

  Step 4: Sunflower sends a letter within 10 business days to acknowledge receipt

  Step 5: SHP sends provider a notice of decision within 30 business days of receipt of the appeal

  Step 6: If not satisfied with the Sunflower appeal decision, provider can request a State Fair Hearing

View the entire Claim Appeals process outlined here → **Claims Dispute/Appeals Process**

Claim Appeals

Provider Claim Appeals Process *(cont.)*

- Definitions:
  - **Reconsideration** - This is the first step and includes a review of the claim and any submitted supporting documentation and reprocessing of the claim. An EOP with the result of the review will be sent to the provider as a result of the Reconsideration; there will not be an additional notification letter.
  - **Claim Dispute/Appeal** - This is the second step and includes an additional review of the claim, the claim dispute form and any additional submitted supporting documentation. A letter with the result of the review will be sent to the providers as a result of the Claim Dispute/Appeal.

View the entire Claim Appeals process outlined here → **Claims Dispute/Appeals Process**

Claim Appeals

STEP OF APPEAL PROCESS	SEND WHERE	SEND WHAT	DEADLINE TO SUBMIT	EXPECTED TIME FOR RESPONSE	NOTIFICATION OF DECISION
Reconsideration	**Call**: Customer Service: 877-644-4623 **Mail**: Sunflower or Specialty Partner address listed in EOP or letter	• Claim number • Reason for request • Supporting documentation • Other items requested	Within 90 calendar days from date of first (original) EOP or Determination letter	30 business days	Revised or unrevised EOP for same claim number
Claim Dispute/Appeal	**Mail**: Sunflower or Specialty Partner address listed in EOP or letter	Claim Dispute form found here or additional form provided with EOP or letter. Pharmacy disputes only use form found here.	Within 30 calendar days of EOP received following Reconsideration (33 days if we mailed the notice to you)	30 business days	Letter with Determination
State Fair Hearing (Note: Provider must exhaust Reconsideration and Claim Dispute/Appeal prior to requesting.	**Mail:** *Office of Administrative Hearings (OAH)* 1020 Kansas Ave. Topeka, KS 66612 785-296-2433	Applicable forms found here.	Within 30 calendar days from date of Claim Dispute/Appeal Determination letter (33 if we mailed it to you) for this claim.	Varies at discretion of OAH.	Written communication from OAH.

Payment Timelines *KNOW YOUR NUMBERS…*

- **180 Days** – Providers have to submit claims from the Date of Service (DOS) or from the date of eligibility determination
- **180 Days** – Providers have to submit claims when the member has Other Insurance, from the date on the primary Payer's EOP
- **30 Days** – Sunflower has to pay or deny Clean Claims
- **30 Days** – Sunflower has to pay or deny claims before Interest begins to apply
- **90 Days** – Sunflower has to pay or deny Non-Clean Claims
- **60 Days** – Providers have to refund Overpayments or establish a payment plan
- **365 Days** – Providers have to submit Corrected Claims*
- **30 Days** – Sunflower has to pay or deny Corrected Claims
- **60 Calendar Days** – Providers have to request an Appeal (+3 calendar days if notice mailed)
- **10 Calendar Days** - Sunflower acknowledges Appeal in writing
- **30 Calendar Days** – Sunflower has to resolve Appeal in writing*
- **30 Calendar Days** – Providers have to file a State Fair Hearing (SFH)* (+3 calendar days if notice mailed)

**From the date on the last EOP or determination letter: Providers must complete the Appeal process before proceeding to a SFH (State Fair Hearing).*

Provider Engagement

Provider Engagement

- Provider/Practitioners
  - **Responsibilities:** To help or advocate for members to make decisions within their scope of practice about their relevant and/or medically necessary care and treatment.
    - Patient Care Rights: To follow all state and federal laws and regulations related to patient care and rights
    - Cultural Awareness: To not discriminate against members on the basis of race, color, national origin, limited language proficiency, religion, age, health status, existence of a pre-existing mental, cognitive or physical disability/ condition including pregnancy and/or hospitalization, and/or the expectation for frequent or high-cost care
    - Advance Directives: To respect members' advance directives and include these documents in the their medical record
    - Access: To provide members with information regarding office location, hours of operation, accessibility, and translation services
    - Patient List (PCP): Review and actively see assigned members regularly. When new members appear on your roster; reach out to encourage a new appointment.
    - Eligibility: Providers are responsible for verifying eligibility every time a member is seen in the office. Sunflower is unable to update member eligibility if KMAP does not show a member is assigned to the MCO.

Provider Engagement

- Provider/Practitioners *(cont.)*
  - **Rights**:
    - To contact Customer Service with any questions, comments, or problems
    - To not be excluded, penalized, or terminated from participating with Sunflower for having developed or accumulated a substantial number of members in the Sunflower plan with high-cost medical conditions or long-term support needs

Patient Analytics

Patient Analytics

Why Was Patient Analytics Created?

Available within Sunflower Health Plan's secure provider portal, Patient Analytics was created to enable providers to optimize patients' care, improve clinical outcomes, and initiate clinical intervention to close health care gaps. Patient Analytics is currently being tested with select provider groups in Kansas and a broader rollout is planned in 2017.

What Does Patient Analytics Do?

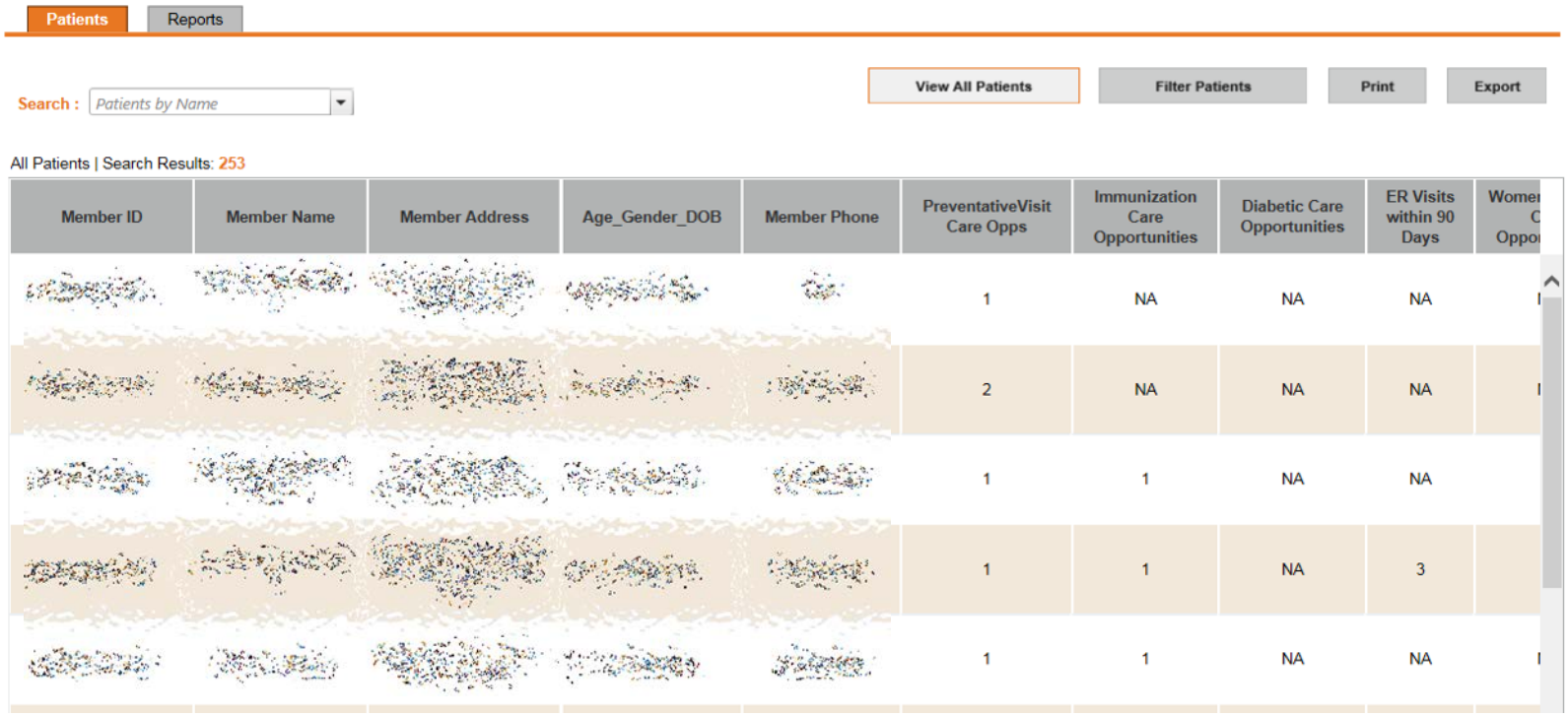
Within Patient Analytics, each patient has a detailed clinical profile. Patients with the most care gaps are identified allowing providers to take a proactive approach to managed care.

Key Benefits

- **Population Health:** Providers are able to manage member's information using patient registries. The information can easily be accessed online and many elements can be printed.
- **Medical History:** Patient Analytics contains up to 27 months of medical, pharmacy, and lab claims.
- **Increased Visibility:** Primary Care Physicians (PCPs) will have access to claims history submitted by other providers.
- **Improved Outcomes:** Patient Analytics helps providers improve patient care, performance, outcomes and adherence to quality measures.

Patient Analytics is an intelligent health platform that enables providers to make informed decisions about patients' healthcare needs. With Patient Analytics, providers will have visibility into quality metrics and gaps in care.

Patient List



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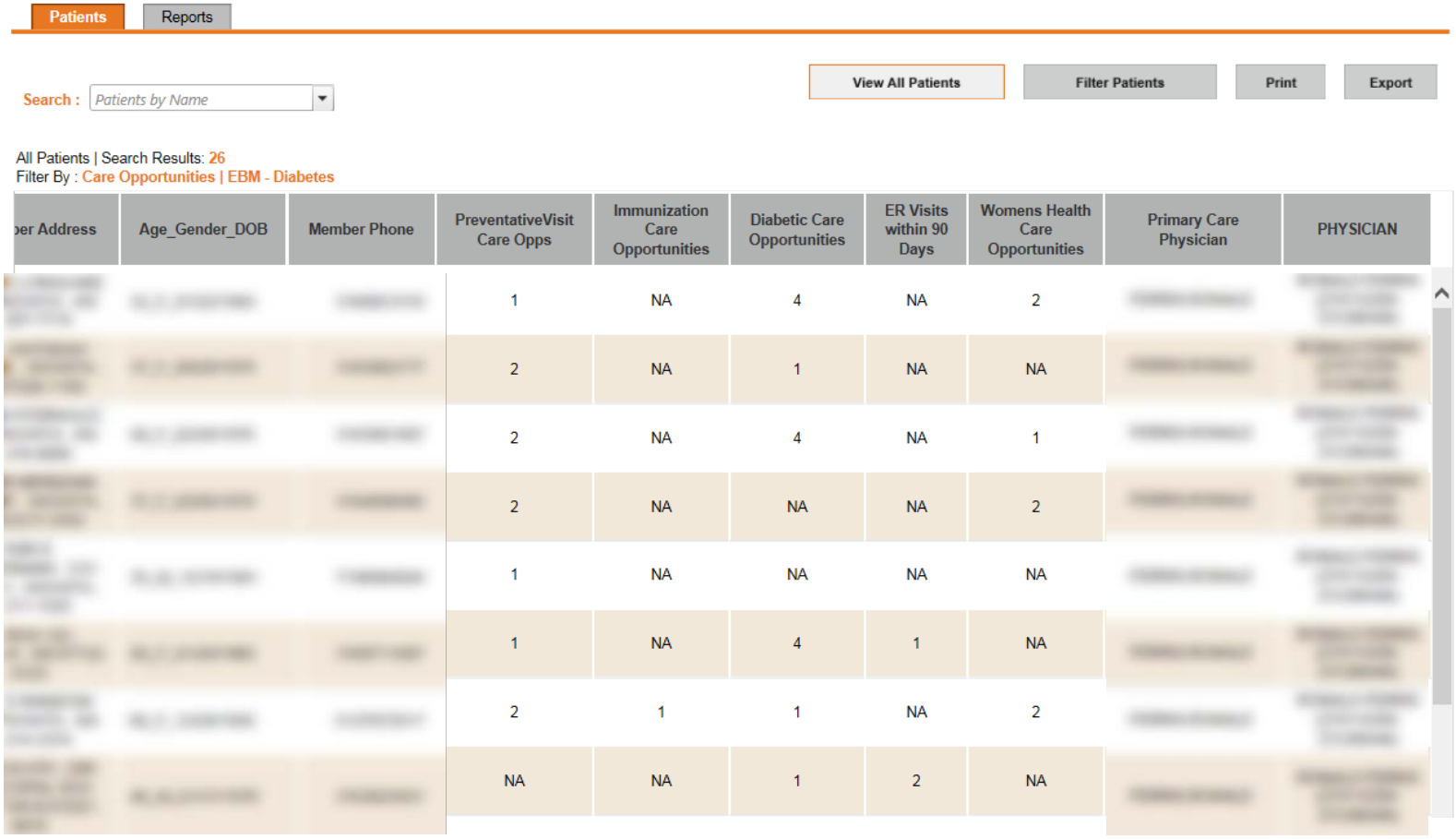
Patient View



ber Address	Age_Gender_DOB	Member Phone	PreventativeVisit Care Opps	Immunization Care Opportunities	Diabetic Care Opportunities	ER Visits within 90 Days	Womens Health Care Opportunities	Primary Care Physician	PHYSICIAN
			1	NA	4	NA	2		
			2	NA	1	NA	NA		
			2	NA	4	NA	1		
			2	NA	NA	NA	2		
			1	NA	NA	NA	NA		
			1	NA	4	1	NA		
			2	1	1	NA	2		
			NA	NA	1	2	NA		

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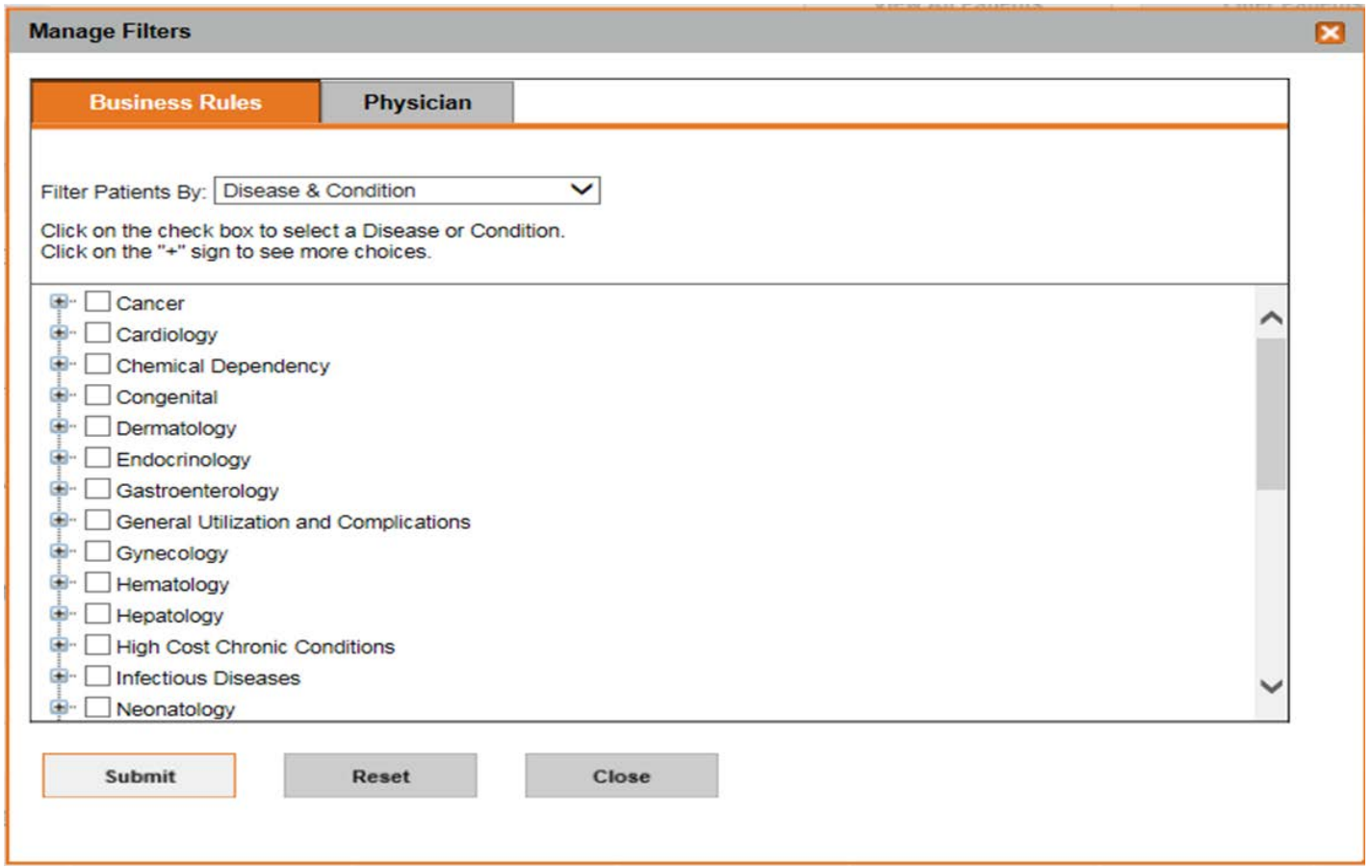
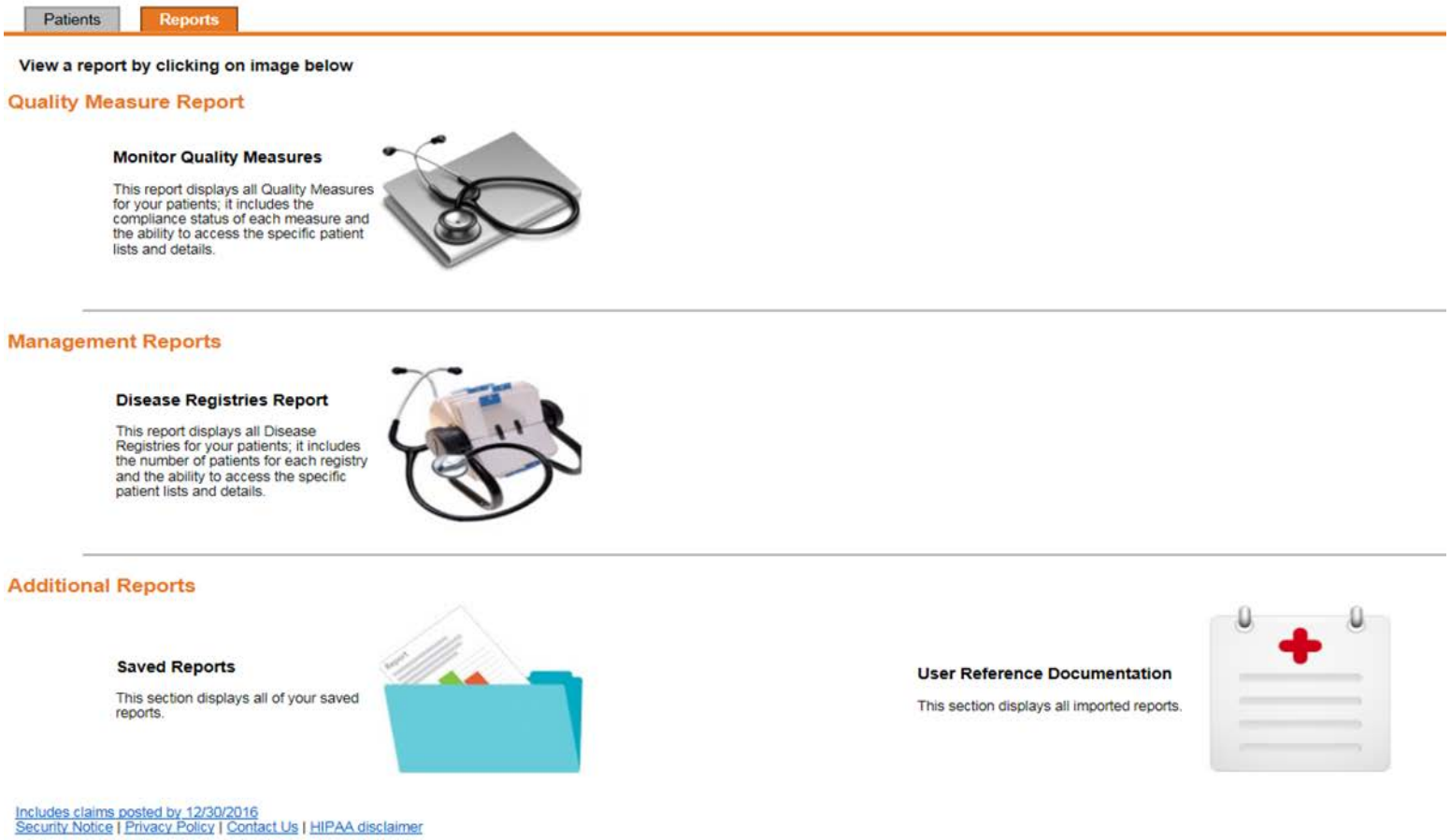
Managing Filters



Reports



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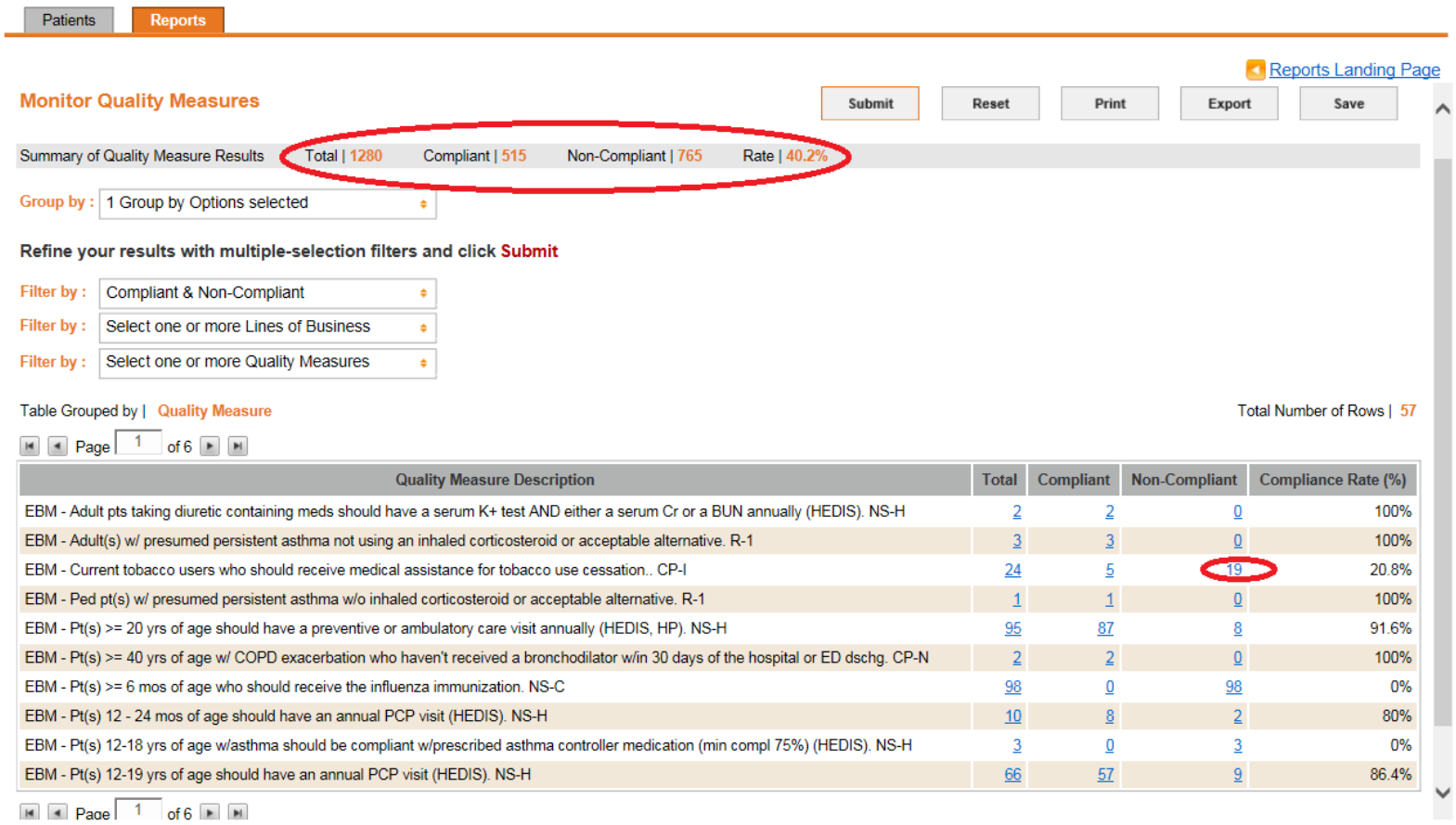
Monitor Quality Measures



Quality Measure Description	Total	Compliant	Non-Compliant	Compliance Rate (%)
EBM - Adult pts taking diuretic containing meds should have a serum K+ test AND either a serum Cr or a BUN annually (HEDIS). NS-H	2	2	0	100%
EBM - Adult(s) w/ presumed persistent asthma not using an inhaled corticosteroid or acceptable alternative. R-1	3	3	0	100%
EBM - Current tobacco users who should receive medical assistance for tobacco use cessation.. CP-I	24	5	19	20.8%
EBM - Ped pt(s) w/ presumed persistent asthma w/o inhaled corticosteroid or acceptable alternative. R-1	1	1	0	100%
EBM - Pt(s) >= 20 yrs of age should have a preventive or ambulatory care visit annually (HEDIS, HP). NS-H	95	87	8	91.6%
EBM - Pt(s) >= 40 yrs of age w/ COPD exacerbation who haven't received a bronchodilator w/in 30 days of the hospital or ED dschg. CP-N	2	2	0	100%
EBM - Pt(s) >= 6 mos of age who should receive the influenza immunization. NS-C	98	0	98	0%
EBM - Pt(s) 12 - 24 mos of age should have an annual PCP visit (HEDIS). NS-H	10	8	2	80%
EBM - Pt(s) 12-18 yrs of age w/asthma should be compliant w/prescribed asthma controller medication (min compl 75%) (HEDIS). NS-H	3	0	3	0%
EBM - Pt(s) 12-19 yrs of age should have an annual PCP visit (HEDIS). NS-H	66	57	9	86.4%

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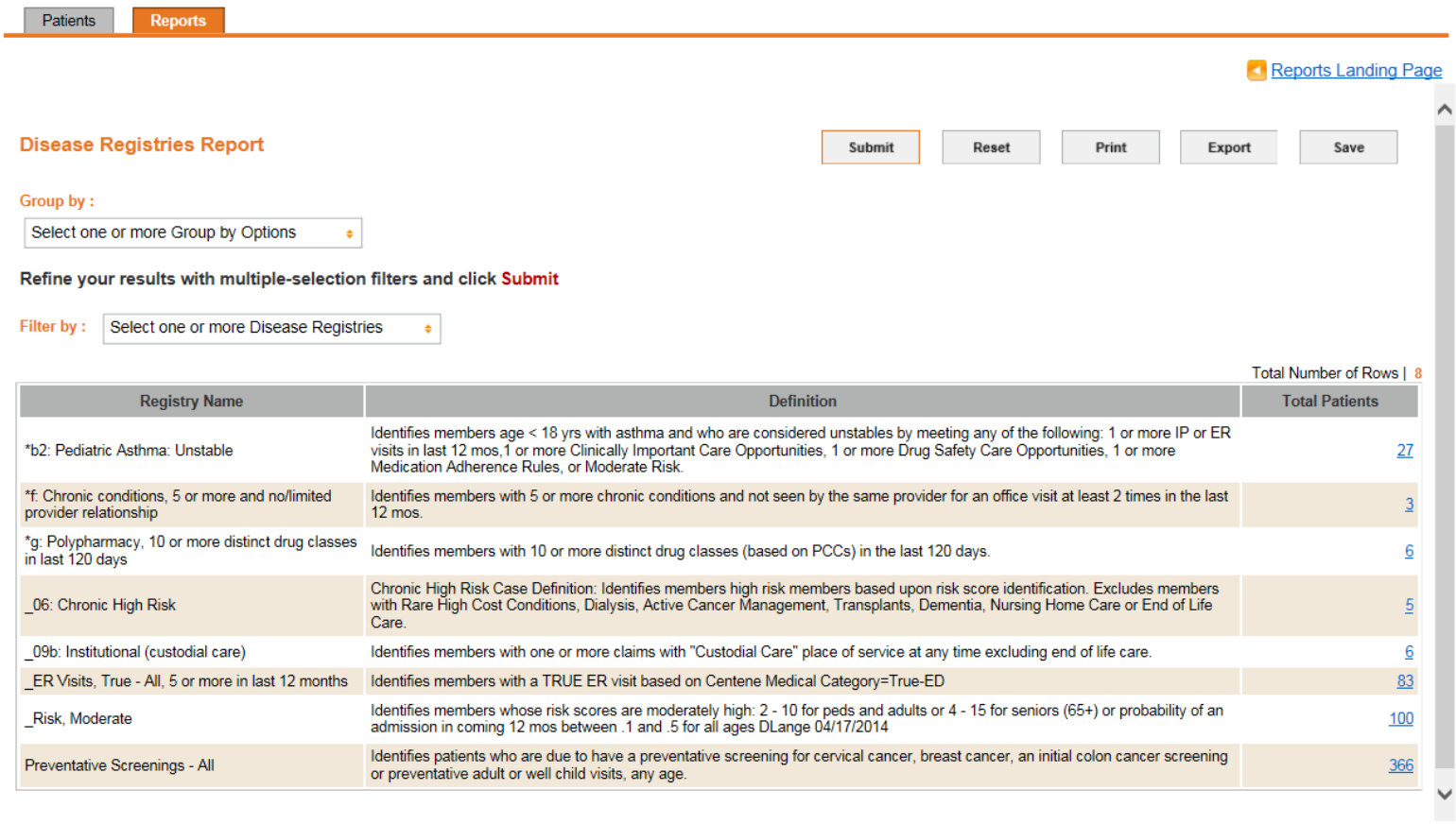
Disease Registries Report



Registry Name	Definition	Total Patients
*b2: Pediatric Asthma: Unstable	Identifies members age < 18 yrs with asthma and who are considered unstables by meeting any of the following: 1 or more IP or ER visits in last 12 mos,1 or more Clinically Important Care Opportunities, 1 or more Drug Safety Care Opportunities, 1 or more Medication Adherence Rules, or Moderate Risk.	27
*f: Chronic conditions, 5 or more and no/limited provider relationship	Identifies members with 5 or more chronic conditions and not seen by the same provider for an office visit at least 2 times in the last 12 mos.	3
*g: Polypharmacy, 10 or more distinct drug classes in last 120 days	Identifies members with 10 or more distinct drug classes (based on PCCs) in the last 120 days.	6
_06: Chronic High Risk	Chronic High Risk Case Definition: Identifies members high risk members based upon risk score identification. Excludes members with Rare High Cost Conditions, Dialysis, Active Cancer Management, Transplants, Dementia, Nursing Home Care or End of Life Care.	5
_09b: Institutional (custodial care)	Identifies members with one or more claims with "Custodial Care" place of service at any time excluding end of life care.	6
_ER Visits, True - All, 5 or more in last 12 months	Identifies members with a TRUE ER visit based on Centene Medical Category=True-ED	83
_Risk, Moderate	Identifies members whose risk scores are moderately high: 2 - 10 for peds and adults or 4 - 15 for seniors (65+) or probability of an admission in coming 12 mos between .1 and .5 for all ages DLange 04/17/2014	100
Preventative Screenings - All	Identifies patients who are due to have a preventative screening for cervical cancer, breast cancer, an initial colon cancer screening or preventative adult or well child visits, any age.	366

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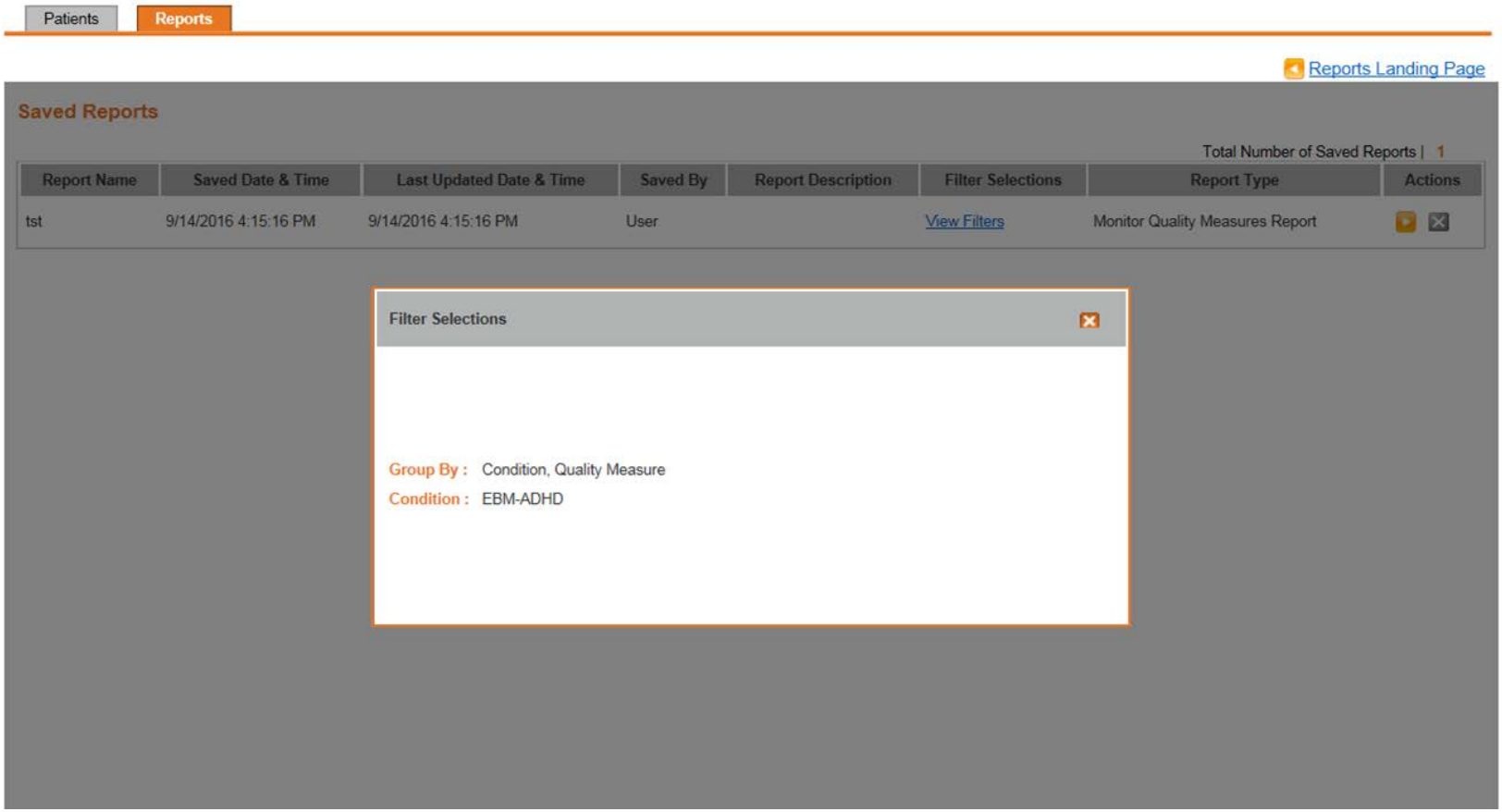
Saved Reports



Pharmacy

Pharmacy Benefit

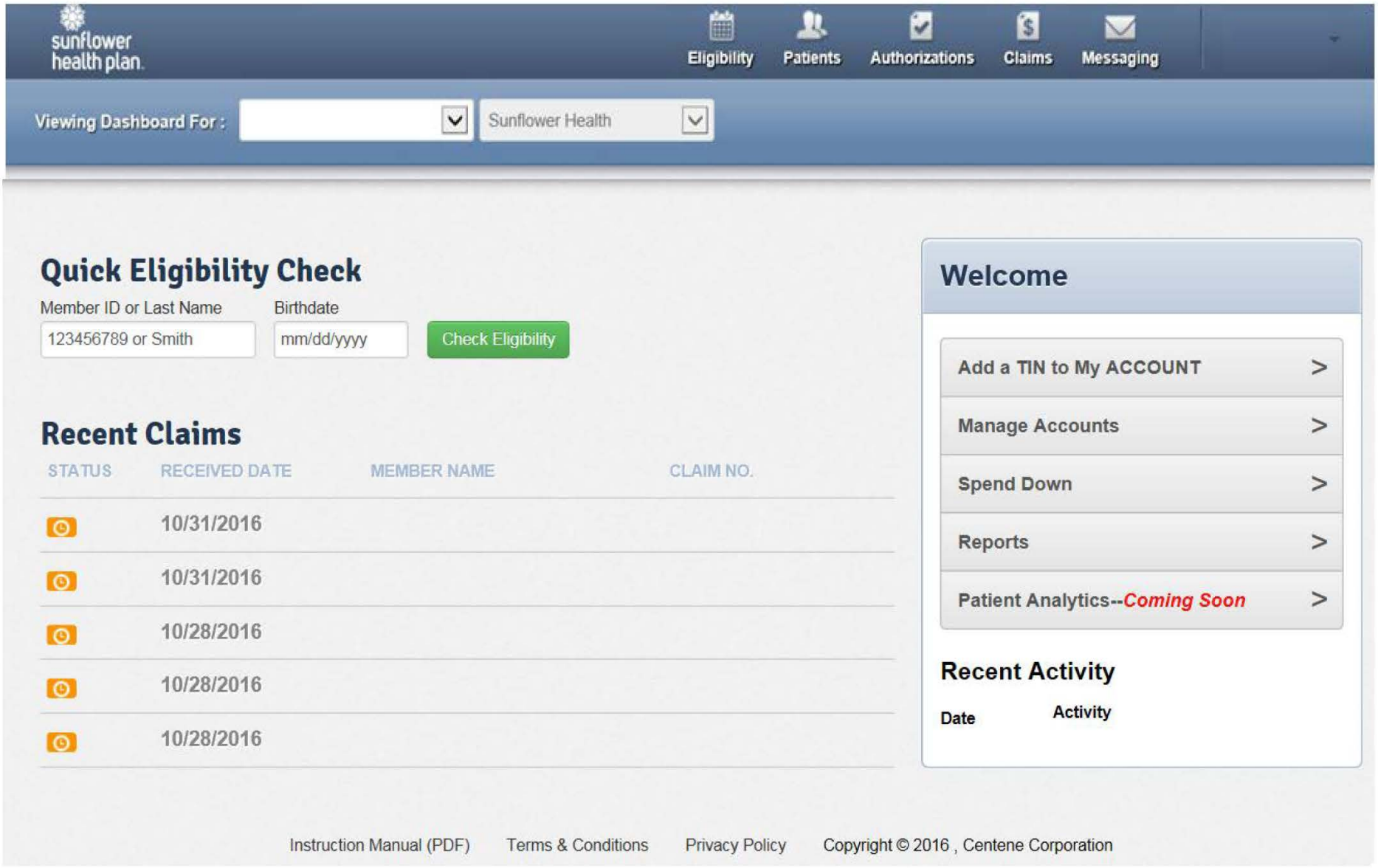
- All three MCOs follow the State PDL (preferred drug list) and State DUR (drug utilization review) Board Clinical Criteria
- **PDL (Preferred Drug List)**
  - Lists the preferred and non-preferred drugs for listed therapeutic classes
  - Updated monthly
  - Determined by the Kansas PDL Advisory Committee, composed of practicing Kansas physicians and pharmacists
  - Link to PDL: http://www.kdheks.gov/hcf/pharmacy/download/PDLList.pdf
- **DUR Board Clinical Criteria**
  - Clinical criteria for drugs are determined by the Kansas DUR (Drug Utilization Review) Board
  - The Board
    - Composed of appointed practicing Kansas physicians, pharmacists, and mid-level practitioners
    - Quarterly meetings to review new and updated clinical criteria
  - Link to Clinical Criteria: http://www.kdheks.gov/hcf/pharmacy/pa_criteria.htm

Pharmacy Benefit

For additional information:

- Visit the Pharmacy webpage on the Sunflower website and sign up for email bulletins for additional pharmacy news
- Sunflower Pharmacy Webpage https://www.sunflowerhealthplan.com/providers/pharmacy.html
- Please visit the KDHE website for additional information about PDL or DUR
- KDHE Pharmacy Webpage http://www.kdheks.gov/hcf/pharmacy/default.htm

Provider Portal



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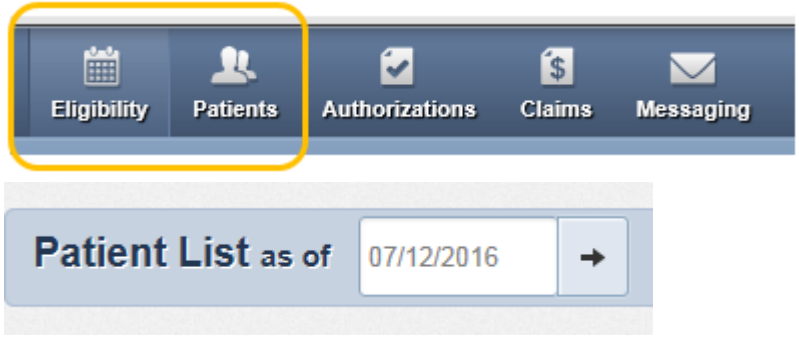
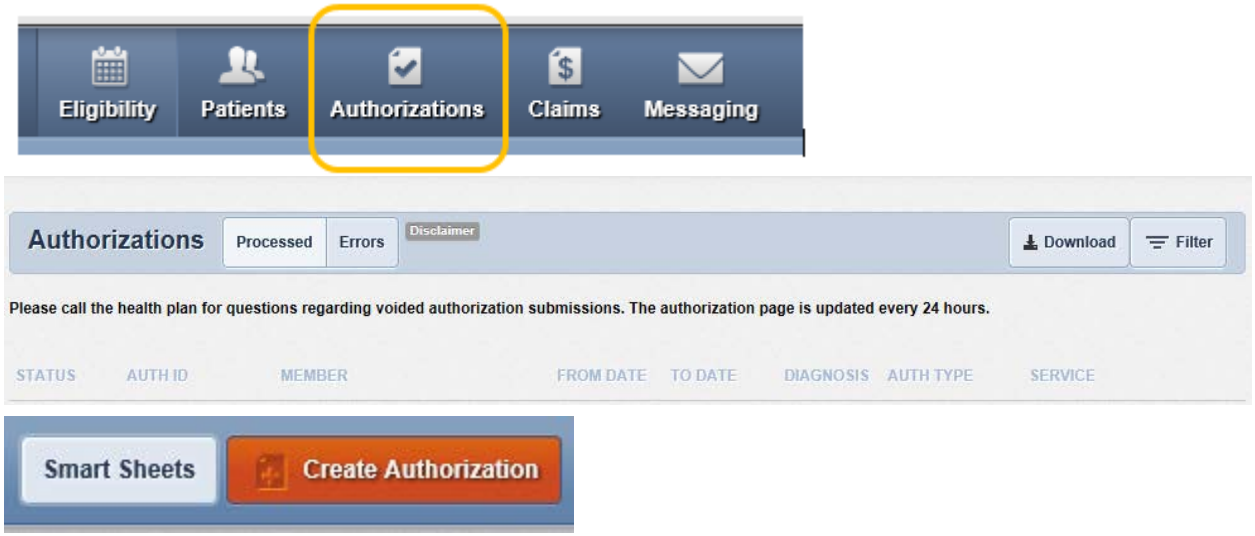
Secure Provider Portal



- View patient lists
  - **Patient List:** Primary Care Providers (PCP) should review their member panel assignment to assure supervision, coordination and provision of care to each assigned member.
    - Review your patient list regularly
    - Engage new members to come in for a visit
    - Notify Sunflower of any changes

Perk of the Portal: View your patients' care gaps, health assessments, Top 5 diagnoses, most recent ER visits, inpatient admissions, pharmacy activity and office visits!

Secure Provider Portal



- Authorization Requests
  - **Smart Sheets:** Smart Sheets for procedures or DME are available for your use. The use of Smart Sheets is recommended, as they provide us with the information we can use to complete your request.
  - **Create Authorization:** After using the "Prior Auth Needed?" tool on the www.sunflowerhealthplan.com site, request prior authorization for your upcoming visit.

Perk of the Portal: Attach your Smart Sheet to your Prior Authorization Request when you submit online.

Claims Correction Using the Portal

Correction of Claims using Sunflower Health Plan's Secure Provider Portal

Submit corrected claims via the secure Provider Portal at www.sunflowerhealthplan.com

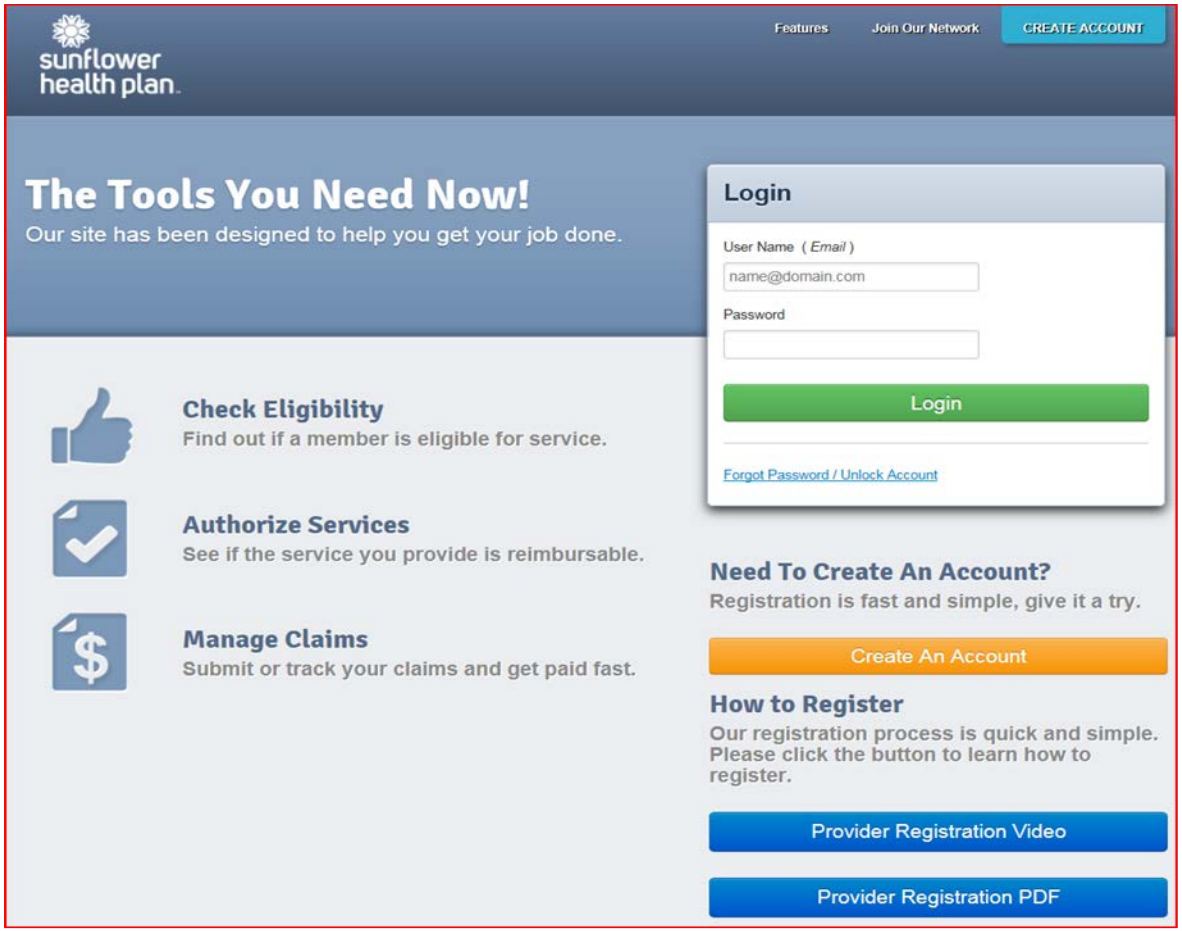
1. Click Claims at the top of the screen.
2. Select an individual paid claim to see the details.
3. The claim displays for you to correct as needed. Click Correct Claim.
4. Proceed through the claims screens correcting the information that you may have omitted when the claim was originally submitted.
5. Continue clicking Next to move through the screens required to resubmit.
6. Review the claim information you have corrected before clicking Submit.
7. You receive a success message confirming your submittal.

The '*Corrected Claims - Quick Reference Guide'* is available to download at sunflowerhealthplan.com under Provider Resources.

Portal Account Creation

- Create Your Account
- Check Eligibility
- Manage Claims

- Step-by-Step Provider Registration PDF and Video



KanCare

KDHE approved 2/17/17

Helpful Tips and Links

- Provider Resources – https://www.sunflowerhealthplan.com/providers/resources.html
- Provider Quick Reference Guide - https://www.sunflowerhealthplan.com/content/dam/centene/sunflower/pdfs/Provider%20Quick%20Reference%20Guide%20QRG%20508.pdf
- Corrected Claims – Quick Reference Guide – https://www.sunflowerhealthplan.com/providers/resources/forms-resources/corrected-claims-qrg.html
- Provider Post-Service or Claim Appeal Process REFERENCE GUIDE - https://www.sunflowerhealthplan.com/providers/resources/dispute-appeal-process.html
- Sunflower Provider Office Manual - https://www.sunflowerhealthplan.com/providers/resources/forms-resources.html
- HEDIS FAQs - https://www.sunflowerhealthplan.com/providers/resources/forms-resources.html