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Welcome

Welcome

Welcome to Sunflower Health Plan (Sunflower). We thank you for joining our network of participating physicians, hospitals, and other healthcare professionals. Our number one priority is the promotion of healthy lifestyles through the provision of preventive healthcare services for persons who are enrolled in Sunflower. By partnering with providers like you, we can reach this goal together.

About Sunflower Health Plan

Sunflower is a Medicaid Managed Care Organization (MCO) contracted with the Kansas Department of Health and Environment (KDHE) – Division of Health Care Finance (DHCF) and the Kansas Department for Aging and Disability Services (KDADS) to serve Medicaid eligible members through the KanCare program. Sunflower's management company, Centene Corporation (Centene), has been managing the provision of healthcare services for individuals receiving benefits under Medicaid and other government-sponsored healthcare programs since 1984. Centene operates Sunflower locally and offers a wide range of health insurance solutions for individuals and families. Sunflower is a physician-driven organization committed to building collaborative partnerships with providers throughout Kansas. We were selected by KDHE and KDADS due to our unique expertise and dedication to serving persons enrolled in Medicaid programs to improve their health status and quality of life. Sunflower will serve our members in a manner consistent with our core philosophy that quality healthcare is best delivered locally.

Our Mission

Sunflower strives to provide improved health status, successful outcomes, and member and provider satisfaction in an environment focused on coordination of care. As an agent of KDHE and KDADS and partner with local healthcare providers, Sunflower seeks to achieve the following goals for our client, KDHE, KDADS, and members:

- 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.

All of our programs, policies, and procedures are designed with these goals in mind. We trust that you, our valued network provider, share our commitment to serving KanCare members and will assist Sunflower in reaching these goals. We look forward to your active involvement in improving access to care for the State of Kansas' most vulnerable citizens.

How to Use This Provider Manual

Sunflower is committed to serving with our Kansas State provider community and supporting their efforts to deliver high quality healthcare to our members. We are committed to disseminating comprehensive and timely information to providers through this Provider Manual as it relates to Sunflower operations, benefits, policies, and procedures. Updates to this manual will be posted on the Sunflower website. Additionally, providers will be notified via bulletins and notices posted on our secure website and on weekly Explanation of Payment (EOP) notices. For hard copies or CD copies of this Provider Manual or if you need further explanation on any topics discussed in this manual, please contact the Customer Service department at 1-877-644-4623.

Key Contacts and Important Phone Numbers

The following chart includes several important telephone and fax numbers available to providers and their office staff. When calling Sunflower, it is helpful to have the following information available:

1. The provider's NPI (National Provider Identifier) number
2. The practice Tax ID Number (TIN)
3. The member's Sunflower ID number or member ID number

HEALTH PLAN INFORMATION		
Website	SunflowerHealthPlan.com	
Main Address	Sunflower Health Plan 8325 Lenexa Drive Lenexa, KS 66214	
DEPARTMENT	**PHONE**	**FAX**
Customer Service	1-877-644-4623	
Prior Authorization (PA) Fax Requests for Inpatient and Outpatient Medical Services – Visit www.sunflowerhealthplan.com to submit Prior Authorization online	1-877-644-4623	1-888-453-4316
Concurrent Review/Clinical Information	1-877-644-4623	1-877-213-7732

Admissions/Census Reports/Face-sheets	1-877-644-4623	1-866-965-5433
Case Management (CM)	1-877-644-4623	1-866-694-3649
Prior Authorization (PA) Behavioral Health	1-877-644-4623	1-866-264-4452
Prior Authorization (PA) Outpatient/Home Health Physical, Occupational, Speech Therapy	1-877-644-4623	
24/7 Nurse Advice Line (NurseWise)	1-877-644-4623	
U.S. Script www.usscript.com	1-877-644-4623	
High-Tech Imaging (NIA) www.radmd.com	1-877-644-4623	
Opticare Vision www.opticare.com	1-877-644-4623	
Opticare Vision www.opticare.com	1-877-644-4623	
Non-Emergent Medical Transportation LogistiCare	1-877-644-4623	
Interpreter Services – Voiance	1-877-644-4623	
To report suspected waste, fraud and abuse to Sunflower	1-866-685-8664	
Ethics and Compliance Helpline	1-800-345-1642	
EDI CLAIMS		
Sunflower Health Plan c/o Centene EDI Department 1-800-225-2573, ext. 25525 or by e-mail to: EDIBA@centene.com		
Specialty Therapy and Rehabilitative Services (STRS) Claims P.O. Box 4070 Farmington, MO 63640-3831		

Contracting and Provider Relations

Sunflower's Contracting and provider Relations departments are dedicated to making each participating provider's experience with Sunflower a positive one.

The contracting process ensures that participating providers meet the criteria established by Sunflower, as well as government regulations and standards of accrediting agencies. For further information about contracting requirements with Sunflower Health Plan, contact the Contracting department at 877-644-4623.

Practitioners (applying to join the network as a solo provider) must submit:

- Completed Participating Provider Agreement
- Completed Ownership and Controls Disclosure Form
- Completed CAQH data form or approved Sunflower roster format
- Copy of provider license
- Copy of current malpractice insurance policy face sheet
- Copy of current KS Controlled Substance registration certificate, if applicable
- Copy of current Drug Enforcement Administration (DEA) registration Certificate, if applicable
- Completed and signed W-9 form
- Copy of Educational Commission for Foreign Medical Graduates (ECFMG) certificate, if applicable
- Copy of current unrestricted medical license to practice in the State of Kansas
- Current copy of specialty board certification certificate, if applicable
- Curriculum vitae listing, at minimum, a five-(5) year work history in month/year format (not required if work history is completed on the application)
- Signed and dated release of information form not older than 120 days
- Proof of highest level of education – copy of certificate or letter certifying formal post-graduate training
- Copy of Clinical Laboratory Improvement Amendments (CLIA), if applicable

Providers (applying to join the network as a hospital, facility, group, clinic or ancillary provider) must submit:

- Completed Participating Provider Agreement
- Completed Ownership and Controls Disclosure Form (for Independent Physician Groups, a Disclosure of Ownership Form is required for each practitioner in the IPG)
- Completed KS Facility/Provider – Initial and Re-credentialing – Application with attachments requested
- Accreditation certificates, if applicable
- If not accredited, a copy of provider's most recent State or CMS survey, including response to any corrective actions, and response from surveyor recognizing corrective action taken by provider
- Completed and signed W-9 form
- Roster (in an approved Sunflower format) or CAQH data form for each practitioner employed by the provider
- Copy of current malpractice insurance policy face sheet
- Copy of Facility license
- Copy of all CDDO Affiliate Agreements (I/DD providers)

The following information applies to Practitioners (and Primary Care Physicians or PCPs) when applying for participation with Sunflower:

- Practitioners must submit a Council for Affordable Quality Health (CAQH) Data Application Form to give authorization to Sunflower to access the Practitioner's application on the CAQH website
- Practitioners must provide signed attestation of application correctness and completeness; history of loss of license, clinical privileges, disciplinary actions, and felony convictions; lack of current illegal substance registration or alcohol abuse; mental and physical competence; and ability to perform essential functions with or without accommodation
- A roster (in the format required by Sunflower) may be used in lieu of completing CAQH data forms for each practitioner.

Refer to the Credentialing and Re-credentialing section in this manual for more information about the process.

The Contracting and Provider Relations departments are responsible for oversight, coordination or initiation of the services listed below for all providers:

- Answering questions about the provider Participating Agreement between Sunflower Health Plan and the provider
- Assisting with provider changes – roster adds/terms, name changes, address changes, NPI and TIN changes, and other demographic changes
- Physician and office staff initial and ongoing education, training
- Hospital, facility, and ancillary provider initial and ongoing education, training
- Distribution of Provider Manuals and similar provider reference materials
- Assistance with claims inquiries and other administrative services
- Assistance with installation, access, and training regarding available web-based tools and functions
- Distribution of notices, bulletins, newsletters, and similar information regarding program, process, or policy updates or changes
- Regularly scheduled in-service meetings

The Contracting and Provider Relations department can be reached toll-free at 1-877-644-4623. Our Provider Relations Specialists work in unison with our team of phone staff (Customer Service representatives) to assist providers and their staff. As a participating provider, you and your office staff will have a dedicated Provider Relations Specialist who will be a key contact for you and will provide education and training regarding Sunflower's administrative processes. He/she will visit you or your designated office manager on a routine basis. Regularly scheduled in-service meetings are intended to be a proactive way for us to build a positive relationship with you and your staff; to identify issues, trends, or concerns quickly; to answer questions; share new information regarding the program; and to identify any changes within your practice (e.g., change in office staff, new location) or scope of service. The primary objective for each Provider Relations Specialist is to ensure you and your staff receive support from Sunflower. Providers and their office staff are encouraged to call or e-mail their dedicated Provider Relations Specialist for assistance at any time. For example, always contact your Provider Relations Specialist to:

1. Report any change to your practice (i.e., practice TIN, name, phone numbers, fax numbers, address, and addition or termination of providers, or patient acceptance status)
2. Initiate credentialing of new providers to the practice
3. Schedule an in-service training for new staff
4. Conduct ongoing education for existing staff
5. Obtain clarification of state and health plan policies and procedures
6. Find out about special programs available for members and/or providers
7. Request fee schedule information
8. Ask questions regarding your membership list (patient panel)
9. Learn how to use electronic solutions on web authorizations and claims submissions, and check eligibility

A key responsibility of the Contracting and Provider Relations Department is to monitor network adequacy to ensure Sunflower members have convenient access to a wide variety of provider types and service options. Your dedicated Provider Relations Specialist will keep you and your staff apprised of any network changes, new additions, or needs within the geographic area you serve, and may – from time to time – survey you regarding your referral network and any preferences you may have with regard to certain providers to target for participation in the Sunflower provider network.

Sunflower Website

SUNFLOWERHEALTHPLAN.COM

The Sunflower website was designed to reduce administrative burdens for providers and their staff while optimizing their ability to access information quickly in order to provide efficient service for members. Utilizing the website allows immediate access to current provider and member information 24 hours a day, seven days a week. Please contact your Provider Relations Specialist or our Customer Service department at 1-877-644-4623 with any questions or concerns regarding the website.

The Sunflower website is located at SunflowerHealthPlan.com. The public website contains useful information, data, and learning tools for providers, such as:

- Provider Reference Manual
- Quick Reference Guides
- The ability to determine if a service requires a prior authorization by entering the CPT, HCPCs, or Revenue Code
- Administrative Forms
- Newsletters and Announcements
- Clinical Guidelines
- Bulletins and Notices

SECURE PROVIDER PORTAL

Through the **Secure Provider Portal**, participating providers can:

- Check member eligibility
- View members' health records
- View the PCP panel
- View member cost of care/client obligation amounts
- View and submit claims and adjustments
- View payment history
- View and submit authorizations
- View member gaps in care
- View quality scorecard
- Contact Sunflower representatives securely and confidentially

The Secure Provider Portal is accessible only to participating providers and their office staff who have completed the registration process once the contract is complete and to non-participating providers who have submitted a claim to Sunflower. Registration is quick and easy. There is also a reference manual on the site to answer any questions you may have. On the home page, select the Login link on the top right to start the registration process. We are continually updating our website with the latest news and information, so save this site to your Internet "Favorites" list and check our site often.

Kansas Medicaid Program Summary

The KDHE-DHCF has oversight authority and manages the provision of healthcare services for all Medicaid beneficiaries. KDHE contracts with Sunflower to manage access to Covered Services and provider networks for those who qualify for the state's KanCare program. Almost all Medicaid members and 100% of CHIP members are required to enroll in a managed care plan. All access protocols will be covered under the State's direction.

Below is a summary of Categories of Eligibility that will be included in the KanCare program.

- Adults and children eligible under the Temporary Assistance to Families (TAF) program
- Certain pregnant women and children through the month of their first birthday
- Certain children over the age of one year and through the month of their sixth birthday
- Certain children over the age of six and through the month of their 21st birthday
- Children under the age of 19 years who are not eligible for Medicaid, but are living in families with incomes less that 200 percent of the federal poverty level
- Aged and disabled individuals receiving Supplemental Security Income (SSI)
- Medically needy aged and disabled individuals (spend-down populations)
- People eligible for Medicaid Buy-In (Working Healthy)
- Children in foster care
- Children whose families receive adoption support
- Beneficiaries in the Health Insurance Premium Payment System (HIPPS)
- Beneficiaries in the State's FFS lock-in program
- Beneficiaries residing in a Nursing Facility (NF)
- Beneficiaries residing in a swing bed NF
- Beneficiaries residing in a private Intermediate Care Facility for individuals with Intellectual Disabilities (ICF-ID)
- Beneficiaries residing in a head injury rehabilitation facility
- Beneficiaries served through one of the Home and Community Based Services (HCBS) (1915(c)) programs
- Children with special healthcare needs (CSHCN)
- Beneficiaries of Native American descent (may opt in or opt out of KanCare)
- Youth residing in an institution (PRTF, State Hospital alternative, or acute inpatient) for more than 30 days
- Beneficiaries who are eligible for Medicaid while residing in a State Mental Hospital
- Qualified Medicare Beneficiary (QMB) – if dually eligible for Medicaid

Credentialing and Recredentialing

The credentialing and re-credentialing process exists to ensure that participating providers meet the criteria established by Sunflower, as well as government regulations and standards of accrediting agencies. For further information about contracting or credentialing requirements with Sunflower Health Plan, contact the Contracting department at 1-877-644-4623.

In order to maintain a current provider profile, providers are required to notify Sunflower of any demographic changes (e.g., office phone/fax number changes, address changes, tax identification number, and national provider indicator number (TIN and NPI) changes, practitioner adds/terms/changes, etc.) at least 30 calendar days prior to the effective date of such changes. Providers are to notify Sunflower of any dissolution or additions of facilities or services (such as the acquisition or selling of a facility) at least 60 calendar days in advance. Some changes may require a new provider agreement and/or an amendment to an existing provider agreement and/or updated credentialing application and documentation.

Provider must give written notice to Sunflower of:

- Any event of which notice must be given to a licensing or accreditation agency or board within 10 calendar days of the event
- Any change in the status of the provider's license within 10 calendar days of the event
- Termination, suspension, exclusion, or voluntary withdrawal of the provider from any State or Federal healthcare program, including the KanCare program within 10 calendar days of the event
- Any lawsuit or claim filed or asserted against the provider alleging professional malpractice involving a member within 30 calendar days from the date the provider first has knowledge of the lawsuit or claim
- Cancellation, non-renewal, lapse, or adverse material modification of insurance coverage within 15 calendar days of such notice

Sunflower will verify the following information submitted for Credentialing and Re-credentialing, including but not limited to:

- Kansas license through appropriate licensing agency
- Board certification, residency training, or medical education
- National Practitioner Data Bank (NPDB) for malpractice claims and license agency actions
- Hospital privileges in good standing or alternate admitting arrangements
- Review five-year work history

- Review federal sanction activity including Medicare/Medicaid services (OIG-Office of Inspector General) and the System for Award Management (SAM)
- Social Security Death Master File

Once the application is received and considered complete, the Sunflower Credentialing Committee will render a final decision on acceptance following its next regularly scheduled meeting. Sunflower will ensure that credentialing of all service providers applying for network provider status shall be completed as follows: 90% within 30 days; 100% within 45 days. The start time begins when all necessary credentialing materials have been received. Completion time ends when written communication is mailed or faxed to the provider notifying them of the decision on their application.

Providers must be credentialed prior to accepting or treating members. PCPs cannot accept member assignments until they are fully credentialed.

Claims Submission for Newly Credentialed Providers: The credentialing letter notification is not a notice of active participation in the Sunflower network. Once the provider/practitioner information is updated in the Sunflower system, providers will be notified of the effective date by letter. This is the date a provider may begin seeing Sunflower Health Plan members. Allow two weeks from the receipt of the credentialing approval letter to receive letter with the effective date.

Credentialing Committee

The Sunflower Credentialing Committee including the Medical Director or his/her physician designee has the responsibility to establish and adopt necessary criteria for provider participation, termination, and direction of the credentialing procedures, including provider participation, denial, and termination. Committee meetings are held at least quarterly and more often as deemed necessary.

Failure of an applicant to adequately respond to a request for missing or expired information may result in termination of the application process prior to committee decision.

Site visits are performed at practitioner offices within 60 days of identification of two or more member complaints related to physical accessibility, physical appearance, and adequacy of waiting and examining room space. If the practitioner's site visit score is less than 80 percent, the practitioner may be subject to termination and/or continued review until compliance is achieved. A site review evaluates appearance, accessibility, record-keeping practices, and safety procedures.

Re-credentialing

Sunflower conducts provider re-credentialing at least every 36 months from the date of the initial credentialing decision and subsequent re-credentialing decisions. The purpose of this process is to identify any changes in the practitioner's licensure, sanctions, certification, competence, or health status that may affect the provider's ability to perform services under the contract. This process includes all practitioners, primary care providers, specialists, facilities, and ancillary providers previously credentialed and currently participating in the Sunflower network.

In between credentialing cycles, Sunflower conducts provider performance monitoring activities on all network providers. This includes an inquiry to the appropriate Kansas State Licensing Agency for a review of newly disciplined providers and providers with a negative change in their current licensure status. This monthly inquiry ensures that providers are maintaining a current, active, unrestricted license to practice in between credentialing cycles. Additionally, Sunflower reviews monthly reports released by the Office of Inspector General to identify any network providers who have been newly sanctioned or excluded from participation in Medicare or Medicaid.

A provider's agreement may be terminated if at any time it is determined by the Sunflower Credentialing Committee that credentialing requirements or standards are no longer being met.

Provider Rights to Review and Correct Information

All providers participating within the Sunflower network have the right to review information obtained by Sunflower to evaluate their credentialing and/or re-credentialing application. This includes information obtained from any outside primary source such as the National Practitioner Data Bank-Healthcare Integrity and Protection Data Bank, CAQH, malpractice insurance carriers, and state licensing agencies. This does not allow a provider to review references, personal recommendations, or other information that is peer review protected.

Providers have the right to correct any erroneous information submitted by another party in the event the provider believes any of the information used in the credentialing or re-credentialing process to be erroneous, or should any information gathered as part of the primary source verification process differ from that submitted by the provider. To request release of such information, a written request must be submitted to the Centene Corporation, Credentialing Manager, 7711 Carondelet Avenue, 4th Floor, St, Louis, MO 63105.

Upon receipt of this information, the provider will have 14 days to provide a written explanation detailing the error or the difference in information to the Credentialing Committee. The Sunflower Credentialing Committee will then include this information as part of the credentialing or re-credentialing process.

Provider Right to Be Informed of Application Status

All providers who have submitted an application to join Sunflower have the right to be informed of the status of their application upon request. To obtain application status, contact Sunflower at 1-877-644-4623. For new contract inquiry status, contact Contracting at sunflowerstatehealth@centene.com. For status of practitioner adds, terms, or changes from providers with an existing Sunflower agreement, contact Provider Relations at providerrelations@sunflowerhealthplan.com.

Provider Right to Appeal Adverse Credentialing Determinations

Applicants who are declined participation or existing providers who are declined continued participation due to adverse credentialing or re-credentialing determinations (for reasons such as quality of care or liability claims issues) have the right to request reconsideration of the decision. Reconsideration requests

must be made in writing within 30 days of formal notice of denial. All written requests should include additional supporting documentation in favor of the applicant's reconsideration for participation in the Sunflower network. Reconsiderations for administrative terminations or denials will be reviewed by the Credentialing Committee at the next regularly scheduled meeting and no later than 60 days from the receipt of the additional documentation. In cases where Reconsiderations is requested for reasons relating to the competence or professional conduct of the provider, the provider will receive notification (usually within 30 days of request) acknowledging their appeal request. The Plan will schedule a review of the case no more than 180 days from the date of request by the provider. The applicant will be sent a written response to his/her request within two weeks of the final decision. A written request for reconsideration shall be sent to:

Centene Corporation
Credentialing Manager
7711 Carondelet Ave., 4th Floor
St. Louis, MO 63105

A provider has the right to appeal Sunflower's decision and request a State Fair Hearing under the Kansas Administrative Procedures Act, K.S.A 77-501, et seq. and K.A.R. 30-7-64 et. seq. A written request for such administrative fair hearing shall be sent to:

Office of Administrative Hearings
1020 South Kansas Avenue
Topeka, KS 66612-1327

The request must specifically request a State Fair Hearing. The request should describe the decision appealed and the specific reasons for the appeal.

Primary Care Provider (PCP) Responsibilities

PCPs are responsible for the provision of primary care services for Sunflower's members including but not limited to:

- Supervision, coordination, and provision of care to each assigned member
- Initiation and coordination of referrals for medically necessary specialty care (no referral form or authorization is required for in-network specialty care)
- Maintaining continuity of care for each assigned member
- Screening for behavioral health needs at each EPSDT (Kan Be Healthy (KBH)) visit and, when appropriate, initiate a behavioral health referral
- Establish and maintain hospital admitting privileges sufficient to meet the needs of his/her members
- Manage the medical and healthcare needs of members to assure that all medically necessary services are made available in a culturally competent and timely manner while ensuring patient safety at all times including members with special needs and chronic conditions
- Educate members on how to maintain healthy lifestyles and prevent serious illness

- Provide screening, well care, and referrals to community health departments and other agencies in accordance with KanCare requirements and public health initiatives
- Offer days and hours of operation, appointment times, and wait times that are indistinguishable from those offered to non-Medicaid patients or patients with commercial health plan coverage
- Ensure follow-up and documentation of all referrals including services available under the State's fee for service program (such as Kan Be Healthy)
- Collaborate with the Sunflower case management team regarding services such as member screening and assessment, development of plan of care to address risks and medical needs, and access to other support services as needed
- For persons with Special Medical and Healthcare Needs, develop necessary treatment plans in conjunction with the Sunflower member and any specialists involved
- Maintain a current and complete medical record for the member in a confidential manner, including documentation of all services and referrals provided to the member, including but not limited to services provided by the PCP, specialists, and ancillary service providers
- Adhere to the EPSDT health and dental periodicity schedules for members under age 21
- Follow established procedures for coordination of and/or transition of care for in-network and out-of-network services, including obtaining authorizations for selected inpatient or outpatient services as listed on the current prior authorization list (except emergency services up to the point of stabilization) as well as coordinating services the member is receiving from another health plan during transition of care
- Out-of-network providers must ensure that the cost to the member is no greater than it would be if the services were furnished within the network
- Share the results of identification and assessment for any member with special healthcare needs with another health plan to which a member may be transitioning or has transitioned so that those services are not duplicated
- Actively participate in and cooperate with all Sunflower quality initiatives and programs

Provider Types That May Serve as PCPs

Primary care physicians are defined as physicians with a primary specialty designation of family medicine, general internal medicine, pediatric medicine, or a subspecialty related to those specialties. Advanced practice clinicians under the personal supervision of an eligible physician may also be eligible and reimbursed at 75% of the increased rate. Increased payments do not apply to Rural Health Clinic and Federally Qualified Health Center services.

Member Panel Capacity

All PCPs reserve the right to state the number of members they are willing to accept into their panel. Sunflower does not and is not permitted to guarantee that any provider will receive a certain number of members.

The PCP to member ratio shall not exceed the following:

- Physicians 1: 2,500
- Nurse Practitioner 1: 1,250
- Physician Assistant 1: 1,250

If a PCP has reached the capacity limit for his/her practice and wants to make a change to their open panel status, the PCP must notify Sunflower Customer Service by contacting their dedicated Provider Relations Specialist or calling Customer Service at 1–877-644-4623. A PCP shall not refuse new members for addition to his/her panel as long as the PCP has not reached their specified capacity limit.

In accordance with the Sunflower Participating Provider Agreement, PCPs shall notify Sunflower in writing at least 45 days in advance of their inability to accept additional Sunflower members. In no event shall any established patient who becomes a Sunflower member be considered a new patient. Sunflower prohibits all providers from intentionally segregating members from fair treatment and covered services provided to other non-Medicaid or non-Sunflower members.

Member Selection or Assignment of PCP

KanCare defaults a health plan from the list of its contracted Medicaid MCOs. Once a member is assigned to a Medicaid MCO, they are given the opportunity to select a PCP from the health plan's list of participating PCPs. When a member is assigned to Sunflower Health Plan, we in turn must ensure the member has selected a PCP within 10 business days of his or her enrollment. For those members who have not selected a PCP during enrollment, Sunflower Health Plan will use a PCP auto-assignment algorithm, approved by KanCare, to assign a PCP for the member. The algorithm assigns members to a PCP according to the following criteria, and in the sequence presented below:

1. **Member history with a PCP.** The algorithm will first look to see if the member is a returning member and attempt to match them to their previous PCP. If the member is new to Sunflower, claim history provided by the state will be used to match a member to a PCP that the member had a previous relationship with, where possible. If the member joins Sunflower and is already established with a provider who is not part of the network, Sunflower will make every effort to arrange for the member to continue with the same provider if the member so desires.
2. **Family history with a PCP.** If the member has no previous relationship with a PCP, the algorithm will look for a PCP that someone in the member's family, such as a sibling, is or has been assigned to.
3. **Geographic proximity of PCP to member residence.** The auto-assignment logic will ensure members travel no more than 30 miles or 30 minutes in rural areas or 20 miles or 30 minutes in urban areas.

4. **Appropriate PCP type.** The algorithm will use age, gender, and other criteria to ensure an appropriate match, such as children assigned to pediatricians.
5. **Language Need.** The algorithm will take into consideration any language need(s) of the member.

Pregnant women should select a pediatrician or other appropriate PCP for their newborn baby before the beginning of the last trimester of pregnancy. In the event the pregnant member does not select a PCP, Sunflower will auto-assign one for her newborn.

The member may change their PCP at any time with the change becoming effective no later than the beginning of the month following the member's request for change. Please contact your Provider Relations Specialist or Customer Service at 1-877-644-4623 for further information.

PCP Referrals to Specialists

PCPs are encouraged to refer members to an appropriate specialist provider when medically necessary care is needed that is beyond the scope of what the PCP can provide. ***Paper referrals are not required.*** Prior authorization from Sunflower may be required to access certain specialty providers as noted on the prior authorization list found in this Manual. All out-of-network referrals, with the exception of emergency care and family planning services, require prior authorization. All providers, whether a PCP or specialist, are also required to promptly notify Sunflower when rendering prenatal care for the first time to a member.

In accordance with Federal and State Law, participating providers are prohibited from making referrals for designated health services to healthcare providers or entities with which the participating provider, the member, or a member of the participating provider's family or the member's family has a financial relationship.

Member Self-Referral Options

Members may initiate access to certain services without first obtaining authorization, PCP referral, or health plan approval for the following services:

- Specialty care services provided by in-network specialists; however, members are encouraged to seek the advice of their primary care provider prior to seeking non-emergent specialty services
- Emergency services including emergency ambulance transportation, whether in or out-of-network
- Urgent Care facilities
- OB/GYN (in-network) for women's routine and preventive healthcare services
- Women's health services provided by participating Federally Qualified Health Centers (FQHC), Rural Health Centers (RHC), or Certified Nurse Practitioners (CNP)
- Family Planning services including screening and treatment services for sexually transmitted diseases (in- or out-of-network)
- Non-Medical Vision Care (i.e., vision exam, eyeglasses)
- HIV/AIDS testing
- STD screening and follow-up
- Immunizations
- Tuberculosis screening and follow-up
- General optometric services (preventive eye care)

PCPs are obligated to coordinate access to these services if the member or a Sunflower representative requests assistance with accessing these services.

Specialists as PCPs

Primary Care Physicians in consultation with other appropriate healthcare professionals must assess and develop individualized clinical treatment plans for those with special healthcare needs, which ensure integration of clinical and non-clinical disciplines and services in the overall plan of care.

Members with special healthcare needs often require regular monitoring and treatment from a specialist. Members with disabling conditions, chronic illness and other special healthcare needs, parents/caregivers, foster care case workers, or providers may request, at any time, that the member be assigned a specialist as their PCP. When requested or when we identify a member whose care plan indicates the need for frequent utilization or a course of treatment with, or monitoring by, a specialist, we will provide prior authorization and direct access to the specialist through the end of the course of treatment or for a specific number of visits. We will allow members with such treatment plans to retain the specialist as their PCP. The specialist must agree in writing to perform all PCP functions including, but not limited to, performing or coordinating preventive care (including EPSDT services) and referral to other specialists as indicated. Prior to the specialist serving as the member's PCP, we will execute a PCP Agreement with the specialist and provide a Provider Directory. The Care Manager will work with the member and previous PCP to safely transfer care to the specialist.

Specialist Provider Responsibilities

Sunflower requires specialists to communicate to the PCP regarding treatment plan and referrals to other specialists. This allows the PCP to better coordinate the member's care and ensures that the PCP is aware of the additional service request.

To ensure continuity of care for the member, every participating specialist provider must:

- Maintain contact and open communication with the member's referring PCP
- Obtain authorization from the Sunflower Medical Management Department, if needed, before providing services
- Coordinate the member's care with the referring PCP
- Provide the referring PCP with consultation reports and other appropriate patient records within five business days of receipt of such reports or test results
- Be available for or provide on-call coverage through another source 24 hours a day for management of member care
- Maintain the confidentiality of patient medical information
- Actively participate in and cooperate with all Sunflower quality initiatives and programs

Sunflower specialist providers should refer to their contract, contact their dedicated Provider Relations Specialist, or call the Sunflower Customer Service department toll free at 1-877-644-4623 for complete information regarding the specialist providers' obligations and mode of reimbursement or if they have any questions or concerns regarding referrals, claims, prior authorization requirements, and other administrative issues.

Appointment Availability and Wait Times

Sunflower follows the accessibility and appointment wait time requirements set forth by KanCare and applicable regulatory and accrediting agencies. Sunflower monitors participating provider compliance with these standards at least annually and will use the results of appointment standards monitoring to ensure adequate appointment availability and access to care and to reduce inappropriate emergency room utilization. The table below depicts the appointment availability and wait time standards for Sunflower members:

TYPE OF PROVIDER	APPOINTMENT STANDARDS
PRIMARY CARE PROVIDERS	
Regular Appointments	Not to exceed 3 weeks from date of member request
Urgent Care	48 hours
SUBSTANCE USE DISORDER (SUD) PROVIDERS	
Emergent	On demand service. No prior authorization is required and members go directly to an emergency room. Members are seen immediately.
Urgent	Assessment conducted within 24 hours of the initial contact and services delivered within 48 hours from initial contact.
IV Drug Users	Within 14 days of initial contact.
Routine	Members assessed within 14 days of initial contact and treatment services are delivered within 14 days of assessment.
MENTAL HEALTH ACCESS STANDARDS	
Post-Stabilization Services	Referral within 1 hour. Assessment and/or Treatment within 1 hour from referral for post-stabilization services (both inpatient and outpatient) in an emergency room.
Emergent	Referral immediately. Assessment and/or Treatment within 3 hours for an outpatient Mental Health service, and within 1 hour from referral for an emergent concurrent utilization review screen.
Urgent	Referral within 24 hours. Assessment and/or Treatment within 48 hours from referral for outpatient Mental Health services, and within 24 hours from referral for an urgent concurrent utilization review screen.
Planned inpatient psychiatric	Referral within 48 hours. Assessment and/or Treatment within 5 working days from referral.

Routine Outpatient	Referral within 5 days. Assessment and/or Treatment within 9 working days from referral; 10 working days from previous treatment.
Pregnant Women	Treatment within 24 hours of an assessment. IV drug users shall be admitted no later than 14 calendar days after an assessment or 120 calendar days after the date of such request. Interim services shall be made available no later than 48 hours after such request.
SPECIALTY AND URGENT CARE (INCLUDES SPECIALTY PHYSICIAN SERVICES, HOSPICE CARE, HOME HEALTHCARE, SUD TREATMENT, REHABILITATION SERVICES, ETC.)	
Routine Care	Not to exceed 30 days.
Urgent Care	Not to exceed 48 hours.
EMERGENCY CARE	
Emergency Care	Immediate, at the nearest facility available, regardless of participation status with Sunflower.
HOSPITALS	
Hospitals	Transport time not to exceed 30 minutes
GENERAL OPTOMETRY SERVICES	
Routine Care	Not to exceed 3 weeks for regular appointments
Urgent Care	Not to exceed 48 hours
LAB AND X-RAY SERVICES	
Routine Care	Not to exceed 3 weeks for regular appointments
Urgent Care	Not to exceed 48 hours

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.

Sunflower requests that PCPs inform our Customer Service department (1-877-644-4623) when a Sunflower member misses an appointment so we may monitor that in our system and provide outreach to the member on the importance of keeping appointments. This will assist our providers in reducing missed appointments and reduce the inappropriate use of Emergency Room services.

Travel Distance and Access Standards

Sunflower offers a comprehensive network of PCPs, Specialist Physicians, Hospitals, FQHCs/RHCs, Behavioral Healthcare Providers and Diagnostic and Ancillary Services Providers to ensure every member has access to Covered Services within the travel distance standards established by KanCare. A list of standards (not all-inclusive) are listed below:

- Access Standards for Primary Care Providers (PCPs):
  - Rural Areas: 30 miles unless documented that community standards are greater
  - Urban Areas: 20 miles
- Access Standards for Hospital Services and Optometry, :
  - Rural Areas: 30 miles unless documented that community standards are greater
  - Urban Areas: 30 miles
- Access Standards for OB/GYN and Psychiatry:
  - Rural Areas: 60 miles
  - Urban Areas: 15 miles
- Access Standards for Other Specialists:
  - Rural Areas: 100 miles
  - Urban Areas: 25 miles
- Access Standards for Dental:
  - Rural Areas: 30 miles
  - Urban Areas: 20 miles
- Access Standards for Behavioral Health:
  - Rural/Frontier Areas: 60 miles
  - Densely Settled Rural Areas: 45 miles
  - Urban Areas: 30 miles

Participating providers must offer access comparable to that offered to commercial members or if the participating provider serves only Medicaid members, comparable to Medicaid fee for service. Sunflower routinely monitors compliance with this requirement and may initiate corrective action if there is a failure to comply with this requirement.

Provider Phone Call Protocol

Providers must:

- Answer the member's telephone inquiries on a timely basis
- Schedule appointments in accordance with Sunflower and KanCare appointment standards and guidelines
- Schedule a series of appointments and follow-up appointments as needed by a member and in accordance with accepted practices for timely occurrence of follow-up appointments for non-Medicaid beneficiaries
- Identify and, when possible, reschedule cancelled and no-show appointments
- Identify special member needs while scheduling an appointment (e.g., wheelchair and interpretive linguistic needs, non-compliant individuals, or persons with cognitive impairments)
- Adhere to the following response time for telephone call-back wait times:
  - After hours for non-emergent, symptomatic issues: within 30 minutes
  - Same day for all other calls during normal office hours

- Schedule continuous availability and accessibility of professional, allied, and supportive personnel to provide covered services within normal office hours
- Protocols shall be in place to provide coverage in the event of a provider's absence
- After-hour calls should be documented in a written format in an after-hour call log and then transferred to the member's medical record

Note: *If after-hours urgent or emergent care is needed, the provider or his/her designee should contact the urgent care center or emergency department in order to notify the facility of the member's impending arrival. Sunflower does not require notification or prior authorization for urgent or emergent care.*

Sunflower will monitor appointment and after-hours availability on an ongoing basis through its Quality Improvement Program (QIP).

24-Hour Access to Providers

Sunflower providers are required to maintain sufficient access to needed healthcare services on an ongoing basis and shall ensure that such services are accessible to members as needed 24 hours a day, 365 days a year as follows:

- A provider's office phone must be answered during normal business hours
- A member must be able to access their provider after normal business hours and on weekends. This may be accomplished through the following:
  - A covering physician
  - An answering service
  - A triage service or voicemail message that provides a second phone number that is answered
  - Any recorded message must be provided in English and Spanish, if the provider's practice includes a high population of Spanish-speaking members

Examples of unacceptable after-hours coverage include, but are not limited to:

- Calls received after hours are answered by a recording telling callers to leave a message;
- Calls received after hours are answered by a recording directing members to go to an Emergency Room for any services needed; and
- Not returning calls or responding to messages left by patients after hours within 30 minutes.

The selected method of 24-hour coverage chosen by the member must connect the caller to someone who can render a clinical decision or reach the PCP or practitioner for a clinical decision. Whenever possible, the PCP, practitioner, or covering medical professional must return the call within 30 minutes of the initial contact. After-hours coverage must be accessible using the provider office's daytime telephone number.

Sunflower will monitor providers' offices through scheduled and unscheduled visits and audits conducted by Sunflower Provider Relations staff.

Hospital Responsibilities

Sunflower has established a comprehensive network of hospitals to provide services to Sunflower members. Hospital services and hospital-based providers must be qualified to provide services under the Medicaid program. All services must be provided in accordance with applicable state and federal laws and regulations and adhere to the requirements set forth by the KanCare program.

Hospitals must:

- Notify the PCP immediately or no later than the close of the next business day after the member's emergency room visit
- Obtain authorizations for all inpatient and selected outpatient services as listed on the current prior authorization list, except for emergency stabilization services
- Notify Sunflower's Medical Management Department of all Inpatient admissions within one business day (by 5 p.m. CST) following the admission. Clinical information must be submitted with the admission to support medical necessity.
- Notify Sunflower's Medical Management Department of all admissions via the ER within one business day (by 5 p.m. CST)
- Notify Sunflower's Medical Management Department of all newborn deliveries within one day (by 5 p.m. CST) of the delivery

Hospital administrators should refer to their Sunflower Provider Agreement for complete information regarding hospital obligations, rights, and responsibilities.

Long Term Care and Long Term Services and Supports

The KanCare program transitions Kansas Medicaid into an integrated care model. Services include physical health services such as doctor appointments and hospital visits, behavioral health services, dental and vision care, pharmacy, transportation, and nursing facility care. All the services offered through the State's Home and Community Based Services will also be in KanCare. Sunflower will coordinate all of the care a Sunflower member receives. These members may reside in a Nursing Facility or receive care in the community from Home Based Community Service providers.

The State of Kansas has an approved Money Follows the Person (MFP) grant effective through June 30, 2016. This grant allows persons currently residing in a Psychiatric Residential Treatment Facility (PRTF), who are 18 years or older who qualify for the I/DD waiver and some qualifying children who reside in PRTFs, to access community-based services.

The goals of the KanCare program are to improve overall health outcomes while slowing the rate of cost growth over time. This will be accomplished by providing the right care, in the right amount, in the right setting, at the right time. Sunflower will focus on ensuring consumers receive the preventive services and screenings they need, helping consumers manage their chronic conditions and reducing unnecessary and duplicative services.

The Home and Community Based Service types included are:

- Autism
- Frail and Elderly Physical Disability Technology Assistance
- Traumatic Brain Injury
- Intellectual/Developmental Disability

Below are the benefits for each HCBS type:

HCBS – Autism:

a. Autism Specialist
b. Financial Management Services (FMS)
c. Intensive Individual Supports (IIS)
d. Respite
e. Parent Support & Training
f. Family Adjustment Counseling

Interpersonal Communication Therapy: Please refer to the most recent revision of the Kansas Medicaid HCBS Autism Provider Manual for the requirements, definitions, and limitations for these services. The manual may be found on the KMAP website at www.kmap-state-ks.us.

HCBS – Intellectual/Developmental Disabilities (IDD):

a. Assistive Services
b. Day Supports
c. Financial Management Services (FMS)
d. Medical Alert Rental
e. Sleep Cycle Support
f. Specialized Medical Care
g. Personal Assistant Services
h. Residential Supports
i. Supported Employment
j. Supportive Home Care
k. Overnight Respite Care
l. Wellness Monitoring

Please refer to the most recent revision of the Kansas Medicaid I/DD HCBS Manual for the requirements, definitions, and limitations for these services. The manual may be found on the KMAP website at www.kmap-state-ks.us.

DEVELOPMENTAL DISABILITIES TARGETED CASE MANAGEMENT

Targeted Case Management is a Medicaid State Plan Service that will continue to be provided by CDDOs and their affiliated, licensed providers. Please refer to the most recent revision of the Kansas Medicaid I/DD TCM Manual located on the KMAP website at www.kmap-state-ks.us.

HCBS – Frail Elderly (FE):

a. Adult Day Care
b. Assistive Technology (Lifetime maximum of $7,500)
c. Attendant Care
d. Financial Management Services (FMS)
e. Comprehensive Support
f. Home Telehealth (remote monitoring system)
g. Medication Reminder
h. Nurse Evaluation Visit
i. Oral Health
j. Personal Emergency Response
k. Sleep Cycle Support
l. Wellness Monitoring
m. Case Management services will be performed by Plan CM staff.

Please refer to the most recent revision of the Kansas Medicaid HCBS Frail Elderly Provider Manual for the requirements, definitions, and limitations for these services. The manual may be found on the KMAP website at www.kmap-state-ks.us.

HCBS – Physical Disabilities (PD)

a. Assistive Services (Maximum lifetime expenditure on Assistive Services is $7,500)
b. Financial Management Services (FMS)
c. Home-Delivered Meals Service
d. Independent Living Counseling
e. Medication Reminder Services (Call, dispenser, and dispenser installation)
f. Personal Emergency Response System and Installation
g. Personal Services Self-Directed or Agency-Directed
h. Sleep Cycle Support

Case Management services will be performed by Plan CM staff. Please refer to the most recent revision of the Kansas Medicaid HCBS Physical Disability Provider Manual for the requirements, definitions, and limitations for these services. The manual may be found on the KMAP website at www.kmap-state-ks.us.

HCBS – Technology-Assisted (TA)

a. Specialized Medical Care (SMC)
b. Financial Management Services (FMS)
c. Long-term Community Care Attendant
d. Medical Respite
e. Home Modification Services
f. Health Maintenance Monitoring (HMM)

Case Management services will be performed by Plan CM staff. Please refer to the most recent revision of the Kansas Medicaid HCBS Technology Assistance Provider Manual for the requirements, definitions, and limitations for these services. The manual is on the KMAP website at www.kmap-state-ks.us/.

HCBS – Traumatic Brain Injury (TBI)

a. Transitional Living Skills
b. Financial Management Services (FMS)
c. Home Delivered Meals
d. Personal Services
e. Assistive Services
f. Rehabilitation Therapies: Physical Therapy / Occupational Therapy / Speech Therapy
g. Cognitive Rehabilitation
h. Behavior Therapy
i. Sleep Cycle Support
j. Personal Emergency Response System (PERS)

Case Management services will be performed by Plan CM staff. Please refer to the most recent revision of the Kansas Medicaid HCBS Traumatic Brain Injury Provider Manual for the requirements, definitions and limitations for these services. The manual is on the KMAP website at www.kmap-state-ks.us.

Information for Long Term Care and Long Term Services and Support providers regarding Billing and Claims Submission, Medical Management, Credentialing and Recredentialing, and the Grievances and Appeal Process may be found in this Manual; however, all sections of this Manual are applicable.

Provider Network Development and Maintenance

Sunflower ensures the provision of covered services as specified by the KanCare program. Our approach to developing and managing the provider network begins with a thorough analysis and evaluation of the State's network adequacy requirements. Sunflower develops and maintains a network of qualified providers/practitioners in sufficient numbers and locations that is adequate and reasonable in number, in specialty type, and in geographic distribution to meet the healthcare needs of its members, both adults and children, without excessive travel requirements, and that is in compliance with KanCare's access and availability requirements.

Sunflower offers a network of primary care providers (PCPs) to ensure every member has access to within KanCare required travel distance standards. PCPs are participating providers who have the responsibility for supervising, coordinating, and providing primary healthcare to members, initiating referrals for specialist care, and maintaining the continuity of care for members. PCPs include, but are not limited to, Pediatricians, Family and General Practitioners, Internists, Physician Assistants (under the supervision of a primary care physician), or Advanced Registered Nurse Practitioners (ARNP). In addition, Sunflower will have specialists available in the following categories for adult and/or pediatric members on at least a referral basis:

- Allergy
- Cardiology
- Dermatology
- Internal Medicine
- Gastroenterology
- General Surgery
- Hematology/Oncology
- Neonatology
- Neurosurgery
- OB/GYN
- Ophthalmology
- Orthopedics
- Otolaryngology
- Physical Medicine/Rehab
- Plastic and Reconstructive Surgery
- Podiatry
- Psychiatry
- Pulmonary Disease
- Urology
- Behavioral Health
- Physical Therapy
- Occupational Therapy

In addition, the following is a selection of the types of facilities and services available to Sunflower members (may not be an all-inclusive list):

- Hospitals
- Federally Qualified Health Centers (FQHC)
- Rural Health Centers (RHC)
- Indian Health Services (IHS)
- Optometry
- Dental Primary Care
- X-Ray
- Lab
- Retail Pharmacy
- Home and Community Based Services (HCBS)
- Skilled Nursing Facilities
- Transportation services
- Durable Medical Equipment (DME) providers
- Home Health
- Hospice

In the event the Sunflower provider network is insufficient (according to KanCare established standards), Sunflower shall ensure timely and adequate coverage of these services through an out-of-network provider until a network provider is available and will ensure coordination with respect to authorization and payment issues in these circumstances. For assistance with referrals to specialists for a Sunflower member, please contact our Medical Management team at 1-877-644-4623.

Referrals to Specialists

PCPs initiate and coordinate access to healthcare services for his/her panel of Sunflower members. PCPs can refer a member to a specialist when care is needed that is beyond the scope of the PCP's training or practice parameters. **Paper referrals *are not* required.** To better coordinate a member's healthcare, Sunflower encourages specialists to communicate to the PCP the need for a referral to another specialist rather than making such a referral themselves.

Hospital and Tertiary Care

Sunflower offers a comprehensive network of hospitals, medical centers, and tertiary care facilities and providers, including trauma centers, burn centers, level III (high risk) nurseries, rehabilitation facilities, and medical subspecialists available 24 hours per day. In the event a Sunflower network provider is unavailable to provide necessary tertiary care services, Sunflower shall ensure timely and adequate coverage of these services through an out-of-network provider and/or facility until a network provider is available and will ensure coordination with respect to authorization and payment issues in these circumstances.

Marketing Requirements

Marketing means any communication to a Medicaid consumer who is not enrolled in that entity, that can be reasonably interpreted as intended to influence the consumer to enroll in that particular entity's Medicaid product. KanCare is responsible for all marketing to members during the enrollment process. Direct solicitation of members is prohibited.

All marketing materials utilized by Sunflower must be approved by KanCare prior to distribution to members. Additionally:

- Marketing materials must be distributed in all service areas where Sunflower has a presence.
- Marketing materials in English provide directions for obtaining understandable materials in the population's primary languages, as identified by KanCare.
- Neither Sunflower nor its contracted providers will offer anything of value as an inducement to enrollment including the sale of other insurance to attempt to influence enrollment.
- Sunflower or its contracted providers will not directly or indirectly conduct door-to-door, telephonic, or other cold-call marketing of enrollment.
- Sunflower or its contracted providers may not make any written or oral statements in marketing materials that a potential member must enroll with Sunflower in order to obtain benefits or in order not to lose benefits.
- Sunflower may not make any assertion or statement in marketing materials that Sunflower is endorsed by CMS, the Federal or State government, or similar entity.
- Marketing materials must provide the greatest degree of understanding and must be written at the fifth grade reading level.

Should you have any questions regarding these marketing requirements, contact Customer Service or your Provider Relations Specialist.

Advance Directives

Sunflower is committed to ensuring members are aware of and are able to avail themselves of their rights to execute Advance Directives. Sunflower is equally committed to ensuring participating providers and their staff are aware of and comply with federal and state laws regarding Advance Directives, and that the Sunflower Medical Management staff are trained on our policies and procedures related to Advanced Directives.

PCPs and providers delivering care to Sunflower members must ensure members age 18 years and older receive information on Advance Directives and are informed of their right to execute an Advance Directive. Providers must document such information in the patient's permanent medical record.

Sunflower recommends to its PCPs and physicians that:

- The first point of contact for the member in the PCP's office should ask if the member has executed an Advance Directive and the member's response should be documented in the medical record.
- If the member has executed an Advance Directive, the first point of contact should ask the member to supply a copy of it for inclusion in the member's medical record. NOTE: The date of the request for the Advance Directive should be noted in the member's medical record. It is recommended that if the Advance Directive is not received within 30 days of the request, the PCP should contact the patient to re-request the Advance Directive.
- An Advance Directive should be made a part of the member's medical record and include mental health directives.
- If an Advance Directive exists, the physician should discuss potential medical emergencies with the member and/or designated family member/significant other (if named in the advance directive and if available) and with the referring physician, if applicable. Any such discussion should be documented in the medical record.
- Providers are prohibited from discriminating against the member based on whether or not the member has or has not executed an Advance Directive.

Interpreter Services

All Sunflower members or potential members with a primary language other than English, or who are deaf or hearing impaired, are entitled to receive interpreter services free of charge. Interpreter services shall be provided as needed for all interactions with members including, but not limited to:

- Customer Service
- When receiving covered services from any provider
- Emergency Services
- Steps necessary to file grievances and appeals

Sunflower will provide Interpreter Services. Providers may call Sunflower directly or direct members to contact Sunflower to arrange for Interpreter Services.

Provider Network Termination

Providers must give Sunflower written notice of their intent to voluntarily terminate their network participation in accordance with the terms of the Participating Provider Agreement. The provider must send a written termination notice via certified mail (return receipt requested) or overnight courier. In addition, providers must supply copies of medical records to each member's new provider upon request and cooperate in the coordination of patient care transitions at no charge, or disruption and delay in services to affected Sunflower members. Written notification shall be sent to:

Sunflower Health Plan Contracting Department
8325 Lenexa Drive
Lenexa, KS 66214

Sunflower will notify affected members in writing of a provider's termination within 15 days of the receipt of the termination notice from the provider, provided that such notice from the provider was timely. If the terminating provider is a PCP, Sunflower will request that the member elect a new PCP within 10 business days of the postmark date of the termination of the PCP notice to members and provide information on options for selecting a new PCP. If a member does not elect a PCP prior to the provider's termination date, Sunflower will automatically assign a PCP to the member.

Providers must continue to render covered services to members who are receiving care at the time of termination until a) completion of the treatment or b) Sunflower can arrange for appropriate healthcare for the member with a participating provider, as determined by the Medical Director or as required by applicable law or the contract. Upon request from a member undergoing active treatment related to a chronic or acute medical condition, Sunflower will reimburse the provider for the provision of covered services for up to 60 days from the termination date. In addition, Sunflower will reimburse providers for the provision of covered services to members who are in the second or third trimester of pregnancy extending through the completion of postpartum care relating to the delivery.

Provider Rights and Responsibilities

Sunflower Provider Rights

- To be treated by their patients, who are Sunflower members, and other healthcare workers with dignity and respect
- To receive accurate and complete information and medical histories for members' care
- To expect Sunflower members act in a way that supports the care given to other individuals and that helps keep the doctor's office, hospital, or other provider offices running smoothly
- To expect other network providers to act as partners in members' treatment plans
- To expect members to follow their healthcare instructions and directions, and their support plans for long term services
- To file a grievance or appeal with Sunflower
- To file a grievance on behalf of a member, with the member's consent
- To have access to information about Sunflower quality improvement programs, including program goals, processes, and outcomes that relate to member care and services
- To contact Customer Service with any questions, comments, or problems
- To collaborate with other healthcare or long-term support professionals who are involved in the care of members
- 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
- Ability to request an administrative State Fair Hearing to appeal actions of Sunflower Health Plan

Sunflower Provider 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, including the right to:
  - Recommend new or experimental treatments
  - Provide information regarding the nature of treatment or support services options
  - Provide information about the availability of alternative treatment options, therapies, consultations, or tests, including those that may be self-administered
  - Be informed of risks and consequences associated with each treatment option or choosing to forego treatment as well as the benefits of such treatment options
- To treat members with fairness, dignity, and respect
- 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
- To maintain the confidentiality of members' personal health information, including medical records and histories, and adhere to state and federal laws and regulations regarding confidentiality
- To give members a notice that clearly explains their privacy rights and responsibilities as it relates to the provider's practice and scope of service
- To provide members with an accounting of the use and disclosure of their personal health information in accordance with HIPAA
- To allow members to request restriction on the use and disclosure of their personal health information
- To provide members, upon request, access to inspect and receive a copy of their personal health information, including medical records and long-term supports assessments and plans
- To provide clear and complete information to members – in a language or communication mode they can understand – about their health condition and treatment, or long-term support needs, regardless of cost or benefit coverage, and allow member participation in the decision-making process
- To tell a member if the proposed medical care or treatment, or long-term support service, is part of a research experiment and give the member the right to refuse experimental treatment
- To allow a member who refuses or requests to stop treatment or services the right to do so, as long as the member understands that by refusing or stopping treatment or services the condition may worsen or be fatal or his/her support needs may not be adequately met
- To respect members' advance directives and include these documents in the their medical record
- To allow members to appoint a parent/guardian, family member, or other representative if they can't fully participate in their treatment or support service decisions

- To allow members to obtain a second opinion, and answer members' questions about how to access healthcare services appropriately
- To follow all state and federal laws and regulations related to patient care and rights
- To participate in Sunflower data collection initiatives, such as HEDIS and other contractual or regulatory programs
- To review clinical practice guidelines distributed by Sunflower
- To comply with Sunflower Medical Management program as outlined herein
- To disclose overpayments or improper payments to Sunflower
- To provide members, upon request, with information regarding the provider's professional qualifications, such as specialty, education, residency, license, and/or board certification status
- To obtain and report to Sunflower information regarding other insurance coverage the member has or may have
- To give Sunflower timely, written notice if provider is leaving/closing a practice or location
- To contact Sunflower to verify member eligibility and benefits, if appropriate
- To invite member participation in understanding any medical, behavioral health, and/or long-term support needs that the member may have and to develop mutually agreed upon treatment and lifestyle goals, to the extent possible
- To provide members with information regarding office location, hours of operation, accessibility, and translation services
- To coordinate and cooperate with other state agencies and providers also serving members through various home and community-based programs
- To object to providing relevant or medically necessary services on the basis of the provider's moral or religious beliefs or other similar grounds

Cultural Competency

Sunflower views Cultural Competency as the measure of a person or organization's willingness and ability to learn about, understand, and provide excellent customer service across all segments of the population. It is the active implementation of a system-wide philosophy that values differences among individuals and is responsive to diversity at all levels in the community and within an organization and at all service levels the organization engages in outside of the organization. A sincere and successful Cultural Competency program is evolutionary and ever-changing to address the continual changes occurring within communities and families. In the context of healthcare delivery, Cultural Competency is the promotion of sensitivity to the needs of patients who are members of various racial, religious, age, gender, and/or ethnic groups and accommodating the patient's culturally based attitudes, beliefs, and needs within the framework of access to healthcare services and the development of diagnostic and treatment plans and communication methods in order to fully support the delivery of competent care to the patient. It is also the development and continued promotion of skills and practices important in clinical practice, cross-cultural interactions, and systems practices among providers and staff to ensure that services are delivered in a culturally competent manner.

Sunflower is committed to the development, strengthening, and sustaining of healthy provider/member relationships. Members are entitled to dignified, appropriate, and quality care. When healthcare services are delivered without regard for cultural differences, members are at risk for sub-optimal care. Members may be unable or unwilling to communicate their healthcare needs in an insensitive environment, reducing effectiveness of the entire healthcare process.

Sunflower has incorporated an evaluation of each provider's cultural competency level within its credentialing program. By virtue of their participation status, all in-network providers have been evaluated regarding their cultural competence level and have been approved for participation in the Sunflower network. Nevertheless, we offer all in-network providers and their employees access to reference materials, training programs, and tool kits to assist each provider to further develop culturally competent staff and culturally proficient practices.

As part of Sunflower's Cultural Competency Program, we require our employees and in-network providers to ensure the following:

- Members understand that they have access to medical interpreters, signers, and TDD/TTY services to facilitate communication without cost to them.
- Medical care is provided with consideration of the members' primary language, race, and/or ethnicity as it relates to the members' health or illness.
- Office staff routinely interacting with members has been given to opportunity to participate in, and have participated in, cultural competency training and development offered by Sunflower.
- Office staff responsible for data collection makes reasonable attempts to collect race- and language-specific information for each member. Staff will also explain race categories to a member in order to assist the member in accurately identifying their race or ethnicity.

- Treatment plans are developed with consideration of the member's race, country of origin, native language, social class, religion, mental or physical abilities, heritage, acculturation, age, gender, sexual orientation, and other characteristics that may influence the member's perspective on healthcare.
- Office sites have posted and printed materials in English and Spanish, and if required by KanCare, any other required non-English language.
- Providers establish an appropriate mechanism to fulfill obligations under the Americans with Disabilities Act including that all facilities providing services to members must be accessible to persons with disabilities. Additionally, no member with a disability may be excluded from participation in or be denied the benefits of services, programs, or activities of a public facility, or be subjected to discrimination by any such facility.

Disabilities Awareness

Sunflower provider contracts require compliance with KDHE, KDADS, and Sunflower non-discrimination and cultural competency requirements, such as timely use of professional interpreter services and meeting access requirements under the Americans with Disabilities Act to accommodate members with disabilities. Sunflower will also offer focused training to providers to better equip staff to meet the needs of our members. Training sessions will focus on sensitivity help, creating an awareness of the societal and personal barriers people with disabilities face, and offer solutions to help accommodate their needs. For example, providers will be encouraged to be flexible with appointment times or help coordinate home visits where possible and recognizing people with disabilities may require additional time to explain healthcare concerns, ask questions, or prepare for examinations. Sunflower will also draw on the expertise of advocacy groups, such as those mentioned above to assist with this training. When Sunflower identifies a provider who excels at providing care that is accessible for people with disabilities, we will ask this provider to serve as a mentor to other providers who are interested in improving their accessibility to these members.

Mainstreaming

Sunflower considers mainstreaming of members an important component of the delivery of care and expects providers to treat members without regard to race, color, creed, sex, religion, age, national origin ancestry, marital status, sexual preference, health status, income status, program membership, or physical or behavioral disabilities except where medically indicated. Examples of prohibited practices include:

- Denying a member a covered service or availability of a facility
- Providing a Sunflower member a covered service that is different or in a different manner, or at a different time or at a different location than to other "public" or private pay members (examples: separate waiting rooms, delayed appointment times)

Verifying Member Eligibility

Member Eligibility Verification

All Sunflower members receive a plan ID card. Sunflower will issue new plan ID cards to members if the information on their card changes; to replace a lost card; or if a member requests additional cards.
NOTE: Presentation of a member ID card is not a guarantee of eligibility. Providers should always verify eligibility on the same day services are to be rendered.

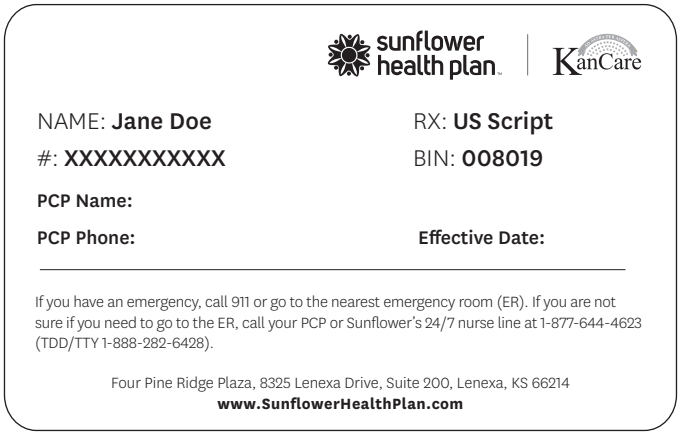
To verify a patient's eligibility with Sunflower, providers can choose one of the following methods:

1. **Log on to SunflowerHealthPlan.com.** Using our secure provider website, any registered provider can quickly check member eligibility. Eligibility information loaded onto this website is obtained from KanCare and reflective of all changes made within the last 24 hours. The eligibility search can be performed using the date of service, patient name and date of birth (DOB), or Medicaid/Sunflower ID number and DOB.
    - **PCP Member Lists (Panels):** Using our secure provider website, PCPs can access a list of their panel members. The list also provides important information including DOB and indicators for patients whose claims data show a gap in care, such as a missed EPSDT service.
    - **Health Home Provider List:** Using our secure provider website, Health Home providers can access their list of members assigned to the health home. The list will include the member's PCP and Sunflower claims data for each member.
2. **Call 1-877-644-4623.** Calling our 24-hour toll-free interactive voice response (IVR) line from any touch-tone phone is a convenient way to obtain eligibility information about the patient. The automated system will prompt you to enter the member Medicaid ID and the month of service to check eligibility.
3. **Call Sunflower Customer Service.** If you cannot confirm a member's eligibility using the methods above, call our toll-free number at 1-877-644-4623. Follow the menu prompts to speak to a Customer Service Representative to verify eligibility before rendering services. Customer Service will need the member's name, date of birth, and KanCare/Sunflower ID number (or Social Security Number) or member Medicaid ID or Sunflower ID to verify eligibility.
4. **Check the KMAP website.** If you are a registered provider on the KMAP website, you may also verify eligibility on this site.

Member Identification Card

Whenever possible, members should present a photo ID card each time services are rendered by a provider. If you are not familiar with the person seeking care as a member of our health plan, please ask to see photo identification. If you suspect fraud, please contact Customer Service at 1-877-644-4623 immediately.

Below is a sample member Identification Card.



IMPORTANT CONTACT INFORMATION

Members:
Customer Service: 1-877-644-4623
(TDD/TTY 1-888-282-6428)
Vision: 1-877-644-4623
Dental: 1-877-644-4623
Behavioral Health: 1-877-644-4623
24/7 NurseWise: 1-877-644-4623

Providers: Pharmacy: 1-877-249-2718
Provider Services & IVR Eligibility Inquiry
- Prior Auth: 1-877-644-4623

EDI/EFT/ERA please visit
For Providers at
www.SunflowerHealthPlan.com

Medical Correspondence/
Non-Claims:
Sunflower Health Plan
PO Box 4070
Farmington, MO 63640-3833

Behavioral Correspondence/
Non-Claims:
Sunflower Health Plan
PO Box 6400
Farmington, MO 63640-3807

Provider Claims information via the web: www.SunflowerHealthPlan.com

Member Rights and Responsibilities

Sunflower Member Rights

- To be treated with respect and with due consideration for his/her dignity and privacy
- To receive information on available treatment and service options and alternatives, presented in a manner appropriate to the member's ability to understand
- To participate in decisions regarding his/her healthcare and support needs, including the right to refuse treatment
- To complete information about his/her specific needs or condition and treatment options, regardless of cost or benefit coverage
- To seek second opinions
- To obtain information about available experimental treatments and clinical trials and how such research can be accessed
- To obtain assistance with care coordination from the PCP's office
- To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation, as specified in the Federal regulations on the use of restraints and seclusion
- To express a concern or appeal about Sunflower or the care and services it provides and receive a response in a reasonable period of time
- To be able to request and receive a copy of his/her medical or other service records (one copy free of charge) and request that they be amended or corrected
- To choose his/her health professional and long-term supports and services providers to the extent possible and appropriate, in accordance with 42 CFR §438.6(m)
- To receive healthcare and other support services that are accessible; are comparable in amount, duration, and scope to those provided under Medicaid FFS, and are sufficient in amount, duration, and scope to reasonably be expected to achieve the purpose for which the services are furnished
- To receive services that are appropriate and are not denied or reduced solely because of diagnosis, type of illness, or medical condition
- To receive all information – e.g., enrollment notices, informational materials, instructional materials, available treatment options, and alternatives – in a manner and format that may be easily understood as defined in the Provider Agreement and the member Handbook
- To receive oral interpretation services free of charge for all non-English languages, not just those identified as prevalent
- To be notified that interpretation services are available and how to access those services
- To request and receive information on Sunflower's Physician Incentive Plan upon request (this includes the right to adequate and timely information on a Physician Incentive Plan)

Sunflower Member Responsibilities

- To inform Sunflower of the loss or theft of an ID card
- Present the Sunflower ID card when using healthcare or other covered services
- Be familiar with Sunflower procedures to the best of the member's abilities
- To call or contact Sunflower to obtain information and have questions clarified
- To provide participating network providers with accurate and complete medical and/or support needs information
- Following the prescribed treatment of care recommended by the provider or letting the provider know the reasons the treatment cannot be followed, as soon as possible
- To make every effort to keep any agreed upon appointments, and follow-up appointments; and accessing preventive care services.
- To live healthy lifestyles and avoid behaviors known to be detrimental
- To provide accurate and complete information to all healthcare and support providers
- To become knowledgeable about Sunflower coverage provisions, rules, and restrictions
- To ask questions of providers to determine the potential risks, benefits, and costs of treatment alternatives, and then making care decisions after carefully weighing all pertinent factors
- To follow the grievance process established by Sunflower (and outlined in the member Handbook) if there is a disagreement with a provider
- To choose a primary care provider (PCP)

Benefit Explanation and Limitations

Sunflower Health Plan Benefits

Sunflower network providers supply a variety of medical benefits and services, some of which are itemized on the following pages. For specific information not found in this Provider Manual, please contact Customer Service at 1-877-644-4623 from 8:00 a.m. to 5:00 p.m. (CST) Monday through Friday. A Customer Service Specialist will assist you in understanding the benefits.

Sunflower covers, at a minimum, those core benefits and services specified in our agreement with KanCare and provides covered benefits for eligible persons. Sunflower members may not be charged or balance billed for covered services.

The list below is not an all-inclusive list of covered services. All services are subject to benefit coverage, limitations, and exclusions as described in applicable plan coverage guidelines. In general, all services provided out-of-network (by an out-of-network or non-participating provider) or outside of the service area require prior authorization, excluding emergency room and family planning services. The table below lists the covered benefits for members, and whether the service is covered and paid for by Sunflower. This is not an exhaustive list. It is subject to change from time to time, and is provided herein for quick reference only. Please contact Customer Service with any questions you may have regarding benefits.

This list does not intend to be an all-inclusive list of covered and non-covered benefits. All services are subject to benefit coverage, limitations, and exclusions as described in the plan coverage guidelines. Some services require prior authorization. The participants are not responsible for any cost sharing for covered services.

FOR INFORMATION REGARDING WHICH SERVICES REQUIRE PRIOR AUTHORIZATION, SEE THE MEDICAL MANAGEMENT SECTION OF THIS PROVIDER MANUAL FOR A SUMMARY LISTING, VISIT OUR WEBSITE AT WWW.SUNFLOWERHEALTHPLAN.COM, OR CONTACT CUSTOMER SERVICE AT 1-877-644-4623.

SERVICE	COVERAGE	BENEFIT LIMITATION	COMMENTS
Alternative Medicine	Not Covered	Acupuncture, Christian Science, faith healing, herbal therapy, homeopathy, massage, massage therapy, or naturopathy	

SERVICE	COVERAGE	BENEFIT LIMITATION	COMMENTS
Abortions	Not Covered – See *exception	*Exception – Abortions are covered in the case of rape and incest Otherwise, only covered when participant suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy	Abortion necessity form is required at the time the claim is submitted.
Adult Care Home Services	Covered	Participant must meet certain medical criteria	
Allergy Services (when billed with office visit)	Covered		
Ambulance (Emergency Transportation)	Covered	Ground and Rotary	
Ambulatory Surgery Center	Covered		
Anesthesia Services	Covered		
Audiology Services	Covered		
Bariatric Surgery	Covered	Participant must meet certain medical criteria	
B-12 Injections	Covered	Only covered for specific diagnosis such as Anemia, Crohn's Disease, Malignant and Benign Neoplasms	

SERVICE	COVERAGE	BENEFIT LIMITATION	COMMENTS
Behavioral Health Services	Covered		Benefits managed by Cenpatico Behavioral Health. 1-877-644-4623
Birthing Centers	Covered		
Cardiac Rehabilitation	Covered	Only covered in an outpatient setting. Participant must meet specific medical criteria.	
Chemical Dependency Treatment	Covered		Benefits managed by Cenpatico Behavioral Health. 1-877-644-4623
Chemotherapy	Covered		
Chiropractor Services	Not Covered. – See exception	Chiropractic services are only covered for dual-eligibles	
Circumcisions (Routine/Elective)	Covered		
Cosmetic or Plastic Surgery	Not Covered	Including Tattoo Removal, Face Lifts, Ear or Body Piercing, and Hair Transplants	Any Medically Necessary procedure that could be considered Cosmetic in nature must be prior authorized. See the Medical Management Section of this Manual.
Dental Services	Covered	For participants under 21 (see Value-Added Services table below for coverage for adults)	Benefits managed by Dental Health and Wellness. 1-877-644-4623

SERVICE	COVERAGE	BENEFIT LIMITATION	COMMENTS
Developmental Testing	Covered	1 per day, up to 3 visits per calendar year	
Diabetic Education	Not Covered		
Diagnosis and Treatment of Infertility, Impotence, and Sexual Dysfunction	Not Covered		
Dialysis	Covered		
Dietician Services	Covered	Services are limited to 12 per calendar year for EPSDT members only	
Durable Medical Equipment	Covered		Only the following providers will be reimbursed for the dispensing of DME: DME/medical supply dealers, Pharmacies, Home Health Agencies, Rural Health Clinics (medical supplies only) and Welding Shops (oxygen only)
Early Periodic Screening Diagnosis and Treatment	Covered	For members less than 21 years old	
Emergency Room Services	Covered		
Enteral and Parenteral	Covered	Oral Supplemental Nutrition is limited to KBH members, age 0-20	

SERVICE	COVERAGE	BENEFIT LIMITATION	COMMENTS
Experimental Procedures, Drugs, and Equipment	Not Covered		
Family Planning	Covered		
FQHC and RHC Services	Covered		
Fluoride Application	Covered	Limited to 3 per calendar year for EPSDT only	
Gender Reassignment Surgery	Not Covered		
Hearing Aids/ Hearing Aid Repairs	Covered	Batteries are limited to 6 per month for monaural hearing aids and 12 per month for binaural hearing aids Hearing aids are covered 1 every 4 years	
Hearing Aid Repairs		Charges for hearing aid repairs under $15 are not covered	
Hearing Aids (Bone Anchored)		For Bone Anchored Hearing Aids, the participant must be five to 20 years of age	
HIV Testing and Counseling	Covered		
Home Births	Covered		
Home Healthcare Services	Covered	Some limitations, exclusions, and quantity limits apply	

SERVICE	COVERAGE	BENEFIT LIMITATION	COMMENTS
Hospice Care	Covered	An individual can elect to receive hospice care during one or more of the following election periods: • An initial 90-day period • A subsequent 90-day period • Unlimited subsequent 60-day periods with appropriate physician recertification for continued hospice care	
Hospital Services: Inpatient	Covered		
Hospital Services: Outpatient	Covered		
Hyperbaric Oxygen Therapy	Covered	Only covered for specific diagnosis	
Hysterectomy	Covered	Not covered if performed for an individual for the sole purpose of becoming permanently incapable of reproducing	Please review the Sterilization Services section contained in this Manual in the Women's Healthcare Section.
Laboratory Services – Outpatient	Covered		
Laboratory Services – Inpatient	Covered		
Long Term Care	Covered		
Maternity (OB Routine Ultrasounds)	Covered	2 allowed in 9 months. Prior authorization required for additional u/s unless performed by a perinatologist.	

SERVICE	COVERAGE	BENEFIT LIMITATION	COMMENTS
Maternity Care Services	Covered	Includes: Nurse mid-wife services, Pregnancy related services for conditions that might complicate pregnancy	
Medical Nutrition Therapy	Covered		
Non-Emergency Medical Transportation – (Ambulance)	Covered	Includes transportation for non-ambulatory patients, patient home to hospital or hospital to patient's home, transfers between hospitals	Requires medical necessity.
Non-Medical Equipment	Not Covered		
Outpatient Hospital/ Outpatient Surgery	Covered		
Oxygen and Respiratory Services	Covered	Some limitations, exclusions, and quantity limits may apply	
Pain Management	Covered	Some limitations, exclusions, and quantity limits may apply	
Personal Comfort Items	Not Covered		
Physician and Nurse Practitioner Services	Covered		
Physical Exam Required for Insurance or Licensing	Not Covered		
Physical, Occupational, and Speech Therapy	Covered		

SERVICE	COVERAGE	BENEFIT LIMITATION	COMMENTS
Podiatrist Services	Covered	2 office visits covered per calendar year for members age 20 and under	For EPSDT, additional visits may be provided with prior authorization
Prescription Drugs	Covered		Benefits managed by U.S. Script. 1-877-644-4623
Preventative Care	Covered		
Prosthetic and Orthotic Devices	Covered		
Psychotherapy	Covered		Benefits managed by Cenpatico Behavioral Health. 1-877-644-4623
Psychological Testing	Covered	These services must be performed by and billed by a psychologist who is an enrolled provider	Benefits managed by Cenpatico Behavioral Health. 1-877-644-4623
Radial Keratotomy	Not Covered		
Radiology and X-rays	Covered		
Radiology (High Tech Imaging)	Covered	CT, MRI, MRA	Benefit managed by NIA. www.radmd.com
Reconstructive Surgery After Mastectomy	Covered		
School Based Services	Not Covered		School Based Services are covered through the Fee for Service Program.

SERVICE	COVERAGE	BENEFIT LIMITATION	COMMENTS
School and Employment Physicals	Covered		
Screening and Treatment for STD	Covered		
Services Not Allowed by Federal or State Law	Not Covered		
Sleep Studies	Covered	Covered for EPSDT members when medically necessary. Not covered for individuals 21 and older.	
Sterilization Procedures	Covered	Covered for age 21 and over	Consent form is required with claim submission. A federally mandated consent form is required. Please see the Women's Healthcare Section of this Manual for the location of the form and additional information.
Transplant Service	Covered		
Transportation (Non-Emergency Medical Transportation; i.e., Taxi to Doctor's Visits)	Covered		Transportation benefits managed through LogistiCare. 1-877-644-4623
Urgent Care Services	Covered		

Vision and Eye Exams	Covered	One complete eye exam and one pair of glasses are covered for members 21 years and older each year. Eyeglasses, repairs and exams as needed for members under 21, up to 3 pairs per calendar year.	Benefits administered by OptiCare. 1-877-644-4623

The following services are located in the Long Term Services and Supports (LTSS) section of this manual.

HCBS

- Children with autism spectrum disorders
- Children and adults with Intellectual and/or Developmental Disabilities (I/DD)
- Individuals age 16-64 with Physical Disability (PD)
- Technology Assisted (TA) – Medically fragile children age 0-22
- Individuals age 16-65 with Traumatic Brain Injury (TBI)
- Individuals 65 and older who are Frail Elderly (FE)
- Children with Serious Emotional Disturbance (SED)
- Community-Based Alternatives to Psychiatric Residential Treatment Facility (PRTF) – age 4-18

Early and Periodic Screening, Diagnosis, and Treatment (KAN Be Healthy)

The Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program is Medicaid's comprehensive and preventive child health program for individuals under the age of 21. EPSDT is a mandated benefit for all Medicaid recipients in accordance with State and federal law. EPSDT services include periodic screening, including physical, mental, developmental, dental, hearing, vision, and other screening tests to help identify potential physical and/or behavioral health conditions. In addition, diagnostic testing and medically necessary treatment to correct or improve physical and mental illnesses or conditions are also available through the EPSDT program. EPSDT encourages early and continuing access to healthcare for children and youth.

Sunflower and its providers will provide the full range of EPSDT services as defined and in accordance with Kansas state regulations and KanCare policies and procedures for EPSDT services. Such services shall include, without limitation, periodic health screenings and appropriate up-to-date immunization using the Advisory Committee on Immunization Practices (ACIP) recommended immunization schedule and the American Academy of Pediatrics periodicity schedule for pediatric preventive and well-child care. In accordance with CMS guidelines, there is a separate dental periodicity schedule as well. This includes provision

of all medically necessary services whether specified in the core benefits and services or not, including Positive Behavioral Services. The following minimum elements are to be included in the EPSDT periodic health screening assessment:

a) Comprehensive health and developmental history (including assessment of both physical and mental development)
b) Comprehensive unclothed physical examination
c) Appropriate behavioral health and substance abuse screening
d) Immunizations appropriate to age and health history
e) Laboratory tests
f) Vision screening and services, including at a minimum diagnosis and treatment for defects in vision, including eyeglasses
g) Dental screening and services
h) Hearing screening and services, including at a minimum, diagnosis and treatment for defects in hearing, including hearing aids
i) Health education, counseling, and anticipatory guidance based on age and health history
j) Blood lead testing mandatory at 12 and 24 months or annually if residing in a high-risk area
k) Annual verbal lead assessment beginning at age 6 months and continuing through age 72 months.

All EPSDT screening elements must be performed or ordered for the visit to be considered an EPSDT screening. Providers must clearly document the provision of all components of the EPSDT benefit in the member's medical record.

Below is the Periodicity Schedule and the required components that must be documented.

YEAR 1 OF LIFE							
VISIT TYPE	**BIRTH**	**2-5 DAYS AFTER**	**1 MONTH**	**2 MONTHS**	**4 MONTHS**	**9 MONTHS**	**1 YEAR**
Medical Screen	X	X	X	X	X	X	X
Vision Screen	X	X	X	X	X	X	X
Hearing Screen	X	X	X	X	X	X	X
Dental Screen						x	x

AFTER YEAR 1 OF LIFE					
VISIT TYPE	**15 MONTHS**	**18 MONTHS**	**24 MONTHS**	**30 MONTHS**	**3- 20 YEARS**
Medical Screen	X	X	X	X	X
Vision Screen	X	X	X	X	X
Hearing Screen	X	X	X	X	X
Dental Screen	x	x	x	x	x

The screening form may be found at https://www.kmap-state-ks.us/Public/forms.asp and at SunflowerHealthPlan.com.

Sunflower requires providers to fully cooperate with Sunflower and KanCare's efforts to improve the health status of Kansas citizens and to actively assist to increase the number of eligible members obtaining EPSDT services in accordance with the adopted periodicity schedules. Sunflower will cooperate and assist providers to identify and immunize all members whose medical records do not indicate up-to-date immunizations.

Provider shall participate in the Medicaid Vaccines for Children (VFC) program. Vaccines must be billed with the appropriate administration code and the vaccine detail code.

Emergency Care Services

Definition of Emergency Medical Condition

Emergency Medical Condition is a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following: (i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; (ii) serious impairment to bodily functions; or (iii) serious dysfunction of any bodily organ or part. [42 U.S.C. 1396-u2(b)(2)(C), as amended.]

Sunflower will not limit what constitutes an emergency medical condition on the basis of lists of diagnoses or symptoms; or refuse to cover emergency services based on the emergency room provider, hospital, or fiscal agent not notifying the member's primary care provider, MCO, or applicable State entity of the member's screening and treatment within 10 calendar days of presentation for emergency services.

Members may access emergency services at any time without prior authorization or prior contact with Sunflower. If members are unsure as to the urgency or emergency of the situation, they are encouraged to contact their Primary Care Provider (PCP) and/or Sunflower's 24-hour nurse triage line, NurseWise, at 1-877-644-4623 for assistance. However, this is not a requirement to access emergency services.

Emergency services are covered by Sunflower when furnished by a qualified provider, including non-network providers, and will be covered until the member is stabilized. Any screening examination services conducted to determine whether an emergency medical condition exists will also be covered by Sunflower. The member will not be held liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the patient. Emergency services will be covered and will be reimbursed regardless of whether the provider is in Sunflower's provider network. Sunflower will not deny payment for treatment obtained under either of the following circumstances:

1. A member had an emergency medical condition, including cases in which the absence of immediate medical attention would not have had the outcomes specified in the definition of Emergency Medical Condition; or
2. A representative from the plan instructs the member to seek emergency services.

Once the member's emergency medical condition is stabilized, Sunflower requires notification for hospital admission or prior authorization for follow-up care as noted elsewhere in this manual.

Definition of Maintenance and Post-Stabilization Care: *Post-stabilization care services are defined as*: covered services, related to an emergency medical condition, that are provided after a member is stabilized in order to maintain the stabilized condition or to improve or resolve the member's condition.

Members may access post-stabilization care services obtained within or outside Sunflower's network that are preapproved.

Sunflower will cover post-stabilization care services obtained within or outside Sunflower's network that are not preapproved but administered to maintain the member's stabilized condition within 1 hour of a request to Sunflower for pre-approval of further post-stabilization care services.

Further, Sunflower will cover post-stabilization care services obtained within or outside of Sunflower's network that are not preapproved but are administered to maintain, improve, or resolve the member's stabilized condition if –

(A) Sunflower does not respond to a request for pre-approval within 1 hour;

(B) Sunflower cannot be contacted; or

(C) The Sunflower representative and the treating physician cannot reach an agreement concerning the member's care and a plan physician is not available for consultation. In this situation, Sunflower will give the treating physician the opportunity to consult with a plan physician and the treating physician may continue with care of the patient until a plan physician is reached or one of the criteria described below is met.

Sunflower's financial responsibility for post-stabilization care services if not preapproved ends when:

(i) A plan physician with privileges at the treating hospital assumes responsibility for the member's care;

(ii) A plan physician assumes responsibility for the member's care through transfer;

(iii) A Sunflower representative and the treating physician reach an agreement concerning the member's care; or

(iv) The member is discharged.

Women's Healthcare

"Women's healthcare services" is defined to include, but not be limited to, maternity care, reproductive health services, gynecological care, general examination, and preventive care as medically appropriate, as well as medically appropriate follow-up visits for these services. General examinations, preventive care, and medically appropriate follow-up care are limited to services related to maternity, reproductive health services, gynecological care, or other health services that are particular to women, such as breast examinations. Women's healthcare services also include any appropriate healthcare service for other health problems, discovered and treated during the course of a visit to a women's healthcare practitioner for a women's healthcare service that is within the practitioner's scope of practice. For purposes of determining a woman's right to directly access health services covered by Sunflower, women's healthcare services include routine and preventive care, contraceptive services, testing and treatment for sexually transmitted diseases, pregnancy termination, breast-feeding, and complications of pregnancy. Members may access women's healthcare services from in- or out-of-network practitioners without first obtaining authorization, PCP referral or health plan approval.

Family Planning

Family planning services, including testing, screening, and contraceptives, are covered for all Sunflower members. Members can obtain family planning services through their own PCP or local departments of health, or they can go to any family planning service provider – whether in or out of network – without a referral or prior authorization. Family planning services include examinations, assessments, traditional contraceptive services, preconception, and inter-conception care services. Sunflower will make every effort to contract with all local family planning clinics and providers and will ensure reimbursement whether the provider is in or out of network.

Sterilization Services

For family planning purposes, sterilization shall only be those elective sterilization procedures performed for the purpose of rendering an individual incapable of reproducing.

- At least 30 calendar days but not more than 180 calendar days must have passed between the date of informed consent and the date of the sterilization, except in the case of premature delivery or emergency abdominal surgery.
- A member may consent to be sterilized at the time of a premature delivery or emergency abdominal surgery if at least 72 hours have passed since the member gave informed consent for the sterilization.
- In the case of premature delivery, the informed consent must have been given at least 30 calendar days before the expected date of delivery.
- The member must be at least 21 years old at the time consent is obtained.
- The member must be mentally competent.
- The member must not be institutionalized.

- The member must have voluntarily given informed consent on the approved "Consent for Sterilization," which is available at: https://www.kmap-state-ks.us/Public/forms.asp and at SunflowerHealthPlan.com. This form should be submitted with the claim.
- The "Sterilization Consent Form" must be completed in its entirety. Consent Forms not fully completed may result in delays in claims processing or a denial of the claim.

Obstetrical Care

Sunflower members who are pregnant have direct access to prenatal/maternal (obstetrical) care providers and do not need to obtain a referral from Sunflower or their PCP to seek care from an obstetrical care provider.

Identifying Pregnant Members

Sunflower relies on our providers to inform us of the pregnant members they are treating. Sunflower has developed a Notification of Pregnancy (NOP) process specifically to assist providers in helping us to identify pregnant members. By informing us of the member's pregnancy we can better assist the provider to identify members who might be at risk for complications. We also work to establish a relationship between the member, her obstetrical care provider, and health plan staff as early as possible. We require all providers to notify Sunflower when prenatal care is rendered for the first time. This notification should occur through completion and submission of the Notification of Pregnancy form, which assesses more than 20 obstetric history factors and can be downloaded from our website. Providers can notify us via fax, mail, or telephone as soon as they become aware of a pregnancy. Early notification of pregnancy allows us to assist the member with prenatal care and coordination of services. Pregnant members identified as high risk will be referred to our Maternal Health Integrated Care Team (ICT) for follow-up and management.

Members may also complete the NOP form by calling the Customer Service department. We also encourage our members to notify us when they are pregnant through ongoing educational programs and member outreach efforts (such as member newsletters) to keep members informed about the importance of early prenatal care and the benefits of the Start Smart for Your Baby® Program. Any Medical Management or Customer Service staff person who identifies a pregnant member will help her complete the NOP form. We will use this information to stratify and determine intensity of interventions in coordination with the member's primary obstetrical care provider.

We may also identify pregnant members through other sources including routine review of enrollment information supplied by the State of Kansas and monthly claim reports that indicate pregnancy diagnoses or prenatal vitamin prescriptions. When we identify a member with an unconfirmed pregnancy, we send audio postcards to the member describing our Start Smart Program and encourage them to call our toll-free number if they are pregnant.

Prenatal Care from Out-of-Network Providers

For pregnant members at high risk for complications, particularly those with serious mental illness or developmental disabilities, Sunflower's policy emphasizes the critical importance of early and consistent prenatal and postnatal care for the health of women and their children. We allow out-of-network prenatal and postpartum care to all pregnant members who enroll with Sunflower in their second trimester of pregnancy, offering them the option to remain with their out-of-network obstetrical care provider for the duration of their pregnancy and postpartum care. Additionally, we do not require medical necessity review for prenatal or postpartum care.

High-Risk Pregnancy Program

Sunflower establishes a Maternal Health Integrated Care Team (ICT) for all identified high-risk pregnancies. Integrated Care Teams for high-risk obstetrical cases consist of health plan clinical staff members, such as the Medical Director and qualified care management, disease management, and other clinical staff, along with Health Coaches and the Pharmacy Director, as needed. The ICT meets weekly to review complex cases and develop care approaches in coordination with the member's healthcare provider(s) to effectively address the unique needs of members with high-risk, complex, or chronic disease conditions. A care manager with obstetrical nursing experience will serve as the lead care manager for members at high risk of early delivery or who experience complications from pregnancy. An experienced neonatal nurse will be the lead care manager for newborns being discharged from the NICU unit and will follow them through the first year of life when they remain members. Physician oversight is provided to advise the ICT on overcoming obstacles, helping identify high-risk members, and recommending interventions.

Home Monitoring for High-Risk Pregnancies

Sunflower partners with qualified home health service providers specializing in maternal and fetal care to augment our Start Smart program with home monitoring for certain high-risk members, including those who live in rural areas and are discharged with orders for home health services. Our specialized maternal and fetal care home health providers offer preterm labor management programs including provision of 17-P, hypertension management, gestational diabetes, coagulation disorder management, and hyperemesis management. They also provide fetal surveillance services that may include, but are not limited to, clinical surveillance of medications, patient education, home and telephonic assessment, home uterine monitoring, 24/7 nursing, and pharmacist support. Our maternal and fetal home health providers also provide a nurse to conduct home monitoring visits for identified high-risk members at intervals dictated by the patient's unique risk factors and health condition. The home health nurse will report monitoring results, including whether home health services are meeting the patient's needs, to the primary obstetrical care provider within 24 hours of the visit. The home health nurse also will provide updates to the Sunflower ICT as dictated by the member's condition and needs.

Value Added Services for Members

NurseWise® – 24/7 Nurse Advice Line

Our members have many questions about their health, their primary care provider, and access to emergency care. Therefore, we offer NurseWise, a nurse advice line, to help members proactively manage their health needs, decide on the most appropriate care, and encourage members to talk with their physician about preventive care. We provide this service to support your practice and offer our members access to a registered nurse at any time – day or night. The toll-free telephone number for NurseWise is 1-877-644-4623.

NurseWise is always open and always available for members. Registered nurses provide basic health education and nurse triage, and they answer questions about urgent or emergency access. Nursing staff members often answer basic health questions but are also available to triage more complex health issues using nationally recognized protocols. NurseWise will refer members with chronic problems, like asthma or diabetes, to our Case Management or Customer Service departments for follow-up assistance, education, and encouragement to improve their health. Members can call NurseWise to request information about providers and services available in the community after hours, when the Sunflower Customer Service department is closed. The NurseWise staff is proficient in both English and Spanish and can provide additional translation services if necessary.

CentAccount® Program

The Sunflower CentAccount Healthy Rewards program is a member incentive program widely used to promote personal healthcare responsibility. CentAccount is designed to increase appropriate utilization of preventive services by rewarding members for practicing a targeted healthy behavior, such as obtaining preventive health services on a regular basis. CentAccount® rewards members with credits to purchase healthcare and personal items, such as over-the-counter medications that they might otherwise not be able to afford. Members can earn rewards for completing annual preventive health visits and other recommended preventive health and chronic disease care screening, such as appropriate diabetes testing. When a member completes a qualifying activity, we load the reward onto a health plan–issued CentAccount card. Members can use the card with participating merchants they already use every day. Our CentAccount program supports the positions taken by the American College of Physicians for ethical use of incentives to promote personal responsibility for health.

HEALTH ACTIVITY	REWARD
Adult Well Visit – age 21 and older	$10 and an additional $10 for new members who see their PCP in the first 90 days
Child Well Visit age 2-20	$10
Infant Well Visit – All 6 visits completed with a PCP in first 15 months	$10 per infant well visit for a total of $60
Cervical Cancer Screening age 21-64	$10 per annual screening
Diabetes Management – have 1 or 2 HbA1c lab draws to earn $20 for each. You can earn a maximum of $40 per year. **To earn an additional $50, get A1C, LDL, kidney screening, and eye screening); must have all 4 screenings in a year. Member can earn $90 for these healthy behaviors**	·$20 HbA1c with max of 2 per year for total of $40 ·$50 if all 4 services are met in addition to the HbA1c ·member can earn $90 total
Notice of Pregnancy to Sunflower in the first trimester	$15
Prenatal Visit: 3rd, 6th, and 9th (each visit at $15)	$45
After baby delivery: Follow-Up Visit	$10

Rewards for EPSDT and Wellness Screenings are based on HEDIS criteria

MemberConnections®

MemberConnections is Sunflower's member outreach program designed to provide education to our members on how to access healthcare and develop healthy lifestyles in a setting where they feel most comfortable. The program components are integrated as a part of our case management program in order to link Sunflower and the community served. The program recruits staff from the local community being served in order to establish grassroots support and awareness of Sunflower within that community. The program has various components that can be provided depending on the need of the member.

Members can be referred to memberConnections through numerous sources. Members who phone Sunflower to talk with Sunflower Customer Service may be referred for more personalized discussion on the topic they are inquiring about. Case managers may identify members who would benefit from one of the many memberConnections components and complete a referral request. Providers may request memberConnections referrals directly to the Connections Representative or their assigned case manager.

Community groups may request that a Connections representative come to their facility to present to groups they have established or at special events or gatherings. Various components of the program are described below.

Start Smart for Your Baby®

Start Smart for Your Baby

Any pregnant member is eligible to participate in our Start Smart for Your Baby (Start Smart) pregnancy program, which provides education and clinical support to members and is available regardless of whether or not the pregnant member's obstetrical care provider is in or out of network. Start Smart is a unique perinatal program that follows women for up to one year after delivery and includes newborns up to one year of age. The program improves maternal and child health outcomes by providing pregnancy and parenting education to all pregnant members and care management to high- and moderate-risk members. Start Smart uses a range of innovative techniques, including health screenings, educational literature, and MP3 players with educational podcasts designed to encourage healthy pregnancies. We ask members who participate in Start Smart to opt in to receive text messages (at no cost) related to healthy prenatal care. This has proven to be an effective communication venue between the health plan and the member that has led to better patient compliance.

For obstetrical care providers, Start Smart assists with the use of newer preventive treatments such as **17 alpha-hydroxyprogesterone caproate (17-P)** for members with a history of spontaneous preterm delivery at less than 37 weeks gestation and current pregnancy between 16-28 weeks gestation (confirmed by ultrasound with no known major fetal anomaly). When a physician determines that a member is a candidate for 17-P, he/she will write a prescription. This prescription is sent to the Sunflower case manager, who will check for eligibility. As needed, the case manager may coordinate the ordering and delivery of 17-P directly to the physician's office. A prenatal case manager will contact the member and conduct an assessment regarding compliance. The nurse will remain in contact with the member and the prescribing physician during the entire treatment period. Providers are encouraged to contact our Maternal Health (ICT) department for enrollment in the 17-P program.

Also, Start Smart offers an enhanced breast-feeding educational program for members. For more information about the Sunflower Start Smart program, please contact Customer Service at 1-877-644-4623 or your dedicated Provider Relations Specialist.

SafeLink® and Connections Plus®

SafeLink and Connections Plus is a part of the memberConnections program that provides free cell phones to select high-risk members, as identified by our case management team, who do not have safe, reliable access to a telephone. Through our SafeLink and Connections Plus program, we provide restricted-use cell phones to certain high-risk members who have serious mental illness or have other chronic and complex needs. We pre-program the phones with important telephone numbers, such as their PCP office number, other treating physicians, Sunflower contact numbers, the nurse advice line, and 911. By ensuring a member has reliable phone access, we provide them with the means to contact key individuals on their healthcare team and empower them to accept more personal accountability for their healthcare needs.

Telemonitoring

Sunflower will provide telemonitoring services to the highest-risk members (with multiple co-morbidities), for whom intensive monitoring is necessary and the condition is amenable to telemonitoring. This patent-pending FDA-approved technology is "device-agnostic", interfacing with virtually any medical home monitoring device via wireless or wired modem utilizing land line, cellular (including a ConnectionsPlus phone) or VOIP communication links. Within seconds of a reading being taken in the home, the value – such as blood glucose level for a diabetic or a blood pressure or weight for a member with congestive heart failure – is transmitted electronically to the member's case manager and evaluated against patient-specific or national guidelines and analyzed for favorable or unfavorable trends. The system can then be set at the member level to alert the case manager, trigger an Interactive Voice Response phone call to the member, and/or alert other members of the Integrated Care Team (ICT) or the member's provider. The technology is entirely web-enabled; all members are provided a login card that enables them, their family, or their physician to access their biometric information from anywhere in the world at any time, as long as they have access to the Internet.

Escorts – Members with SPMI and/or DD

Sunflower will pay for an escort to accompany members with serious and persistent mental illness and/or significant developmental disability to visits with their primary care or other medical or behavioral health provider. Escorts may be group home workers (if the member is living in a group home) or personal care attendants for members living at home with family. Healthcare Visit Escorts enable members who may lack adequate support to attend appointments independently and get personalized assistance and behavioral health and medical care that meets their needs.

Below is a table identifying additional value-added services offered by Sunflower Health Plan.

SUNFLOWER VALUE-ADDED SERVICES
Dental visits for adults 21 and older – one dental checkup every six months
Members can earn rewards on our CentAccount card when they get health checkups and screenings. Members can earn $10-$50 or more in CentAccount rewards.
SafeLink® and Connections Plus are programs that provide a free cell phone to members. SafeLink® provides up to 250 free minutes of service per month, with free calls to and from Sunflower Health Plan. Members will be able to have telephone access to their healthcare providers.
Start Smart for Your Baby gives support and education for moms, babies, and families. The program includes the services below. There is no cost to members. • Start Smart home visits for new mothers • Start Smart baby showers for pregnant mothers • Start Smart birthday programs for children

Community Programs for Healthy Children: Sunflower offers free services to promote healthy lifestyles for kids, such as membership fees to Boys & Girls Clubs and the Adopt-a-School Program.
We provide members of certain waiver populations with a medical escort if needed. We also provide practice visits to OBGYNs and dentists for members with developmental disabilities to help them become more comfortable with preventive care visits.
Sunflower provides hands-on education and outreach to local community schools through its Healthy Lifestyles, Adopt-a-School and Reading programs.
Members can participate in a smoking cessation program, including www.kanquit.com, or they can have a referral by their Primary Care Physician or Case Manager to be eligible for Sunflower's smoking cessation program offered through ***Healthy Solutions for Life***.
In-home telemonitoring is available for adults only. This service helps members to be more independent, have access to providers, and monitor their long-term health conditions from their home. This service is offered to members needing help managing their chronic heart failure, heart diseases, or high blood pressure.
Our MyStrength online program offers eLearning to help members overcome depression and anxiety with simple tools, weekly exercises, mood trackers, and daily inspirational quotes and videos in a safe and confidential environment. The program may be used independently or in conjunction with other care.
We offer medication review and coordination to ensure safe and appropriate prescribing practices for members living in foster care and/or living with intellectual developmental disabilities.
We provide additional respite for caregivers. We provide up to 8 hours a year of respite for caregivers of persons who receive F/E waiver services. We also provide up to 50 hours for respite care or hospital companionship for those on the DD waiver.
Our Choose Health program targets members with chronic health conditions to determine how emotions can impact their condition (i.e., stress, poor sleep, change in appetite). As a part of the program, participants are assigned a Choose Health coach who works with the entire healthcare team to ensure members have everything they need to feel their best.
We provide targeted disease management to at-risk members for the following diseases under the **Healthy Solutions for Life Program:** Asthma (adults and children); COPD (adults); Diabetes (adults and children); Heart Disease (CAD) (adults); Hypertension (adults); Weight Management (adults).(Members may be referred by their physician, referred by the health plan, or self-enrolled in any of these programs.) Note: Adults are classified as 18 years and older.

Medical Management

Overview

Medical Management hours of operation are Monday through Friday from 8:00 a.m. to 5:00 p.m., CST (excluding holidays). Calls made to our Medical Management department after normal business hours and on weekends are automatically routed to Sunflower's after-hours nurse advice line, NurseWise.

NurseWise staff are Registered Nurses who can answer questions about prior authorization requirements and offer guidance to members regarding urgent and emergent needs. Medical Management services include the areas of utilization management, care management, disease management, and quality review. The department clinical services are overseen by the Sunflower Medical Director. The VP of Medical Management has responsibility for direct supervision and operation of the department. To reach the Medical Director or VP of Medical Management contact:

Sunflower Medical Management Department
1-877-644-4623, SunflowerHealthPlan.com

Utilization Management

The Sunflower Utilization Management (UM) program is designed to ensure members receive access to the right care, at the right place and right time. Our program is comprehensive and applies to all eligible members across all product types, age categories, and range of diagnoses. The UM program incorporates all care settings, including preventive care, emergency care, primary care, specialty care, acute care, short-term care, and ancillary care services.

Our UM initiatives are focused on optimizing each member's health status, sense of well-being, productivity, and access to quality healthcare, while at the same time actively managing cost trends. The UM program aims to provide covered services that are medically necessary, appropriate to the patient's condition, rendered in the appropriate setting, and meet professionally recognized standards of care.

Our UM program goals include:

- Monitoring utilization patterns to guard against over- or under-utilization
- Development and distribution of clinical practice guidelines to providers to promote improved clinical outcomes and satisfaction
- Identification and provision of care and/or disease management for members at risk for significant health expenses or ongoing care

- Development of an infrastructure to ensure that all Sunflower members establish a relationship with their PCP to obtain preventive care
- Implementation of programs that encourage preventive services and chronic condition self-management
- Creation of partnerships with members/providers to enhance cooperation and support for UM goals

Prior Authorization and Notifications

Prior authorization (PA) is a request to the Sunflower Utilization Management (UM) department for approval of certain services before the service is rendered. Authorization must be obtained prior to the delivery of certain elective and scheduled services. **Prior authorization should be requested at least five business days before the scheduled service delivery date or as soon as the need for service is identified.**

Most services that require Sunflower's authorization are listed in the following table. Our website offers a pre-screen tool that provides authorization requirements at the billing code level. (Please see further in this manual for authorization requirements related to retroactive eligibility and for home and outpatient physical, occupational, and speech therapy.)

Example of Services Requiring Prior Authorization at Sunflower Health Plan
Use Sunflower's Prior Authorization Pre-Screening Tool Online at SunflowerHealthPlan.com

ANCILLARY SERVICES
✓ Air-ambulance transport (non-emergent fixed-wing airplane)
✓ Certain bio-pharmaceuticals and specialty injections (please refer to website for complete list)
✓ To find out which DME/Orthotics/Prosthetics require prior authorizations, use Sunflower's "Prior-Auth Needed?" Tool online at SunflowerHealthPlan.com
✓ Home healthcare services including home hospice, home infusion, skilled nursing, personal care services, and therapy
✓ Therapy (ongoing home or outpatient services) – occupational, physical, and speech
✓ Cochlear implants
✓ Genetic testing
✓ Quantitative urine drug testing

Sunflower Health Plan will administratively deny coverage of services when notification requirements are not met. Hospitals serving Sunflower members are to notify the health plan within one business day (by 5 p.m. CST) of patient admission.

HOME AND COMMUNITY BASED SERVICES (HCBS):

- ✓ Adult day care
- ✓ Assistive services
- ✓ Attendant care
- ✓ Emergency alert systems
- ✓ Habilitation
- ✓ Home-delivered meals
- ✓ Home health services
- ✓ Homemaker services
- ✓ Home modifications
- ✓ Personal care
- ✓ Respite and group respite care
- ✓ Specialized medical care
- ✓ Supported employment
- ✓ Transitional living services
- ✓ Wellness monitoring

Inpatient Authorization all observation stays after the second day, Urgent/Emergent admission require notification within *1 business day* (by 5 p.m. CST) following date of admission. Newborn deliveries must include birth outcomes.

All elective/scheduled admission notifications at least *five business days* prior to the scheduled date of admission including:

- ✓ Medical inpatient
- ✓ All services performed in out-of-network facility
- ✓ Hospice care
- ✓ Rehabilitation facilities
- ✓ Skilled nursing facility
- ✓ Transplants, including evaluation
- ✓ Nursing facilities – custodial stay
- ✓ Acute medical detoxification
- ✓ Assisted living facility
- ✓ Head injury rehab facility

PROCEDURES/SERVICES
✓ All procedures and services performed by **out-of-network providers** (except ER, urgent care, and family planning) ✓ Potentially cosmetic including but not limited to: blepharoplasty, mammoplasty, otoplasty, rhinoplasty, septoplasty, varicose vein procedures, reconstructive or plastic surgery ✓ Bariatric surgery ✓ Experimental or investigational ✓ High tech imaging (i.e., CT, MRI, – administered by NIA) ✓ Obstetrical ultrasound: 2 allowed in 9 months **Prior authorization required for additional u/s** except if rendered by a perinatologist ✓ Oral surgery that is potentially cosmetic ✓ Pain management

Emergency room and post-stabilization services do not require prior authorization. Providers should notify Sunflower of post-stabilization services including, but not limited to, the weekend or holiday provision of home health, durable medical equipment, or urgent outpatient surgery, within one business day of the service initiation. **Providers should notify Sunflower of emergent inpatient admissions within one business day** of the admission for medical necessity review and ongoing concurrent review and discharge planning. Maternity admissions require notification and information on the delivery outcome. Clinical information is required for ongoing care authorization of the service.

The PCP should contact the UM department via fax, the Sunflower website, or telephone with appropriate supporting clinical information to request an authorization. The NPI number that will be submitted on the claim should be the NPI number utilized when requesting an authorization. All out-of-network services require prior authorization (excluding emergency care) from Sunflower.

Sunflower Medical Management/Prior Authorization Department
Phone: 1-877-644-4623
SunflowerHealthPlan.com

Prior authorization requests may also be made electronically following the ANSI X 12N 278 transaction code specifications. For more information on conducting these transactions electronically, contact:

Sunflower
c/o Centene EDI Department
1-800-225-2573, extension 25525
Or by e-mail at: EDIBA@centene.com

Radiology and Diagnostic Imaging Services

As part of a continued commitment to further improve the quality of advanced imaging and radiology services, Sunflower is using National Imaging Associates (NIA) to provide prior authorization services and utilization. NIA focuses on radiation awareness designed to assist providers in managing imaging services in the safest and most effective way possible.

Prior authorization is required for the following outpatient radiology procedures:

- CT/CTA/CCTA
- MRI/MRA

Key provisions:

- Emergency room, observation, and inpatient imaging procedures do not require authorization.
- It is the responsibility of the ***ordering*** physician to obtain authorization.
- Providers rendering the above services should verify that the necessary authorization has been obtained. Failure to do so may result in claim non-payment.

NIA provides an interactive website (www.RadMD.com), which should be used to obtain online authorizations. For urgent authorization requests please call 1-877-644-4623 and follow the prompt for radiology authorizations. For more information call our Customer Service department.

Specialty Therapy and Rehabilitation Services (STRS)

Sunflower offers our members access to all covered, medically necessary outpatient and home-based physical, occupational, and speech therapy services through its subcontractor, Cenpatico STRS.

Prior authorization is required for outpatient and home-based occupational, physical or speech therapy services. Prior authorization requests should be submitted using the Outpatient Treatment Request (OTR) form and sent via fax to Cenpatico STRS. The OTR form can be located on Cenpatico's website atCenpatico.com or on Sunflower's website at SunflowerHealthPlan.com.

Cenpatico STRS Outpatient Therapies Prior Authorization
Fax number 1-866-264-4452

Providers can also submit authorization online on the Sunflower website at SunflowerHealthPlan.com.

All therapy prior authorization requests should include the following documents:

- Outpatient Treatment Request
- A Plan of Care (POC); Specific requirements are as follows:
  - Home Health: Must be updated and signed every 60 days
  - EPSDT: Must be updated and signed every 6 months
  - If POC is out of date, new POC is required for authorization
- Physician prescription or physician-signed POC

Cenpatico STRS created and applies medical necessity criteria developed using Clinical Practice Guidelines of the physical, occupational, and speech professional associations, as well as InterQual criteria for both adults and pediatrics guidelines. The criteria can be found on the Cenpatico website at: Cenpatico.com. Cenpatico STRS utilizes occupational, physical, and speech therapists to process Outpatient Treatment Requests. Our specialized approach allows for real-time interaction with the provider to best meet the overall therapeutic needs of the members.

In the event that the practitioner is unable to provide timely access for a member, Cenpatico will assist in securing authorization to a practitioner to meet the member's needs in a timely manner.

STRS Outpatient Treatment Request (OTR)

When requesting sessions for outpatient and home-based therapy services that require authorization, the provider must complete an Outpatient Treatment Request (OTR) form and submit the completed form to Cenpatico for clinical review prior to provision of services. The OTR can be found at Cenpatico.com or SunflowerHealthPlan.com. Providers may call the Customer Service department at 1-877-644-4623 to check the status of an OTR.

IMPORTANT:

- The OTR must be completed in its entirety. Failure to submit a completed request will result in an upfront rejection and the request will not be processed. Incomplete submissions include:
  - Name of provider is missing/illegible
  - Contact name was not provided and/or is illegible
  - Eligibility cannot be verified for the member with the information provided
  - MD signature on prescription or Plan of Care is missing, outdated, or stamped (must be actual or electronic signature)
  - Documentation of Verbal Order is missing or out-of-date (not required if there is a prescription)
  - Plan of Care or Evaluation missing or out of date
  - An authorization for the same service has already been issued to a different provider
- For Plans of Care (POC), the specific requirements are as follows:
  - Home Health: Must be updated and signed every 60 days
  - EPSDT: Must be updated and signed every 6 months

- Physician prescription or physician-signed POC must be included in submission
    - Cenpatico will not retroactively certify routine sessions. Exceptions:
        - member did not have their Medicaid card or otherwise indicate Medicaid coverage (providers should check eligibility every 30 days)
        - Services authorized by another payer who subsequently determined member was not eligible at the time of services
        - member received retro-eligibility from Department of Medicaid Services
        - member has a primary insurance that denied claim payment for non-administrative reasons
    - The dates of the authorization request must correspond to the dates of expected sessions. Treatment must occur within the dates of the authorization.
    - Cenpatico's utilization management decisions are based on Cenpatico's established medical necessity Guidelines. Cenpatico does not reimburse for unauthorized services, and each Provider Agreement precludes network providers from balance billing (billing a member directly) for covered services. Cenpatico's authorization of covered services is an indication of medical necessity, not a confirmation of member eligibility and not a guarantee of payment.

Authorization Determination Timelines

Sunflower decisions are made as expeditiously as the member's health condition requires. For standard service authorizations, the decision and notification will be made within 14 calendar days from receipt. Sunflower may extend the timeline by up to 14 calendar days if the extension is requested by the member or provider or if Sunflower justifies to the State agency, upon request, a need for additional information and how the extension is in the member's interest. "Necessary information" includes the results of any face-to-face clinical evaluation (including diagnostic testing) or second opinion that may be required. Failure to submit necessary clinical information can result in a denial of the requested service. For urgent/expedited prior authorization requests, a decision and notification is made within 72 hours of the receipt of the request. Sunflower may extend the timeline by up to 14 calendar days if an extension is requested by the member or provider or if Sunflower justifies to the State agency, upon request, a need for additional information and how the extension is in the member's interest. For urgent concurrent review of ongoing inpatient admission, decisions are made within 24 hours of receipt of the request. Written or electronic notification includes the number of days of service approved and the next review date.

Second Opinion

Members or a healthcare professional with the member's consent may request and receive a second opinion from a qualified professional within the Sunflower network. If there is not an appropriate provider to render the second opinion within the network, the member may obtain the second opinion from an out-of-network provider at no cost to the member. Out-of-network providers must obtain prior authorization from Sunflower for second opinions.

Clinical Information Needed for Prior Authorization Requests

Authorization requests may be submitted by fax, phone, or secure web portal. Authorization determinations may be communicated to the provider by fax, phone, secure e-mail, or secure web portal. Adverse determinations will be followed up in writing. For all services on the prior authorization list, documentation supporting medical necessity will be required.

Sunflower clinical staff request clinical information minimally necessary for clinical decision making. All clinical information is collected according to federal and state regulations regarding the confidentiality of medical information. Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Sunflower is entitled to request and receive protected health information (PHI) for purposes of treatment, payment, and healthcare operations, with the authorization of the member.

Information necessary for authorization of covered services may include but is not limited to:

- member's name, date of birth, and Sunflower or Medicaid ID number
- Provider's name and telephone number
- Facility name, if the request is for an inpatient admission or outpatient facility services
- Provider location if the request is for an ambulatory or office procedure
- Reason for the authorization request (e.g., primary and secondary diagnosis, planned surgical procedures, surgery date)
- Relevant clinical information (e.g., past/proposed treatment plan, surgical procedure, and diagnostic procedures to support the appropriateness and level of service proposed)
- Admission date or proposed surgery date, if the request is for a surgical procedure
- Discharge plans
- For obstetrical admissions, the date and method of delivery, estimated date of confinement, and information related to the newborn or neonate

If additional clinical information is required, a nurse or medical service representative will notify the caller of the specific information needed to complete the authorization process.

Clinical Decisions

Sunflower affirms that utilization management decision making is based on appropriateness of care and service and the existence of coverage. Sunflower does not reward practitioners or other individuals for issuing denials of service or care.

Delegated providers must ensure that compensation to individuals or entities that conduct utilization management activities is not structured so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any member.

The treating physician, in conjunction with the member, is responsible for making all clinical decisions regarding the care and treatment of the member. The PCP, in consultation with the Sunflower Medical Director, is responsible for making utilization management (UM) decisions in accordance with the member's plan of covered benefits and established medical necessity criteria. Failure to obtain authorization for services that require plan approval may result in payment denials.

Lock-In

The Administrative Lock-In program is designed to help members get consistent care from providers in the Sunflower Health Plan network who know the member's specific needs. Members are identified for the lock-in program through utilization analysis, provider referrals, and various other referral sources. Referrals to the Lock-In program are reviewed by Sunflower's Lock-In Committee to determine if the member should be placed in lock-in.

Lock-In is a program provided by Sunflower Health Plan, based on analysis of utilization of the member, or by referral of a member by the practitioner or anonymous person, with the intention to identify members who are utilizing services and products above the benchmark rates as established and defined by the regulations of the State of Kansas. Sunflower's Lock-In policy is available upon request.

- To identify if a member is in active lock-in, providers may call Sunflower Health Plan at 1-877-644-4623 to determine the status of the member.
- If a provider has reason to believe a Sunflower member is over-utilizing or misusing their Medicaid benefits, providers may make an anonymous or known referral to Sunflower Health Plan by phone, mail, fax, or e-mail. When making a referral, please include the member's name, date of birth, and Medicaid ID number.
- To make a referral by phone or for questions about the Lock-in program, providers may call 1-877-644-4623.
- To make a referral by fax, send your request to Sunflower Health Plan, Attn: Pharmacy Department Lock-In Coordinator, Fax: 1-888-453-4756.
- E-mail referrals can be sent to pharmacy@sunflowerhealthplan.com
- Mailed referrals can be sent to Sunflower Health Plan, Attn: Pharmacy Department Lock-In Coordinator, 8325 Lenexa Drive, Suite 200, Lenexa, KS 66214.

Pharmacy Services

Sunflower Health Plan provides pharmacy benefits through its Pharmacy Benefits Manager, US Script.

Sunflower adheres to the State of Kansas Preferred Drug List (PDL) to determine medications that are covered under the Sunflower pharmacy benefit, as well as which medications may require prior authorization.

Medical Necessity

Medical necessity means that a health intervention in an otherwise covered category of service, is not specifically excluded from coverage, and is medically necessary, according to all of the following criteria:

1. Authority – The health intervention is recommended by the treating physician and is determined to be necessary
2. Purpose – The health intervention has the purpose of treating a medical condition
3. Scope – The health intervention provides the most appropriate supply or level of service, considering potential benefits and harms to the patient
4. Evidence – The health intervention is known to be effective in improving health outcomes. For new interventions, effectiveness shall be determined by scientific evidence
5. Value – The health intervention is cost-effective for the condition compared to alternative interventions, including no intervention. Cost-effective shall not necessarily be construed to mean lowest price

Personal care services on HCBS programs are medical, therapeutic, social, or rehabilitative-related services in the home or community for members with chronic or stable conditions, and are considered medically necessary when all of the following criteria are met:

1. The services must be medically oriented and required to meet the member's personal physical needs, including activities of daily living.
2. The services must include the performance of direct care and cannot consist solely of oversight or supervision.
3. The services must maintain or increase the functional capability of the member.
4. The services must be provided by a qualified individual who is not a spouse or legal representative unless approved under exception by the plan.
5. The services cannot be met by other available resources.
6. The services enable the member to remain in his or her home rather than in a hospital or nursing facility.
7. In the case of children, the services must be reasonable and necessary for health maintenance and enhancement of quality of life.

Sunflower will cover services related to the following:

1. The prevention, diagnosis, and treatment of health impairments
2. The ability to achieve age-appropriate growth and development
3. The ability to attain, maintain, or regain functional capacity

For nursing facilities, an initial authorization for three months may be granted with re-review for medical necessity and to ensure that the medical care is appropriate for the member.

Utilization Review Criteria

Sunflower has adopted utilization review criteria developed by McKesson InterQual® products to determine medical necessity for healthcare services. InterQual appropriateness criteria are developed by specialists representing a national panel from community-based and academic practices. InterQual criteria cover medical and surgical admissions, outpatient procedures, referrals to specialists, and ancillary services. Criteria are established and periodically evaluated and updated with appropriate involvement from physicians. InterQual is utilized as a screening guide and is not intended to be a substitute for practitioner judgment. The Medical Director, or other healthcare professional that has appropriate clinical expertise in treating the member's condition or disease, reviews all potential adverse determination and will make a decision in accordance with currently accepted medical or healthcare practices, taking into account special circumstances of each case that may require deviation from the norm in the screening criteria.

- The Medical Director may be contacted by calling the Sunflower main toll-free phone number and requesting a peer-to-peer with the Medical Director from the Medical Management department. Information on the appeal process for members and providers are included in the Member Appeal or Provider Appeal/Claim Dispute sections of this manual.

Medical and Behavioral Health Services – Sunflower will use McKesson's **InterQual** adult and pediatric guidelines for the following categories:

- Acute Observation and Inpatient Care
- Chiropractic
- Durable Medical Equipment (DME)
- Home Healthcare
- Mental Health Services
- Procedures
- Rehabilitation
- Subacute and Skilled Nursing Facility

We will provide written criteria related to specific determinations to the member or provider upon request as our license to use InterQual criteria will not permit distribution of all criteria to all providers.

High Tech Imaging – Sunflower will use an internally developed criteria set to determine medical necessity of CT scan or MRI/MRA, as developed by National Imaging Associates (NIA), our high technology imaging subcontractor. NIA is committed to the philosophy of supporting safe and effective treatment for patients. The medical necessity criteria that follow are guidelines for the provision of diagnostic imaging. These criteria are designed to guide both providers and reviewers to the most appropriate diagnostic tests based on a patient's unique circumstances. In all cases, clinical judgment consistent with the standards of good medical practice will be used when applying the guidelines. Guideline determinations are made based on the information provided at the time of the request. It is expected that medical necessity decisions may change as new information is provided or based on unique aspects of the patient's condition. The treating clinician has final authority and responsibility for treatment decisions regarding the care of the patient.

NIA has developed these criteria for the purpose of making clinical review determinations for requests for diagnostic tests. The developers of the criteria sets included representatives from the disciplines of radiology, internal medicine, nursing, and cardiology. They were developed following a literature search pertaining to established clinical guidelines and accepted diagnostic imaging practices. These criteria are available on NIA's public website, www.radmd.com.

Outpatient Rehabilitative Therapies – Sunflower will use an internally developed criteria set to determine medical necessity including scope, frequency, and duration of outpatient and home health rehabilitative therapies that encompass occupational therapy, physical therapy, and speech therapy. These criteria are an accumulation of recommendations found in several nationally recognized clinical practice guideline sources as listed below and have been reviewed and approved by the Cenpatico Quality Improvement Committee. The criteria will also be submitted to the Sunflower Utilization Review and Quality Improvement Committees for review and approval by physicians practicing in Kansas, prior to implementation of said criteria.

MODALITY	GUIDELINES
Occupational Therapy	• Standards of Practice, the American Occupational Therapy Association. • Clark GF. Guidelines for documentation of occupational therapy (2003). Am J Occupational Therapy. 2003 Nov-Dec; 57(6):646-9.
Physical Therapy	• The American Physical Therapy Association (APTA), Criteria for Standards of Practice for Physical Therapy (2009). • The American Physical Therapy Association (APTA), Guidelines: Physical Therapy Documentation of Patient/Client Management (2009).
	• Standards for Appropriateness of Physical Therapy Care Prepared by the WSPTA Delivery of Care Committee Board Approved 9/26/98; Revised and Board Approved 10/00 • World Confederation for Physical Therapy, Position Statement: Standards of Physical Therapy Practice (2007).
Speech Therapy	• American Speech Language Hearing Association, Medical Review Guidelines for Speech-Language Pathology Services (2001).

Substance Abuse Criteria – Sunflower will use the Kansas Client Placement Criteria (KCPC) based on the American Society for Addiction Medicine (ASAM) Patient Placement Criteria as required in the contract. The KCPC is an outcome-oriented and results-based placement criteria for care in the treatment of addiction. Cenpatico, our behavioral health and substance abuse management affiliate, has extensive experience in using ASAM criteria for placement, continued stay, and discharge of patients with addictive disorders.

Physician Peer-to-Peer (P2P)

Medical directors in Sunflower's Medical Affairs and Medical Management departments may conduct a peer-to-peer review with providers following a denied request for KanCare services. A peer-to-peer (P2P) can be conducted with Primary Care Physicians (Physicians, Nurse Practitioners, and Attending/Hospitalist Physicians) or Specialists. These professionals may delegate their peer-to-peer rights to a Resident Physician (except standing contract with specific hospital(s) that allows Residents to have primary peer-to-peer rights), Registered Nurse, Physician Assistant, or a licensed ancillary healthcare professional. A licensed ancillary healthcare professional includes the following: Occupational Therapists, Physical Therapists, Speech Therapists, and Audiologists.

Benefit Determination: New Technology

New/Emerging Technologies. The **Clinical Policy Committee** (CPC) of Centene Corporation, Sunflower's parent company, which includes Medical Directors from each Centene health plan, develops medical necessity criteria in the form of clinical policies for a number of services that do not have InterQual guidelines or if local practice does not align with InterQual. The CPC reviews sources including, but not limited to, scientific literature, government agencies such as Centers for Medicare and Medicaid Services (Coverage Determinations and other policies), specialty societies, and input from relevant specialists with expertise in the technology or procedure. Sunflower will also use **Hayes Technology Assessments** to evaluate new technology. Sunflower's Chief Medical Director (CMD) will participate in the CPC and submit guideline development requests to Centene's Chief Medical Officer. The CPC will develop or revise criteria based on a new technology or procedure, a new use for existing technology, or a negative trend in length of stay or utilization. The Sunflower CMD will work with the CPC and KDADS to ensure guidelines address Kansas requirements and the needs of our members. Sunflower will also conduct a comparative review of our UM guidelines and clinical practice guidelines to ensure consistency between the guidelines.

If you need a new technology benefit determination or have an individual case review for new technology, please contact the Medical Management department at 1-877-644-4623.

Concurrent Review and Discharge Planning

Nurse Care Managers perform ongoing concurrent review for inpatient admissions through onsite or telephonic methods through contact with the hospital's Utilization and Discharge Planning departments and, when necessary, with the member's attending physician. The Care Manager will review the member's current status, treatment plan, and any results of diagnostic testing or procedures to determine ongoing medical necessity and appropriate level of care. Concurrent review decisions will be made within 24 hours of receipt of the request. Written or electronic notification includes the number of days of service approved and the next review date.

Routine, uncomplicated vaginal or C-section delivery does not require concurrent review; however, the hospital must notify Sunflower within one business day (by 5 p.m. CST) of delivery with complete information regarding the delivery status and condition of the newborn.

Retrospective Review

Retrospective review is an initial review of services after services have been provided to a member. This may occur when authorization or timely notification to Sunflower was not obtained due to extenuating circumstances (i.e., member was unconscious at presentation, member did not have their Sunflower ID card, services authorized by another payer who subsequently determined member was not eligible at the time of service). Requests for retrospective review must be submitted promptly. A decision will be made within 30 calendar days following receipt of the request, not to exceed 180 calendar days from the date of service.

Retrospective Review Due to Members Awarded Retroactive Eligibility

If prior authorization is not obtained due to a member being awarded retroactive eligibility with Sunflower Health Plan, providers can submit a request for reconsideration with documentation indicating the member was retroactively enrolled to:

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

All requests for reconsiderations due to retroactive eligibility will be verified.

Clinical Practice Guidelines

Sunflower clinical and quality programs are based on evidence-based preventive and clinical practice guidelines. Whenever possible, Sunflower adopts guidelines that are published by nationally recognized organizations or government institutions as well as statewide collaborative and/or a consensus of healthcare professionals in the applicable field. Sunflower providers are expected to follow these guidelines, and adherence to the guidelines will be evaluated at least annually as part of the Quality Improvement Program. Following is a *sample* of the clinical practice guidelines adopted by Sunflower.

- American Academy of Pediatrics: Recommendations for Preventive Pediatric Healthcare in addition to the Federal EPSDT dental periodicity schedule
- American Diabetes Association: Standards of Medical Care in Diabetes
- Centers for Disease Control and Prevention (CDC): Adult and Child Immunization Schedules
- National Heart, Lung, and Blood Institute: Guidelines for the Diagnosis and Management of Asthma and Guidelines for Management of Sickle Cell
- U.S. Preventive Services Task Force Recommendations for Adult Preventive Health

For links to the most current version of the guidelines adopted by Sunflower, visit our website at SunflowerHealthPlan.com.

Care Management Program

The Sunflower case management/care coordination program is designed to help members obtain needed services, whether those services are covered within the Sunflower array of covered services, from community resources or from other non-covered venues. Our program will support our extensive provider network. The care managers will be available to every member and will work closely with existing I/DD Targeted Case Managers to meet the needs of members accessing HCBS programs or behavioral health services.

The program is based upon a Sunflower model that uses a multidisciplinary, integrated care management team and fosters a holistic approach to care to yield better outcomes. The goal of our program is to help members achieve the highest possible levels of wellness, functionality, and quality of life, while decreasing the need for disruption at the PCP or specialist office with administrative work.

The program includes a systematic approach for early identification of eligible members, needs assessment, and development and implementation of an individualized care plan that includes member goals and member/family education and actively links the member to providers and support services as well as outcome monitoring and reporting. Our care management team will integrate covered and non-covered services and provide a holistic approach to a member's medical, as well as functional, social, employment, community resource, and other needs. Our program incorporates consideration of clinical determinations of need, functional status, and barriers to care such as lack of caregiver supports, impaired cognitive ability to understand treatment prescribed by local providers, and transportation needs.

A care management team is available to help all providers manage access to services for their patients who are Sunflower members. Listed below are programs and components of special services that are available and can be accessed through the care management team. We look forward to hearing from you about any Sunflower members that you think can benefit from the addition of a Sunflower care management team member.

To contact a care manager call:

Sunflower Care Management Department
1-877-644-4623

Disease Management Programs

Disease Management is the concept of reducing healthcare costs and improving quality of life for individuals with a chronic condition through ongoing integrative care. Disease management supports the physician or practitioner/patient relationship and plan of care; emphasizes prevention of exacerbations and complications using evidence-based practice guidelines and patient empowerment strategies; and evaluates clinical, humanistic, and economic outcomes on an ongoing basis with the goal of improving overall health.

For disease management, Sunflower has contracted with Nurtur to administer services. Nurtur's programs promote a coordinated, proactive, disease-specific approach to management that will improve members' self-management of their condition, improve clinical outcomes and control high costs associated with chronic medical conditions. Sunflower programs include but are not limited to: asthma, COPD, coronary artery disease, diabetes, and congestive heart failure.

It is worth noting that diagnosis of a certain condition, such as diabetes, does not mean automatic enrollment in a disease management program. Members with selected disease states will be stratified into risk groups that will determine need and the level of intervention most appropriate for each case. High-risk members with co-morbid or complex conditions will be referred for case management program evaluation.

To refer a member for chronic care management call:
Sunflower Case Management at 1-877-644-4623

Integrated Care Teams (IC Teams)

Sunflower provides Care Management services through Integrated Care Teams (IC Teams). IC Teams consist of Care Managers, Program Specialists, IDD Behavioral Healthcare Coordinators (when appropriate), Program Coordinators, Health Coaches, member Connections Representatives, Medical Directors, Pharmacy Directors, and other key individuals involved in Customer Service and care coordination activities on the member's behalf. IC Teams will be led by clinical licensed nurses and care coordinators who are familiar with evidence-based resources and best practice standards and experience with the population including program service populations (autism, intellectual/developmental disability, physical disability, technology assisted, traumatic brain injury, frail elderly, seriously emotionally disturbed, and community-based alternatives to psychiatric residential treatment facility), the barriers and obstacles they face, and socioeconomic impacts on their ability to access services. The Sunflower IC Team will manage care for members whose needs are primarily functional as well as those with such complex conditions as hemophilia, breast/cervical cancer, trauma, organ transplants, and renal dialysis. Foster care members, children with special healthcare needs, and member receiving HCBS programs are also eligible for enrollment in care management that may result in the formation of an IC Team to address the member's complex needs. Sunflower will use a holistic approach by integrating referral and access to community resources, transportation, follow-up care, medication review, specialty care, and education to assist members in making better healthcare choices.

A **Transplant Coordinator** will provide support and coordination for members who need organ transplants. All members considered as potential transplant candidates should be immediately referred to the Sunflower Care Management department for assessment and Care Management services. Each candidate is evaluated for coverage requirements and will be referred to the appropriate agencies and transplant centers.

Health Homes Program

The Health Homes program is a Medicaid service for people with serious mental illness (SMI). Health Homes coordinate physical and behavioral healthcare with long-term services and supports for members who qualify. Members who meet the criteria for a Health Home will receive a letter from Sunflower Health Plan telling them about Health Homes. This letter will provide the member with his or her Health Home assignment. The assignment to a Health Home is based on the member's condition, the member's existing doctors, and location of that member.

The Health Home program is voluntary for KanCare members. The Health Homes Program is in addition to other services the member receives from KanCare. Health Home services will help members meet health goals through the creation of a Health Action Plan. The Health Home services are supported by Sunflower Health Plan and provided by a community Health Home Partner (HHP). Members have a choice of Health Home Partners. For more information, please call Sunflower Health Plan Customer Service at 1-877-644-4623.

Health Homes Rights and Responsibilities

- KanCare members eligible for Health Homes will be given a choice of Health Home providers.
- Members who have both Medicare and Medicaid have the right to receive Health Home services.
- Sunflower Health Plan has a responsibility for recruiting and training Health Home providers to ensure that the requirements of a Health Home provider as outlined by the State Plans and Health Home Program Manuals are met.
- Members have the right to opt out of the Health Home at any time. (Call 1-866-305-5147)
- Members have the right to opt back in to a Health Home at any time. (Call 1-877-644-4623)
- Members have the right to switch to a different Health Home provider within their area.
- I/DD members have the right to keep their Targeted Case Manager involved in their Health Home team when the request is made to their Health Home Partner agency.
- Members have the right to be treated with respect and consideration for his/her dignity and privacy.
- Members have the right to express a concern or appeal about Sunflower Health Plan or the Health Plan Partner agency and a responsibility to follow the grievance process established by Sunflower Health Plan.
- Members have the right and responsibility to participate in decisions regarding his/her healthcare, including the right to refuse treatment.
- Members have the right to understand their health conditions and participate in developing mutually agreed-upon treatment goals, to the degree possible.

Steps to Become a Health Home Partner (HHP)

The Preparedness and Planning Tool for Potential Health Home Partners is available on the Sunflower Health Plan website: http://www.kancare.ks.gov/health_home/providers_materials.htm. This tool helps providers determine their understanding of Health Homes services and requirements and serves as a road map for providers looking to become HHPs. After completing the tool, organizations will be able to:

- Understand the current state of the organization's ability to support progress toward becoming an HHP
- Assess the organization's strengths and challenges in undertaking different approaches to integration
- Set and prioritize goals for your organization's move to becoming an HHP

Potential Health Home Partners must complete the Preparedness and Planning Tool electronically and submit the information directly to the Kansas Department of Health and Environment's Division of Health Care Finance at the e-mail address provided in the process for submission. KDHE-DHCF completes a review of the completed tool before sending it to the KanCare health plans for coordination and operations toward contract amendment.

Additional KanCare Health Homes resources are online at: http://www.kancare.ks.gov/health_home.htm

Behavioral Health and Utilization Management

Please note: *Self referral, prior authorization and utilization management standards regarding mental health and substance use disorder services are addressed in the Cenpatico Behavioral Health Provider Manual.*

Sunflower offers our members access to all covered, medically necessary behavioral services through Cenpatico. The Cenpatico Utilization Management department's hours of operation are Monday through Friday (excluding holidays) from 8:00 a.m. to 5:00 p.m. CST. Additionally, clinical staff are available after hours if needed to discuss urgent issues. UM staff can be reached during business hours at 1-877-644-4623. The Cenpatico Utilization Management team is comprised of qualified behavioral health professionals whose education, training, and experience are commensurate with the Utilization Management reviews they conduct.

The Cenpatico Utilization Management Program strives to ensure that:

- member care meets medical necessity criteria;
- Treatment is specific to the member's condition, is effective, and is provided at the least restrictive, most clinically appropriate level of care;
- Services provided comply with Cenpatico quality improvement requirements;
- Utilization Management policies and procedures are systematically and consistently applied; and
- Focus for members and their families' centers on promoting resiliency and hope.

The purpose of Cenpatico's UM program's procedures and Clinical Practice Guidelines is to ensure treatment is specific to the member's condition, effective, and provided at the least restrictive, most clinically appropriate level of care.

Cenpatico's utilization review decisions are made in accordance with currently accepted behavioral healthcare practices, taking into account special circumstances of each case that may require deviation from the norm stated in the screening criteria. Medical necessity criteria are used for the review and approval of treatment. Plans of care that do not meet medical necessity guidelines are referred to a licensed physician advisor or psychologist for review and peer-to-peer discussion.

Cenpatico conducts UM in a timely manner to minimize any disruption in the provision of behavioral healthcare services. The timeliness of decisions adheres to specific and standardized time frames yet remains sufficiently flexible to accommodate urgent situations. Utilization Management files include the date of receipt of information and the date and time of notification and resolution.

Cenpatico's Utilization Management Department is under the direction of our licensed Medical Director. The Utilization Management Staff regularly confer with the Medical Director or physician designee on any cases where there are questions or concerns.

Behavioral Health Case Management

Cenpatico Behavioral Health offers Care Coordination/Case Management as an added benefit to members who need assistance with their Behavioral health needs. Cenpatico's Case Managers assess member status, coordinate care for the members and assist them in needs they may have to ensure appointments are kept.

The Case Management Department provides a unique function at Cenpatico. The essential function of the department is to increase community tenure, reduce recidivism, improve treatment compliance, and facilitate positive treatment outcomes through the identification of members with complex or chronic behavioral health conditions that require coordination of services and periodic monitoring in order to achieve desirable outcomes.

For more information regarding Behavioral Health and Cenpatico, please visit the Cenpatico website at www.cenpatico.com.

Medical Records

Medical Records Management and Records Retention

Sunflower providers must keep accurate and complete patient medical records that are consistent with 42 CFR §456 and National Committee for Quality Assurance (NCQA) standards, and financial and other records pertinent to Sunflower members. Such records will enable providers to render the highest quality healthcare service to members. They will also enable Sunflower to review the quality and appropriateness of the services rendered. To ensure the member's privacy, medical records should be kept in a secure location. Sunflower requires providers to maintain all records for members for at least six (6) years; however, when an audit, litigation, or other action involving records is initiated prior to the end of such period, records shall be maintained for a minimum of six years following resolution of such action. See the member Rights section of this provider manual for policies on member access to medical records.

Required Information

To be considered a complete and comprehensive medical record, the member's medical record (file) should include, at a minimum, provider notes regarding examinations, office visits, referrals made, tests ordered, and results of diagnostic tests ordered (i.e., x-rays, laboratory tests). Medical records should be accessible at the site of the member's participating primary care physician or provider. All medical services received by the member, including inpatient, ambulatory, ancillary, and emergency care, should be documented and prepared in accordance with all applicable state rules and regulations, and signed by the medical professional rendering the services.

Providers must maintain complete medical records for members in accordance with the following standards:

- member's name, and/or medical record number on all chart pages
- Personal/biographical data is present (i.e., employer, home telephone number, spouse, next of kin, legal guardianship, primary language, etc.)
- Prominent notation of any spoken language translation or communication assistance
- All entries must be legible and maintained in detail
- All entries must be dated and signed, or dictated by the provider rendering the care
- Significant illnesses and/or medical conditions are documented on the problem list and all past and current diagnoses
- Medication, allergies, and adverse reactions are prominently documented in a uniform location in the medical record; if no known allergies, NKA, or NKDA are documented
- An up-to-date immunization record is established for pediatric members or an appropriate history is made in chart for adults

- Evidence that preventive screening and services are offered in accordance with Sunflower and KanCare practice guidelines
- Appropriate subjective and objective information pertinent to the member's presenting complaints is documented in the history and physical
- Past medical history (for members seen three or more times) is easily identified and includes any serious accidents, operations, and/or illnesses, discharge summaries, and ER encounters; for children and adolescents (18 years and younger) past medical history relating to prenatal care, birth, any operations and/or childhood illnesses
- Working diagnosis is consistent with findings.
- Treatment plan is appropriate for diagnosis
- Documented treatment prescribed, therapy prescribed, and drug administered or dispensed including instructions to the member
- Documentation of prenatal risk assessment for pregnant women or infant risk assessment for newborns
- Signed and dated required consent forms.
- Unresolved problems from previous visits are addressed in subsequent visits
- Laboratory and other studies ordered as appropriate
- Abnormal lab and imaging study results have explicit notations in the record for follow-up plans; all entries should be initialed by the primary care provider (PCP) to signify review
- Referrals to specialists and ancillary providers are documented including follow-up of outcomes and summaries of treatment rendered elsewhere including family planning services, preventive services, and services for the treatment of sexually transmitted diseases
- Health teaching and/or counseling is documented
- For members 10 years and over, appropriate notations concerning use of tobacco, alcohol, and substance use (for members seen three or more times, substance abuse history should be queried)
- Documentation of failure to keep an appointment
- Encounter forms or notes have a notation, when indicated, regarding follow-up care calls or visits. The specific time of return should be noted as weeks, months, or as needed
- Evidence that the member is not placed at inappropriate risk by a diagnostic or therapeutic problem
- Confidentiality of member information and records protected
- Evidence that an advance directive has been offered to adults 18 years of age and older

Medical Records Release

All member medical records shall be confidential and shall not be released without the written authorization of the member or their parent/legal guardian, in accordance with state and federal law and regulation. When the release of medical records is appropriate, the extent of that release should be based upon medical necessity or on a need to know basis.

All release of specific clinical or medical records for Substance Use Disorders must meet Federal guidelines at 42 CFR part 2.

Medical Records Transfer for New Members

All PCPs are required to document in the member's medical record attempts to obtain historical medical records for all newly assigned Sunflower members. If the member or member's parent/legal guardian is unable to remember where they obtained medical care, or they are unable to provide addresses of the previous providers, then this should also be noted in the medical record.

Medical Records Audits

Sunflower will conduct random medical record audits as part of its QAPI Program to monitor compliance with the medical record documentation standards noted above. The coordination of care and services provided to members, including over-/under-utilization of services, as well as the outcome of such services, is also subject to review and assessment during a medical record audit. Sunflower will provide written notice prior to conducting a medical record review.

The standard provider contract with Sunflower Health Plan indicates that a provider and contracted provider are to provide access to records to Sunflower, government agencies (to the extent to comply with regulatory requirements) and to accreditation organizations. The requested records will be provided at no cost to any of these requestors. The provider and contracted provider shall cooperate in providing the member's medical records in a timely fashion at no charge when requested under appropriate regulatory requirements.

In the event the provider has negotiated a special agreement with Sunflower, please follow that contract section related to transfer or providing of medical records.

Billing and Claims Submission

Sunflower processes claims in accordance with applicable prompt pay and timely claims payment standards specified for Medicaid fee-for-service in Section 1902(a) (37) (A) of the Social Security Act, 42 CFR 447.46 and applicable State law and regulation. **Providers may not charge Sunflower Health Plan beneficiaries, or any financially responsible relative or representative of that individual any amount in excess of the Sunflower Health Plan paid amount. Section 1902(a)(25)(C) of the Social Security Act prohibits Sunflower Health Plan providers from directly billing Sunflower Health Plan beneficiaries.** Sunflower agrees to comply with these timely claims payment standards and will pay or deny, and shall require our subcontracted vendors that process claims to pay or deny clean claims as follows:

- Clean claims including adjustments will be processed and paid or processed and denied within 30 days of receipt
- Non-clean claims including adjustments will be processed and paid or processed and denied within 90 days of receipt
- Claims including adjustments will be processed and paid or processed and denied within 90 days of receipt

The date of receipt is the date Sunflower receives the claim as indicated by its date stamp on the claim.

Clean Claim Definition

In order to eliminate confusion among providers and further ensure compliance, Sunflower has adopted the State of Kansas definition of Clean Claim: A clean claim means the definition set forth in 42 C.F.R 447.45, as amended. As of the effective date of a contract, such definition is a claim that can be processed without obtaining additional information from the provider of services or from a third party. It includes a claim with errors originating the State's claims system. It does not include a claim from a provider who is under investigation for fraud or abuse, or a claim under review for Medical Necessity.

Sunflower shall pay Clean Claims from provider for Covered Services provided to Covered Persons within the greater of: (i) for Medicaid and CHIP Clean Claim: thirty (30) days, as applicable, or (ii) the applicable timeframe under applicable State or federal law or the Provider Agreement. The provider's sole remedy shall be payment by Sunflower of any amounts owed under the Provider Agreement in connection with the applicable Clean Claim, as well as any interest or penalties required under applicable State or federal law or the Provider Agreement.

Non-Clean Claim Definition

A non-clean claim is 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.

In addition, non-clean claims may involve issues regarding medical necessity and include claims not submitted within the filing deadlines.

Timely Filing

Original provider claims (first-time claims) must be received by Sunflower within 180 calendar days from the date of service (discharge date for inpatient or observation claims). For retroactive eligibility, claims must be submitted within 180 calendar days from the eligibility determination date. When Sunflower is the secondary payer, claims must be received within 365 calendar days from the date of disposition (final determination) of the primary payer. Claims received from both in-network and out-of-network providers outside of this timeframe will be denied for untimely submission.

All corrected claims must be received within 180 calendar days from the date of notification of payment. Timely filing requirements may be evaluated in the event of one of the following qualifying circumstances:

- Catastrophic events that substantially interfere with normal business operations of the provider or damage or destruction of the provider's business office or records by a natural disaster.
- Mechanical or administrative delays or errors by Sunflower or the Kansas Department of Health and Environment.
- The member was eligible; however, the provider was unaware that the member was eligible for services at the time services were rendered. Consideration is granted in this situation ***only if all*** of the following conditions are met:
    - The provider's records indicate that the member refused or was physically unable to provide their ID card or information.
    - The provider can substantiate that the provider continually pursued reimbursement from the patient until eligibility was discovered
    - The provider can substantiate that a claim was filed within 180 calendar days of discovering Plan eligibility
    - The provider has not filed a claim for this member prior to the filing of the claim under review

Who Can File Claims?

All providers – whether in-network or out-of-network – who have rendered services to Sunflower members can file claims. It is important that providers ensure Sunflower has accurate billing information on file. Please confirm with the Customer Service department or your dedicated Provider Relations Specialist that the following information is current in our files:

- Provider Name (as noted on current W-9 form)
- National Provider Identifier (NPI)
- Tax Identification Number (TIN)
- Taxonomy Code
- Physical Location Address (as noted on current W-9 form)
- Billing Name and Address
- Current Valid License

We recommend that providers notify Sunflower as soon as possible, but no later than 30 days in advance of changes to billing information. Please submit this information on a W-9 form. Changes to a provider's TIN and/or address are NOT acceptable when conveyed via a claim form. Providers may send changes to: ProviderRelations@sunflowerhealthplan.com

How to File a Claim

Providers must file claims using standard claim forms (UB-04 for hospitals and facilities; CMS 1500 for physicians or practitioners). Enter the **RENDERING** provider's NPI number in the "Rendering Provider ID#" section of the CMS 1500 form (see box 24J). **The NPI number entered on the claim form must be the same NPI number that was utilized when requesting an authorization (if the service required an authorization). Providers must list their taxonomy code (e.g., 207Q00000X for Family Practice) in this section to avoid processing delays.** Claims missing the necessary requirements are not considered "clean claims" and will be returned to providers with a written notice describing the reason for return.

Sunflower will accept claims from our providers in multiple, HIPAA compliant methods. Also, Sunflower will accept claims for Home and Community Based (HCBS) providers through the AuthentiCare system. We support all HIPAA EDI (Electronic Data Interchange) transaction formats, including HIPAA 837 Institutional and Professional transactions and HIPAA compliant NCPDP format for pharmacies. Providers may submit EDI using over 60 claims clearinghouses, through the Kansas Medical Assistance Program (KMAP), or submit HIPAA 837 claims to us directly via our secure web-based Provider Portal. Providers may enter claims directly online in HIPAA Direct Data Entry (DDE) compliant fashion via our online claims entry feature – another component of our secure Provider Portal.

Claims eligible for payment must meet the requirements as stipulated in the Sunflower Billing Manual, which can be found at SunflowerHealthPlan.com.

Online Claims Submission

For providers who have internet access and choose not to submit claims via a clearinghouse, Sunflower has made it easy and convenient to submit claims directly to us on our secure provider portal at www.sunflowerhealthplan.com.

You must request access to our secure site by registering for a user name and password. To register:

- Go to www.sunflowerhealthplan.com.
- Click "For Providers".
- Click "Login/Registration" and follow the instructions.

If you have technical support questions, please contact Customer Service at 1-877-644-4623.

Once you have access to the secure portal you may file first-time claims individually or submit first-time batch claims. You will also have the capability to find, view, and correct any previously submitted claims.

Electronic Claims Submission

We encourage all providers to submit claims and encounter data electronically. Sunflower can receive an ANSI X12N 837 professional, institution, or encounter transaction. In addition, we can generate an ANSI X12N 835 electronic remittance advice known as an Explanation of Payment (EOP) and deliver it securely to providers electronically or in paper format, dependent on provider preference. For more information on electronic claims and encounter data filing, contact:

Sunflower Health Plan
c/o Centene EDI Department
1-800-225-2573, extension 25525
or by e-mail at: EDIBA@centene.com

Providers who bill electronically are responsible for filing claims within the same timely filing requirements as providers filing paper claims. Providers who bill electronically must monitor their error reports and Explanation of Payment (EOP) to ensure all submitted claims and encounters appear on the reports. Providers are responsible for correcting any errors and resubmitting the affiliated claims and encounter information.

KMAP will maintain a single, front-door billing interface where providers can submit claims. You can also submit claims to Sunflower directly through our secure web portal, or use an established commercial clearinghouse.

The Sunflower Payer ID is 68069 and we accept claims from the following clearinghouses:

- Emdeon
- SSI
- Gateway
- Availity
- Smart Data Solutions

Optometrists and Ophthalmologists (CMS-1500 or 837P):

- Claims submitted by Optometrists or Ophthalmologists can be submitted electronically.
- Information on submission of claims to Opticare can be found on their website at www.opticare.com.

- If submitting electronic claims through KMAP, there is no requirement to submit using a separate payer ID; the claims will be routed appropriately to OptiCare.

Dental Providers (ADA or 837D):

- Dental claim forms can be submitted electronically. Information on submission of claims to Dental Health and Wellness can be found on their website at www.dentalhw.com.
- If submitting electronic claims through KMAP, there is no requirement to submit using a separate payer ID; the claims will be routed appropriately to Dental Health and Wellness.

Electronic Secondary Claims

Sunflower has the ability to receive coordination of benefit (COB or Secondary) claims electronically. The field requirements for successful electronic COB submission are below (5010 Format):

COB FIELD NAME The below should come from the primary payer's Explanation of Payment	**837I - INSTITUTIONAL EDI SEGMENT AND LOOP**	**837P - PROFESSIONAL EDI SEGMENT AND LOOP – COB INFORMATION MUST BE SUBMITTED AT DETAIL LINE LEVEL**
COB Paid Amount	If 2320/AMT01=D, MAP AMT02 or 2430/SVD02	If 2320/AMT01=D, MAP AMT02 or 2430/SVD02
COB Total Non-Covered Amount	If 2320/AMT01=A8, map AMT02	If 2320/AMT01=A8, map AMT02
COB Remaining Patient Liability	If 2300/CAS01 = PR, map CAS03 Note: Segment can have 6 occurrences. Loop2320/ AMT01=EAF, map AMT02 which is the sum of all of CAS03 with CAS01 segments presented with a PR	If 2320/AMT01=EAF, map AMT02
COB Patient Paid Amount		If 2320/AMT01 = F5, map AMT02
COB Patient Paid Amount Estimated	If 2300/AMT01=F3, map AMT02	

Total Claim Before Taxes Amount	If 2400/AMT01 = N8, map AMT02	If 2320/AMT01 = T, map AMT02
COB Claim Adjudication Date	IF 2330B/DTP01 = 573, map DTP03	IF 2330B/DTP01 = 573, map DTP03
COB Claim Adjustment Indicator	IF 2330B/REF01 = T4, map REF02	IF 2330B/REF01 = T4, map REF02 with a Y

Specific Data Record Requirements

Claims transmitted electronically must contain all the same data elements identified within the Claim Filing section of this manual. Contact your clearinghouse to ask if they require additional data record requirements. The Companion Guide is located on Sunflower's website at www.sunflowerhealthplan.com.

Electronic Claim Flow Description and Important General Information

In order to send claims electronically to Sunflower, all EDI claims must first be forwarded to one of Sunflower's clearinghouses. This can be completed via a direct submission to a clearinghouse or through another EDI clearinghouse.

Once the clearinghouse receives the transmitted claims, they are validated against their proprietary specifications and Sunflower's specific requirements. Claims not meeting the requirements are immediately rejected and sent back to the sender via a clearinghouse error report. It is important to review this error report daily to identify any claims that were not transmitted to Sunflower. The name of this report can vary based upon the provider's contract with their intermediate EDI clearinghouse. Accepted claims are passed to Sunflower, and the clearinghouse returns an acceptance report to the sender immediately.

Claims forwarded to Sunflower by a clearinghouse are validated against provider and member eligibility records. Claims that do not meet provider and/or member eligibility requirements are rejected and sent back on a daily basis to the clearinghouse. The clearinghouse in turn forwards the rejection back to its trading partner (the intermediate EDI clearinghouse or provider). It is very important to review this report daily. The report shows rejected claims and these claims must be reviewed and corrected timely. Claims passing eligibility requirements are then passed to the claim processing queues.

Providers are responsible for verification of EDI claims receipts. Acknowledgements for accepted or rejected claims received from the clearinghouse must be reviewed and validated against transmittal records daily.

Since the clearinghouse returns acceptance reports directly to the sender, submitted claims not accepted by the clearinghouse are not transmitted to Sunflower.

If you would like assistance in resolving submission issues reflected on either the acceptance or claim status reports, please contact your clearinghouse or vendor customer service department.

Rejected electronic claims may be resubmitted electronically once the error has been corrected.

Invalid Electronic Claim Record Rejections/Denials

All claim records sent to Sunflower must first pass the clearinghouse proprietary edits and Plan-specific edits prior to acceptance. Claim records that do not pass these edits are invalid and will be rejected without being recognized as received by Sunflower. In these cases, the claim must be corrected and re-submitted within the required filing deadline of 180 calendar days from the date of service. It is important that you review the acceptance or claim status reports received from the clearinghouse in order to identify and re-submit these claims accurately.

Questions regarding electronically submitted claims should be directed to our EDI BA Support at 1-800-225-2573 Ext. 25525 or via e-mail at EDIBA@centene.com. If you are prompted to leave a voicemail, you will receive a return call within 24 business hours.

The Sunflower Companion Guides for electronic billing are available on our website at www.sunflowerhealthplan.com. Go to the section on electronic claim filing for more details.

Exclusions

EXCLUDED CLAIM CATEGORIES • Excluded from EDI Submission Options • Must Be Filed Paper • Applies to Inpatient and Outpatient Claim Types
Claim records requiring supportive documentation or attachments (i.e., consent forms, invoices) ***Note:*** COB claims can be filed electronically, but if they are not, the primary payer EOB must be submitted with the paper claim.
Claim for services that are reimbursed based on purchase price (e.g., custom DME, prosthetics). Provider is required to submit the invoice with the claim.

Electronic Billing Inquiries

Please direct inquiries as follows:

ACTION	CONTACT
Clearinghouses Submitting Directly to Sunflower Health Plan	Emdeon Availity Gateway EDI SSI
Sunflower State Payer ID	68069 NOTE: Please reference the vendor provider manuals at www.sunflowerhealthplan.com for their individual payer IDs. • US Script • OptiCare • Centpatico Behavioral Health
General EDI Questions:	Contact EDI Support at 1-800-225-2573 Ext. 25525 or (314) 505-6525 or via e-mail at EDIBA@centene.com
Claims Transmission Report Questions:	Contact your clearinghouse technical support area
Claim Transmission Questions (Has my claim been received or rejected?):	Contact EDI Support at 1-800-225-2573 Ext. 25525 or via e-mail at EDIBA@centene.com
Remittance Advice Questions:	Contact Sunflower Provider Services at 1- 877-644-4623 or the secure Provider Portal at www.sunflowerhealthplan.com
Provider Payee, UPIN, Tax ID, Payment Address Changes:	Notify Provider Services in writing at: Sunflower Health Plan Four Pine Ridge Plaza 8325 Lenexa Drive Lenexa, KS 66214

Important Steps to a Successful Submission of EDI Claims

1. Select a clearinghouse to utilize or register for access to the Sunflower secure provider portal.
2. Contact the clearinghouse to inform them you wish to submit electronic claims to Sunflower.
3. Inquire with the clearinghouse what data records are required.
4. You will receive two reports from the clearinghouse. ALWAYS review these reports daily. The first report will be a report showing the claims that were accepted by the clearinghouse and are being transmitted to Sunflower and those claims not meeting the clearinghouse requirements. The second

report will be a claim status report showing claims accepted and rejected by Sunflower.

ALWAYS review the acceptance and claim status reports for rejected claims. If rejections are noted you must correct and resubmit.

5. MOST importantly, all claims must be submitted with provider identifying numbers. See the companion guide on the Sunflower website for claim form instructions and claim forms for details. NOTE: Provider identification number validation is not performed at the clearinghouse level. The clearinghouse will reject claims for provider information only if the fields are empty.

Paper Claims Submission

Paper claims for Front End Billing (FEB) must be submitted directly to Sunflower Health Plan using the addresses below. Beginning February 1, 2015, the State of Kansas Medical Assistance Program (KMAP) will not accept paper claims from KanCare providers. Beginning March 1, 2015, if KanCare providers submit paper claims to KMAP, the claims will be returned to the provider.

Sunflower and its benefit managers will accept paper claims (Initial, Resubmissions, or Corrected) at the following addresses:

PAPER CLAIMS SUBMISSIONS	
Behavioral Health	Cenpatico Behavioral Health PO Box 6400 Farmington, MO 63640-3807
Dental	Dental Health & Wellness Claims: KS PO Box 1164 Milwaukee, WI 53201
Pharmacy	Sunflower Health Plan PO Box 4070 Farmington, MO 63640-3833
Transportation	LogistiCare Claims Dept. 2552 West Erie Driver Suite 101 Tempe, AZ 85282
Vision	OptiCare Managed Vision PO Box 7548 Rocky Mount, NC 27804
Medical, NF/LTC, and HCBS Services	Sunflower Health Plan PO Box 4070 Farmington, MO 63640-3833

Sunflower only accepts the CMS 1500 and CMS UB-04 paper claim forms. Other claim form types will be rejected and returned to the provider. Information on the CMS 1500 form can be found under Provider Resources on the Sunflower website.

Listed below are names and addresses of vendors who supply these forms. This list is not all-inclusive:

Administrative Services of Kansas, Inc.
(A subsidiary of Blue Cross and Blue Shield of Kansas, Inc.)
P.O. Box 3500
Topeka, KS 66601-0110

Advantage Business Forms
211 Southwest 6th
Topeka, KS 66603
785-235-6868

Professional providers and medical suppliers complete the CMS 1500 form and institutional providers complete the CMS UB-04 claim form. Sunflower does not supply claim forms to providers. Providers should purchase these from a supplier of their choice. It is required that all paper claim forms be free of handwritten verbiage and submitted on a standard red and white form to ensure clean acceptance and processing. If you have questions regarding what type of form to complete, contact Customer Service at 1-877-644-4623.

Sunflower encourages all providers to submit claims electronically. Sunflower's Companion Guides for electronic billing are available online at www.sunflowerhealthplan.com.

Paper submissions are subject to the same HIPAA level edits as electronic and web submissions.

Coding of Claims/Billing Codes

Sunflower requires claims to be submitted using codes from the current version of ICD-9- CM, ICD-10, ASA, DRG, CPT4, and HCPCS Level II for the date the service was rendered. These requirements may be amended to comply with federal and state regulations as necessary.

Below are some code-related reasons a claim may reject or deny:

- For dates of service prior to 10/1/2015:
  - Diagnosis code missing the 4th or 5th digit as appropriate
- For dates of service on or after 10/1/2015:
  - ICD 10 diagnosis codes that require additional characters
  - ICD 10 diagnosis codes only allowed as secondary "manifestation" codes
- Procedure code is pointing to a diagnosis that is not appropriate to be billed as primary
- Code billed is inappropriate for the location or specialty billed
- Code billed is a part of a more comprehensive code billed on same date of service
- Code billed is missing, invalid, or deleted at the time of service
- Code inappropriate for the age or sex of the member

Documentation Required with Claims:

- Invoices
  - Invoices are required for all manually priced and miscellaneous procedure codes. Refer to the appropriate KMAP Provider Manual or the KMAP website to obtain a specific list of these codes. Invoices that are changed, altered, or whited-out are not permissible and may result in claims being denied.
- Consent Forms
  - Consent forms are located on the Kansas Medical Assistance Program website at:
    - Sterilization: https://www.kmap-state-ks.us/Documents/Content/Forms/Consent/Sterilization.pdf
    - The physician must complete the Abortion Necessity Form: https://www.kmap-state-ks.us/Documents/Content/Forms/Consent/Abortion.pdf
- Abortions are only covered under the following conditions-
  - In the case where a woman suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself.
  - Use modifier G7 when billing for abortion services if the pregnancy is the result of an act of rape or incest.
- The physician must complete the Abortion Necessity Form: https://www.kmap-state-ks.us/Documents/Content/Forms/Consent/Abortion.pdf

Code Auditing and Editing

Sunflower uses code-auditing software to assist in improving accuracy and efficiency in claims processing, payment, and reporting, as well as meeting HIPAA compliance regulations. The software will detect, correct, and document coding errors on provider claims prior to payment by analyzing CPT, HCPCS, modifier, and place of service codes. Claims billed in a manner that does not adhere to the standards of the code editing software will be denied.

The code editing software contains a comprehensive set of rules addressing coding inaccuracies such as unbundling, fragmentation, up-coding, duplication, invalid codes, and mutually exclusive procedures. The software offers a wide variety of edits that are based on:

- American Medical Association (AMA) – the software utilizes the CPT Manuals, CPT Assistant, CPT Insider's View, the AMA website, and other sources
- Centers for Medicare & Medicaid Services' (CMS) National Correct Coding Initiative (NCCI), which includes column 1/column 2, mutually exclusive, and outpatient code editor (OCE0 edits). In addition to using the AMA's CPT manual, the NCCI coding policies are based on national and local policies and edits, coding guidelines developed by national societies, analysis of standard medical and surgical practices, and a review of current coding practices.
- Public-domain specialty society guidance (i.e., American College of Surgeons, American College of Radiology, American Academy of Orthopedic Surgeons)

- Clinical consultants who research, document, and provide edit recommendations based on the most common clinical scenario
- In addition to nationally recognized coding guidelines, the software has added flexibility to its rule engine to allow business rules that are unique to the needs of individual product lines.

CPT Category II Codes are supplemental tracking codes developed to assist in the collection and reporting of information regarding performance measurement, including HEDIS. Submission of CPT Category II Codes allows data to be captured at the time of service and may reduce the need for retrospective medical record review.

Uses of these codes are optional and are not required for correct coding. They may not be used as a substitute for Category I codes. However, as noted above, submission of these codes can minimize the administrative burden on providers and health plans by greatly decreasing the need for medical record review.

Code Editing Assistant

A web-based code auditing reference tool designed to "mirror" how Sunflower code auditing product(s) evaluate code combinations during the auditing of claims is available for participating providers via the secure provider portal. This allows Sunflower to share with our contracted providers the claim auditing rules and clinical rationale we use to pay claims. You can access the tool in the Claims Module by clicking "Claim Auditing Tool."

This tool offers many benefits:

- *Prospectively* access the appropriate coding and supporting clinical edit clarifications for services before claims are submitted
- *Proactively* determine the appropriate code/code combination representing the service for accurate billing purposes

The tool will review what was entered and will determine if the code or code combinations are correct based on the age, sex, location, modifier (if applicable), or other code(s) entered.

The Code Editing Assistant is intended for use as a "what if" or hypothetical reference tool. It is meant to apply coding logic only. The tool does not take into consideration historical claims information that may have been used to determine an edit. The tool assumes all CPT codes are billed on a single claim.

The tool will not take into consideration individual fee schedule reimbursement, authorization requirements, or other coverage considerations.

Rejections Vs. Denials

All paper claims sent to the claims office must first pass specific edits prior to acceptance. Claim records that do not pass these edits are invalid and will be rejected or denied.

Rejection:

A REJECTION is defined as an unclean claim that contains invalid or missing data elements required for acceptance of the claim into the claim processing system. These data elements are identified in the Companion Guide located on the website at www.sunflowerhealthplan.com. A list of common upfront rejections can be found listed below, and a more comprehensive list with explanations can be located in Appendix 1. Rejections will not enter our claims adjudication system, so there will be no Explanation of Payment (EOP) for these claims. The provider will receive a letter or a rejection report if the claim was submitted electronically.

Denial:

If all edits pass and the claim is accepted, it will then be entered into the system for processing. A DENIAL is defined as a claim that has passed edits and is entered into the system, but has been billed with invalid or inappropriate information causing the claim to deny. An EOP will be sent that includes the denial reason. A list of common delays and denials can be found listed below, and a more comprehensive list with explanations can be located in Appendix 2.

Corrected Claims

If a provider has a question related to a claim, they can review the claim in question on the secure provider portal. Participating providers who have registered for access to the secure provider portal can access claims to obtain claim status, submit claims, or submit a corrected claim. A provider can contact Sunflower if they need assistance regarding a claim that has been processed, their EOP, or help with submitting a corrected claim. To do so:

1. Contact a Sunflower Provider Service Representative at 1-877-644-4623. Providers may inquire about claim status, payment amounts, or denial reasons.
2. Submit an adjusted or corrected claim to Sunflower:
    - Corrected claims must be received within 180 calendar days of the original explanation of payment
    - Corrected claims must clearly indicate they are corrected in one of the following ways:
        - Submit corrected claim via the secure provider portal
            - Follow the instructions on the portal for submitting a correction
        - Submit corrected claim electronically via Clearinghouse
            - Institutional Claims (UB): Field CLM05-3 = 7 and REF*F8 = Original claim number
            - Professional Claims (CMS): Field CLM05-3 = 6 and REF*F8 = Original claim number
        - Submit corrected paper claims to Sunflower Health Plan using the values specified for the fields below:

- CMS 1500 / Professional Claims:
  - Box 22 = Must contain the original 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
- Corrected paper claims can be mailed to:
  Sunflower Health Plan
  Attn: Reconsideration
  P.O. Box 4070
  Farmington, MO 63640-3833

If the corrected claim results in an adjusted claim, the provider will receive a revised Explanation of Payment (EOP).

Sunflower shall process and finalize all corrected claims within 30 calendar days of receipt.

Electronic Funds Transfers (EFT) and Electronic Remittance Advices (ERA)

Sunflower provides an innovative web-based solution for Electronic Funds Transfers (EFTs) and Electronic Remittance Advices (ERAs). Through this service, providers can take advantage of EFTs and ERAs to settle claims electronically. As a participating provider, you can gain the following benefits from using EFT and ERA:

- *Reduce accounting expenses* – Electronic remittance advices can be imported directly into practice management or patient accounting systems, eliminating the need for manual re-keying.
- *Improve cash flow* – Electronic payments mean faster payments, leading to improvements in cash flow.
- *Maintain control over bank accounts* – You keep TOTAL control over the destination of claim payment funds and multiple practices and accounts are supported.
- *Match payments to advices quickly* – You can associate electronic payments with electronic remittance advices quickly and easily.

For more information, please visit our provider home page on our website at SunflowerHealthPlan.com. If further assistance is needed, please contact our Customer Service department at 1-877-644-4623.

Refunds and Overpayments

Sunflower Health Plan routinely audits all claims for payment errors. Claims identified to have been underpaid or overpaid will be reprocessed appropriately. Providers have the responsibility to report overpayments or improper payments to Sunflower Health Plan. Providers have 30 days from the date of notification to refund overpayments or to establish a payment plan (when available) before claims are reprocessed. Providers have the right to appeal.

Providers have the option of requesting future off-sets to payments or may mail refunds and overpayments, along with supporting documentation (copy of the remittance advice along with affected claims identified) to the following address:

Sunflower Health Plan
P.O. Box 955889
St. Louis, MO 63195-5889

Third Party Liability

Third party liability refers to any other health insurance plan or carrier (e.g., individual, Medicare, group, employer-related, self-insured or self-funded, or commercial carrier, automobile insurance and workers' compensation) or program that is or may be liable to pay all or part of the healthcare expenses of the member.

As a Medicaid managed care plan, Sunflower is always the payer of last resort. Sunflower shall make reasonable efforts to determine the legal liability of third parties to pay for services furnished to Sunflower members; however, since providers have direct contact with members, providers may have the most accurate and complete information regarding third party liability. Should a provider become aware of third party liability not known by Sunflower, the provider shall notify Sunflower Customer Service at 1-877-644-4623 or follow the procedure currently in place with the State.

When Sunflower has established the probable existence of third party liability at the time the claim is filed, Sunflower will reject the claim and return it to the provider with instructions to bill the primary insurance with the following exception: Sunflower will pay the provider's negotiated rate and then seek reimbursement from any liable third party if the claim is for preventive and prenatal services.

If a provider becomes aware of an insurance policy or other liable party after Sunflower has paid the claim, the provider must bill the carrier or third party and attempt to collect payment. The provider should not adjust the claim with Sunflower until after the provider receives payment from the third party. If Sunflower has made payment, the provider must submit an adjustment request within one month of receiving payment from the third party. If a third-party carrier makes payment to a provider while a claim is pending to Sunflower, the provider should wait until the Sunflower claim has processed and then adjust the Sunflower claim within one month. The provider must also notify Sunflower of the TPL carrier and Sunflower will notify KanCare.

Sunflower also utilizes the services of a third party for post-payment review of potential third party liability issues. The third party analyzes post-payment claims data, investigates potential third party liability situations, and pursues any potential recoveries. Any identified third party liability will be reported to KanCare.

The member/provider is required to follow the rules of the primary payer. If the primary payer denies for administrative reasons, Sunflower will NOT coordinate with the primary insurance. Examples of administrative denials include: no authorization, untimely filing, or duplicate denial.

Note: *Sunflower requires that providers submit COB information at the line level for each claim detail line when billed on a HCFA 1500. Sunflower will honor the KDHE TPL non-covered list as published on the KMAP website in the form of a provider bulletin each year. This list can be found at: www.kmap-state-ks.us/public/Bulleting/BulletinSearch.asp.*

Claims Vs. Encounter Data

A claim is a bill for services, a line item of services, or all services for one member within a bill, which may be submitted either electronically or by paper for any medical service rendered. A claim must be filed on the proper form, such as CMS 1500 or UB 04. A claim will be paid or denied with an explanation of payment or denial (EOP). For each claim processed, an EOP (or an ERA if provider is set up to receive electronic remittance advice) will be mailed to the provider who submitted the original claim.

For providers who receive capitation as a means of reimbursement, the following section applies. An *encounter* is a claim (usually for well-care, immunizations, and other preventive care services involving EPSDT or HEDIS) that is processed and paid at zero dollars because the provider has been pre-paid for these services. If you are the designated PCP for a Sunflower member and receive a monthly capitation payment, you must file an encounter claim (also referred to as a proxy claim or encounter data) on a CMS 1500 form for each service provided *even though you have already been paid for providing these services.* **It is mandatory for all PCPs to submit encounter data.** Each month, Sunflower generates an encounter report to evaluate all aspects of provider compliance, quality, and utilization management related to encounter data submission. Both the state and federal governments have strict requirements regarding the timely and accurate submission of encounter data. If you are unsure of these requirements or unsure of your ability to comply with these requirements, please contact the Sunflower Customer Service department at 1-877-644-4623 for further assistance. Encounter claims do not generate an EOP.

Providers are required to submit a claim for each service that is rendered to a Sunflower member regardless of the provider's claims reimbursement expectations.

Procedures for Filing Claims and Encounter Data

Although we accept claims and encounter data submitted on paper, Sunflower encourages all providers to file claims and encounter data electronically. See the Electronic Claims Submission section and the Provider Billing Manual for more information on how to submit electronic claims and encounters.

Electronic Visit Verification (EVV) – "KS AuthentiCare"

Information about the State's AuthentiCare System can be found at: http://www.aging.ks.gov/HCBSProvider/KS_AuthentiCare/KAC_Index.html. See Appendix IX in this provider manual for services requiring the use of KS AuthentiCare.

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.

Specifically, members may not be held liable for the following situations:

- Payment for covered services for which KDHE and KDADS does not reimburse Sunflower
- Payment for covered services for which KDHE and KDADS or Sunflower pays the individual or healthcare provider that furnishes the services under a contractual, referral, or other arrangement
- No member shall be held liable for Sunflower's debts in the event of Sunflower's insolvency.

If a member asks for a service to be provided that is not a covered service, you must ask the member to sign a statement indicating that they will pay for the specific service. This documentation must include the specific service and an estimation of the cost associated with the service provided and be signed prior to the service being rendered to the member. You may be asked to provide this document to Sunflower on request.

Waste, Abuse, and Fraud

Sunflower takes the detection, investigation, and prosecution of waste, abuse, and fraud (WAF) very seriously. Sunflower's WAF program complies with the State of Kansas and federal laws. Sunflower, in conjunction with its parent company, Centene, operates a WAF unit. Sunflower routinely conducts audits to ensure compliance with billing regulations. Our code editing software performs systematic audits during the claims payment process. Centene's Special Investigation Unit (SIU) performs retrospective audits that, in some cases, may result in taking actions against providers who commit waste, abuse, and/or fraud. These actions include but are not limited to:

- Remedial education and training to prevent the billing irregularity
- More stringent utilization review
- Recoupment of previously paid monies
- Termination of provider agreement or other contractual arrangement
- Civil and/or criminal prosecution
- Any other remedies available to rectify

Some of the most common WAF practices include:

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

If you suspect or witness a provider inappropriately billing or a member receiving inappropriate services, please call our anonymous and confidential WAF hotline at 1-866-685-8664. Sunflower and Centene take all reports of potential waste, abuse, or fraud very seriously and investigate all reported issues.

WAF Program Compliance Authority and Responsibility

The Sunflower Vice President of Compliance and Regulatory Affairs has overall responsibility and authority for carrying out the provisions of the compliance program.

Sunflower is committed to identifying, investigating, sanctioning, and prosecuting suspected fraud and abuse. If you wish to report any type of compliance concern, please call 1-800-345-1642.

The Sunflower provider network will cooperate fully in providing any requested documentation, making personnel and/or subcontractor personnel available in person for interviews, consultation, grand jury proceedings, pre-trial conferences, hearings, trials, and in any other process, including investigations.

False Claims Act

The False Claims Act establishes liability when any person or entity improperly receives from or avoids payment to the Federal government (tax fraud is suspected). The Act prohibits:

1. Knowingly presenting, or causing to be presented, a false claim for payment or approval;
2. Knowingly making, using, or causing to be made or used, a false record or statement material to a false or fraudulent claim;
3. Conspiring to commit any violation of the False Claims Act;
4. Falsely certifying the type or amount of property to be used by the Government;
5. Certifying receipt of property on a document without completely knowing that the information is true;
6. Knowingly buying Government property from an unauthorized officer of the Government, and;
7. Knowingly making, using, or causing to be made or used a false record to avoid or decrease an obligation to pay or transmit property to the Government.

For more information regarding the False Claims Act, please visit www.cms.hhs.gov.

Grievance and Appeal Process

Grievance Process:

Sunflower Health Plan wants to fully resolve your problems or concerns. Sunflower Health Plan has steps for handling any problems you may have. Sunflower offers all of our members and providers the following processes to achieve satisfaction:

- Grievance/Complaint Process
- Member Appeal Process and Provider Claim Dispute Process

Sunflower Health Plan keeps records of each grievance/complaint and appeal filed by our members, their authorized representatives, and providers for seven years.

A grievance is any expression of dissatisfaction about any matter, other than an action that would be resolved through the appeals or Claim Dispute process. Grievances may include, but are not limited to: unclear and inaccurate information from staff, lack of action being taken on a case, the quality of care or services provided to a member, or any aspects of interpersonal business relationships such as the rudeness of a Sunflower employee, or failure to respect the member's rights.

Grievance Basics:

- Sunflower will not treat you, or our member, differently if you file a grievance.
- Filing a grievance will not affect your contract with Sunflower.
- A grievance may be filed verbally by calling the plan or in writing within 180 days of the event.
- For Sunflower to completely review your concern, please provide your first and last name, Provider NPI, phone number where we can reach you, what you are unhappy with, and what you would like to happen when contacting us to file a grievance.
- You may file a grievance for yourself or on behalf of a member. If acting on behalf of a member, you will need to provide an Authorized Representative Form, signed by the member, to Sunflower to allow them to consent to the submission and designate you to receive information about the grievance. To obtain this form, contact Customer Service or get it from the Sunflower website. You or the member can return it by mail or fax, then Sunflower can review your concern on behalf of the member.
- Information or documents that support the grievance can be sent to Sunflower by mail or fax.
- Documentation used to make the decision about the grievance will be provided to you on your request.
- Sunflower will provide assistance with filling out any forms needed for the process.

- If you do not like the resolution provided by Sunflower for your grievance, you can ask for them to review the decision.
- Sunflower wants to resolve your concerns quickly. If we cannot resolve your concern in 30 days, we can ask for an extension to gather more information to assist in our decision. You can also ask for an extension. If an extension is needed Sunflower will notify you in writing of the reason we need more time to resolve your concern...

Grievance Timeline

Step 1:	**Step 2:**	**Step 3:**
Grievance filed by calling Customer Service, or by sending a fax or letter to Sunflower	Sunflower sends a letter within 10 working days of receipt of the grievance acknowledging the grievance has been received, unless the grievance is resolved in less than 10 business days.	Sunflower resolves the grievance and sends a notice of their decision within 30 working days of receipt of the grievance.

Grievances are mailed to:

Sunflower Health Plan Quality Department
8325 Lenexa Drive
Lenexa, KS 66214

Appeal Process

An appeal is a request to review an action by Sunflower. An action is the denial or limiting of a member service. An appeal of an action is a request for Sunflower to review the action of concern, including existing or additional documentation, and make an appeal decision. You can request this review by phone or in writing. There are two kinds of appeals described as follows:

- member appeals – Also referenced as “pre-service appeals”. Examples include denial or partial denial of service or prior authorization or actions by the plan that make a change to the member’s benefit or primary care or provider assignment.
- Provider appeals- Also referenced as “Claim Disputes” or “post-service appeals.”

Examples include requests for review of a denied claim, adjustment of payment amount of a claim, or request for review of retro-eligibility.

A provider, or other member designated person, may represent a member and request a member or pre-service appeal with the consent of the member. The information below outlines both processes, deadlines, and contacts to successfully complete each.

Member/Pre-Service Appeals

Member Appeal Basics:

- Sunflower will not treat you or the member differently if you file an appeal.
- An appeal must be filed within 33 calendar days of the mailing date of the letter noting an adverse action that is sent to you and the member. This letter may be called "Notice of Action" or "Notice of Adverse Action or Determination." If you receive a letter and you don't know if it is an action letter, please contact us to review it with you.
- An appeal may be filed by phone, by fax, or in writing.
- Information on how to appeal will be included in the action letter you receive.
- The member may allow someone to file an appeal for them. To do so the member must sign a form giving that person permission to act on their behalf. The form will be included in the action letter or can be obtained by contacting Customer Service, or from the Sunflower website. The member will need to fill it out and return it by mail or fax before Sunflower can review or process the member appeal.
- Information or documents that support the appeal can be sent to Sunflower by mail or fax.
- Sunflower will provide assistance in filling out any forms needed for the process.
- A physician with appropriate clinical expertise will review appeal requests involving clinical issues or medical necessity decisions, be a clinical peer or similar specialty, and not be the subordinate of the individual who made the initial adverse determination.
- For appeals related to services that put the member health or functioning at immediate risk, you may file an **expedited** appeal. These can be submitted verbally, and do not require a written request or member consent. Expedited appeals will be reviewed within three calendar days of the request. To get an expedited appeal, please call Sunflower at 1-877-644-4623. Sunflower will make reasonable efforts to call you and the member with the appeal decision. If the request is found to be non-urgent, you will be notified and it will be processed in the standard appeal timeframe and require the member consent/ Authorized Representative Form. A member may not file a state fair hearing at the same time as an expedited appeal.
- A State Fair Hearing may be requested at the same time or instead of a Sunflower member appeal. If you or the member files it instead of a Sunflower appeal, you need to do so within 33 calendar days of the letter date notifying you and the member of the action. If you wait until Sunflower completes your appeal, you need to file it within 33 calendar days of the date you receive a decision on the member appeal. The member has the right to have a representative of their choice at the State Fair Hearing, and the rules that govern the hearing and who can be included will be provided in the action letter sent to the member and provider.
- Sunflower wants to resolve appeal concerns quickly, and will resolve member appeals within 30 calendar days of filing with us or notify the member of the delay reason and expectation for resolution.
- If Sunflower needs more than 30 calendar days to resolve the appeal, with approval of the State, Sunflower will notify the member in writing of the reason for the delay.

WHERE TO SEND MEMBER OR PRE-SERVICE APPEALS

TYPE OF SERVICE	SUNFLOWER SPECIALTY PARTNER	MEMBER APPEALS: PRIOR AUTHORIZATION OR PRE-SERVICE *Requires Authorized Rep form from member and information included in member Appeals section
Medical or HCBS Service	None	Sunflower Health Plan Attn: Quality Department 8325 Lenexa Dr., Suite 200 Lenexa, Kansas 66214 Fax: 1-888-453-4755 OR Expedited Appeal Call: 1-877-644-4623
High Resolution Imaging	National Imaging Associate, Inc. (NIA)	
Behavioral Health Services	Cenpatico, Behavioral Health (CBH)	
Physical Therapy (PT), Occupational Therapy (OT), and Speech Therapy (ST)	Cenpatico, Specialty Therapy, and Rehabilitative Services (STRS)	
Vision	OptiCare	
Dental	Dental Health and Wellness (DHW)	
Pharmacy	US Script (USS)	
Please use the Notice of Action/Adverse Determination letter for mailing address and information requested, as this is a guide only.		

Member Standard Appeal Process Timeline:

Step 1:

member files appeal by calling Customer Service, or by sending a fax or letter to Sunflower.

Step 2:

**member may request to have services continue while they are waiting for Sunflower to make a decision, but this request must be made within 10 calendar days of filing the appeal.

Step 3:

Sunflower sends a letter within 5 working days of the receipt of the appeal to let member know the appeal has been received.

Step 4:

Sunflower will resolve the appeal and send the member a written notice of their decision within 30 calendar days of receipt of the appeal.

Step 5:

If a member is not satisfied with the Sunflower appeal decision they have the right to request a State Fair Hearing.

** For HCBS services, services provided will continue without change until the appeal process is complete.

What Happens to the Member Services While Appealing the Action with Sunflower or the Office of Administrative Hearings?

Non-HCBS Services:

If the appeal is related to reducing or eliminating services the member is currently receiving that are not provided as a Home and Community Based Service (HCBS), they may ask to keep getting those services during the appeal process. This request must be made within 10 days of the mailing of the letter noting the action. However, the member may have to pay for this care, if the decision is not in their favor.

HCBS Services:

If the appeal is related to an action by the plan related to reducing or eliminating services the member is currently receiving as a Home and Community Based Service (HCBS), the member will keep getting those services during the appeal process. The member will not have to pay for this care if the appeal decision is not in their favor.

If you or the member do not know if the services related to the appeal are Home and Community Based Services (HCBS), please contact Customer Service at 1-877-644-4623.

State Fair Hearing for Member Appeals

The member or their representative (with the member-signed Authorized Representative Form) can ask the Kansas Office of Administrative Hearings to review Sunflower's decision or to hold a State Fair Hearing without an appeal first with Sunflower. This is initiated in three ways:

1. Call Sunflower and ask us to file a State Fair Hearing request.
2. Send a letter to Sunflower and ask us to file a State Fair Hearing request.
3. Complete the Request for Administrative Hearing form included with the action letter and mail it to: Office of Administrative Hearings (OAH), 1020 Kansas Avenue, Topeka, KS, 66612.

Provider Post-Service or Claim Disputes/Appeals

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.

Provider post-service or Claims Dispute basics:

- Sunflower will not treat you differently if you file an appeal.
- The provider will receive a written letter or EOP noting payment amount, denial, or adjustment and receive appeal instructions in that notification.
- The post-service appeal process must be filed within 90 days of the mailing date of the initial Explanation of Payment (EOP) or Determination letter.
- The first step, Reconsideration, may be filed by phone, by fax, or in writing and must be completed prior to submitting a Claim Dispute.
- A Claim Dispute must be filed in writing and include the form located on the Sunflower website under provider resources, within 30 calendar days of the Reconsideration response by Sunflower.
- Information on how and where to appeal will be included in the EOP or Determination letter you receive; general guides are provided below.
- The member may not file a post-service appeal or Claim Dispute.
- Providers may not charge Sunflower Health Plan beneficiaries, or any financially responsible relative or representative of that individual, any amount in excess of the Sunflower Health Plan paid amount. Section 1902(a)(25)(C) of the Social Security Act prohibits Sunflower Health Plan providers from directly billing Sunflower Health Plan beneficiaries.
- The provider may not balance bill a member
- Information or documents that support the appeal can be sent to Sunflower by mail or fax.
- Sunflower wants to resolve appeal concerns quickly, and will resolve provider appeals within 30 business days of filing with us or notify you of the delay reason and expectation for resolution.
- The provider will receive a final determination letter with the appeal decision, rationale, and date of resolution/decision.
- If the appeal decision is not in the favor of the provider, the provider may not bill the member for services or payment denied by the plan in post-service appeals.
- A State Fair Hearing should only be requested after the provider has exhausted the Sunflower provider appeal process, including a Reconsideration and Claim Dispute.

Provider Appeal Process Steps and Timelines:

STEP OF PROVIDER APPEAL PROCESS	SEND WHERE	SEND WHAT	DEADLINE TO SUBMIT	EXPECTED TIMELINE FOR RESPONSE	NOTIFICATION OF DECISION
Reconsideration	**Call Customer Service:** 1-877-644-4623 **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 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:** http://www.sunflowerhealthplan.com/for-providers/provider-resources/forms/ or additional form provided with EOP or letter **Pharmacy disputes only use form found here:** http://www.sunflowerhealthplan.com/files/2013/01/USS-MAC-Pricing-Inquiry-Form.pdf	Within 30 calendar days from date on EOP or Determination letter received following Reconsideration (33 days if we mailed the notice to you)	30 business days	Letter with determination
You should only file for a State Fair Hearing after you have completed the appeal process that includes both reconsideration and dispute/appeal filing with determinations received by Sunflower. If you disagree with the decision made in the dispute/appeal response, you may then appeal to the Office of Administrative Hearings and request a State Fair Hearing within 30 days of the dispute/appeal response (or 33 days if we mailed it to you).					
State Fair Hearing	Office of Administrative Hearings (OAH) 1020 Kansas Avenue Topeka, KS 66612 Phone: 1-785-296-2433	Applicable forms found here: http://oah.ks.gov/forms.htm	30 calendar days from date of the Claim Dispute/ Appeal Determination letter (33 if we mailed it to you) for this claim *Note – Provider must exhaust Reconsideration and Claim Dispute prior to requesting	Varies at discretion of OAH	Written Communication from OAH

WHERE TO SEND PROVIDER OR POST-SERVICE APPEALS

TYPE OF SERVICE	SUNFLOWER SPECIALTY PARTNER	PROVIDER APPEALS: POST-SERVICE OR CLAIM DISPUTES *Requires information included in Provider Appeal section
Medical, NF/LTC, or HCBS Services	None	Sunflower Health Plan Attn: Reconsideration OR Claim Dispute PO Box 4070 Farmington, MO 63640-3833
High Resolution Imaging	National Imaging Associate, Inc. (NIA)	Sunflower Health Plan Attn: Reconsideration OR Claim Dispute PO Box 4070 Farmington, MO 63640-3833
Behavioral Health Services	Cenpatico Behavioral Health	Cenpatico Claim Appeals P.O. Box 6000 Farmington, MO 63640-3809 OR Fax to: 1-866-714-7991
Physical Therapy (PT), Occupational Therapy (OT), and Speech Therapy (ST)	Cenpatico, Specialty Therapy and Rehabilitative Services (STRS)	Sunflower Health Plan Attn: Reconsideration OR Claim Dispute PO Box 4070 Farmington, MO 63640-3833
Vision	OptiCare	OptiCare Attn: Claims Appeal Committee PO Box 7548 Rocky Mount, NC 27804
Dental	Dental Health and Wellness (DHW)	Dental Health & Wellness Attn: Appeals PO Box 1432 Milwaukee, WI 53201

Pharmacy	US Script (USS)	E-mail: MAC_Pricing@usscript.com Fax: 866-912-0334 Include only form found at: http://www.sunflowerhealthplan.com/files/2013/01/USS-MAC-Pricing-Inquiry-Form.pdf
***Note: This chart is only a guide; please use the Notice of Action/Adverse Determination letter for mailing address and information requested.**		

Provider Appeal Process Timeline

Step 1:

Provider files Reconsideration by calling Customer Service or by sending a fax/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 Claim 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

Quality Improvement Program

Overview

Sunflower culture, systems, and processes are structured around its mission to improve the health of all enrolled members. The Quality Assessment and Performance Improvement (QAPI) Program utilizes a systematic approach to quality improvement initiatives using reliable and valid methods of monitoring, analysis, evaluation, and improvement in the delivery of healthcare provided to all members, including those with special needs. This system provides a continuous cycle for assessing the quality of care and service among plan initiatives including preventive health, acute and chronic care, behavioral health, over- and under-utilization, continuity and coordination of care, patient safety, and administrative and network services. This includes the implementation of appropriate interventions and designation of adequate resources to support the interventions.

Sunflower recognizes its legal and ethical obligation to provide members with a level of care and access to services that meets recognized professional standards and is delivered in the safest, most appropriate settings. To that end, Sunflower will provide for the delivery of quality care with the primary goal of improving the health status of its members. Where the member's condition is not amenable to improvement, Sunflower will implement measures to prevent any further decline in condition or deterioration of health status or provide for comfort measures as appropriate and requested by the member. This will include the identification of members at risk of developing conditions, the implementation of appropriate interventions, and designation of adequate resources to support the interventions. Whenever possible, the Sunflower QAPI Program supports these processes and activities that are designed to achieve demonstrable and sustainable improvement in the health status of its members.

QAPI Program Structure

The Sunflower Board of Directors (BOD) has the ultimate authority and accountability for the oversight of the quality of care and service provided to members. The BOD oversees the QAPI Program and has established various committees and ad-hoc committees to monitor and support the QAPI Program.

The Quality Improvement Committee (QIC) is a senior management committee with physician representation that is directly accountable to the BOD. The purpose of the QIC is to provide oversight and direction in assessing the appropriateness of services and continuously enhance and improve the quality of care and services provided to members. This is accomplished through a comprehensive, plan-wide system of ongoing, objective, and systematic monitoring; the identification, evaluation, and resolution of process problems; the

identification of opportunities to improve member outcomes; and the education of members, providers, and staff regarding the QI, UM, and Credentialing and Re-credentialing programs.

The following subcommittees report directly to the Quality Improvement Committee (QIC):

- Credentialing Committee
- Grievance and Appeals Committee
- Utilization Management Committee
- Performance Improvement Team
- Member, Provider, and Community Advisory Committees
- Joint Operations Committees
- Peer Review Committee (Ad Hoc Committee)

Practitioner Involvement

Sunflower recognizes the integral role practitioner involvement plays in the success of its QAPI Program. Practitioner involvement in various levels of the process is highly encouraged through provider representation. Sunflower encourages PCP, behavioral health, specialty, and OB/GYN representation on key quality committees such as, but not limited to, the QIC, Credentialing Committee, and select ad-hoc committees.

Quality Assessment and Performance Improvement Program Scope and Goals

The scope of the QAPI Program is comprehensive and addresses both the quality of clinical care and the quality of service provided to the Sunflower members. The Sunflower QAPI Program incorporates all demographic groups and ages, lines of business, benefit packages, care settings, providers, and services in quality improvement activities, including preventive care, primary care, specialty care, acute care, short-term care, long-term care, ancillary services, and operations.

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.

To that end, the Sunflower QAPI Program monitors the following:

- Acute and chronic care management
- Behavioral healthcare
- Compliance with member confidentiality laws and regulations
- Compliance with preventive health guidelines and practice guidelines
- Continuity and coordination of care
- Customer service
- Delegated entity oversight
- Department entity oversight
- Department performance and service
- Employee and provider cultural competency
- Fraud and abuse detection and prevention
- Information management
- Marketing practices
- member enrollment and disenrollment
- member grievance system
- member satisfaction
- Network performance
- Organizational structure
- Patient safety
- Primary care provider changes
- Pharmacy
- Provider and plan accessibility
- Provider availability
- Provider complaint system
- Provider network adequacy and capacity
- Provider satisfaction
- Quality management
- Records management
- Selection and retention of providers (credentialing and re-credentialing)
- Utilization management, including under- and over-utilization

Patient Safety and 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. A potential quality of care issue is any alleged act or behavior that may be detrimental to the quality or safety of patient care, is not compliant with evidence-based standard practices of care, or that signals a potential sentinel event, up to and including death of a member. Sunflower employees (including medical management staff, customer service staff, complaint coordinators, etc.), panel practitioners, facilities or ancillary providers, members or member representatives, Medical Directors, or the BOD may advise the Quality Improvement (QI) Department of potential quality of care issues. Adverse events may also be identified through claims-based reporting and analyses. 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. 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.

Performance Improvement Process

The Sunflower QIC reviews and adopts an annual QAPI Program and Work Plan based on Medicaid (and, where appropriate, Medicare) managed care appropriate industry standards. The QIC adopts traditional quality/risk/utilization management approaches to identify problems, issues, and trends with the objective of developing improvement opportunities. Most often, initiatives are selected based on data that indicates the need for improvement in a particular clinical or non- clinical area, and includes targeted interventions that have the greatest potential for improving health outcomes or service standards.

Performance improvement projects, focus studies, and other QI initiatives are designed and implemented in accordance with principles of sound research design and appropriate statistical analysis. Results of these studies are used to evaluate the appropriateness and quality of care and services delivered against established standards and guidelines for the provision of that care or service. Each QI initiative is also designed to allow Sunflower to monitor improvement over time.

Annually, Sunflower develops a QAPI Work Plan for the upcoming year. The QAPI Work Plan serves as a working document to guide quality improvement efforts on a continuous basis. The Work Plan integrates QIC activities, reporting, and studies from all areas of the organization (clinical and service) and includes timelines for completion and reporting to the QIC as well as requirements for external reporting. Studies and other performance measurement activities and issues to be tracked over time are scheduled in the QAPI Work Plan.

Sunflower communicates activities and outcomes of its QAPI Program to both members and providers through avenues such as the member newsletter, provider newsletter, and the Sunflower web portal at www.sunflowerhealthplan.com.

At any time, Sunflower providers may request additional information on the health plan programs including a description of the QAPI Program and a report on Sunflower progress in meeting the QAPI Program goals by contacting the Quality Improvement department.

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. HEDIS gives purchasers and consumers the ability to distinguish between health plans based on comparative quality instead of simply cost differences.

As both the State of Kansas and the Federal government move toward a healthcare industry that is driven by quality, HEDIS rates are becoming more and more important, not only to the health plan, but to the individual provider. Kansas purchasers of healthcare use the aggregated HEDIS rates to evaluate the effectiveness of a health insurance company's ability to demonstrate an improvement in preventive health outreach to its beneficiaries. Physician specific scores are being used as evidence of preventive care from primary care office practices. The rates then serve as a basis for physician incentive programs such as "pay for performance" and "quality bonus funds." These programs pay providers an increased premium based on scoring of such quality indicators as HEDIS.

HEDIS Rate Calculations

HEDIS rates can be calculated in two ways: administrative data or hybrid data. Administrative data consists of claim and encounter data submitted to the health plan. Measures typically calculated using administrative data include: annual mammogram, annual chlamydia screening, appropriate treatment of asthma, cholesterol management, antidepressant medication management, access to PCP services, and utilization of acute and mental health services.

Hybrid data consists of both administrative data and a sample of medical record data. Hybrid data requires review of a random sample of medical records to extract data regarding services rendered but not reported to the health plan through claims or encounter data. Accurate and timely claims and encounter data and submission using appropriate CPT, ICD-9, and HCPCS codes can reduce the necessity of medical record reviews (see Sunflower website and HEDIS brochure for more information on reducing HEDIS medical record reviews). HEDIS measures typically requiring medical record review include: childhood immunizations, well child visits, diabetic HbA1c, LDL, eye exam and nephropathy, controlling high-blood pressure, cervical cancer screening, and prenatal care and postpartum care.

Who Conducts Medical Record Reviews (MRR) for HEDIS?

Sunflower may contract with an independent national MRR vendor to conduct the HEDIS MRR on its behalf. Medical record review audits for HEDIS are usually conducted March through May each year. At that time, if any of your patient's medical records are selected for review, you will receive a call or letter from a medical record review representative. Your prompt cooperation with the representative is greatly needed and appreciated.

As a reminder, protected health information (PHI) that is used or disclosed for purposes of treatment, payment, or healthcare operations is permitted by HIPAA Privacy Rules (45 CFR 164.506) and does not require consent or authorization from the member. The MRR vendor will sign a HIPAA compliant Business Associate Agreement with Sunflower, which allows them to collect PHI on our behalf.

How Can Providers Improve Their HEDIS Scores?

- ***Understand the specifications*** established for each HEDIS measure.
- ***Submit claims and encounter data for each and every service rendered.*** All providers must bill (or submit encounter data) for services delivered, regardless of their contract status with Sunflower. Claims and encounter data is the most clean and efficient way to report HEDIS.
- ***Submit claims and encounter data correctly, accurately, and on time***. If services rendered are not filed or billed accurately, then they cannot be captured and included in the scoring calculation. Accurate and timely submission of claims and encounter data will reduce the number of medical record reviews required for HEDIS rate calculation.
- ***Ensure chart documentation reflects all services provided.***
- ***Submit claims and encounter data using CPT codes related to HEDIS*** measures such as diabetes, eye exam, and blood pressure.

If you have any questions, comments, or concerns related to the annual HEDIS project or the medical record reviews, please contact the Quality Improvement department at 1-877-644-4623.

Provider Satisfaction Survey

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. The survey is conducted by an external vendor. Participants are randomly selected by the vendor, meeting specific requirements outlined by Sunflower, and the participants are kept anonymous. We encourage you to respond timely to the survey as the results of the survey are analyzed and used as a basis for forming provider-related quality improvement initiatives.

Consumer Assessment of Healthcare Provider Systems (CAHPS) Survey

The CAHPS survey is a member satisfaction survey that is included as a part of HEDIS and NCQA accreditation. It is a standardized survey administered annually to members by an NCQA certified survey vendor. The survey provides information on the experiences of members with health plan and practitioner services and gives a general indication of how well the plan is meeting the members' expectations. Member responses to the CAHPS survey are used in various aspects of the quality program including monitoring of practitioner access and availability. Members receiving behavioral health services have the opportunity to respond to the Experience of Care Health Outcomes (ECHO) survey to provide feedback and input into the quality oversight of the behavioral health program.

Provider Performance Monitoring and Incentive Programs

Over the past several years, it has been nationally recognized that pay-for-performance (P4P) programs, which include provider profiling, have emerged as a promising strategy to improve the quality and cost-effectiveness of care. In Kansas, Sunflower will manage a provider performance monitoring program to capture data relating to healthcare access, costs, and quality of care that Sunflower members receive.

The Sunflower Provider Profiling Program is designed to analyze utilization data to identify provider utilization and quality issues. Sunflower will use Provider Profiling data to identify opportunities to improve communications to providers regarding Clinical Practice Guidelines. Provider Profiling is a highly effective tool that compares individual provider practices to normative data, so that providers can improve their practice patterns, processes, and quality of care in alignment with evidence-based clinical practice guidelines. The Sunflower Program and Provider Overview Reports will increase provider awareness of performance, identify opportunities for improvement, and facilitate plan-provider collaboration in the development of clinical improvement initiatives. Sunflower's Profiling Program incorporates the latest advances in this evolving area.

The P4P program promotes efforts that are consistent with the Institute of Medicine's aims for advancing quality (safe, beneficial, timely, patient-centered, efficient, and equitable) as well as recommendations from other national agencies such as the CMS-AMA Physician Consortium, NCQA, and NQF. Additionally, Sunflower Health Plan may provide an opportunity for financial reward to PCPs and specialists using an incentive payment that encourages accurate and timely submission of preventive health and disease monitoring services in accordance with evidence-based clinical practice guidelines.

The goals of Sunflower's P4P program are:

- Increase provider awareness of their performance in key, measurable areas
- Motivate providers to establish measurable performance improvement processes relevant to Sunflower member populations in their practices
- Use peer performance data and other established benchmarks to identify outlier provider practices that reflect best practices or less than optimal performance and to share this data (as appropriate) to educate and for future performance improvement
- Increase opportunities for Sunflower to partner with providers to achieve measurable improvement in health outcomes by developing and implementing nationally recognized, practice-based performance improvement initiatives

Sunflower will accomplish these goals by:

- Producing and distributing provider-specific reports containing meaningful, reliable, and valid data for evaluation by Sunflower and the provider
- Creating incentives for provider implementation of practice-based performance improvement initiatives that are pertinent to Sunflower member populations linked with adopted evidence-based clinical practice guidelines and that yield measurable outcomes
- Establishing and maintaining an open dialogue with providers related to performance improvement objectives

Physicians, meeting a minimum panel threshold, may receive a profile report with individual group scores based on certain measures. Scores will be benchmarked per individual measure and compared to the Sunflower network average and, as applicable, to the current NCQA Quality Compass Medicaid mean. Provider profile indicator data is not risk adjusted and scoring is based on provider performance within the service area range.

PCPs who meet or exceed established performance goals and who demonstrate continued excellence or significant improvement over time may be recognized by Sunflower in publications such as newsletters, bulletins, press releases, and recognition in our provider directories as well as being eligible for applicable financial incentive programs. Additionally, Sunflower offers several financial incentive programs such as claim-based incentive programs. More information on our incentive programs can be found on the provider web portal or by contacting the Sunflower Contracting and/or Provider Relations departments.

Physician Incentive Programs

On an annual basis and in accordance with Federal regulations, Sunflower must disclose to the Centers for Medicare and Medicaid Services, and KanCare, any Performance Incentive Programs that could potentially influence a physician's care decisions. The information that must be disclosed includes the following:

- Effective date of the Physician Incentive Program
- Type of Incentive Arrangement
- Amount and type of stop loss protection
- Patient panel size
- Description of the pooling method, if applicable
- For capitation arrangements, provide the amount of the capitation payment that is broken down by percentage for primary care, referral, and other services
- The calculation of Significant Financial Risk (SFR)
- Whether Sunflower does not have a Physician Incentive Program
- The name, address, and other contact information of the person at Sunflower who may be contacted with questions regarding Physician Incentive Programs

Physician Incentive Programs may not include any direct or indirect payments to providers/provider groups that create inducements to limit or reduce the provision of necessary services. In addition, Physician Incentive Programs that place providers/provider groups at SFR may not operate unless there is adequate stop loss protection, member satisfaction surveys, and satisfaction of disclosure requirements satisfying the Physician Incentive Program regulations.

Significant Financial Risk occurs when the incentive arrangement places the provider/provider group at risk beyond the risk threshold, which is the maximum risk if the risk is based upon the use or cost of referral services. The risk threshold is set at 25% and does not include amounts based solely on factors other than a provider/provider group's referral levels. Bonuses, capitation, and referrals may be considered incentive arrangements that result in SFR.

If you have questions regarding the Physician Incentive Program Regulations, please contact your Provider Relations Specialist.

Appendices

Appendix I: Common Causes of Upfront Rejections

- Unreadable Information – The ink is faded, too light, or too bold (bleeding into other characters or beyond the box), the font is too small, or handwritten information is present
- Member Date of Birth is missing
- Member Name or Identification Number is missing or incomplete
- Provider Name, Taxpayer Identification Number (TIN), or National Practitioner Identification (NPI) Number is missing or does not match the records on file
- Attending Provider information missing from Loop 2310A on Institutional claims when CLM05-1 (Bill Type) is 11, 12, 21, 22, or 72 or missing from box 76 on the paper UB claim form
- Date of Service is not prior to the received date of the claim (future date of service)
- Date of Service or Date Span is missing from required fields
    - Example: "Statement From" or "Service From" dates
- Type of Bill is invalid
- Diagnosis Code is missing, invalid, or incomplete
- Service Line Detail is missing
- Date of Service is prior to member's effective date
- Admission Type is missing (Inpatient Facility Claims – UB-04, field 14)
- Patient Status is missing (Inpatient Facility Claims – UB-04, field 17)
- Occurrence Code/Date is missing or invalid
- Revenue Code is missing or invalid
- CPT/Procedure Code is missing or invalid
- Incorrect Form Type is used
- Provider not valid on DOS
- Modifiers are missing or invalid
- Institutional Claim (UB-04) exceeded the maximum 97 service line limit
- Professional Claim (CMS-1500) exceeded the maximum 50 service line limit

Appendix II: Common Causes of Claim Processing Delays and Denials

- For dates of service prior to 10/1/2015:
  - Diagnosis Code is missing the 4th or 5th digit
- For date of service on or after 10/1/2015:
  - ICD 10 Diagnosis Codes that require additional characters
  - ICD 10 Diagnosis Codes only allowed as secondary "manifestation" codes
- Procedure or Modifier Codes entered are invalid or missing
  - This includes GN, GO, or GP modifier for therapy services
- DRG code is missing or invalid
- Explanation of Benefits (EOB) from the primary insurer is missing or incomplete
- Third Party Liability (TPL) information is missing or was not provided at the detail line level for CMS-1500s
- member ID is invalid
- Place of Service Code is invalid
- Provider TIN and NPI does not match services billed
- Revenue Code is invalid
- Dates of Service span do not match the listed days/units
- Tax Identification Number (TIN) is invalid
- Administration codes must be billed with vaccine codes on the same claim form
- Missing or incomplete consent forms
- Missing or incomplete CPT/HCPCS Codes
- Missing or invalid POA/HAC Codes
- Missing or incomplete Type of Bill
- For I/DD specific claims, Residential Supports and Day Supports billed on the same claim (these services must be billed separately to process and pay correctly).
- Dentoalveolar Structures Facility Reimbursement (41899) must include an accurate description of the services provided in the comments section of the claim.

Appendix III: Common EOP Denial Codes and Descriptions

See the bottom of your paper EOP for the updated and complete description of all explanation codes associated with your claims. Electronic Explanations of Payment will use standard HIPAA denial codes.

CODE	DESCRIPTION
07	DENY: THE PROCEDURE CODE IS INCONSISTENT WITH THE PATIENT'S SEX
09	DENY: THE DIAGNOSIS CODE IS INCONSISTENT WITH THE PATIENT'S AGE
10	DENY: THE DIAGNOSIS CODE IS INCONSISTENT WITH THE PATIENT'S SEX
18	DENY: DUPLICATE CLAIM/SERVICE
28	DENY: COVERAGE NOT IN EFFECT WHEN SERVICE PROVIDED
29	DENY: THE TIME LIMIT FOR FILING HAS EXPIRED
35	DENY: BENEFIT MAXIMUM HAS BEEN REACHED
46	DENY: THIS SERVICE IS NOT COVERED
50	DENY: NOT A MCO COVERED BENEFIT
86	DENY: THIS IS NOT A VALID MODIFIER FOR THIS CODE
99	DENY: MISC/UNLISTED CODES CAN NOT BE PROCESSED W/O DESCRIPTION/REPORT
1K	DENY: CPT OR DX CODE IS NOT VALID FOR AGE OF PATIENT
3D	For dates of service prior to 10/1/2015: DENY: NON-SPECIFIC DIAGNOSIS - REQUIRES 4TH DIGIT PLEASE RESUBMIT
4D	For dates of service on or after 10/1/2015: DENY: NON-SPECIFIC DIAGNOSIS - REQUIRES 5TH DIGIT PLEASE RESUBMIT
d1	ICD 10 DIAGNOSIS CODES THAT REQUIRE ADDITIONAL CHARACTERS
d2	ICD 10 PROCEDURE CODES THAT REQUIRE ADDITIONAL CHARACTERS
d3	ICD 10 DIAGNOSIS CODES NOT ALLOWED AS PRIMARY IN THE INPATIENT SETTING
d4	ICD 10 DIAGNOSIS CODES ONLY ALLOWED AS SECONDARY "MANIFESTATION" CODES
9M	DENY: THIS CPT CODE IS INVALID WHEN BILLED WITH THIS DIAGNOSIS
A1	DENY: AUTHORIZATION NOT ON FILE
BG	DENY: TYPE OF BILL MISSING OR INCORRECT ON CLAIM, PLEASE RESUBMIT
BI	DENY: CLAIM CANNOT BE PROCESSED WITHOUT AN ITEMIZED BILL
CF	DENY: WAITING FOR CONSENT FORM
DS	DENY: DUPLICATE SUBMISSION - ORIGINAL CLAIM STILL IN PEND STATUS
DW	DENY: INAPPROPRIATE DIAGNOSIS BILLED, CORRECT AND RESUBMIT
DX	DIAGNOSIS BILLED IS INVALID, PLEASE RESUBMIT WITH CORRECT CODE
EC	DIAGNOSIS CANNOT BE USED AS PRIMARY DIAGNOSIS, PLEASE RESUBMIT
HQ	DENY: EDI CLAIM MUST BE SUBMITTED IN HARD COPY WITH CONSENT FORM
IM	DENY: RESUBMIT WITH CORRECT MODIFIER

L6	DENY: BILL PRIMARY INSURER 1ST, RESUBMIT WITH EOB
LO	DENY: CPT AND LOCATION ARE NOT COMPATIBLE, PLEASE RESUBMIT
MG	DENY: SIGNATURE MISSING FROM BOX 31, PLEASE RESUBMIT
MO	MODIFIER BILLED IS NOT VALID, PLEASE RESUBMIT WITH CORRECT CODE
MQ	DENY: member NAME/NUMBER/DATE OF BIRTH DO NOT MATCH, PLEASE RESUBMIT
NT	DENY: PROVIDER NOT CONTRACTED FOR THIS SERVICE - DO NOT BILL PATIENT
U1	CLAIM CANNOT BE PROCESSED WITHOUT MEDICAL RECORDS
VI	GLOBAL FEE PAID
x3	PROCEDURE CODE UNBUNDLED FROM GLOBAL PROCEDURE CODE
x4	PROCEDURE CODE/ICD-9 CODE INCONSISTENT WITH member'S GENDER
x5	PROCEDURE CODE CONFLICTS WITH member'S AGE
x6	ADD-ON CODE REQUIRED WITH PRIMARY CODE FOR QUANTITY GREATER THAN ONE
x7	ADD-ON CODE CANNOT BE BILLED WITHOUT PRIMARY CODE
x8	MODIFIER INVALID FOR PROCEDURE OR MODIFIER NOT REPORTED
x9	PROCEDURE CODE PAIRS INCIDENTAL, MUTUALLY EXCLUSIVE, OR UNBUNDLED
xa	CODE IS A COMPONENT OF A MORE COMPREHENSIVE CODE
xb	PROCEDURE CODE NOT ELIGIBLE FOR ANESTHESIA
xc	PROCEDURE/DIAGNOSIS CODE DELETED, INCOMPLETE, OR INVALID
xd	PROCEDURE CODE APPENDED WITH BILATERAL 50 MODIFIER
xe	PROCEDURE CODE INCONSISTENT WITH member'S AGE
xf	MAXIMUM ALLOWANCE EXCEEDED
xh	PROCEDURE CODE EXCEEDS MAXIMUM ALLOWED PER DATE OF SERVICE
xp	PROCEDURE CODE PREVIOUSLY BILLED ON HISTORICAL CLAIM
xq	PROCEDURE CODE EXCEEDS MAXIMUM ALLOWED PER DATE OF SERVICE
Y6	DENY: INSUFFICIENT INFO FOR PROCESSING, RESUBMIT W/ PRIME'S ORIGINAL EOB
ye	CLAIM CANNOT BE PROCESSED WITHOUT MEDICAL RECORDS
ym	30 DAY READMISSION. SUBMIT ALL MEDICAL RECORDS FOR 30 DAY PERIOD
ZC	DENY: PROCEDURE IS INAPPROPRIATE FOR PROVIDER SPECIALTY

Appendix IV: Instructions for Supplemental Information CMS-1500 (8/05) Form, Shaded Field 24A-G

CMS-1500 Form, Shaded Field 24A-G

The following types of supplemental information are accepted in a shaded claim line of the CMS 1500 form field 24A-G:

- Anesthesia duration
- Narrative description of unspecified/ miscellaneous/unlisted codes
- Vendor Product Number–Health Industry Business Communications Council (HIBCC)
- Product Number Healthcare Uniform Code Council–Global Trade Item Number (GTIN), formerly Universal Product Code (UPC) for products

The following qualifiers are to be used when reporting these services.

7	Anesthesia information
ZZ	Narrative description of unspecified/miscellaneous/unlisted codes
OZ	Product Number Healthcare Uniform Code Council – Global Trade Item Number (GTIN)
VP	Vendor Product Number – Health Industry Business Communications Council (HIBCC) Labeling Standard

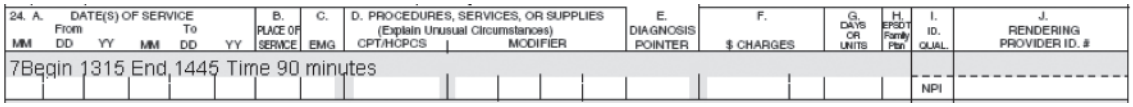
To enter supplemental information, begin at 24A by entering the qualifier and then the information. Do not enter a space between the qualifier and the supplemental information.

When reporting a service that does not have a qualifier, enter two blank spaces before entering the information.

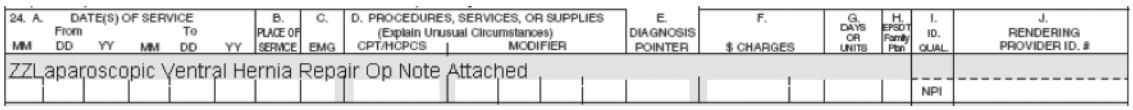
More than one supplemental item can be reported in a single shaded claim line IF the information is related to the un-shaded claim line item it is entered on. When entering more than one supplemental item, enter the first qualifier at the start of 24A followed by the number, code, or other information. Do not enter a space between the qualifier and the supplemental information. Do not enter hyphens or spaces within the HIBCC, or GTIN number/code. After the entry of the first supplemental item, enter three blank spaces and then the next qualifier and number, code, or other information. Do not enter a space between the qualifier and the supplemental information. Do not enter hyphens or spaces within the HIBCC, or GTIN number/code.

Examples:

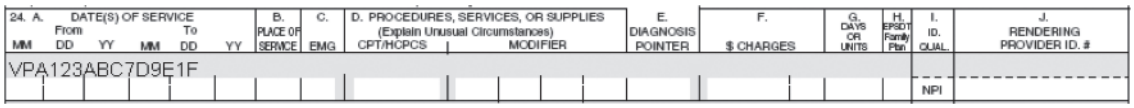
Anesthesia



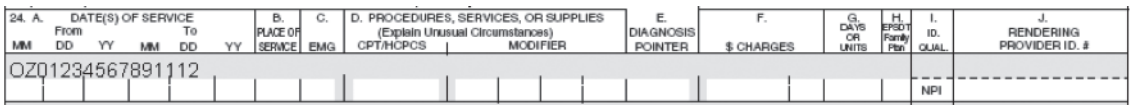
Unlisted, Non-Specific, or Miscellaneous CPT or HCPC Code



Vendor Product Number – HIBCC



Product Number Healthcare Uniform Code Council – GTIN



Appendix V: Common HIPAA Compliant EDI Rejection Codes

These codes are the standard national rejection codes for EDI submissions. All errors indicated for the code must be corrected before the claim is resubmitted. Please see Sunflower's list of common EDI rejections to determine specific actions you may need to take to correct your claims submission.

ERROR_ID	ERROR_DESC
01	Invalid Mbr DOB
02	Invalid Mbr
06	Invalid Prv
07	Invalid Mbr DOB & Prv
08	Invalid Mbr & Prv
09	Mbr not valid at DOS
10	Invalid Mbr DOB; Mbr not valid at DOS
12	Prv not valid at DOS
13	Invalid Mbr DOB; Prv not valid at DOS
14	Invalid Mbr; Prv not valid at DOS
15	Mbr not valid at DOS; Invalid Prv
16	Invalid Mbr DOB; Mbr not valid at DOS; Invalid Prv
17	Invalid Diag
18	Invalid Mbr DOB; Invalid Diag
19	Invalid Mbr; Invalid Diag
21	Mbr not valid at DOS; Prv not valid at DOS
22	Invalid Mbr DOB; Mbr not valid at DOS; Prv not valid at DOS
23	Invalid Prv; Invalid Diag
24	Invalid Mbr DOB; Invalid Prv; Invalid Diag
25	Invalid Mbr; Invalid Prv; Invalid Diag
26	Mbr not valid at DOS; Invalid Diag
27	Invalid Mbr DOB; Mbr not valid at DOS; Invalid Diag
29	Prv not valid at DOS; Invalid Diag
30	Invalid Mbr DOB; Prv not valid at DOS; Invalid Diag
31	Invalid Mbr; Prv not valid at DOS; Invalid Diag
32	Mbr not valid at DOS; Prv not valid; Invalid Diag
33	Invalid Mbr DOB; Mbr not valid at DOS; Prv not valid; Invalid Diag
34	Invalid Proc
35	Invalid DOB; Invalid Proc

36	Invalid Mbr; Invalid Proc
37	Invalid or future date
37	Invalid or future date
38	Mbr not valid at DOS; Prv not valid at DOS; Invalid Diag
39	Invalid Mbr DOB; Mbr not valid at DOS; Prv not valid at DOS; Invalid Diag
40	Invalid Prv; Invalid Proc
41	Invalid Prv; Invalid Proc; Invalid Mbr DOB
42	Invalid Mbr; Invalid Prv; Invalid Proc
43	Mbr not valid at DOS; Invalid Proc
44	Invalid Mbr DOB; Mbr not valid at DOS; Invalid Proc
46	Prv not valid at DOS; Invalid Proc
48	Invalid Mbr; Prv not valid at DOS; Invalid Proc
49	Invalid Proc; Invalid Prv; Mbr not valid at DOS
51	Invalid Diag; Invalid Proc
52	Invalid Mbr DOB; Invalid Diag; Invalid Proc
53	Invalid Mbr; Invalid Diag; Invalid Proc
55	Mbr not valid at DOS; Prv not valid at DOS; Invalid Proc
57	Invalid Prv; Invalid Diag; Invalid Proc
58	Invalid Mbr DOB; Invalid Prv; Invalid Diag; Invalid Proc
59	Invalid Mbr; Invalid Prv; Invalid Diag; Invalid Proc
60	Mbr not valid at DOS; Invalid Diag; Invalid Proc
61	Invalid Mbr DOB; Mbr not valid at DOS; Invalid Diag; Invalid Proc
63	Prv not valid at DOS; Invalid Diag; Invalid Proc
64	Invalid Mbr DOB; Prv not valid at DOS; Invalid Diag; Invalid Proc
65	Invalid Mbr; Prv not valid at DOS; Invalid Diag; Invalid Proc
66	Mbr not valid at DOS; Invalid Prv; Invalid Diag; Invalid Proc
67	Invalid Mbr DOB; Mbr not valid at DOS; Invalid Prv; Invalid Diag; Invalid Proc
72	Mbr not valid at DOS; Prv not valid at DOS; Invalid Diag; Invalid Proc
73	Invalid Mbr DOB; Mbr not valid at DOS; Prv not valid at DOS; Invalid Diag; Invalid Proc
74	Reject. DOS prior to 6/1/2006
75	Invalid Unit
76	Original claim number required
77	INVALID CLAIM TYPE
81	Invalid Unit; Invalid Prv
83	Invalid Unit; Invalid Mbr & Prv

89	Invalid Prv; Mbr not valid at DOS; Invalid DOS
92	Invalid referring provider NPI
93	Invalid Admission Type
A2	CLAIM EXCEEDED THE MAXIMUM 97 SERVICE LINE LIMIT
A2	DIAGNOSIS POINTER INVALID
ZZ	Claim not processed

Appendix VI: Coordination of Benefits (COB) Third Party Liability (TPL)

Third Party Liability refers to another health insurance plan or carrier (e.g., individual, Medicare, group, employer-related, self-insured, self-funded, commercial carrier, automobile insurance, and worker's compensation) that is or may be liable to pay all or part of a member's healthcare expenses. Coordination of Benefits refers to Sunflower Health Plan determining the remainder to pay.

Sunflower Health Plan is *always* the payer of last resort. The only exceptions to this policy are listed below:

- Children and Youth with Special Healthcare Needs (CYSHCN) program
- Department for Children and Families
- Indian Health Services (IHS)
- Crime Victim's Compensation

If probable existence of other insurance is established at the time a claim is filed, Sunflower Health Plan will deny the claim and return it to the provider for a determination of the amount of liability. This means that the provider must attempt to bill the other insurance company prior to filing the claim to Sunflower Health Plan. If a member has other insurance that applies and providers are submitting paper claims, providers need to attach a copy of the EOB from the other insurance company for all affected services.

The paper claim and EOB from the primary carrier must be sent to:

Sunflower Health Plan
P.O. Box 4070
Farmington, MO 63640-3833

CMS-1500

- Complete one of the following to indicate other insurance is involved:
  - Fields 9 and 9A-D (Other Insured's Name)
  - Field 11 and 11A-D (Insured's Policy Group or FECA Number)
- Field 29 (Amount Paid) – Make sure it is completed with any amount paid by insurance or other third-party sources known at the time the claim is submitted. If the amount shown in this field is the result of other insurance, documentation of the payment must be attached. **Do not enter copayment or spenddown payment amounts. They are deducted automatically.**
- Providers submitting claims electronically must include TPL/COB information for each detail line level, where applicable.

UB 04

- Field 50 (Payer Name) – Indicate all third-party resources (TPR). If TPR exists, it must be billed first. Lines B and C should indicate secondary and tertiary coverage. Medicaid will be either the secondary or tertiary coverage and the last payer. When B and C are completed, the remainder of this line must be completed as well as Fields 58-62.

- Field 54 (Prior Payments Payer) – Required if other insurance is involved. Enter amount paid by other insurance. Documentation of the payment must be attached. **Do not enter copayment or spenddown payment amounts. They are deducted automatically.**
  - Field 58 (Insured's Name) – Required.
  - Field 59 (Patient's Relationship to Insured)
    - Line A – Required.
    - Line B and C – Situational.
  - Field 60 (Insured's Unique ID) – Required. Enter the 11-digit beneficiary number from the State of Kansas Medical Card on Line C. If billing for newborn services, use the mother's beneficiary number. The mother's number should only be used if the newborn's ID number is unknown.
  - Field 61 (Insured's Group Name) – Required, if group name is available. Enter the primary insurance information on Line A and Medicare on Line C.
  - Field 62 (Insured's Group Number) – Required, when insured's ID card shows a group number.

Sunflower processes professional and institutional claims using the same calculation applied to other third-party claims. When the Sunflower allowed amount is ***greater*** than the other insurance's paid amount (not including patient liability), Sunflower will make a payment.

Sunflower will pay the lesser of:

- Patient liability amount
- The difference between Sunflower's allowed amount and the other insurance paid amount

When Sunflower's allowed amount is **equal** to or **less** than other insurance allowed paid amount, Sunflower will not make a payment.

When Sunflower denies a claim for primary carrier information, the provider may obtain this information via:

- Paper Explanation of Payment (EOP)
- Secure Portal using the member Eligibility link

The primary carrier information, however, will **not** be located on the 835.

Sunflower Health Plan will not coordinate benefits when the primary insurer denies for the following administrative reasons:

- No Authorization
- Untimely Filing
- Duplicate Denial

If the primary insurer denies for non-administrative reasons, the provider would be required to obtain an authorization for any service Sunflower Health Plan would require an authorization for if we were the primary payer. The provider is encouraged to obtain an authorization for the following potential denials:

- Non-covered Service
- Benefits Exhausted

Long-Term Care Insurance

- When a long-term care (LTC) insurance policy exists, it must be treated as TPL and be cost avoided. The provider must either collect the LTC policy money from the beneficiary or have the policy assigned to the provider. Beneficiaries and their family members must comply with assignment of the LTC policy and the money from the LTC policy. If the beneficiary does not comply, the provider should notify the fiscal agent or the beneficiary's case worker.
- If a beneficiary has LTC insurance and elects hospice care while residing in a nursing facility (NF), the LTC insurance benefit should be collected and reported to Sunflower by the hospice provider. If the LTC insurance money is paid directly to the NF or the NF is collecting the money from the beneficiary, the NF must give the insurance money to the hospice provider while the beneficiary is in hospice care. The hospice must report this money as TPL insurance when submitting claims to Sunflower Health Plan.
- Routine services and/or supplies are included in NF per diem rate and not billable separately. Therefore, any other insurance payments should be subtracted from the Sunflower Health Plan-allowed amount for room and board.

Billing TPL After Receipt of Sunflower Payment

- A provider should not bill Sunflower prior to receiving payment or denial of a claim from another insurance company.
- If a provider discovers an insurance policy or other liable third party that should have paid primary to Sunflower after receiving payment from Sunflower, the provider must bill that insurance carrier and attempt to collect payment. However, the provider should not adjust the claim with Sunflower until after that provider receives payment from the insurance carrier. The State of Kansas has a contractor who collects payments from insurance carriers on claims that Sunflower should have paid secondary but got billed primary. This contractor may have already collected that money. Therefore, the provider should wait until receiving payment from the insurance carrier before adjusting the claim, as the insurance carrier may deny for previous payment.
- If a third-party carrier makes any payment to a provider after Sunflower has made payment, the provider must submit an adjustment request within 30 days. If a third-party carrier makes payment to a provider while a claim to Sunflower is pending, the provider should wait until the Sunflower claim has been processed and then adjust the Sunflower claim within one month. The provider must also notify Sunflower of the TPL carrier.
- Sunflower may be rebilled after the claim has been adjudicated by the third-party resource.

TPL Payment After Sunflower Payment

If a provider receives payment from a third party after Sunflower has made payment to the provider, the provider must reimburse Sunflower. The provider needs to adjust the claim and indicate the TPL payment.

No Response from Other Insurance

- If a provider bills a third-party insurance and after 30 days has not received a written or electronic response to the claim from the third-party insurance, the provider can submit the claim within 12 months of the service date to the Sunflower Health Plan as a denial from the insurance company.

  - If submitting a paper claim, any documentation sent to the third-party insurance must be attached with the claim.
  - If submitting electronically, the documentation must be kept on file as proof of prior billing to the third-party insurance and available upon request.
- This 30-day stipulation does not apply to:
  - Self-insured employer plans
  - Medicare/Medicare supplement policies
  - Other Medicaid MCOs
  - Workers' compensation
  - Federal employee plans
  - Vision or drug plans
  - Disability income
  - Medical claims paid by auto or homeowners insurance
- If the third-party insurance sends any requests to the provider for additional information, the provider must respond appropriately. If the provider complies with the requests for additional information and after 90 days from the date of the original claim to the third-party insurance has not received payment or denial from the third-party insurance, then the provider can submit the claim within 12 months of the service date to Sunflower Health Plan as a denial from the insurance company.

Note: This does not apply to the insurance plan types listed above.

- If submitting a paper claim, any documentation sent to the third-party insurance must be attached with the claim. When submitting a claim electronically, the documentation must be kept on file and available upon request.

Documentation Requirements

Adequate documentation is important for claims with TPL. Attachment of acceptable proof of payment or denial is required for paper claim submissions. Claims billed using electronic submissions are not required to submit paper documentation, but documentation must be retained in the patient's file and is subject to request and review by the State.

Billing Documentation

The only acceptable forms of documentation proving that insurance was billed first are an RA or EOB from the other insurer. The provider can use a copy of the claim filed with the insurance company by the provider or the policyholder as proof of billing, if the other insurance company never responded.

Paper Billing Documentation

If a beneficiary has other insurance that applies and providers are submitting paper claims, providers need to attach a copy of the EOB from the other insurance company for all affected services.

Acceptable Proof of Payment or Denial

Documentation of proper payment or denial of TPL is considered acceptable if it corresponds with the beneficiary name, dates of service, charges, and TPL payment listed on the Sunflower claim. Exception: If there is a reason why the charges do not match (such as other insurance requires another code to be billed, which generates a different charge), the provider should note this on the EOB.

Acceptable documentation:

- Insurance carrier's EOB
- Insurance carrier's RA
- Correspondence from insurance carrier indicating payment
- Copy of provider's ledger account

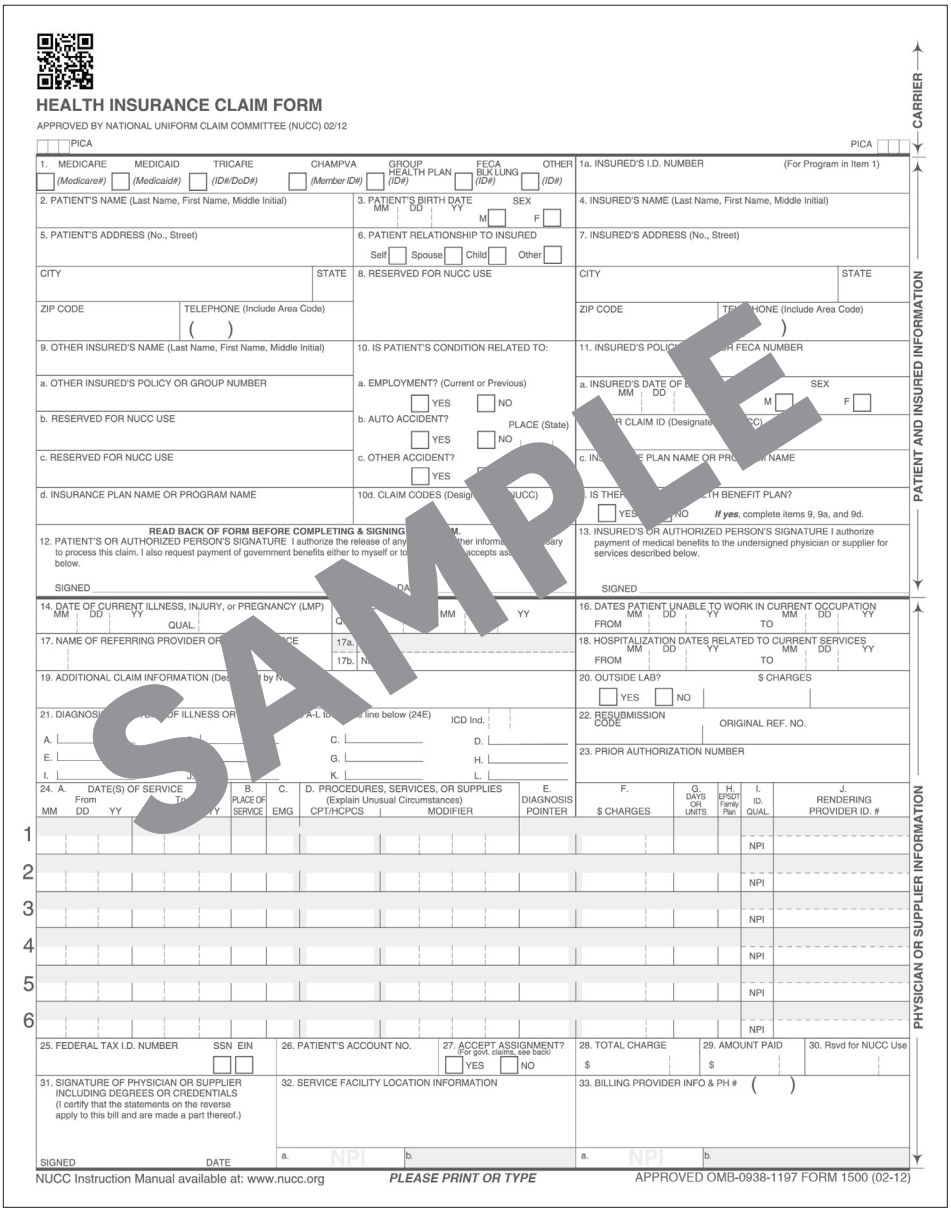
Appendix VII: Claim Form Instructions

Billing Guide for a CMS-1500 and CMS UB-04

Required (R) fields must be completed on all claims. Conditional (C) fields must be completed if the information applies to the situation or the service provided.

Note: *Claims with missing or invalid Required (R) field information will be rejected or denied*

Completing a CMS 1500 Form



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

1. MEDICARE (Medicare#) MEDICAID (Medicaid#) TRICARE (ID#/DoD#) CHAMPVA (Member ID#) GROUP HEALTH PLAN (ID#) FECA BLK LUNG (ID#) OTHER (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. RESERVED FOR NUCC USE

CITY STATE

ZIP CODE TELEPHONE (Include Area Code)

ZIP CODE TELEPHONE (Include Area Code)

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF B MM DD SEX M F

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? PLACE (State) YES NO

R CLAIM ID (Designate

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES

c. INS E PLAN NAME OR PRO N NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Desig UCC)

. IS THE TH BENEFIT PLAN? YES NO *If yes*, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING M.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any ther informa sary to process this claim. I also request payment of government benefits either to myself or to accepts as below.

SIGNED DA

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

MM YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PROVIDER OR CE

17a.

17b. NI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. ADDITIONAL CLAIM INFORMATION (Des by NU

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSI OF ILLNESS OR A-L to line below (24E) ICD Ind.

A. C. D.

E. G. H.

I. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

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. #
1									NPI	
2									NPI	
3									NPI	
4									NPI	
5									NPI	
6									NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

APPROVED OMB-0938-1197 FORM 1500 (02-12)

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

SAMPLE

FIELD #	FIELD DESCRIPTION	INSTRUCTIONS OR COMMENTS	REQUIRED OR CONDITIONAL
1	INSURANCE PROGRAM IDENTIFICATION	Check only the type of health coverage applicable to the claim. This field indicated the payer to whom the claim is being filed. Enter "X" in the box noted "Other"	R
1a	INSURED'S ID NUMBER	The 9-digit identification number on the member's Sunflower ID card	R
2	PATIENT'S NAME (Last Name, First Name, Middle Initial)	Enter the patient's name as it appears on the member's Sunflower ID card. Do not use nicknames.	R
3	PATIENT'S BIRTH DATE / SEX	Enter the patient's 8-digit date of (MM/DD/YYYY) and mark the appropriate box to indicate the patient's sex/gender. M= Male F= Female	R
4	INSURED'S NAME	Enter the patient's name as it appears on the member's Sunflower ID card.	C
5	PATIENT'S ADDRESS (Number, Street, City, State, Zip code) Telephone (include area code)	Enter the patient's complete address and telephone number including area code on the appropriate line. First line – Enter the street address. Do not use commas, periods, or other punctuation in the address (e.g., 123 N Main Street 101 instead of 123 N. Main Street, #101). Second line – In the designated block, enter the city and state. Third line – Enter the zip code and phone number. When entering a 9-digit zip code (zip+4 codes), include the hyphen. Do not use a hyphen or space as a separator within the telephone number (i.e., (803)5551414). Note: Patient's Telephone does not exist in the electronic 837 Professional 4010A1.	C

6	PATIENT'S RELATION TO INSURED	Always mark to indicate self.	C
7	INSURED'S ADDRESS (Number, Street, City, State, Zip code) Telephone (include area code)	Enter the patient's complete address and telephone number including area code on the appropriate line. First line – Enter the street address. Do not use commas, periods, or other punctuation in the address (e.g., 123 N Main Street 101 instead of 123 N. Main Street, #101). Second line – In the designated block, enter the city and state. Third line – Enter the zip code and phone number. When entering a 9-digit zip code (zip+4 codes), include the hyphen. Do not use a hyphen or space as a separator within the telephone number (i.e., (803)5551414). Note: Patient's Telephone does not exist in the electronic 837 Professional 4010A1.	C
8	PATIENT STATUS		Not Required
9	OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	Refers to someone other than the patient. REQUIRED if patient is covered by another insurance plan. Enter the complete name of the insured.	C
9a	*OTHER INSURED'S POLICY OR GROUP NUMBER	REQUIRED if field 9 is completed. Enter the policy or group number of the other insurance plan.	C
9b	RESERVED FOR NUCC USE		Not Required
9c	RESERVED FOR NUCC USE		Not Required

9d	INSURANCE PLAN NAME OR PROGRAM NAME	REQUIRED if field 9 is completed. Enter the other insured's (name of person listed in field 9) insurance plan or program name.	C
10a, b, c	IS PATIENT'S CONDITION RELATED TO:	Enter a Yes or No for each category/line (a, b, and c). Do not enter a Yes and No in the same category/line. When marked Yes, primary insurance information must then be shown in Item Number 11.	R
10d	CLAIM CODES (Designated by NUCC)	When reporting more than one code, enter three blank spaces and then the next code.	C
11	INSURED'S POLICY OR FECA NUMBER	REQUIRED when other insurance is available. Enter the policy, group, or FECA number of the other insurance. If Item Number 10abc is marked Y, this field should be populated.	C
11a	INSURED'S DATE OF BIRTH / SEX	Enter the 8-digit date of birth (MM/DD/YYYY) of the insured and an X to indicate the sex (gender) of the insured. Only one box can be marked. If gender is unknown, leave blank.	C
11b	OTHER CLAIM ID (Designated by NUCC)	The following qualifier and accompanying identifier has been designated for use: Y4 Property Casualty Claim Number FOR WORKERS' COMPENSATION OR PROPERTY & CASUALTY: Required if known. Enter the claim number assigned by the payer.	C
11c	INSURANCE PLAN NAME OR PROGRAM NUMBER	Enter name of the insurance health plan or program.	C
11d	IS THERE ANOTHER HEALTH BENEFIT PLAN	Mark Yes or No. If Yes, complete field's 9a-d and 11c.	R

12	PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE	Enter "Signature on File", "SOF", or the actual legal signature. The provider must have the member's or legal guardian's signature on file or obtain their legal signature in this box for the release of information necessary to process and/or adjudicate the claim.	C
13	PATIENT'S OR AUTHORIZED PERSONS SIGNATURE	Obtain signature if appropriate.	Not Required
14	DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR Pregnancy (LMP)	Enter the 6-digit (MM/DD/YY) or 8-digit (MM/DD/YYYY) date of the first date of the present illness, injury, or pregnancy. For pregnancy, use the date of the last menstrual period (LMP) as the first date. Enter the applicable qualifier to identify which date is being reported. 431 Onset of Current Symptoms or Illness 484 Last Menstrual Period	C
15	IF PATIENT HAS SAME OR SIMILAR ILLNESS. GIVE FIRST DATE	Enter another date related to the patient's condition or treatment. Enter the date in the 6-digit (MM/DD/YY) or 8-digit (MM/DD/YYYY) format	C
16	DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION		C
17	NAME OF REFERRING PHYSICIAN OR OTHER SOURCE	Enter the name of the referring physician or professional (first name, middle initial, last name, and credentials).	C
17a	ID NUMBER OF REFERRING PHYSICIAN	Required if field 17 is completed. Use ZZ qualifier for Taxonomy code	C

17b	NPI NUMBER OF REFERRING PHYSICIAN	Required if field 17 is completed. If unable to obtain referring NPI, servicing NPI may be used.	C
18	HOSPITALIZATION DATES RELATED TO CURRENT SERVICES		C
19	RESERVED FOR LOCAL USE – NEW FORM: ADDITIONAL CLAIM INFORMATION		C
20	OUTSIDE LAB / CHARGES		C
21	DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS A-L to ITEM 24E BY LINE). NEW FORM ALLOWS UP TO 12 DIAGNOSES, AND ICD INDICATOR	Enter the codes to identify the patient's diagnosis and/or condition. List no more than 12 ICD-9-CM or ICD-10-CM diagnosis codes. Relate lines A – L to the lines of service in 24E by the letter of the line. Use the highest level of specificity. Do not provide narrative description in this field. Note: Claims missing or with invalid diagnosis codes will be rejected or denied for payment.	R
22	RESUBMISSION CODE / ORIGINAL REF.NO.	For re-submissions or adjustments, enter the original claim number of the original claim. New form – for resubmissions only: 7 – Replacement of Prior Claim 8 – Void/Cancel Prior Claim	C
23	PRIOR AUTHORIZATION NUMBER or CLIA NUMBER	Enter the authorization or referral number. Refer to the Provider Manual for information on services requiring referral and/or prior authorization. CLIA number for CLIA waived or CLIA certified laboratory services	If auth = C If CLIA = R (If both, always submit the CLIA number)

24a-j General Information		Box 24 contains six claim lines. Each claim line is split horizontally into shaded and un-shaded areas. Within each un-shaded area of a claim line there are 10 individual fields labeled A-J. Within each shaded area of a claim line there are four individual fields labeled 24A-24G, 24H, 24J, and 24Jb. Fields 24A through 24G are a continuous field for the entry of supplemental information. Instructions are provided for shaded and unshaded fields. The shaded area for a claim line is to accommodate the submission of supplemental information, EPSDT qualifier, and Provider Number. Shaded boxes 24 a–g is for line item supplemental information and provides a continuous line that accepts up to 61 characters. Refer to the instructions listed below for information on how to complete. The un-shaded area of a claim line is for the entry of claim line item detail.	
24a-g shaded	SUPPLEMENTAL INFORMATION	The shaded top portion of each service claim line is used to report supplemental information for: NDC Narrative description of unspecified codes Contract Rate For detailed instructions and qualifiers refer to Appendix IV of this guide.	C
24a unshaded	DATE(S) OF SERVICE	Enter the date the service listed in field 24D was performed (MMDDYYYY). If there is only one date, enter that date in the “From” field. The “To” field may be left blank or populated with the “From” date. If identical services (identical CPT/HCPC code(s)) were performed each date must be entered on a separate line.	R
24b unshaded	PLACE OF SERVICE	Enter the appropriate 2-digit CMS Standard Place of Service (POS) Code. A list of current POS Codes may be found on the CMS website..	R

24c unshaded	EMG	Enter Y (Yes) or N (No) to indicate if the service was an emergency..	Not Required
24d unshaded	PROCEDURES, SERVICES OR SUPPLIES CPT/HCPCS MODIFIER	Enter the 5-digit CPT or HCPC code and 2-character modifier, if applicable. Only one CPT or HCPC and up to four modifiers may be entered per claim line. Codes entered must be valid for date of service. Missing or invalid codes will be denied for payment. Only the first modifier entered is used for pricing the claim. Failure to use modifiers in the correct position or combination with the Procedure Code, or invalid use of modifiers, will result in a rejected, denied, or incorrectly paid claim.	R
24e unshaded	DIAGNOSIS CODE	In 24E, enter the diagnosis code reference letter (pointer) as shown in Item Number 21 to relate the date of service and the procedures performed to the primary diagnosis. When multiple services are performed, the primary reference letter for each service should be listed first, other applicable services should follow. The reference letter(s) should be A – L or multiple letters as applicable. ICD-9-CM (or ICD-10-CM, once mandated) diagnosis codes must be entered in Item Number 21 only. Do not enter them in 24E. Do not use commas between the diagnosis pointer numbers. Diagnosis Codes must be valid ICD-9/10 Codes for the date of service or the claim will be rejected/denied.	R
24f unshaded	CHARGES	Enter the charge amount for the claim line item service billed. Dollar amounts to the left of the vertical line should be right justified. Up to eight characters are allowed (i.e., 199,999.99). Do not enter a dollar sign ($). If the dollar amount is a whole number (i.e., 10.00), enter 00 in the area to the right of the vertical line.	R

24g unshaded	DAYS OR UNITS	Enter quantity (days, visits, units). If only one service provided, enter a numeric value of one.	R
24h shaded	EPSDT (Family Planning)	Leave blank or enter "Y" if the services were performed as a result of an EPSDT referral.	C
24h unshaded	EPSDT (Family Planning)	Enter the appropriate qualifier for EPSDT visit.	C
24i shaded	ID QUALIFIER	Use ZZ qualifier for Taxonomy Use 1D qualifier for ID, if an Atypical Provider.	R
24j shaded	NON-NPI PROVIDER ID#	Typical Providers: Enter the Provider taxonomy code that corresponds to the qualifier entered in field 24I shaded. Use ZZ qualifier for Taxonomy Code. Atypical Providers: Enter the Provider ID number.	R
24j unshaded	NPI PROVIDER ID	Typical Providers ONLY: Enter the 10-character NPI ID of the provider who rendered services. If the provider is billing as a member of a group, the rendering individual provider's 10-character NPI ID may be entered. Enter the billing NPI if services are not provided by an individual (e.g., DME, Independent Lab, Home Health, RHC/FQHC General Medical Exam, etc.).	R
25	FEDERAL TAX ID NUMBER SSN/EIN	Enter the provider or supplier 9-digit Federal Tax ID number and mark the box labeled EIN	R
26	PATIENT'S ACCOUNT NO.	Enter the provider's billing account number	C

27	ACCEPT ASSIGNMENT	Enter an X in the YES box. Submission of a claim for reimbursement of services provided to an Ambetter recipient using state funds indicates the provider accepts assignment. Refer to the back of the CMS 1500 (02-12) Claim Form for the section pertaining to payments.	C
28	TOTAL CHARGES	Enter the total charges for all claim line items billed – claim line 24F. Dollar amounts to the left of the vertical line should be right justified. Up to 8 characters are allowed (i.e., 199999.99). Do not use commas. Do not enter a dollar sign ($). If the dollar amount is a whole number (i.e., 10.00), enter 00 in the area to the right of the vertical line.	R
29	AMOUNT PAID	REQUIRED when another carrier is the primary payer. Enter the payment received from the primary payer prior to invoicing Ambetter. Ambetter programs are always the payers of last resort. Dollar amounts to the left of the vertical line should be right justified. Up to eight characters are allowed (i.e., 199999.99). Do not use commas. Do not enter a dollar sign ($). If the dollar amount is a whole number (i.e., 10.00), enter 00 in the area to the right of the vertical line.	C

30	BALANCE DUE	REQUIRED when field 29 is completed. Enter the balance due (total charges minus the amount of payment received from the primary payer). Dollar amounts to the left of the vertical line should be right justified. Up to eight characters are allowed (i.e., 199999.99). Do not use commas. Do not enter a dollar sign ($). If the dollar amount is a whole number (i.e., 10.00), enter 00 in the area to the right of the vertical line.	C
31	SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS	If there is a signature waiver on file, you may stamp, print, or computer-generate the signature; otherwise, the practitioner or practitioner's authorized representative MUST sign the form. If signature is missing or invalid the claim will be returned unprocessed. Note: Does not exist in the electronic 837P.	R

32	SERVICE FACILITY LOCATION INFORMATION	REQUIRED if the location where services were rendered is different from the billing address listed in field 33. Enter the name and physical location. (P.O. Box numbers are not acceptable here.) First line – Enter the business/facility/ practice name. Second line – Enter the street address. Do not use commas, periods, or other punctuation in the address (e.g., 123 N Main Street 101 instead of 123 N. Main Street, #101). Third line – In the designated block, enter the city and state. Fourth line – Enter the zip code and phone number. When entering a 9-digit zip code (zip+4 codes), include the hyphen.	C
32a	NPI – SERVICES RENDERED	Typical Providers ONLY: REQUIRED if the location where services were rendered is different from the billing address listed in field 33. Enter the 10-character NPI ID of the facility where services were rendered.	C
32b	OTHER PROVIDER ID	REQUIRED if the location where services were rendered is different from the billing address listed in field 33. Typical Providers: Enter the 2-character qualifier ZZ followed by the Taxonomy Code (no spaces). Atypical Providers: Enter the 2-character qualifier ID (no spaces).	C

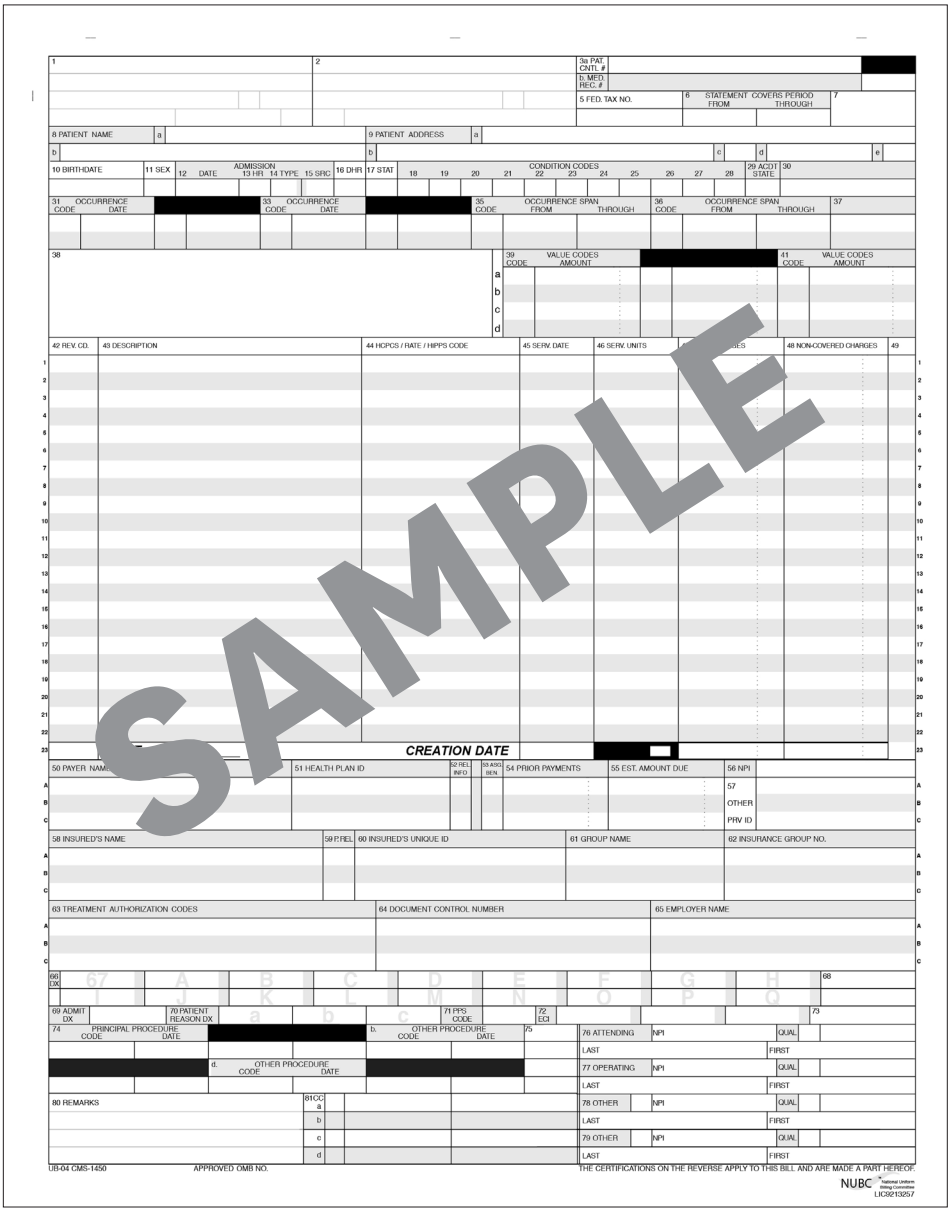
33	BILLING PROVIDER INFO & PH #	Enter the billing provider's complete name, address (include the zip+4 code), and phone number. First line – Enter the business/facility/practice name. Second line – Enter the street address. Do not use commas, periods, or other punctuation in the address (e.g., 123 N Main Street 101 instead of 123 N. Main Street, #101). Third line – In the designated block, enter the city and state. Fourth line – Enter the zip code and phone number. When entering a 9-digit zip code (zip+4 code), include the hyphen. Do not use a hyphen or space as a separator within the telephone number (i.e., (555)555-5555). NOTE: The 9-digit zip code (zip+4 code) is a requirement for paper and EDI claim submission.	R
33a	GROUP BILLING NPI	Typical Providers ONLY: REQUIRED if the location where services were rendered is different from the billing address listed in field 33. Enter the 10-character NPI ID.	R
33b	GROUP BILLING OTHERS ID	Enter as designated below the Billing Group taxonomy code. Typical Providers: Enter the Provider Taxonomy Code. Use ZZ qualifier. Atypical Providers: Enter the Provider ID number.	R

UB-04 Claim Form

A UB-04 is the only acceptable claim form for submitting inpatient or outpatient hospital claim charges for reimbursement by Sunflower. Hospital and Long Term Care providers must use the UB-04 red/white claim form when requesting payment for medical services and supplies . Any UB-04 claim not submitted on the red claim from will be returned to the provider.

Incomplete or inaccurate information will result in the claim/encounter being rejected for corrections.

Completing a CMS UB-04 Form



1	(UNLABELED FIELD)	LINE 1: Enter the complete provider name. LINE 2: Enter the complete mailing address. LINE 3: Enter the city, state, and zip+4 codes (include hyphen). NOTE: The 9-digit zip (zip+4 codes) is a requirement for paper and EDI claims. LINE 4: Enter the area code and phone number.	R
2	(UNLABELED FIELD)	Enter the Pay-to Name and Address.	Not Required
3a	PATIENT CONTROL NO.	Enter the facility patient account/control number.	Not Required
3b	MEDICAL RECORD NUMBER	Enter the facility patient medical or health record number.	R
4	TYPE OF BILL	Enter the appropriate Type of Bill (TOB) Code as specified by the NUBC UB-04 Uniform Billing Manual minus the leading "0" (zero). A leading "0" is not needed. Digits should be reflected as follows: 1st Digit – Indicating the type of facility. 2nd Digit – Indicating the type of care. 3rd Digit – Indicating the bill sequence (Frequency code).	R
5	FED. TAX NO.	Enter the 9-digit number assigned by the federal government for tax reporting purposes.	R

6	STATEMENT COVERS PERIOD FROM/ THROUGH	Enter begin and end, or admission and discharge, dates for the services billed. Inpatient and outpatient observation stays must be billed using the admission date and discharge date. Outpatient therapy, chemotherapy, laboratory, pathology, radiology, and dialysis may be billed using a date span. All other outpatient services must be billed using the actual date of service (MMDDYY).	R
7	(UNLABELED FIELD)	Not used	Not Required
8a	PATIENT NAME	8a – Enter the first 9 digits of the identification number on the member's Ambetter ID card.	R
8b	PATIENT NAME	8b – enter the patient's last name, first name, and middle initial as it appears on the Sunflower ID card. Use a comma or space to separate the last and first names. Titles: (Mr., Mrs., etc.) should not be reported in this field. Prefix: No space should be left after the prefix of a name (e.g., McKendrick. H). Hyphenated names: Both names should be capitalized and separated by a hyphen (no space). Suffix: A space should separate a last name and suffix.	R

9	PATIENT ADDRESS	Enter the patient's complete mailing address. Line a: Street address Line b: City Line c: State Line d: Zip code Line e: Country Code (NOT REQUIRED)	R (except line 9e)
10	BIRTHDATE	Enter the patient's date of birth (MMDDYYYY).	R
11	SEX	Enter the patient's sex. Only M or F is accepted.	R
12	ADMISSION DATE	Enter the date of admission for inpatient claims and date of service for outpatient claims. Enter the time using 2-digit military time (00-23) for the time of inpatient admission or time of treatment for outpatient services.	R

13	ADMISSION HOUR	00- 12:00 midnight to 12:59 01- 01:00 to 01:59 02- 02:00 to 02:59 03- 03:00 to 03:59 04- 04:00 to 04:59 05- 05:00 to 05:59 06- 06:00 to 06:59 07- 07:00 to 07:59 08- 08:00 to 08:59 09- 09:00 to 09:59 10- 10:00 to 10:59 11- 11:00 to 11:59 12- 12:00 noon to 12:59 13- 01:00 to 01:59 14- 02:00 to 02:59 15- 03:00 to 03:59 16- 04:00 to 04:59 17- 05:00 to 05:59 18- 06:00 to 06:59 19- 07:00 to 07:59 20- 08:00 to 08:59 21- 09:00 to 09:59 22- 10:00 to 10:59 23- 11:00 to 11:59	R
14	ADMISSION TYPE	Require for inpatient and outpatient admissions (Enter the 1-digit code indicating the nature of the admission using the appropriate following codes): 1 Emergency 2 Urgent 3 Elective 4 Newborn 5 Trauma	R

15	ADMISSION SOURCE	Required for inpatient and outpatient admissions. Enter the 1-digit code indicating the source of the admission or outpatient service using one of the following codes. For type of admission 1,2,3, or 5: 1 – Physician Referral 2 – Clinic Referral 3 – Health Maintenance Referral (HMO) 4 – Transfer from a Hospital 5 – Transfer from Skilled Nursing Facility 6 – Transfer from Another Health Care Facility 7 – Emergency Room 8 – Court/Law Enforcement 9 – Information Not Available For type of admission 4 (newborn): 1 – Physician Referral 2 – Not Available	R

16	DISCHARGE HOUR	Enter the time using 2-digit military times (00-23) for the time of the inpatient or outpatient discharge. 00- 12:00 midnight to 12:59 01- 01:00 to 01:59 02- 02:00 to 02:59 03- 03:00 to 03:59 04- 04:00 to 04:59 05- 05:00 to 05:59 06- 06:00 to 06:59 07- 07:00 to 07:59 08- 08:00 to 08:59 09- 09:00 to 09:59 10- 10:00 to 10:59 11- 11:00 to 11:59 12- 12:00 noon to 12:59 13- 01:00 to 01:59 14- 02:00 to 02:59 15- 03:00 to 03:59 16- 04:00 to 04:59 17- 05:00 to 05:59 18- 06:00 to 06:59 19- 07:00 to 07:59 20- 08:00 to 08:59 21- 09:00 to 09:59 22- 10:00 to 10:59 23- 11:00 to 11:59	C

17 **(continued on next page)**	PATIENT STATUS	REQUIRED for inpatient claims. Enter the 2-digit disposition of the patient as of the "through" date for the billing period listed in field 6 using one of the following codes: 01 Routine discharge 02 Discharged/transferred to another short-term general hospital for inpatient care 03 Discharged to SNF 04 Discharged to ICF 05 Discharged to another type of institution 06 Discharged to care of home health service organization 07 Left against medical advice 08 Discharged/transferred to home under care of a home IV provider 09 Admitted as an inpatient to this hospital (only for use on Medicare outpatient hospital claims) 20 Expired or did not recover 30 Still patient (To be used only when the client has been in the facility for 30 consecutive days if payment is based on DRG) 40 Expired at home (hospice use only) 41 Expired in a medical facility (hospice use only) 42 Expired – place unknown (hospice use only) 43 Discharged/transferred to a federal hospital (such as a Veteran's Administration [VA] hospital) 50 Hospice – home 51 Hospice – medical facility	R

17 (continued from previous page)	PATIENT STATUS (continued)	61 Discharged/transferred within this institution to a hospital-based Medicare-approved swing bed 62 Discharged/transferred to an inpatient rehabilitation facility (IRF), including rehabilitation distinct part units of a hospital 63 Discharged/transferred to a Medicare certified long-term care hospital (LTCH) 64 Discharged/transferred to a nursing facility certified under Medicaid but not certified under Medicare 65 Discharged/transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital 66 Discharged/transferred to a critical access hospital (CAH)	R
18 – 28	CONDITION CODES	REQUIRED when applicable. Condition codes are used to identify conditions relating to the bill that may affect payer processing. Each field (18-24) allows entry of a 2-character code. Codes should be entered in alphanumeric sequence (numbered codes precede alphanumeric codes). For a list of codes and additional instructions refer to the NUBC UB-04 Uniform Billing Manual.	C
29	ACCIDENT STATE		Not Required
30	(UNLABELED FIELD)	Not Used	Not Required

31-34 a-b	OCCURRENCE CODE and OCCURENCE DATE	Occurrence Code: REQUIRED when applicable. Occurrence Codes are used to identify events relating to the bill that may affect payer processing. Each field (31-34a) allows for entry of a 2-character code. Codes should be entered in alphanumeric sequence (numbered codes precede alphanumeric codes). For a list of codes and additional instructions refer to the NUBC UB-04 Uniform Billing Manual. Occurrence Date: REQUIRED when applicable or when a corresponding Occurrence Code is present on the same line (31a-34a). Enter the date for the associated Occurrence Code in MMDDYYYY format.	C
35-36 a-b	OCCURRENCE SPAN CODE and OCCURRENCE DATE	Occurrence Span Code: REQUIRED when applicable. Occurrence Codes are used to identify events relating to the bill that may affect payer processing. Each field (31-34a) allows for entry of a 2-character code. Codes should be entered in alphanumeric sequence (numbered codes precede alphanumeric codes). For a list of codes and additional instructions refer to the NUBC UB-04 Uniform Billing Manual. Occurrence Span Date: REQUIRED when applicable or when a corresponding Occurrence Span code is present on the same line (35a-36a). Enter the date for the associated Occurrence Code in MMDDYYYY format.	C

37	(UNLABELED FIELD)	REQUIRED for re-submissions or adjustments. Enter the DCN (Document Control Number) of the original claim.	C
38	RESPONSIBLE PARTY NAME AND ADDRESS		Not Required
39-41 a-d	VALUE CODES CODES and AMOUNTS	Code: REQUIRED when applicable. Value codes are used to identify events relating to the bill that may affect payer processing. Each field (39-41) allows for entry of a 2-character code. Codes should be entered in alphanumeric sequence (numbered codes precede alphanumeric codes). Up to 12 codes can be entered. All "a" fields must be completed before using "b" fields, all "b" fields before using "c" fields, and all "c" fields before using "d" fields. For a list of codes and additional instructions refer to the NUBC UB-04 Uniform Billing Manual. Amount: REQUIRED when applicable or when a Value Code is entered. Enter the dollar amount for the associated value code. Dollar amounts to the left of the vertical line should be right justified. Up to eight characters are allowed (i.e., 199,999.99). Do not enter a dollar sign ($) or a decimal. A decimal is implied. If the dollar amount is a whole number (i.e., 10.00), enter 00 in the area to the right of the vertical line.	C
General Information Fields 42-47	SERVICE LINE DETAIL	The following UB-04 fields – 42-47: Have a total of 22 service lines for claim detail information. Fields 42, 43, 45, 47, 48 include separate instructions for the completion of lines 1-22 and line 23.	

42 **Lines 1-22**	REV CD	Enter the appropriate revenue codes itemizing accommodations, services, and items furnished to the patient. Refer to the NUBC UB-04 Uniform Billing Manual for a complete listing of revenue codes and instructions. Enter accommodation revenue codes first followed by ancillary revenue codes. Enter codes in ascending numerical value.	R
42 **Line 23**	Rev CD	Enter 0001 for total charges.	R
43 **Lines 1-22**	DESCRIPTION	Enter a brief description that corresponds to the revenue code entered in the service line of field 42.	R
43 **Line 23**	PAGE _____ OF _____	Enter the number of pages. Indicate the page sequence in the "PAGE" field and the total number of pages in the "OF" field. If only one claim form is submitted, enter a "1" in both fields (i.e., PAGE "1" OF "1"). (Limited to 4 pages per claim).	C
44	HCPCS/RATES	REQUIRED for outpatient claims when an appropriate CPT/HCPCS Code exists for the service line revenue code billed. The field allows up to 9 characters. Only one CPT/HCPC and up to two modifiers are accepted. When entering a CPT/HCPCS with a modifier(s) do not use spaces, commas, dashes, or the like between the CPT/HCPC and modifier(s). Refer to the NUBC UB-04 Uniform Billing Manual for a complete listing of revenue codes and instructions. Please refer to your current provider contract.	C
45 **Lines 1-22**	SERVICE DATE	REQUIRED on all outpatient claims. Enter the date of service for each service line billed. (MMDDYY) Multiple dates of service may not be combined for outpatient claims.	C

45 **Line 23**	CREATION DATE	Enter the date the bill was created or prepared for submission on all pages submitted (MMDDYY).	R
46	SERVICE UNITS	Enter the number of units, days, or visits for the service. A value of at least "1" must be entered. For inpatient room charges, enter the number of days for each accommodation listed.	R
47 **Lines 1-22**	TOTAL CHARGES	Enter the total charge for each service line.	R
47 **Line 23**	TOTALS	Enter the total charges for all service lines.	R
48 **Lines 1-22**	NON-COVERED CHARGES	Enter the non-covered charges included in field 47 for the revenue code listed in field 42 of the service line. Do not list negative amounts.	C
48 **Line 23**	TOTALS	Enter the total non-covered charges for all service lines.	C
49	(UNLABELED FIELD)	Not Used	Not Required
50 **A-C**	PAYER	Enter the name of each payer from which reimbursement is being sought in the order of the payer liability. Line A refers to the primary payer; B, secondary; and C, tertiary	R
51	HEALTH PLAN IDENTIFICATION NUMBER		Not Required

52 **A-C**	REL. INFO	REQUIRED for each line (A, B, C) completed in field 50. Release of Information Certification Indicator. Enter "Y" (yes) or "N" (no). Providers are expected to have necessary release information on file. It is expected that all released invoices contain "Y."	R
53	ASG. BEN.	Enter "Y" (yes) or "N" (no) to indicate a signed form is on file authorizing payment by the payer directly to the provider for services.	R
54	PRIOR PAYMENTS	Enter the amount received from the primary payer on the appropriate line when Ambetter is listed as secondary or tertiary.	C
55	EST. AMOUNT DUE		Not Required
56	NATIONAL PROVIDER IDENTIFIER or PROVIDER ID	Required: Enter provider's 10-character NPI ID.	R
57	OTHER PROVIDER ID	Enter the numeric provider identification number. Enter the TPI number (non-NPI number) of the billing provider.	R
58	INSURED'S NAME	For each line (A, B, C) completed in field 50, enter the name of the person who carries the insurance for the patient. In most cases this will be the patient's name. Enter the name as last name, first name, middle initial.	R
59	PATIENT RELATIONSHIP		Not Required
60	INSURED'S UNIQUE ID	REQUIRED: Enter the patient's Insurance ID exactly as it appears on the patient's ID card. Enter the Insurance ID in the order of liability listed in field 50.	R

61	GROUP NAME		Not Required
62	INSURANCE GROUP NO.		Not Required
63	TREATMENT AUTHORIZATION CODES	Enter the prior authorization or referral when services require pre-certification.	Not Required
64	DOCUMENT CONTROL NUMBER	Enter the 12-character original claim number of the paid/denied claim when submitting a replacement or void on the corresponding A, B, C line reflecting Ambetter Health Plan from field 50. Applies to claim submitted with a Type of Bill (field 4) Frequency of "7" (Replacement of Prior Claim) or Type of Bill Frequency of "8" (Void/Cancel of Prior Claim). *Please refer to reconsider/corrected claims section.	C
65	EMPLOYER NAME		Not Required
66	DX VERSION QUALIFIER		Not Required
67	PRINCIPAL DIAGNOSIS CODE	Enter the principal/primary diagnosis or condition using the appropriate release/ update of ICD-9/10-CM Volumes 1 & 3 for the date of service.	R

67 A-Q	OTHER DIAGNOSIS CODE	Enter additional diagnosis or conditions that coexist at the time of admission or that develop subsequent to the admission and have an effect on the treatment or care received using the appropriate release/update of ICD-9/10-CM Volumes 1 & 3 for the date of service. Diagnosis codes submitted must be valid ICD-9/10 Codes for the date of service and carried out to its highest level of specificity – 4th or 5th digit. "E" and most "V" codes are NOT acceptable as a primary diagnosis. Note: Claims with incomplete or invalid diagnosis codes will be denied.	C
68	PRESENT ON ADMISSION INDICATOR		R
69	ADMITTING DIAGNOSIS CODE	Enter the diagnosis or condition provided at the time of admission as stated by the physician using the appropriate release/ update of ICD-9/10- CM Volumes 1 & 3 for the date of service. Diagnosis Codes submitted must be valid ICD-9/10 Codes for the date of service and carried out to its highest level of specificity – 4th or 5th digit. "E" codes and most "V" codes are NOT acceptable as a primary diagnosis. Note: Claims with missing or invalid diagnosis codes will be denied.	R

70	PATIENT REASON CODE	Enter the ICD-9/10-CM Code that reflects the patient's reason for visit at the time of outpatient registration. Field 70a requires entry, fields 70b-70c are conditional. Diagnosis Codes submitted must be valid ICD-9/10 Codes for the date of service and carried out to its highest digit – 4th or 5th. "E" codes and most "V" codes are NOT acceptable as a primary diagnosis. NOTE: Claims with missing or invalid diagnosis codes will be denied.	R
71	PPS/DRG CODE		Not Required
72 a, b, c	EXTERNAL CAUSE CODE		Not Required
73	(UNLABELED)		Not Required
74	PRINCIPAL PROCEDURE CODE/ DATE	CODE: Enter the ICD-9/10 Procedure Code that identifies the principal/primary procedure performed. Do not enter the decimal between the 2nd or 3rd digits of code, it is implied. DATE: Enter the date the principal procedure was performed (MMDDYY).	C
74 a-e	OTHER PROCEDURE CODE DATE	REQUIRED on inpatient claims when a procedure is performed during the date span of the bill. CODE: Enter the ICD-9 procedure code(s) that identify a significant procedure(s) performed other than the principal/primary procedure. Up to five ICD-9 Procedure Codes may be entered. Do not enter the decimal between the 2nd or 3rd digits of code, it is implied. DATE: Enter the date the principal procedure was performed (MMDDYY).	C

75	(UNLABELED)		Not Required
76	ATTENDING PHYSICIAN	Enter the NPI and name of the physician in charge of the patient's care. NPI: Enter the attending physician's 10-character NPI ID. Taxonomy Code: Enter valid taxonomy code. QUAL: Enter one of the following qualifiers and ID number: 0B – State License #. 1G – Provider UPIN. G2 – Provider Commercial #. B3 – Taxonomy Code. LAST: Enter the attending physician's last name. FIRST: Enter the attending physician's first name.	R

77	OPERATING PHYSICIAN	REQUIRED when a surgical procedure is performed. Enter the NPI and name of the physician in charge of the patient's care. NPI: Enter the attending physician's 10-character NPI ID. Taxonomy Code: Enter valid taxonomy code. QUAL: Enter one of the following qualifiers and ID number: 0B – State License #. 1G – Provider UPIN. G2 – Provider Commercial #. B3 – Taxonomy Code. LAST: Enter the attending physician's last name. FIRST: Enter the attending physician's first name.	C

78 & 79	OTHER PHYSICIAN	Enter the Provider Type qualifier, NPI, and name of the physician in charge of the patient's care. (Blank Field): Enter one of the following Provider Type Qualifiers: DN – Referring Provider ZZ – Other Operating MD 82 – Rendering Provider NPI: Enter the other physician 10-character NPI ID. QUAL: Enter one of the following qualifier and ID number: 0B – State License # 1G – Provider UPIN G2 – Provider Commercial # LAST: Enter the other physician's last name. FIRST: Enter the other physician's first name.	C
80	REMARKS		Not Required
81	CC	A: Taxonomy of billing provider. Use B3 qualifier.	R
82	ATTENDING PHYSICIAN	Enter name or 7-digit provider number of ordering physician.	R

Appendix VIII: HCBS Programs Billing Information

The Home and Community Based Services (HCBS) programs are designed to meet the needs of beneficiaries who would be institutionalized without these services. The variety of services are designed to provide the most integrated means for maintaining overall health, socialization, independence, and community integration of those beneficiaries with the desire to live outside of an institution.

FOR DATES OF SERVICE PRIOR TO 10/1/2015 USE DIAGNOSIS CODE 780.99

HCBS – Autism

The HCBS program for children with autism is designed for Medicaid-eligible children from zero through five years of age (at the time of the application) who are at risk of admission to an inpatient psychiatric facility for individuals under 21 years of age.

BENEFIT	HCPCS	DIAGNOSIS	LIMITS
Consultative Clinical and Therapeutic Services	H2015	ASD	Max 200 units per calendar year. 1 unit equals 15 minutes
Family Adjustment Counseling	S9482 – Individual S9482HQ – Group	ASD	Max 48 units per calendar year
Intensive Individual Support	H2019	ASD	Max 100 units per calendar year
Interpersonal Communication Therapy	G0153	ASD	Max 8 units per calendar week
Parent Support and Training	T1027 – Individual T1027HQ – Group	ASD	Max 120 units per calendar year
Respite Care	T1005	ASD	Max 672 units per calendar year

HCBS – Frail Elderly (FE)

The Home and Community Based Services for the Frail Elderly (HCBS FE) program is designed to meet the needs of beneficiaries 65 years of age and older who would be institutionalized without these services.

BENEFIT	HCPCS	DIAGNOSIS	LIMITS
Adult Day Care – <5 hours	S5101	*R68.89 or R41.9 or R45.84	1 units equals 1-5 hours, max 1 unit in 24 hours

Adult Day Care – > 5 hours	S5102	*R68.89 or R41.9 or R45.84	1 unit equals >5 hours, max 1 unit in 24 hours
Assistive Technology	T2029	*R68.89 or R41.9 or R45.84	1 unit equals 1 purchase. $7,500 lifetime max
Attendant Care Level II – Provider Directed	S5125	*R68.89 or R41.9 or R45.84	1 unit equals 15 minutes Max
Attendant Care Level III – Provider Directed	S5125UA	*R68.89 or R41.9 or R45.84	1 unit equals 15 minutes. Max 48 units (12 hours per day)
Attendant Care Level I – Provider Directed	S5130	*R68.89 or R41.9 or R45.84	1 unit equals 15 minutes. Max 48 units (12 hours) per day
Attendant Care – Self Directed	S5125UD	*R68.89 or R41.9 or R45.84	1 unit equals 15 minutes. Max 48 units (12 hours) per day
Comprehensive Support – Provider Directed	S5135	*R68.89 or R41.9 or R45.84	Max 48 units (12 hours) per day. Cannot exceed 24 hours w/ other program combo. Cannot be provided same time as Attendant Care or Sleep Cycle Support
Comprehensive Support – Self Directed	S5135UD	*R68.89 or R41.9 or R45.84	Max 48 units (12 hours) per day. Cannot exceed 24 hours with other program combo. Cannot be provided same time as Attendant Care or Sleep Cycle Support
Financial Management Services	T2040U2	*R68.89 or R41.9 or R45.84	1 unit equals 1 month

Home Telehealth	S0317	*R68.89 or R41.9 or R45.84	1 unit equals 1 day
Home Telehealth – Install	S0315	*R68.89 or R41.9 or R45.84	1 unit equals 1 install. Max 2 units per calendar year
Medication Reminder Call/Alarm	S5185	*R68.89 or R41.9 or R45.84	1 unit equals 1 month. Excludes adult care homes
Nursing Evaluation Visit	T1001	*R68.89 or R41.9 or R45.84	1 unit equals 1 face-to-face visit. Provided by Attendant Care RN or LPN. Max is 1 unit per lifetime
Personal Emergency Response System – Install	S5160	*R68.89 or R41.9 or R45.84	1 unit equals one install. Max 2 per year
Personal Emergency Response System – Rental	S5161	*R68.89 or R41.9 or R45.84	1 unit equals 1 month
Sleep Cycle Support	T2025	*R68.89 or R41.9 or R45.84	1 unit equals one sleep cycle. Not to exceed 12 hours in 24-hour period. Only 1 unit in 24-hour period. Not to exceed 24 hours with other program combo
Wellness Monitoring	S5190	*R68.89 or R41.9 or R45.84	1 unit equals 1 face-to-face visit. Max 1 visit per 60 days
Money Follows the Person – All Above Program Services	Same HCPCS as listed above for Program Services	*R68.89 or R41.9 or R45.84	Same limits as listed above apply for all services

HCBS – Physical Disability (PD)

The Home and Community Based Services for Physical Disability (HCBS PD) program is designed for Medicaid-eligible beneficiaries from a minimum of 16 years to under 65 years of age who are determined physically disabled by Social Security standards, excluding beneficiaries with a diagnosis of Severe and Persistently Mentally Ill (SPMI), Severely Emotionally Disturbed (SED), or Developmentally Disabled (DD), and who are determined by qualified targeted case managers to need assistance to accomplish the normal rhythms of the day.

BENEFIT	HCPCS	DIAGNOSIS	LIMITS
Assistive Services	S5165	*R68.89 or R41.9 or R45.84	Max $7,500 lifetime
Financial Management Services	T2040U2	*R68.89 or R41.9 or R45.84	1 unit equals 1 month
Home-Delivered Meals	S5170	*R68.89 or R41.9 or R45.84	1 unit equals 1 meal. Max 2 meals per day
Medication Reminder Call/Alarm	S5185	n/a	1 unit equals 1 month
Medication Reminder Dispenser	T1505U6	n/a	1 unit equals 1 month
Medication Reminder – Install	T1505	n/a	1 unit equals install. Max 1 per
Personal Emergency Response System – Install	S5160	n/a	1 unit equals install. Max 2 per year
Personal Emergency Response System – Rental	S5161	n/a	1 unit equals 1 month
Personal Services – Agency Directed	S5125U9	*R68.89 or R41.9 or R45.84	1 unit equals 15 minutes, max 10 hours/day, 1240 units per month

Personal Services – Self Directed	S5125U6	*R68.89 or R41.9 or R45.84	1 unit equals 15 minutes, max 10 hours/day, 1240 units per month
Sleep Cycle Support	T2025	n/a	1 unit equals 6-12 hours. Only 1 unit in 24-hour period
Money Follows the Person – All Above Program services	Same HCPC as listed above for services	*R68.89 or R41.9 or R45.84	Same limits as listed above apply for all services

HCBS – Technology Assisted (TA)

The Home and Community Based Services (HCBS) Technology Assisted (TA) program is designed to meet the needs of individuals under 22 years of age who are chronically ill, technology-dependent, and medically fragile. These individuals have an illness or disability that requires the level of care provided in a hospital setting. In the absence of home care services, they would require admission and prolonged stay in a hospital or medical institution. Additionally, the individual requires both a medical device to compensate for the loss of vital body function and substantial, ongoing care to avert death or further disability. In order to be eligible for services, the individual must be Medicaid-eligible and meet the level of care eligibility criteria.

BENEFIT	HCPCS	DIAGNOSIS	LIMITS
Assistive Services (Home Mods)	S5165	*R68.89 or R41.9 or R45.84	Max $7,500 lifetime
Financial Management Services	T2040U2	*R68.89 or R41.9 or R45.84	1 unit equals 1 month
Health Maintenance Monitoring	T1001	*R68.89 or R41.9 or R45.84	1 unit every 3 months. Service cannot be provided or overlap with – T1002, T1000, or T1005

Intermittent Intensive Medical Care	T1002	*R68.89 or R41.9 or R45.84	1 unit equals 15 min. Provided by RN. 4 hours per day max, not to exceed 14 days per month (224 units). Cannot be provided or overlap with T1001, T1000, or T1005
LTC Community Care Attendant/Medical Service Technician – Agency Directed	T1004	*R68.89 or R41.9 or R45.84	1 unit equals 15 minutes. Max 12 hours per day (48 units) or 372 hours equating to 1488 units/month
Personal Service Attendant– Self Directed	T1019	*R68.89 or R41.9 or R45.84	1 unit equals 15 minutes. Max 12 hours per day (48 units) or 372 hours equating to 1488 units/month
Medical Respite	T1005	*R68.89 or R41.9 or R45.84	1 unit equals 15 minutes. Max of 168 hours (672 units) per year. T1005 cannot be billed on same day as T1000
Specialized Medical Care RN/LPN	T1000	*R68.89 or R41.9 or R45.84	1 unit equals 15 minutes. Max 252 hours (1008 units) per month. T1000 cannot be billed with on same day as T1005

HCBS – Traumatic Brain Injury

The Home and Community Based Services (HCBS) Traumatic Brain Injury (TBI) program is designed to meet the needs of beneficiaries who have sustained a traumatically acquired external nondegenerative, structural brain injury resulting in residual deficits and disability.

BENEFIT	HCPCS	DIAGNOSIS	LIMITS
Assistive Services (Home Mods)	S5165	n/a	Max $7,500 lifetime
Behavior Therapy	H0004	n/a	1 unit equals 15 minutes. Combined max of 780 hours (3120 units) per calendar year for the following: H004, 97532, G0151, G0152, & G0153
Cognitive Rehabilitation	97532	n/a	1 unit equals 15 minutes. Combined max of 780 hours (3120 units) per calendar year for the following: H004, 97532, G0151, G0152, & G0153
Occupational Therapy	G0152	n/a	1 unit equals 15 minutes. Combined max of 780 hours (3120 units) per calendar year for the following: H004, 97532, G0151, G0152, & G0153

Physical Therapy	G0151	n/a	1 unit equals 15 minutes. Combined max of 780 hours (3120 units) per calendar year for the following: H004, 97532, G0151, G0152, & G0153
Speech Therapy	G0153	n/a	1 unit equals 15 minutes. Combined max of 780 hours (3120 units) per calendar year for the following: H004, 97532, G0151, G0152, & G0153
Sleep Cycle Support	T2025	*R68.89 or R41.9 or R45.84	1 unit equals one sleep cycle. Max 1 unit in 24-hour period. Combined HCBS program services will not exceed 24 hours
Personal Services – Agency Directed	S5125U9	*R68.89 or R41.9 or R45.84	1 unit equals 15 minutes, max 10 hours/day, 1240 units per month. Not to be overlapped with other services without plan approval
Personal Services – Self Directed	S5125UB	*R68.89 or R41.9 or R45.84	1 unit equals 15 minutes, max 10 hours/day, 1240 units per month. Not to be overlapped with other services without plan approval

Personal Emergency Response System – Install	S5160	n/a	1 unit equals install. Max 2 per year
Personal Emergency Response System – Rental	S5161	n/a	1 unit equals 1 month
Financial Management Services	T2040U2	*R68.89 or R41.9 or R45.84	1 unit equals 1 month
Home Delivered Meals	S5170	*R68.89 or R41.9 or R45.84	1 unit equals 1 meal. Max of 2 meals per day
Medication Reminder Call/Alarm	S5185	n/a	1 unit equals 1 month
Medication Reminder Dispenser	T1505UB	n/a	1 unit equals 1 month
Medication Reminder Install	T1505	n/a	1 unit equals 1 install, max 1 unit per calendar year
Money Follows the Person – All Above Program services	Same HCPC as listed above for services	*R68.89 or R41.9 or R45.84	Same limits as listed above apply for all services

HCBS – Intellectual/Developmental Disabilities

The Home and Community Based Services (HCBS) for those with Intellectual and Developmental Disabilities (I/DD) program is designed to meet the needs of beneficiaries who would be institutionalized without these services. The variety of services described below are designed to provide the least restrictive means for maintaining the overall health and safety of those beneficiaries with the desire to live outside of an institution. It is the beneficiary's choice to participate in the HCBS program.

BENEFIT	HCPCS	DIAGNOSIS	LIMITS
Residential Regular Tier 1-5	T2016	n/a	1 unit = 1 day, max of 31 per month. (Cannot be billed with S5125, H0045, & T2025/deny)

Residential Super Tier 1-5	T2016	n/a	1 unit = 1 day, max of 31 per month. (Cannot be billed with S5125, H0045, T1000, and T1000TD & T2025/deny)
Day Service Regular Tier 1-5	T2021	n/a	1 unit = 15 minutes. Max of 23 days (460 units a month)
Day Service Super Tier 1-5	T2021	n/a	1 unit = 15 minutes. Max of 23 days (460 units a month)
Supportive Home Care – Agency Directed	S5125	n/a	1 unit = 15 minutes. Max of 12 hours or 48 units/day or 1488 units per month
Personal Assistant Services – Self Directed	T1019	n/a	1 unit = 15 minutes. Max of 12 hours or 48 units/day or 1488 units per month
Respite Overnight	H0045	n/a	1 unit = 1 day, 60 days per calendar year. Not allowable with T2016 in same day
Supported Employment	H2023	n/a	1 unit = 15 minutes
Sleep Cycle Support	T2025	n/a	1 unit = 1 day. Max of 31 per month
Specialized Medical Care (RN)	T1000TD	n/a	1 unit = 15 minutes, limited to 12 hours/ day (48 units) and 1488 units per month (372 hours)

Specialized Medical Care (LPN)	T1000	n/a	1 unit = 15 minutes, limited to 12 hours/ day (48 units) and 372 hours (1488 units)/month
Medical Alert Rental	S5161	n/a	1 unit = 1 month, max of 12 per year
Financial Management Services	T2040U2	*R68.89 or R41.9 or R45.84	1 unit = 1 month, max of 12 per year
Wellness Monitoring	S5190	n/a	1 unit equals 1 visit. Max 1 per 60 days
Assistive Services	S5165	n/a	Lifetime max $7,500
PBS Environmental Assessment	H2027	n/a	1 unit = 15 minutes max of 120 units/year (Max of $1,200/year)
PBS Treatment	H2027U3	n/a	1 unit = 15 minutes, max of 240 units/year (Max of $6,000/year)
PBS Person-Centered Planning	9088222	n/a	1 unit = 15 minutes, max of 240 units/year (Max of $1,600/year)
Targeted Case Management	T1017	n/a	1 unit = 15 minutes. Max of 240 units per year

Refer to the KMAP *HCBS Financial Management Services Provider Manual* for criteria and information.

DATE SPAN BILLING WITH EXAMPLES

- Span billing means you can bill for services over a range of dates, within the same month. The number of units billed for these dates do not have to be an exact match. Examples of the correct way to bill with date spans are below:

(Example – T2016 has a max of 31 units a month)

DATES OF SERVICE	PROCEDURE CODE	BILLED UNITS
1/1/14 – 1/31/14	T2016	31 units
1/1/14 – 1/5/14	T2016	5 units
1/1/14 – 1/1/14	T2016	1 unit
1/6/13 – 1/12/14	T2016	3 units
1/1/14 – 1/31/14	T2016	27 units

- You must bill within the same calendar month, and you cannot overlap any given calendar month, e.g., 01/15/14 thru 02/10/14 – this would be two claims, one for January and one for February.
- Day Supports (T2020/T2021) – Effective with dates of service January 1, 2014, and thereafter, the current HCBS I/DD Day Supports procedure code and unit of service T2010 (1 unit = 1 day) was replaced with T2021 (1 unit = 15 minutes). Maximum limits for T2021 are as follows: 100 units per week (a week is defined as 7 days), 460 units per month (a month is defined as the 1st to 31st of any calendar month). Day Supports should not be billed on the same claim with Residential Supports. The State of Kansas allows up to 8 hours a day for Day Supports with a limit of 25 hours per week. Therefore, a person can work up to 8 hours but only three days a week.
- Residential Services (T2016) – Residential Supports T2016 – allows 31 days maximum per calendar month. Residential Services should not be billed on the same claim with Day Supports.
- Day and Residential Services must be billed as separate claims.
- Targeted Case Manager (T1017) – Billing must be in whole units and cannot be billed as a partial unit (1 unit = 15 minutes), with a maximum of 240 units (16 hours) per year. Prior authorization is not required within the T1017 benefit limit for TCM services for members with I/DD. Note: Providers cannot bill for T1017 for members in a Health Home.

Appendix IX: Electronic Visit Verification (EVV) – KS AuthentiCare

Information regarding implementation of the state's AuthentiCare System can be found at: http://www.aging.ks.gov/HCBSProvider/KS_AuthentiCare/KAC_Index.html.

The following Home and Community Based Services (HCBS) are required to use the KS AuthentiCare system. Other codes may be added as directed by the state or health plan for future program expansion or monitoring:

Frail Elderly HCBS Programs

SERVICE CODE	SERVICE
HCFES5125	FE - Level 2 Attendant Care
HCFES5125UD	FE - Self-Directed Attendant Care
HCFES5130	FE - Level 1 Attendant Care
HCFES5101	FE - Adult Day Care
HCFES5160	FE - Personal Emergency Response – Install
HCFES5190	FE - Wellness Monitoring
HCFET1001	FE - Nurse Evaluation Visit
HCFET2025	FE - Sleep Cycle Support
HCFES5135	FE - Provider-Directed Comprehensive Support
HCFES5135UD	FE - Self-Directed Comprehensive Support
HCFET2040U2	FE - Financial Management Service
HCFES5161	FE - Personal Emergency Response – Rental
HCFET2029	FE - Assistive Technology
HCFES0315	FE - Home Telehealth – Install
HCFES0317	FE - Home Telehealth – Rental
HCFES5185	FE - Medication Reminder

Intellectual/Developmental Disability (I/DD) HCBS Programs

SERVICE CODE	SERVICE NAME
HCDDT1019	IDD - Self-Directed Personal Assistant Services
HCDDT2025	IDD - Sleep Cycle Support
HCDDH0045	IDD - Overnight Respite
HCDDT1000	IDD - LPN Specialized Medical Care
HCDDT1000TD	IDD - RN Specialized Medical Care
HCDDS5125	IDD - Supportive Home Care
HCDDS5161	IDD - Medical Alert Rental
HCDDT2040U2	IDD - Financial Management Service

Physical Disability (PD) HCBS Programs

SERVICE CODE	SERVICE NAME
HCPDS5125U6	PD - Self-Directed Personal Services
HCPDT2025	PD - Sleep Cycle Support
HCPDS5125U9	PD - Agency-Directed Personal Services
HCPDS5160	PD - Personal Emergency Response – Install
HCPDS5161	PD - Personal Emergency Response – Rental
HCPDS5185	PD - Medication Reminder (call/alarm)
HCPDT1505U6	PD - Medication Reminder/Dispenser
HCPDT1505	PD - Medication Reminder/Dispenser – Installation
HCPDT2040U2	PD - Financial Management Service

Physical Disability (PD) HCBS Programs

SERVICE CODE	SERVICE NAME
HCPDS5125U6	PD - Self-Directed Personal Services
HCPDT2025	PD - Sleep Cycle Support
HCPDS5125U9	PD - Agency-Directed Personal Services
HCPDS5160	PD - Personal Emergency Response – Install
HCPDS5161	PD - Personal Emergency Response – Rental
HCPDS5185	PD - Medication Reminder (call/alarm)
HCPDT1505U6	PD - Medication Reminder / Dispenser
HCPDT1505	PD - Medication Reminder / Dispenser – Installation
HCPDT2040U2	PD - Financial Management Service

Traumatic Brain Injury HCBS Programs

SERVICE CODE	SERVICE NAME
HCHIS5125UB	TBI - Self-Directed Personal Services
HCHIT2025	TBI - Sleep Cycle Support
HCHIS5125U9	TBI - Agency-Directed Personal Services
HCHIS5160	TBI - Personal Emergency Response – Install
HCHIS5161	TBI - Personal Emergency Response – Rental
HCHIS5185	TBI - Medication Reminder (call/alarm)
HCHIT1505UB	TBI - Medication Reminder/Dispenser
HCHIT1505	TBI - Medication Reminder/Dispenser – Installation
HCHIT2040U2	TBI - Financial Management Service
S5170	TBI - Home-Delivered Meals

Technology-Assisted HCBS Programs

SERVICE CODE	SERVICE NAME
HCTAT1019	TA - Personal Service Attendant
HCTAT2040U2	TA - Financial Management Service

MFP – Frail Elderly HCBS Programs

SERVICE CODE	SERVICE NAME
MFFES5125	MF FE - Level 2 Attendant Care
MFFES5125UD	MF FE - Self-Directed Attendant Care
MFFES5130	MF FE - Level 1 Attendant Care
MFFES5101	MF FE - Adult Day Care
MFFES5160	MF FE - Personal Emergency Response – Install
MFFES5190	MF FE - Wellness Monitoring
MFFET1001	MF FE - Nurse Evaluation Visit
MFFET2025	MF FE - Sleep Cycle Support
MFFES5135	MF FE - Provider-Directed Comprehensive Support
MFFES5135UD	MF FE - Self-Directed Comprehensive Support
MFFET2040U2	MF FE - Financial Management Service
MFFES5161	MF FE - Personal Emergency Response – Rental
MFFET2029	MF FE - Assistive Technology
MFFES0315	MF FE - Home Telehealth – Install
MFFES0317	MF FE - Home Telehealth – Rental
MFFES5185	MF FE - Medication Reminder

MFP – I/DD HCBS Programs

SERVICE CODE	SERVICE NAME
MFDDT1019	MF IDD - Self-Directed Personal Assistant Services
MFDDT2025	MF IDD - Sleep Cycle Support
MFDDH0045	MF IDD - Overnight Respite
MFDDT1000	MF IDD - LPN Specialized Medical Care
MFDDT1000TD	MF IDD - RN Specialized Medical Care
MFDDS5125	MF IDD - Supportive Home Care
MFDDS5161	MF IDD - Medical Alert Rental
MFDDT2040U2	MF MRDD - Financial Management Service
HCDDH2023	IDD - Supported Employ, Per 15 MIN
HCDDS5150	IDD - Unskilled Respite Care, Per15 MIN
HCDDS5190	IDD - Wellness Monitoring
HCDDT1015	IDD - Respite Care Services, Up To 15 MIN
HCDDT1017U7	IDD – Targeted Case Management
HCDDT2016	IDD - Habil Res Waiver Per Diem
HCDDT2020	IDD - Day Habil Waiver Per Diem
HCDDT2021	IDD - Day Habil Waiver, Per 15 MIN

MFP – Physical Disability HCBS Programs

SERVICE CODE	SERVICE NAME
MFPDS5125U6	MF PD - Self-Directed Personal Services
MFPDT2025	MF PD - Sleep Cycle Support
MFPDS5125U9	MF PD - Agency-Directed Personal Services
MFPDS5160	MF PD - Personal Emergency Response – Install
MFPDS5161	MF PD - Personal Emergency Response – Rental
MFPDS5185	MF PD - Medication Reminder (call/alarm)
MFPDT1505U6	MF PD - Medication Reminder/Dispenser
MFPDT1505	MF PD - Medication Reminder/Dispenser – Installation
MFPDT2040U2	MF PD - Financial Management Service

MFP – Traumatic Brain Injury HCBS Programs

SERVICE CODE	SERVICE NAME
MFHIS5125UB	MF TBI - Self-Directed Personal Services
MFHIT2025	MF TBI - Sleep Cycle Support
MFHIS5125U9	MF TBI - Agency-Directed Personal Services
MFHIS5160	MF TBI - Personal Emergency Response – Install
MFHIS5161	MF TBI - Personal Emergency Response – Rental
MFHIS5185	MF TBI - Medication Reminder (call/alarm)
MFHIT1505UB	MF TBI - Medication Reminder/Dispenser
MFHIT1505	MF TBI - Medication Reminder/Dispenser – Installation
MFHIT2040U2	MF TBI - Financial Management Service

As mentioned previously, Sunflower will utilize the KS AuthentiCare system to accept claims from Home and Community Based Service (HCBS) providers. If you are not currently registered with KS AuthentiCare, go to https://www.authenticare.com/kansas/register.aspx.

Appendix X: Billing Tips and Reminders

Accommodation and Ancillary Charges

- If the individual accommodation and ancillary services exceed the detail lines on the UB-04 claim form, providers may combine all similar revenue code charges together (e.g., lab, radiology) when necessary. Accommodation codes may also be lumped together when necessary. This will not affect the reimbursement of the claim.

Admission and Readmission (Same Day)

- When a patient is discharged or transferred from an inpatient hospital and is readmitted to the same inpatient hospital on the same day for symptoms related to or for evaluation and management of the prior stay's medical condition, hospitals must adjust the original claim generated by the original stay by combining the original and subsequent stay onto a single claim.
- When a patient is discharged or transferred from an inpatient hospital and is readmitted to the same inpatient hospital on the same day for symptoms unrelated to and not for evaluation and management of the prior stay's medical condition, hospitals must bill for two separate stays on two separate claims.

Ambulance

- Ambulance services must be billed on a CMS-1500.
- Modifiers that are used on claims for ambulance services are created by combining two alpha characters. Each alpha character, with the exception of X, represents an origin (source) code or a destination code. The pair of alpha codes creates one modifier. The first-position alpha code equals origin; the second-position alpha code equals destination.
- Origin and destination codes are the following: D, E, G, H, I, J, N, P, R, S, and X.

Anesthesia

- Medicaid claims for anesthesia must be billed using the American Society of Anesthesiologists (ASA) codes. Medical direction or supervision of anesthesia services by an anesthesiologist cannot be billed in addition to certified registered nurse anesthetist (CRNA) anesthesia services. Only bill for direct face-to-face patient time, not wait time.
- In field 24G, indicate the number of minutes anesthesia was administered. Give only whole numbers. Round all decimals up to the nearest whole number. Example: 13.4 minutes of anesthesia administered should be indicated as 14 in field 24G.
- Please refer to the ASA guidelines around all other billing questions: http://www.asahq.org/

Audiology Services

- Billing for audiology services now requires the use of left (LT) and right (RT) modifiers on all monaural services.
- If the services are binaural the use of left and right modifiers is not allowed.

Compound and Multiple Injection Claims:

- The compound drug or multiple injection would need to be billed on the same claim.
- The compound drug must have the same prescription number.
- Multiple injections (two different times or two different sites) submitted on the same day must include the appropriate modifier for payment to indicate a non-duplicate service. (59, 76, 77, etc.)

DME/Supplies/Prosthetics and Orthotics

- All DME services are covered for in-home use only. DME services (purchase or rental) are noncovered in nursing facilities, swing bed facilities, state institutions, intermediate care facilities/ mental retardation (ICF/MR), psychiatric residential treatment facilities (PRTF), head injury facilities (HI), rehab facilities, and hospitals
- Add modifier BO to the base code (XXXXX-BO) and place in field 24D when billing for oral supplemental nutrition.
- Add modifier "BA" to the base code (XXXXX-BA) and place in field 24D when billing for items supplied in conjunction with total parenteral nutrition.
- If hearing aid batteries exceed six per month, indicate in field 21 if services are for a binaural hearing aid.
    - When dispensing multiple months' supply of batteries, note this in field 19. Enter the number of months, the manufacturer's battery stock number, and whether silver or mercury. One unit equals one battery.
- Add modifier "RR" to the base procedure code (XXXXX-RR) and place in field 24D.
- Modifier KX must be used if the beneficiary is insulin treated (insulin-dependent diabetic). Modifier KS must be used if the beneficiary is not insulin treated (noninsulin-dependent diabetic). Modifiers KX and KS cannot be billed together on each detail line. If no modifier is included, the claim will deny.
- All hearing aid replacements require the use of modifier RA. Modifier RA must be present on all claims for replacement hearing aids.
- Referring physician's name and NPI (NOT KMAP ID) is required in fields 17 and 17B of the CMS-1500.
- Rental of all DMEPOS must include modifier RR. Omission of modifier RR indicates a purchase. A blank modifier field indicates modifier NU (purchase of DMEPOS).
- Manually priced DMEPOS requires a copy of invoice and/or MSRP. Without submission of invoice or MSRP manually priced claims will pend.

Drug Pricing Program – 340 B

- Sunflower Health Plan works to identify providers participating in the 340B Drug Pricing Program. Information can be obtained from http://www.hrsa.gov/opa/index.html. 340B providers must bill Sunflower Health Plan with the NPI that was used when registering for the 340B program. If a code is billed that would normally require an NDC to be billed, the NPI on the claim and the registry must match in order for the NDC requirements to be bypassed in Sunflower Health Plan's claims payment system.

Emergency Renal Dialysis

- Inpatient renal dialysis must be billed using revenue code 809 in FL 42 of the UB-04 claim form.
- Outpatient emergency renal dialysis must be billed using appropriate diagnosis codes in FL 67 of the UB-04 claim form.

Emergency Room Department Services

- Enter the time of day (using the continental time system, such as 0000-2300) in FL 13, admission hour.
- Emergency services provided in the emergency department must be billed using the appropriate evaluation and management (E&M) emergency department or critical care procedure code from the CPT® codebook.
- Modifier ET must be added to the base E&M procedure code when billing the hospital ER/ observation room and supplies. When billing for the hospital-based physician, indicate the base code only (no modifier).

EPSDT/KBH

- Beneficiaries must be 20 years of age and under.
- Bill modifier EP when billing evaluation and management preventative medicine or office visit services.
- A wellness diagnosis must be billed.
- Referral values to be billed in 24H are:
  - AV: Upon completion of the KBH screen, the screen provider initiated a referral; the beneficiary refused this referral.
  - ST: A new referral request has been initiated and the beneficiary accepted the referral.
  - S2: An abnormality was observed during the KBH screen; however, the beneficiary is currently under treatment for the observed condition.
- When a referral value is present a referral indicator must be billed:
  - "E"– EPSDT
  - "F" Family Planning
  - "B" EPSDT and Family Planning
- Populate 24h with appropriate indicator "E" if the service is an EPSDT/HCY screening, "F" if the service is family planning related, "B" if the service is both EPSDT/HCY and family planning related.

Erroneous Surgery

- Hospitals are required to bill two claims when an erroneous surgery is reported.
  - One claim with covered service(s)/procedure(s) unrelated to an erroneous surgery on a type of bill (TOB) 11X (with the exception of 110).
  - One claim with the noncovered service(s)/procedure(s) related to an erroneous surgery on a TOB 110 (no-pay claim).
  - The noncovered TOB 110 will be required to be submitted on the UB-04 (hard copy) claim form.

- Providers are required to report as an "other diagnosis" one of the applicable External Cause of Injury Codes for wrong surgery performed:
  - Performance of wrong operation (procedure) on correct patient
  - Performance of operation (procedure) on patient not scheduled for surgery
  - Performance of correct operation (procedure) on wrong side/body part
  - These E codes are to be submitted in the E code field on the UB-04
- Outpatient, Ambulatory Surgical Centers, Other Appropriate Bill Types, and Practitioner Claims
  - Providers are required to append one of the following applicable modifiers to all lines related to the erroneous surgery:
    - PA: Surgery Wrong Body Part
    - PB: Surgery Wrong Patient
    - PC: Wrong Surgery on Patient

GLOBAL OB BILLING

Use the KMAP professional manual section 8400 pg. 8-21 for a reference. In instances when a patient's pregnancy is not covered by a single MCO, split bill previous/current MCO in accordance with the guidelines below:

Obstetrical and Gynecological Billing Guidelines

- The following procedures are content of service of total obstetrical (OB) care:
  - Office visits (nine months before and six weeks after delivery)
  - Urinalysis
  - Internal fetal monitor
- Total OB care generally consists of 13 office visits, delivery (vaginal or cesarean), and postpartum care. The provider of total OB care should either bill code 59400 or 59510 depending on which applies. If an ARNP or PA provides part of the prenatal care but does not deliver the baby, the physician may bill the global fee without indicating the PA or ARNP as the performing provider.
- If the ARNP or PA provides part of the prenatal care and delivers the baby, the services must be broken out and the PA or ARNP indicated as the performing provider. Providers should not bill for OB services until care is completed (for example, the beneficiary delivers or the beneficiary is no longer a patient).
- When a provider does not complete total OB care and only partial antepartum care has been provided, the following guidelines apply when billing services:
  - **One to three prenatal visits only** – Bill using E&M office visit codes.
  - **Four to six prenatal visits only** – Bill using code 59425. This code must NOT be billed by the same provider in conjunction with one to three office visits or in conjunction with code 59426.
  - **Complete antepartum care without delivery** – Bill using code 59426. Complete antepartum care is limited to one beneficiary pregnancy per provider.
  - **Delivery only** (no antepartum care provided) – Bill using code 59409 or 59514.

- **Delivery and postpartum care only** – Bill using code 59410 or 59515.

- Codes 59425 and 59426
  - Can only be billed once per provider, per beneficiary pregnancy.
  - Must not be billed together by the same provider for the same beneficiary, during the same pregnancy.
  - Must not be billed in conjunction with pregnancy-related (E&M) office visits by the same provider for the same beneficiary, during the same pregnancy.
- The following services are not covered in place of service 21 (inpatient):
  - Fetal oxytocin stress testing (initial or subsequent)
  - Fetal non-stress test (electronic, external fetal monitor applied)
- Global OB codes 59400, 59510, 59610, & 59612 are set up to deny for service dates prior to 07/01/2013. The claims system is set up to pay the global OB codes for service dates 07/01/2013 forward. If all global OB care was provided in 2013 and you have experienced claim denials, please contact provider services at 877-644-4623, and impacted claims can be reprocessed.

FLUORIDE BILLING BY HEALTH DEPARTMENTS

Fluoride services provided by RNs at Health Departments must be billed through Dental Health & Wellness for reimbursement. If the provider is submitting via paper or electronically through a clearinghouse, the filed claim must include the items listed below.

Before providers can submit electronically through Sunflower's Online Provider Portal, providers must pre-register their information with DHW at www.dentalhw.com.

Required Data Elements

Provider data
First Name:
Last Name:
License Number:
Individual NPI (if they have one, but not required):

Business data
Group Name:
Service Office Address:
Phone Number:
Payment Address (if different):
Business/Group NPI:
Tax ID Number:

Paper claims for Dental Health & Wellness are sent to the following address:

Dental Health & Wellness
Claims: KS
P.O. Box 1164
Milwaukee, WI 53201

If you choose to submit electronically through your clearinghouse, you may use Payer ID CX014 and the claims will go directly to Dental Health & Wellness.

FQHC/RHC

- Bill with correct place of service (50 – FQHC; 72 – RHC)
- Bill with appropriate encounter codes

Hospice

- Hospice providers billing services for members residing in an SNF must bill HCPCS code T2046 or T2046 U4 (leave days) and must submit the SNF NPI in box 17b and the SNF facility name in box 17. Previously it was only required to submit the NPI, but as of January 1, 2013, the SNF facility name is also required for the information to be transmitted to Sunflower.

Hospitals

- For all hospitals, outpatient procedures (including, but not limited to, surgery, X- rays, and EKGs) provided within three days of a hospital admission for the same or similar diagnosis are considered content of service and must be billed on the same inpatient hospital claim. The outpatient procedure date should be changed on the claim to correspond with the actual hospital admission date. There is one exception to this policy: complications from an outpatient sterilization resulting in an inpatient admission. In this instance, the outpatient charges and the inpatient charges should be billed on two separate claims. This is necessary in order for the service dates on the claim form to match the service dates on the Sterilization Consent Form.
- For all hospitals, the appropriate CPT/HCPCS codes are required to be billed for each service reported.
- Hospitals billing for lifeline services must use the correct NPI on the claim submission to avoid processing delays or denials.

Immunization/Vaccines/Injections

- Providers must bill the appropriate administration code in addition to the vaccine/toxoid code for each dose administered.
- In field 24D, enter the injection code, strength, and dosage.
- Vitamin B-12 injections should be billed with correct diagnosis in the first position of diagnosis coding.
- Fields 24 A-G of a CMS-1500 and field 43 of a UB-04 can be used to report NDC supplemental information. The KMAP form used as an attachment to a claim to report NDC numbers and injections is ***NOT*** required by Sunflower Health Plan.

Interim Billing

- When interim billing, be sure to enter the appropriate Type of Bill code (e.g., 112, 113, 114). A Patient Status code of 30 (still a patient) must use the appropriate Type of Bill code (e.g., 112, 113, 114). A Patient Status code of 30 (still a patient) must be indicated when Type of Bill is 112 or 113.

Locum Tenens

- The regular physician must identify the services of the locum tenens physician by appending HCPCS Code Modifier Q6 after the procedure code.

Modifiers

- GN, GO, GP Modifiers – therapy modifiers required for speech, occupational and physical therapy.
- For all other rules around modifiers please refer to: https://www.kmap-state-ks.us/Documents/Content/Provider/Coding%20Modifiers%20Table.pdf.

Missed Appointments

- Missed appointments should never be billed nor will be reimbursed.

Multi-page Claims

- The page leading up to the last page of a multi-page claim should contain the word "continued" or "cont.".
- Totaling each page will result in separate claims that may incorrectly reimburse.

Newborn Billing

- Sunflower Health Plan members 45 days old or less are considered "newborn." Date of delivery reported on the claim is used to validate the newborn member's age. It is recommended that all claims are billed under the actual member's ID number. If a newborn has not yet been issued an ID number, the claim can be submitted under the mother's ID (this can cause payment delays). Newborns who do not receive an ID number for a Sunflower Health Plan can be processed under the mother if any of the following codes appear on the claim: CPT-4 codes – 31500, 36450, 36510, 36660, 43831, 54000, 54160, 88029, 94780, 94781, 99460-99465, 99468, 99469, 99477-99480, 99502, and S3620. Revenue Codes – 0170-0175 or 0179.

NDC Requirements

- Sunflower Health Plan has mirrored the NDC requirements that the State of Kansas has in place. We download the NDC/Procedure code crosswalk file from the KMAP website monthly and update our configuration accordingly. The most up-to-date crosswalk can be found at the following link: https://www.kmap-state-ks.us/Provider/KanCare%20MCO/MCOpage.asp.

Nursing Facility (NF/ICF/Bed Hold)

- Nursing facility (NF) and Intermediate Care facility (ICF) providers must bill using the UB-04 claim form.
- Intermediate Care facilities should bill with Type of Bill 65X or 66X.
- Revenue Code 120 should be billed for room and board charges. All other ancillary services are considered inclusive of the reimbursement for room and board.

- Bed hold days should be billed with the following revenue codes:
  180 – NF/MH Inpatient Psychiatric Hospital Stay (21-day limit per admission)
  181 – NF/MH Home Therapeutic Reserve days (21 days per calendar year)
  183 – NF hospital reserve days (10-day limit per admission).
  185 – hospital leave days.
  189 – other leave of absence; non-covered days. No reimbursement for these days.

Room and board is not billable by the nursing facility when a member elects hospice benefits.

Observation Room

- Code 99218 ET should be billed for any service that requires monitoring a patient's condition beyond the usual amount of time in an outpatient setting.
- Observation room should not be billed for the following:
  - Recovery room services following inpatient or outpatient surgery.
  - Recovery/observation following scheduled diagnostic tests such as arteriograms, cardiac catheterization, etc.

Obstetrics & Gynecology

- Sunflower requests all OBGYN providers follow guidelines for Maternity Care.

Physician Clinic Services

- Currently, some physicians make scheduled visits once or twice a week to rural hospitals and see patients in the emergency room, which functions as their office. Physician clinic services provided in a hospital location are considered content of the physician service and should not be billed to Medicaid or the beneficiary.

However, in this instance the hospital can bill code 99070 for use of room and supplies.

POA Indicator

- All claims involving inpatient admissions to general acute care hospitals will require submission of present on admission (POA) indicator(s). POA is defined as present at the time the order for inpatient admission occurs – conditions that develop during an outpatient encounter, including emergency department, observation, or outpatient surgery, are considered as POA. The POA indicator is assigned to principal and secondary or other diagnoses (as defined in Appendix I of the Official Guidelines for Coding and Reporting) and the external cause of injury codes. The validity of the POA indicator will be edited and claims are subject to denial when the POA indicator is invalid. The hospital will need to supply the correct POA indicator(s) and resubmit the claim. A POA indicator for the external cause of injury code is not required unless it is being reported as an "other diagnosis" on the UB-04.

- Definitions.
  - Y (for yes): Present at the time of inpatient admission.
  - N (for no): Not present at the time of inpatient admission.
  - U (for unknown): The documentation is insufficient to determine if the condition was present at the time of inpatient admission.
  - W (for clinically undetermined): The provider is unable to clinically determine whether the condition was present at the time of inpatient admission or not.
  - Exempt from POA reporting: 5010 claim billing an exempt diagnosis code, leave the POA indicator field blank.
  - The ICD-9/10-CM Official Guidelines for Coding and Reporting includes a list of diagnosis codes that are exempt from POA reporting.

Professional Fees

- The only physician services that can be billed by the hospital on the UB-04 claim form are hospital-based physicians assigned to the emergency department.

Prosthetic and Orthotic

- Hospitals must enroll as prosthetic and orthotic (P&O) providers and bill on the professional claim form (CMS-1500) or 837 professional transaction when providing these services.
- Prosthetic and orthotic items cannot be billed as ancillary services on the UB-04 claim form.
  - Exception: Prosthesis implanted by a surgical procedure may be billed on the hospital claim form for inpatient services.

Readmissions

- When a KanCare beneficiary is discharged prematurely and subsequently readmitted within 30 days with the same DRG or similar diagnosis at the same hospital, only the DRG payment for the first stay will be reimbursed.
- If the discharging and readmitting hospitals are not the same, only the readmitting hospital will be reimbursed.

Swing Bed Nursing Facility

- The appropriate revenue code applicable to the patient's level of care must be entered.
- Room and board must be billed on a UB-04 claim form.
- Bill the total number of days (units).
- Indicate the total charges for the number of days billed.
- Ancillary charges cannot be billed on the Swing Bed NF facility claim. They must be billed on another UB-04 claim form with an outpatient type of bill.
- Supplies provided by the swing bed facility that are over and above the supplies included in the reimbursement rate, bill procedure code – 99070 and 1 unit.
- Claims must include both revenue codes and HCPCS codes.

Transfers

- When billing medically necessary incoming transfers, field 84 of the UB-04 must indicate remarks – "direct transfer from (hospital, City").

Urgent Care Centers

- Place of service 20 can be billed on a CMS-1500 claim form.

Appendix XI: Provider Manual Updates

REVISION DATE	PROVIDER MANUAL SECTION	REVISION DESCRIPTIONS
April 14, 2015	New Provider Manual	Sunflower's Provider Manual was redesigned, updated, and republished as the 2015 Edition. Information from all 2014 provider bulletins and announcements were incorporated. An announcement was made to Sunflower's provider network
October 2015	Appendix VIII: HCBS Programs Billing Information	Pages 172-177, 179-180 and 182. Diagnosis codes for these programs were updated from ICD-09 Diagnosis 780.99 to the ICD-10 diagnosis codes which are effective October 1, 2015. Page 172: Appendix heading includes ICD-9 code for dates of service prior to 10/1/2015.
October 2015	Provider Appeal Process Timeline	Page 117: Step 4 was updated from 5 business days to 10 business days to acknowledge receipt
October 2015	Appendix I: Common Causes of Upfront Rejections	Page 126: Attending provider box 48 was updated to box 76 on the paper UB claim form
October 2015	Sunflower Health Plan Benefits Grid: Enteral and Parenteral	Page 47: Oral Supplements Nutrition was changed to Oral Supplemental Nutrition
October 2015	Health Homes Program	Page 83: "chronic conditions" was replaced with "serious mental illness" 2nd paragraph includes creation of a Health Action Plan 11th bullet "problems" was replaced with "conditions"
October 2015	Provider Types That May Serve As PCPs	Page 19: The definition of PCP was updated to reflect the definition found on the KMAP site

October 2015	Coding of Claims/Billing Codes	Page 99: ICD-10 diagnosis code-related rejection or denial reasons added
October 2015	Appendix II: Common Causes of Claim Procession Delays and Denials	Page 127: first bullet point was updated to include ICD-10 diagnosis code-related delays or denials
October 2015	Appendix III: Common EOP Denial Codes and Descriptions	Page 128: ICD-10 diagnosis denial codes and descriptions added for d1, d2, d3, d4. Codes 3D and 4D were updated to reflect dates of service prior to 10/1/2015
October 2015	Appendix X: Billing Tips and Reminders	Page 198: ICD-10 was added to the last bullet on the POA Indicator definiton
October 2015	Benefit Explanation and Limitations	Page 50: Benefit limitation for Oxygen and Respiratory Services entry was updated to: some limitations, exclusions, and quantity limits may apply
October 2015	Appendix III Common EOP Denial Codes and Descriptions	Page 129: Code ym 30 DAY READMISSION. SUBMIT ALL MEDICAL RECORDS FOR 30 DAY PERIOD, was added.
October 2015	Appendix X: Billing Tips and Reminders	Page 198: Readmissions section added
January 2016	Provider Rights and Responsibilities	Page 35: Sixth bullet point updated to “To file a grievance or appeal with Sunflower”
February 2016	Benefit Explanation and Limitations	Page 57: Women’s Healthcare section updated.

Notes

Notes