Provider Manual

Current as of October 26, 2020. Please see sunflowerhealthplan.com/providers/resources/forms-resources.html for updates.

1-877-644-4623
TTY: 711

SunflowerHealthPlan.com
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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 clients, 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’s most vulnerable citizens.

How to Use This Provider Manual

Sunflower is committed to serving 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 of 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

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<td><strong>Website</strong></td>
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<th><strong>DEPARTMENT</strong></th>
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<tr>
<td><strong>Customer Service</strong></td>
<td>1-877-644-4623</td>
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<tr>
<td><strong>Prior Authorization (PA) Fax Requests for Inpatient and Outpatient Medical Services</strong> – visit SunflowerHealthPlan.com to submit prior authorization online</td>
<td>1-877-644-4623</td>
<td>1-888-453-4316</td>
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<td><strong>Concurrent Review/Clinical Information</strong></td>
<td>1-877-644-4623</td>
<td>1-877-213-7732</td>
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<td><strong>Admissions/Census Reports/Face Sheets</strong></td>
<td>1-877-644-4623</td>
<td>1-866-965-5433</td>
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<td><strong>Case Management (CM)</strong></td>
<td>1-877-644-4623</td>
<td>1-866-694-3649</td>
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<td><strong>Prior Authorization (PA) Behavioral Health</strong></td>
<td>1-877-644-4623</td>
<td>1-866-264-4452</td>
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<td><strong>Prior Authorization (PA) Outpatient/Home Health Physical, Occupational, Speech Therapy</strong></td>
<td>1-877-644-4623</td>
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<td><strong>24/7 Nurse Advice Line</strong></td>
<td>1-877-644-4623</td>
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<td><strong>Envolve Pharmacy Services - pharmacy.envolvehealth.com</strong></td>
<td>1-877-644-4623</td>
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<td><strong>High-Tech Imaging (NIA) - <a href="http://www.radmd.com">www.radmd.com</a></strong></td>
<td>1-877-644-4623</td>
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<td><strong>Envolve Dental - dental.envolvehealth.com</strong></td>
<td>1-855-434-9245</td>
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<td><strong>Envolve Vision - visionbenefits.envolvehealth.com</strong></td>
<td>1-877-644-4623</td>
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<td><strong>Non-Emergent Medical Transportation LogistiCare</strong></td>
<td>1-877-644-4623</td>
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<td><strong>Interpreter Services – Voiance</strong></td>
<td>1-877-644-4623</td>
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<tr>
<td><strong>To report suspected waste, fraud and abuse to Sunflower</strong></td>
<td>1-866-685-8664</td>
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<tr>
<td><strong>Ethics and Compliance Helpline</strong></td>
<td>1-800-345-1642</td>
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<th><strong>EDI CLAIMS</strong></th>
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<tr>
<td><strong>Sunflower Health Plan</strong> c/o Centene EDI Department 1-800-225-2573, ext. 607-5525 or by e-mail to: <a href="mailto:EDIBA@centene.com">EDIBA@centene.com</a></td>
</tr>
<tr>
<td><strong>Specialty Therapy and Rehabilitative Services (STRS) Claims</strong> P.O. Box 4070 Farmington, MO 63640-3831</td>
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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 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
- New Contract/Amendment Requests
- Provider/Practitioner Changes, including credentialing material

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 and submit claims
  - Correct claims
  - Submit reconsiderations and appeals
  - Void/recoup claims
- 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 percent 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 than 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
Long-Term Services and Supports

The KanCare program transitioned 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. Sunflower will assist with coordinating all of the care a Sunflower member receives. These members may reside in a nursing facility, intermediate care facility or receive services in the community from Home Based Community Service providers.

The goals of the KanCare program are to improve overall health and independent living outcomes while slowing the rate of cost growth over time. This will be accomplished by providing the right service, in the right amount, in the right setting, at the right time.

Sunflower will focus on ensuring consumers receive the preventive services, screenings and independent living services 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
- Brain Injury
- Intellectual/Developmental Disability
- Serious Emotional Disturbance
- For more information about these services, please refer to Appendices VIII and IX of this manual and the KMAP manuals at www.kmap-state-ks.us.

- 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
Contracting and Network Development

Provider Network Development

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 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 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, pediatrics, family and general practitioners, internists, physician assistants (under the supervision of a primary care physician), and advanced registered nurse practitioners (ARNP). In addition, Sunflower will have specialists available in the following categories for adult and/or pediatric members on a consultative basis. Referrals are not required for in-network care.

- Allergy
- Behavioral Health
- Cardiology
- Dermatology
- Internal Medicine
- Gastroenterology
- General Surgery
- Hematology/Oncology
- Neonatology
- Nephrology
- Neurology
- Neurosurgery
- OB-GYN
- Ophthalmology
- Orthopedics
- Otolaryngology
- Physical Medicine/Rehab
- Plastic and Reconstructive Surgery
- Podiatry
- Psychiatry
- Pulmonary Disease
- Urology
- 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 Clinics (RHC)
- Emergency Care
- Indian Health Services (IHS)
- Optometry (Envolve Vision)
- Dental Primary Care (Envolve Dental)
- Behavioral Health and Psychiatry
- X-Ray (NIA)
- Lab
- Retail Pharmacy (Envolve Pharmacy Solutions)
- Home and Community Based Services (HCBS)
- Skilled Nursing Facilities
- Long-term Care Services
- Transportation Services (LogistiCare)
- Durable Medical Equipment (DME)
- Home Health
- Hospice

A key responsibility of the Contracting and Provider Relations Department is to monitor network adequacy to ensure Sunflower members have 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 network.

In the event that the Sunflower network is insufficient (according to KanCare-established standards), Sunflower shall ensure timely and adequate coverage of 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 finding a specialist for a Sunflower member, please contact our Customer Service department at 1-877-644-4623.

KMAP Enrollment

Effective since January 1, 2019, all KanCare providers must enroll and obtain a KMAP ID before contracting or recredentialing with an MCO. Visit the KMAP Provider Enrollment Wizard (https://portal.kmap-state-ks.us/Home/Index) to learn more or manage your KMAP ID application.

Credentialing

The credentialing and recredentialing process exists to ensure that participating providers meet the criteria established by Sunflower, as well as government regulations and standards of accrediting agencies.

Sunflower will verify the following information submitted for credentialing and recredentialing, 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
- Five-year work history
- Hospital privileges (must be in good standing or have alternate admitting arrangements)
- 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

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 Kansas 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-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

The following information applies to practitioners 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

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)
- Accreditation certificates, if applicable

- Completed Kansas facility/provider – initial and recredentialing – Application with attachments requested. (Application is signed and dated not more than 180 calendar days.)
- 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)

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 percent within 30 days; 100 percent 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 him or her of the decision on his or her application.

Providers must be credentialed prior to accepting or treating members, unless prior authorization has been obtained. 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 the letter with the effective date.

**Recredentialing**

Sunflower conducts provider recredentialing at least every 36 months from the date of the initial credentialing decision and subsequent recredentialing 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 Participating Provider 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 in the Sunflower network have the right to review information obtained by Sunflower to evaluate their credentialing and/or recredentialing 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 that the provider believes any of the information used in the credentialing or recredentialing 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:

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

Upon receipt of this information, the provider will have 14 calendar 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 recredentialing process.

Provider Right to Be Informed of Application Status

All providers who have submitted an application to join the Sunflower network have the right to be informed of the status of their application upon request. To obtain application status, contact the Contracting Department at 1-877-644-4623 or sunflowerstatehealth@centene.com. For status of practitioner additions, terminations, or changes from providers with an existing Participating Provider 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 recredentialing determinations (for reasons such as quality of care or liability claims issues) have the right to request an appeal. Appeal requests must be made in writing within 30 calendar days of formal notice of denial. All written requests should include additional supporting documentation in favor of the applicant’s appeal for participation in the Sunflower network. Appeals for administrative terminations or denials will be reviewed by the Credentialing Committee at the next regularly scheduled meeting and no later than 60 calendar days from the receipt of the additional documentation. In cases where appeal is requested for reasons relating to the competence or professional conduct of the provider, the provider will receive notification (usually within 30 calendar days of request) acknowledging his or her appeal request. Sunflower will schedule a review of the case no more than 180 calendar days from the date of the 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 appeal should 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 should be sent to:

Office of Administrative Hearings
1020 South Kansas Ave.
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.
Provider Network Maintenance

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. The Contracting and Provider Relations Departments are responsible for oversight, coordination or initiation of services for all providers. The 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, nonrenewal, lapse, or adverse material modification of insurance coverage, within 15 calendar days of such notice
- Any change in provider panel status, at least 30 days prior to the effective date of such change

Support from Provider Relations Specialists

Provider relations specialists work in unison with our team of customer service representatives to assist providers and their staff. As a participating provider, you and your office staff will have a provider relations specialist who will be a key contact for you and will provide education and training regarding Sunflower’s administrative processes. He/she may visit you or your designated office manager. 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; to 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 Health Plan. Providers and their office staff are encouraged to call or e-mail the provider relations specialist to:

1. Schedule an orientation/in-service training for new staff
2. Conduct ongoing education for existing staff
3. Obtain clarification of state and Sunflower Health Plan policies and procedures
4. Ask questions regarding your membership list (patient panel)
5. Learn how to use electronic solutions on web authorizations and claims submissions, and check eligibility
6. Request Provider Manuals and similar provider reference materials
7. Request assistance with accessing the available web-based tools and functions
8. Ask questions about the Participating Provider Agreement between Sunflower Health Plan and the provider. Questions regarding the Participating Provider Agreement may also be sent to Sunflower’s Contracting Department at sunflowerstatehealth@centene.com

Provider and Practitioner Change Requests

In order to maintain a current provider profile, providers are required to notify Sunflower Health Plan 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 and practitioner additions/terminations/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 Participating Provider Agreement and/or an amendment to an existing Participating Provider Agreement and/or updated credentialing application and documentation.
Please refer to the Provider Resources section of the SunflowerHealthPlan.com website for additional information and required material, or by contacting the Contracting and Provider Relations Department at 1-877-644-4623.

**Provider Network Termination**

Providers must give Sunflower written notice of their intent to voluntarily terminate their network participation in accordance with the Terms and Termination section 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 and with no disruption or delay in services to affected Sunflower members. Written notification should be sent to:

**Sunflower Health Plan**  
**Contracting Department**  
**8325 Lenexa Dr., Suite 410**  
**Lenexa, KS 66214**  
**Fax: 877-285-8469**

**Member Impact from Provider Termination**

Sunflower will notify affected members in writing of a provider’s termination within 15 days of the receipt of the termination notice. Sunflower will ensure transitional care to members as noted in the **PCP Member Assignment** section of this Provider Manual.

If the terminating provider is a specialist, Sunflower’s Medical Management department will work to transition care and authorizations for services to another in-network specialist.

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 Participating Provider Agreement. 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 with dignity and respect by their patients
- To receive accurate and complete information and medical histories for members’ care
- To expect Sunflower members to act in a way 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 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
- To request an administrative state fair hearing to appeal actions of Sunflower Health Plan

Sunflower Provider Responsibilities

- To advocate for, or help members make decisions about their relevant and/or medically necessary care and treatment within the provider’s scope of practice. This includes the rights 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 forgo 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 use all health information – including that related to patient conditions, medical utilization and pharmacy utilization, and available through the portal or any other means – exclusively for patient care and other related purposes as permitted by the HIPAA Privacy Rule.
- 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 collaborate with Sunflower to ensure safe and appropriate discharges for our members regardless of Sunflower’s level of payer (primary, secondary, or tertiary).
▪ 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 of 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, 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 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, including providing medical records for HEDIS.
▪ To review clinical practice guidelines distributed by Sunflower.
▪ To comply with the 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 and/or Kansas Medical Assistance Program (KMAP) information regarding other insurance coverage the member has or may have.
▪ To give Sunflower timely, written notice if the provider is leaving/closing a practice or location, or if a new practitioner has joined the 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 refer Sunflower members to another physician if the relevant or medically necessary services conflict with the provider’s moral or religious beliefs or other conscientious grounds.

Beneficiary and Attorney Requests and Subpoenas

Occasionally a Medicaid beneficiary, or an attorney for a Medicaid beneficiary, will request or subpoena copies of itemized statements or bills. This may mean there is a pending or proposed lawsuit or some other form of third-party liability (TPL). To operate most effectively, Medicaid requires the cooperation from both beneficiaries and providers in identifying TPL. Medicaid has the following requirement so Medicaid may discover and recover TPL and operate the program more efficiently.

Providers must notify the Kansas Medicaid subrogation contractor whenever providers have a request to release bills or itemized statements to beneficiaries or their lawyers.

You can notify the Kansas Medicaid subrogation contractor by phone, fax, letter or email at:
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, initiating a behavioral health referral. Behavioral health referrals may be submitted online at provider.sunflowerhealthplan.com
- Educating members on how to maintain healthy lifestyles and prevent serious illness
- Managing 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
- Establishing and maintaining hospital admitting privileges sufficient to meet the needs of his/her members
- Providing screening, well care, and referrals to community health departments and other agencies in accordance with KanCare requirements and public health initiatives
- Offering 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
- Adhering to the EPSDT health and dental periodicity schedules for members under age 21
- Ensuring follow-up and documentation of all referrals, including services available under the state’s Fee-for-Service program (such as Kan Be Healthy)
- Collaborating with the Sunflower case management team regarding services such as member screening and assessment, development of a plan of care to address risks and medical needs, and access to other support services as needed
- Developing necessary treatment plans in conjunction with the Sunflower member and any specialists involved for persons with special medical and healthcare needs
- Following 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
- Maintaining 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
- Ensuring that out-of-network providers’ costs to the member are no greater than they would be if

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 percent of the increased rate. Increased payments do not apply to Rural Health Clinic and Federally Qualified Health Center services.

Include this information in your notification to the Kansas Medicaid subrogation contractor:
- Name of the Medicaid beneficiary
- Medicaid ID number
- Date of accident or incident
- Type of injury
- Name, address and phone number of attorney (if applicable)
- Name, address and phone number of insurance company (if applicable)

www.kmap-state-ks.us/Public/providersmanuals.asp
the services were furnished within
the network

▪ Sharing 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 participating in and
cooperating with all Sunflower
quality initiatives and programs

PCP Member
Assignment

KanCare defaults to a health plan from
the list of its contracted Medicaid
MCOs. Once a member is assigned
to a Medicaid MCO, he or she is 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, Sunflower 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
him or her to his or her previous
PCP. If the member is new to
Sunflower, claim history provided
by the state will be used to
match the 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. **If the member has no
previous relationship with a
PCP, the algorithm will try
to assign a PCP listed for
someone in the member’s
family, such as a sibling.

3. **Geographic proximity of
PCP to member residence.**
The auto-assignment logic will
ensure members travel no more
than 30 miles or 45 minutes
in rural areas or 20 miles or 40
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 that the
pregnant member does not select a
PCP, Sunflower will auto-assign one for
her newborn.

The member may change his or her
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 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

PCPs and specialists who want to
change their panel status (open,
closed, existing members only) must
notify Sunflower Customer Service at
1-877-644-4623 or contact Provider
Relations at providerrelations@
sunflowerhealthplan.com. Sunflower
prefers that PCPs and specialists
submit panel status changes using the
Sunflower-approved roster located on
the Sunflower Health Plan website.

Please note that PCPs and specialists
may not refuse acceptance of new
members if the panel status is open.

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.
PCPs Can Be Specialists

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 his or her 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.

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.

Specialist Provider Responsibilities

Sunflower requires specialists to communicate to the PCP regarding treatment plans 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, including providing reports to the member’s PCP on a regular basis
- 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. Providers are encouraged to contact their dedicated provider relations specialist or contact customer service with questions or concerns regarding referrals, claims, prior authorization requirements, or other administrative issues.

Hospital Responsibilities 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. 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. CT) following the admission. Clinical information must be submitted with the admission to support medical necessity.
- Partner with Sunflower’s Medical Management Department by providing discharge dispositions or additional documentation on admissions where Sunflower may not be the primary payer.
- Notify Sunflower’s Medical Management Department of all admissions via the ER within one business day (by 5 p.m. CT).
- Notify Sunflower’s Medical Management Department of all newborn deliveries within one day (by 5 p.m. CT) of the delivery.

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

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.

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 his or her 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.

Provider Phone Call Protocol

Providers must:
- Answer the member’s telephone inquiries on a timely basis
- 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

- 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 canceled 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)

**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).

**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.

For the list below, urban includes the requirements for urban and semiurban counties, and rural includes the requirements for densely settled rural, rural and frontier counties. A list of access standards (not all-inclusive) is below:

- **Primary Care Providers (PCPs):**
  - Rural Areas: 30 miles or 45 minutes
  - Urban Areas: 20 miles or 40 minutes
- **Hospital Services:**
  - Rural Areas: 60 miles or 90 minutes
  - Urban Areas: 30 miles or 60 minutes
- **OB-GYN:**
  - Rural Areas: 60 miles or 90 minutes
  - Urban Areas: 15 miles or 30 minutes
- **Other Specialists:**
  - Rural Areas: 90 miles or 135 minutes
  - Urban Areas: 30 miles or 60 minutes
- **Dental:**
  - Rural Areas: 30 miles or 45 minutes
  - Urban Areas: 20 miles or 40 minutes
- **Lab and X-ray:**
  - Rural Areas: 30 miles or 60 minutes
  - Urban Areas: 30 miles or 60 minutes
- **X-ray:**
  - Rural Areas: 60 miles or 90 minutes
  - Urban Areas: 30 miles or 60 minutes
- **Home and Community Based Services (Adult Day Care and Day Supports):**
  - Rural Areas: 60 miles or 100 minutes
- **Behavioral Health:**
  - Rural Areas: 60 miles or 90 minutes
  - Urban Areas: 30 miles or 60 minutes
- **Optometry**
  - Urban Areas: 30 miles or 60 minutes
  - Rural Areas: 60 miles or 90 minutes
- **Psychiatrist**
  - Urban Areas: 15 miles or 30 minutes
  - Rural Areas: 60 miles or 90 minutes
- **Pharmacy**
  - Urban Areas: 10 miles or 20 minutes
  - Rural Areas: 30 miles or 45 minutes
- **Occupational Therapy**
  - Urban Areas: 30 miles or 60 minutes
  - Rural Areas: 60 miles or 90 minutes
- **Physical Therapy**
  - Urban Areas: 30 miles or 60 minutes
  - Rural Areas: 60 miles or 90 minutes
- **Speech Therapy**
  - Urban Areas: 30 miles or 60 minutes
  - Rural Areas: 60 miles or 90 minutes

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.

## 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:

<table>
<thead>
<tr>
<th>TYPE OF PROVIDER</th>
<th>APPOINTMENT STANDARDS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>PRIMARY CARE PROVIDERS</strong></td>
<td></td>
</tr>
<tr>
<td>Regular Appointments</td>
<td>Not to exceed three weeks from date of member request</td>
</tr>
<tr>
<td>Urgent Care</td>
<td>48 hours</td>
</tr>
<tr>
<td><strong>SUBSTANCE USE DISORDER (SUD) PROVIDERS</strong></td>
<td></td>
</tr>
<tr>
<td>Emergent</td>
<td>On-demand service. No prior authorization is required, and members go directly to an emergency room. Members are seen immediately.</td>
</tr>
<tr>
<td>Urgent</td>
<td>Assessment conducted within 24 hours of the initial contact, and services delivered within 24 hours of the date and time of assessment.</td>
</tr>
<tr>
<td>IV Drug Users</td>
<td>IV drug users must receive an assessment and shall be admitted to treatment no later than 14 calendar days after making the request for an assessment. If no program has the capacity to admit the member within the required timeframe, interim services shall be made available no later than 48 hours after such request. Admission to treatment must not exceed 120 calendar days of the request for assessment.</td>
</tr>
<tr>
<td>Routine</td>
<td>Members are assessed within 14 days of initial contact.</td>
</tr>
<tr>
<td>Pregnant Women</td>
<td>Pregnant women who are intravenous drug users and all other pregnant substance users, regardless of Title XIX status, must receive treatment within 24 hours of assessment. When it is not possible to admit the member within this timeframe, interim services shall be made available within 48 hours of initial contact, to include prenatal care.</td>
</tr>
<tr>
<td><strong>MENTAL HEALTH ACCESS STANDARDS</strong></td>
<td></td>
</tr>
<tr>
<td>Post-Stabilization Services</td>
<td>Referral within one hour. Assessment and/or treatment within 1 hour of referral for post-stabilization services (both inpatient and outpatient) in an emergency.</td>
</tr>
<tr>
<td>Emergent</td>
<td>Referral immediately.</td>
</tr>
<tr>
<td>Urgent</td>
<td>Assessment within 72 hours from request for services.</td>
</tr>
<tr>
<td>Routine Outpatient</td>
<td>Assessment within fourteen (14) business days of the date services are requested.</td>
</tr>
<tr>
<td><strong>SPECIALTY AND URGENT CARE (INCLUDES SPECIALTY PHYSICIAN SERVICES, HOSPICE CARE, HOME HEALTHCARE, SUD TREATMENT, REHABILITATION SERVICES, ETC.)</strong></td>
<td></td>
</tr>
<tr>
<td>Routine Care</td>
<td>Not to exceed 30 days.</td>
</tr>
<tr>
<td>Urgent Care</td>
<td>Not to exceed 48 hours.</td>
</tr>
</tbody>
</table>

**EMERGENCY CARE**

| Emergency Care | Immediate, at the nearest facility available, regardless of participation status with Sunflower. |
## 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.

### Dismissing a Member from Your Practice

There may be limited times when providers need to dismiss members from their practices. Example dismissal reasons include:

- **Member Behavior:** Narrative including dates and description of disruptive, abusive, or hostile behavior toward the provider and/or office staff describing incidents that impede a provider’s ability to administer care, obstructs communication, threatens the well-being of others, or causes damage to property and equipment. Providers may involve an internal security team or local law enforcement at their discretion.

- **Member Fraud:** Documentation must state the circumstances leading to this suspicion or conclusion. Drug-seeking behavior is considered member fraud.

- **Chronic Missed Appointments:** Documentation should include a written log of chronically missed appointments, including appointment dates missed, and a copy of your office no-show policy. In lieu of providers’ existing policy, a missed appointment may be defined as an intended appointment that was not cancelled or rescheduled at least two hours before the designated time. A habitual no-show patient may be defined as those who missed four or more visits in a 12-month period.

- **Unengaged Member:** If member fails to respond to multiple attempts to engage with provider, attach a description and a count of the number of outreach attempts. If there has been a mutual breakdown in the physician/patient relationship, include an explanation describing the circumstances leading to the mutual breakdown of the relationship that can be verified with the patient.

- **Provider Type:** If member does not fit the criteria of the PCP’s focus, include a description of the member’s condition and explanation of the reason for the decision. For example:
  - Child aging out of pediatric care to adult primary care.
  - Patient with long-term chronic condition prefers to have primary care services managed by their specialist.
  - Women of childbearing age prefers to have primary care services managed by their OBGYN.

To dismiss a member from your practice, complete the Provider Request for Member Dismissal Cover Sheet located on our website under Provider Resources and Forms. Fax the completed form, documentation and a copy of your notification letter to the member to Customer Service at 1-866-491-1824.

Continuity of care must be provided to the member for up to 30 days following the dismissal request submission or until the change is completed.
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 of suboptimal care. Members may be unable or unwilling to communicate their healthcare needs in an insensitive environment, reducing effectiveness of the entire healthcare process.

Providers should note that the experience of a member begins at the front door. Failure to use culturally and linguistically competent practices could result in the following:
- Feelings of being insulted or treated rudely
- Reluctance and fear of making future contact with the office
- Confusion and misunderstanding
- Treatment non-compliance
- Feelings of being uncared for, looked down on, or devalued
- Parents resisting to seek help for their children
- Unfilled prescriptions
- Missed appointments
- Misdiagnosis due to lack of information sharing
- Wasted time
- Increased grievances

The road to developing a culturally competent practice begins with the recognition and acceptance of the value of meeting the needs of your patients. Sunflower is committed to helping you reach this goal. Take into consideration the following as you provide care to the Sunflower Health Plan members:
- What are your own cultural values and identity?
- How do or can cultural differences impact your relationship with your patients?
- How much do you know about your patient’s culture and language?
- Does your understanding of culture take into consideration values, communication styles, spirituality, language ability, literacy, and family definitions?
- Do you embrace differences as allies in your patients’ healing process?

The U.S Department of Health and Human Services’ Office of Minority Health has published a suite of online educational programs to Advance Health Equity at Every Point of Contact through development and promotion of culturally and linguistically appropriate services. Visit Think Cultural Health at www.thinkculturalhealth.hhs.gov to access these free online resources.

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.
- Providers and their office staff routinely interacting with members have been given the opportunity to participate in, and have participated in, cultural competency training and development offered by Sunflower.
- 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 preference, and other characteristics that may influence the member’s perspective on healthcare.
- Provider office sites have materials posted and printed in English and Spanish and made available in other languages upon request.

- 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.

Sunflower provider agreements require compliance with state and federal nondiscrimination 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.

**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, in a different manner, at a different time or at a different location, than to other “public” or private-pay members (examples: separate waiting rooms or 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. **Check the KMAP website.** If you are a registered provider on the KMAP website, you may also verify eligibility on this site.

2. **Log on to Provider. 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 last name and date of birth (DOB), or Medicaid 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. Members who are assigned within the past three months have a “new member” indicator.

3. **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.

4. **Call Sunflower Customer Service.** If you cannot confirm a member’s eligibility using the methods above, call our toll-free number, 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.

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.
Member Rights and Responsibilities

**SUNFLOWER MEMBERS HAVE THE FOLLOWING RIGHTS:**

- To get information about Sunflower Health Plan, its services, its practitioners and providers and member rights and responsibilities.
- To give ideas for Sunflower’s member rights and responsibilities policy.
- To be treated with respect, dignity and privacy.
- To get information on care options in a way that they can understand, regardless of cost or coverage.
- To participate in decisions about their health care. This includes the right to refuse treatment.
- To seek second opinions.
- To get help with care coordination from the PCP’s office.
- To not be restrained or secluded if doing so is:
  - Meant to force them to do something they do not want to do.
  - To punish them.
  - For someone else’s convenience.
  - To get back at them.
- To express a concern or appeal about Sunflower or the care it provides. To receive a response in a reasonable period of time.
- To receive a copy of their medical records upon request. (One copy is free of charge.) To ask that they be amended or corrected.
- To choose their health professional and long-term supports and services providers to the extent possible and appropriate, as per 42 CFR §438.6(m).
- To be given health care services as per 42 CFR §§ 438.206 through 438.210.
- To get health care services that are similar in amount and scope to those given under Medicaid Fee-For-Service. This includes the right to get health care services that will achieve the purpose for which the services are given.
- To get services that are fitting and are not denied or reduced due to:
  - Diagnosis
  - Type of illness
  - Medical condition
- To be given information in a manner and format they can understand as defined in the Provider Agreement and the Member Handbook. This includes:
  - Enrollment notices
  - Informational materials
  - Instructional materials
- To be given treatment options and alternatives
- To get free oral interpretation services for all non-English languages.
- To be notified that interpretation services are available and how to access them.
- To get adequate and timely information on Sunflower’s Physician Incentive Plan upon request.

**SUNFLOWER MEMBERS HAVE THE FOLLOWING RESPONSIBILITIES:**

- To inform Sunflower of the loss or theft of an ID card.
- To inform Sunflower, their provider and the State Medicaid program of any change of address or phone number.
- To present the Sunflower ID card when using health care services.
- To be familiar with Sunflower procedures to the best of their abilities.
- To contact Sunflower to get information and have questions answered.
- To give providers accurate and complete medical information.
- To follow care prescribed by the provider or to let the provider know why treatment cannot be followed, as soon as possible.
- To keep appointments and follow-up appointments. To access preventive care services.
- To live healthy lifestyles and avoid behaviors known to be harmful.
- To understand their health problems and participate in developing mutually agreed-upon treatment goals, to the degree possible.
- To give accurate and complete information needed for care to Sunflower and all their health care and support providers.
To make their primary care provider aware of all other providers who are treating them. This is to ensure communication and coordination in care. This also includes behavioral health providers.

To learn about Sunflower coverage provisions, rules and restrictions.

To ask questions of providers to learn the risks, benefits, and costs of treatment options. To make care decisions after carefully weighing all factors.

To follow Sunflower’s grievance process outlined in the Member Handbook if there is a disagreement with a provider.

To choose a primary care provider (PCP).

To treat providers and staff with dignity and respect.

**Member Self-Referral Options**

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

- 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
- Behavioral health services
- Emergency services, including emergency ambulance transportation, whether in or out of network
- Urgent care facilities
- OB-GYN (in or out of network) for women’s routine and preventive healthcare services
- Women’s health services provided by participating Federally Qualified Health Centers (FQHC), Rural Health Clinics (RHC), or certified nurse practitioners (CNP)
- Family planning services including screening and treatment services for sexually transmitted diseases (in or out of network)
- Nonmedical vision care (e.g., 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.

**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 advance 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

**Member 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.
medications 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.

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. (CT) 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.

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 SunflowerHealthPlan.com, or contact customer service at 1-877-644-4623.
<table>
<thead>
<tr>
<th>SERVICE</th>
<th>COVERAGE</th>
<th>BENEFIT LIMITATION</th>
<th>COMMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alternative Medicine</td>
<td>Not Covered</td>
<td></td>
<td>Examples are acupuncture, Christian Science, faith healing, herbal therapy, homeopathy, massage, massage therapy or natur-opathy.</td>
</tr>
<tr>
<td>Abortions</td>
<td>Not Covered - See *exception</td>
<td>Only covered when a member suffers from a rape or incest, or the life of the mother is threatened.</td>
<td>Abortion necessity form is required at the time the claim is submitted.</td>
</tr>
<tr>
<td>Adult Care Home Services</td>
<td>Covered</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Allergy Services</td>
<td>Covered</td>
<td>Procedure code 95165 is limited to 156 doses per year. Allergy Injections are not covered when billed on the same day as an office visit by the same provider.</td>
<td></td>
</tr>
<tr>
<td>Ambulance (Emergency Transportation)</td>
<td>Covered</td>
<td>Ground, rotary and fixed wing</td>
<td></td>
</tr>
<tr>
<td>Ambulatory Surgery Center</td>
<td>Covered</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anesthesia Services</td>
<td>Covered</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Audiology Services</td>
<td>Covered</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bariatric Surgery</td>
<td>Covered</td>
<td></td>
<td>A member must meet certain medical criteria</td>
</tr>
<tr>
<td>B-12 Injections</td>
<td>Covered</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Behavioral Health Svcs</td>
<td>Covered</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Birthing Centers</td>
<td>Covered</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cardiac Rehabilitation</td>
<td>Covered</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chemical Dependency Treatment</td>
<td>Covered</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chemotherapy</td>
<td>Covered</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chiropractor Services</td>
<td>Not Covered</td>
<td></td>
<td>Only covered if member has Medicare coverage in a Qualified Medicare Beneficiary program plan.</td>
</tr>
<tr>
<td>Circumcisions (Routine/ Elective)</td>
<td>Covered</td>
<td></td>
<td>Examples are tattoo removal, face lifts, ear or body piercing and hair transplants. Any medically necessary procedures that could be considered cosmetic in nature must be prior authorized.</td>
</tr>
<tr>
<td>Cosmetic or Plastic Surgery</td>
<td>Not Covered</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dental Services</td>
<td>Covered</td>
<td>For members under 21 (see Value-Added Services table below for coverage for adults)</td>
<td></td>
</tr>
</tbody>
</table>

All services are subject to benefit coverage, limitations, and exclusions, some of which are described here. Call Customer Service at 877-644-4623 to get more information on benefit coverage.
<table>
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</thead>
<tbody>
<tr>
<td>Developmental Testing</td>
<td>Covered</td>
<td>1 per day, up to 3 visits per calendar yr</td>
<td></td>
</tr>
<tr>
<td>Diabetic Education</td>
<td>Not Covered</td>
<td></td>
<td>Provided by the Healthy Solutions for Life Program</td>
</tr>
<tr>
<td>Diagnosis and Treatment of Infertility, Impotence and Sexual Dysfunction</td>
<td>Not Covered</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dialysis</td>
<td>Covered</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dietitian Services</td>
<td>Covered</td>
<td>Services limited to members age 20 and under.</td>
<td></td>
</tr>
<tr>
<td>Durable Medical Equipment</td>
<td>Covered</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Early Periodic Screening Diagnosis and Treatment</td>
<td>Covered</td>
<td>Members under 21 years old</td>
<td></td>
</tr>
<tr>
<td>Emergency Room Svcs</td>
<td>Covered</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Experimental Procedures, Drugs and Equipment</td>
<td>Not Covered</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Family Planning</td>
<td>Covered</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fluoride Application</td>
<td>Covered</td>
<td>Limited to 3 per calendar year for children under 21 meeting EPSDT criteria.</td>
<td></td>
</tr>
<tr>
<td>Gender Reassignment Surgery</td>
<td>Not Covered</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hearing Aids</td>
<td>Covered</td>
<td>Some limitations apply for ages over 20.</td>
<td>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.</td>
</tr>
<tr>
<td>Hearing Aid Repairs</td>
<td>Covered</td>
<td>Charges for hearing aid repairs under $15 are not covered.</td>
<td></td>
</tr>
<tr>
<td>Hearing Aids (Bone Anchored)</td>
<td>Covered</td>
<td>Limited to members 5 to 20 years of age.</td>
<td></td>
</tr>
<tr>
<td>HIV Testing &amp; Counseling</td>
<td>Covered</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Home Births</td>
<td>Covered</td>
<td>Doula services are not covered.</td>
<td></td>
</tr>
<tr>
<td>Home Healthcare Svcs</td>
<td>Covered</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospice Care</td>
<td>Covered</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospital Services: Inpatient</td>
<td>Covered</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospital Services: Outpatient</td>
<td>Covered</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hyperbaric Oxygen Therapy</td>
<td>Covered</td>
<td></td>
<td></td>
</tr>
</tbody>
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</thead>
<tbody>
<tr>
<td>Hysterectomy</td>
<td>Covered</td>
<td>Not covered if only to prevent pregnancy.</td>
<td>Sterilization consent form is no longer required for hysterectomies performed for medical reasons.</td>
</tr>
<tr>
<td>Laboratory Services - Outpatient</td>
<td>Covered</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Laboratory Services - Inpatient</td>
<td>Covered</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maternity (OB Routine Ultrasounds)</td>
<td>Covered</td>
<td>Two routine OB sonograms covered per fetus per pregnancy.</td>
<td></td>
</tr>
<tr>
<td>Maternity Care Services</td>
<td>Covered</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical Nutrition (through stomach or veins)</td>
<td>Covered</td>
<td>Some limitations apply.</td>
<td>Oral supplements excluded.</td>
</tr>
<tr>
<td>Non-Emergency Medical Transportation (Ambulance)</td>
<td>Covered</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-Emergency Medical Transportation (NEMT)</td>
<td>Covered</td>
<td></td>
<td>For transportation call: 1-877-917-8162</td>
</tr>
<tr>
<td>Non-Medical Equipment</td>
<td>Not Covered</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outpatient Hospital/Outpatient Surgery</td>
<td>Covered</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Oxygen and Respiratory Services</td>
<td>Covered</td>
<td>Some limitations apply.</td>
<td></td>
</tr>
<tr>
<td>Pain Management</td>
<td>Covered</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Personal Comfort Items</td>
<td>Not Covered</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physician and Nurse Practitioner Services</td>
<td>Covered</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physical Exam Required for Insurance or Licensing</td>
<td>Not Covered</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physical, Occupational, and Speech Therapy</td>
<td>Covered</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Podiatrist Services</td>
<td>Covered</td>
<td>For members age 20 and under.</td>
<td>For EPSDT additional visits may be provided with prior authorization.</td>
</tr>
<tr>
<td>Prescription Drugs</td>
<td>Covered</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Preventive Care</td>
<td>Covered</td>
<td>Certain limitations may apply.</td>
<td></td>
</tr>
</tbody>
</table>

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</tr>
</thead>
<tbody>
<tr>
<td>Prosthetic &amp; Orthotic Devices</td>
<td>Covered</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Psychotherapy</td>
<td>Covered</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Psychological Testing</td>
<td>Covered</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Radial Keratotomy</td>
<td>Not Covered</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Radiology and X-rays</td>
<td>Covered</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Radiology (High Tech Imaging)</td>
<td>Covered</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reconstructive Surgery after Mastectomy</td>
<td>Covered</td>
<td>Related to diagnosis of breast cancer only.</td>
<td>School-Based Services are covered through the State’s Fee-for-Service program.</td>
</tr>
<tr>
<td>School-Based Services</td>
<td>Not Covered</td>
<td></td>
<td></td>
</tr>
<tr>
<td>School and Employment Physicals</td>
<td>Covered</td>
<td></td>
<td>Some exclusions apply. Please see the KMAP Professional Manual for details.</td>
</tr>
<tr>
<td>Screening and Treatment for STD</td>
<td>Covered</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Services Not Allowed by Federal or State Law</td>
<td>Not Covered</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sleep Studies</td>
<td>Covered</td>
<td></td>
<td>For members age 20 and under or as part of the pre-operative work-up for bariatric surgery.</td>
</tr>
<tr>
<td>Transplant Services</td>
<td>Covered</td>
<td>Covered for certain organs. Limitations apply. Confirm with the plan during prior authorization or by calling customer service.</td>
<td>Members needing a kidney transplant for end-stage renal disease should apply for Medicare prior to transplant. Provide denial information if asking the plan to cover as primary payer.</td>
</tr>
<tr>
<td>Transportation (See Non-Emergency Medical Transportation)</td>
<td>Covered</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Urgent Care Services</td>
<td>Covered</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vision and Eye Exams</td>
<td>Covered</td>
<td></td>
<td>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. Additional coverage for exams following eye surgeries or for monitoring of certain medical conditions may be covered.</td>
</tr>
</tbody>
</table>

All services are subject to benefit coverage, limitations, and exclusions, some of which are described here. Call Customer Service at 877-644-4623 to get more information on benefit coverage.
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 16-64 with Brain Injury (BI)
- Individuals 65 and older who are Frail Elderly (FE)
- Children with Severe 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. For children receiving EPSDT services, any limits on services may be exceeded when medically necessary.

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

<table>
<thead>
<tr>
<th>VISIT TYPE</th>
<th>BIRTH</th>
<th>2-5 DAYS AFTER</th>
<th>1 MONTH</th>
<th>2 MONTHS</th>
<th>4 MONTHS</th>
<th>9 MONTHS</th>
<th>1 YEAR</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Screen</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Vision Screen</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Hearing Screen</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Dental Screen</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>X</td>
</tr>
</tbody>
</table>
AFTER YEAR 1 OF LIFE

<table>
<thead>
<tr>
<th>VISIT TYPE</th>
<th>15 MONTHS</th>
<th>18 MONTHS</th>
<th>24 MONTHS</th>
<th>30 MONTHS</th>
<th>3-20 YEARS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Screen</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Vision Screen</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Hearing Screen</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Dental Screen</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
</tbody>
</table>

The screening form may be found at www.kmap-state-ks.us/Public/forms.asp.

Sunflower requires providers to fully cooperate with Sunflower and KanCare’s efforts to improve the health status of Kansas citizens and to actively help increase the number of eligible members obtaining EPSDT services in accordance with the adopted periodicity schedules. Sunflower will cooperate with 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

An 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 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 instructed 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 one hour of a request to Sunflower for preapproval 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:

- Sunflower does not respond to a request for preapproval within one hour;
- Sunflower cannot be contacted; or
- The Sunflower representative and the treating physician cannot reach an agreement concerning the member’s care; or
- The member is discharged.

**Women’s Healthcare**

Women’s healthcare services are 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, breastfeeding, 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 interconception 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 form, which is available at www.kmap-state-ks.us/Public/forms.asp and at SunflowerHealthPlan.com. This form should be submitted with the claim.

The Consent for Sterilization 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.

Prenatal 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 her to call our toll-free number if she is 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.

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**Value-Added Services for Members**

**24-Hour Nurse Advice Line**

Our members have many questions about their health, their primary care provider, and access to emergency care. Therefore, we offer a nurse advice line to help members proactively manage their health needs and 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 is 1-877-644-4623.

The nurse advice line 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. Nurses will refer members with chronic problems, like asthma or diabetes, to our Care Management or Customer Service departments for follow-up assistance, education, and encouragement to improve their health. Members can call the nurse advice line to request information about providers and services available in the community after hours, when the Sunflower Customer Service department is closed. The staff is proficient in both English and Spanish and can provide additional translation services if necessary.

**My Health Pays® Program**

The Sunflower My Health Pays® Rewards program is a member incentive program widely used to promote personal healthcare responsibility. My Health Pays 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. 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 My Health Pays® Visa® Prepaid Card*. Rewards can be used for utilities, transportation, telecommunications, childcare services, education, rent or everyday items at Walmart.

Our My Health Pays program supports the positions taken by the American College of Physicians for ethical use of incentives to promote personal responsibility for health.

* This My Health Pays Rewards Visa Prepaid card is issued by The Bancorp Bank pursuant to a license from Visa U.S.A. Inc. The Bancorp Bank; Member FDIC. Card cannot be used everywhere Visa debit cards are accepted.

<table>
<thead>
<tr>
<th>HEALTH ACTIVITY</th>
<th>REWARD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Complete an annual Health Risk Screening (One per calendar year)</td>
<td>$10</td>
</tr>
<tr>
<td>Child Well Visit with PCP (One per calendar year; ages 2-20)</td>
<td>$10</td>
</tr>
<tr>
<td>Infant Well Visit – All 6 visits completed with a PCP in first 15 months (These visits are recommended before 30 days old and at 2, 4, 6, 9, 12 and 15 months old.)</td>
<td>$10 per infant well visit for a total of $60</td>
</tr>
<tr>
<td>Immunizations Bonus - MMR and VZV – (given between 12 and 15 months)</td>
<td>$10 bonus for each immunization</td>
</tr>
<tr>
<td>HPV Vaccine – Males and females, ages 9-12. Must get both shots in the HPV series in a 12-month period.</td>
<td>$15 for complete series in 12 months</td>
</tr>
<tr>
<td>Diabetes Management – Have one or two HbA1c lab draws to earn $10 for each. Members can earn a maximum of $20 per year. (Ages 18-75)</td>
<td>$10 HbA1c with max of 2 per year for total of $20</td>
</tr>
<tr>
<td>To earn an additional $50, complete an A1C, kidney screening &amp; dilated eye screening once in the calendar year. Must have all three screenings in the year. (Ages 18-75)</td>
<td>$50 if all 3 services are completed</td>
</tr>
<tr>
<td>Notice of Pregnancy to Sunflower in the first trimester</td>
<td>$50</td>
</tr>
<tr>
<td>Notice of Pregnancy to Sunflower in the second trimester</td>
<td>$25</td>
</tr>
<tr>
<td>After baby delivery – Follow-up visit</td>
<td>$10</td>
</tr>
</tbody>
</table>

Rewards for EPSDT and wellness screenings are based on HEDIS criteria.

**Community Health Services**

Community Health Services is Sunflower’s member outreach program designed to provide health education and coaching to our members on how to access healthcare and develop healthy lifestyles in settings where they feel most comfortable. The program components are integrated as a part of our care management program in order to link Sunflower and the community served. The program recruits staff from the local community in order to establish grassroots support and awareness of Sunflower.

Members can be referred to Community Health Services through numerous channels: Sunflower Customer Service, care coordinators, community groups and members’ physicians.

**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 our eligible female members 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 conversations to improve health outcomes.
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 care manager, who will check for eligibility. As needed, the care manager may coordinate the ordering and delivery of 17-P directly to the physician’s office. A prenatal care 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 breastfeeding educational program for members. For more information about the Sunflower Start Smart program, please contact Customer Service at 1-877-644-4623 or the member’s assigned case manager.

**SafeLink® Phones**

SafeLink provides a free smart phone with free limited data and voice minutes per month, unlimited texting and free calls to and from Sunflower. Members can apply at www.safelink.com by calling 1-877-631-2550.

**Telemonitoring**

Sunflower will provide telemonitoring services to the highest-risk members (with multiple comorbidities), 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 landline, cellular (including a SafeLink 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 care 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 care 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.
## Value-Added Services

Additional value-added services offered by Sunflower Health Plan:

<table>
<thead>
<tr>
<th>Service</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dental Visits</td>
<td>For adults 21 and older - one dental checkup every six months.</td>
</tr>
<tr>
<td>My Health Pays Rewards</td>
<td>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.</td>
</tr>
<tr>
<td>Cell Phones</td>
<td>Free smart phone through SafeLink®. These come with free limited data and voice minutes per month, unlimited texting and free calls to and from Sunflower.</td>
</tr>
<tr>
<td>Maternal &amp; Child Health</td>
<td><strong>Start Smart® for Your Baby</strong> – This program gives support, education and gifts for moms, babies, and families. The program includes the services below. There is no cost to the member.</td>
</tr>
<tr>
<td></td>
<td>- In-home help with healthcare and social service benefits.</td>
</tr>
<tr>
<td></td>
<td>- Special texting program for Start Smart participants</td>
</tr>
<tr>
<td></td>
<td>- Group baby showers for pregnant mothers. Members are given diapers and other health items.</td>
</tr>
<tr>
<td></td>
<td>- NEW IN 2020: Transportation to WIC appointments. (Four round trips)</td>
</tr>
<tr>
<td></td>
<td>- Start Smart birthday programs for children</td>
</tr>
<tr>
<td>Community Programs for Healthy Children</td>
<td><strong>Start Smart® for Your Baby</strong> – This program gives support, education and gifts for moms, babies, and families. The program includes the services below. There is no cost to the member.</td>
</tr>
<tr>
<td></td>
<td>- In-home help with healthcare and social service benefits.</td>
</tr>
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</tr>
<tr>
<td></td>
<td>- Start Smart birthday programs for children</td>
</tr>
<tr>
<td></td>
<td>Free services to promote healthy lifestyles for kids, such as membership fees to Boys &amp; Girls Clubs. Sunflower’s Adopt-a-School Program brings activities, speakers and books into the schools, as well as summer program locations like YMCAs, libraries, parks &amp; recreation departments, and Boys &amp; Girls Clubs.</td>
</tr>
<tr>
<td></td>
<td>Sunny’s Kids Club – Subscribers receive a welcome packet with a club membership card and educational books four times a year.</td>
</tr>
<tr>
<td>In-home Tele-Health</td>
<td>In-home telehealth is available for adults. This service helps members stay at home when they need help to manage their chronic conditions.</td>
</tr>
<tr>
<td>MyStrength Program</td>
<td>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 in-dependently or in conjunction with other care.</td>
</tr>
<tr>
<td>Farmers’ Market Vouchers</td>
<td>We promote healthy eating. Members can receive $10 farmers’ market vouchers at special events with participating farmers’ markets.</td>
</tr>
<tr>
<td>Medication Review</td>
<td>A comprehensive medication review with a local pharmacist is available to eligible members. The review includes a 30 minute face-to-face consultation with a local pharmacist.</td>
</tr>
<tr>
<td>Healthy Solutions for Life - Chronic Disease Management &amp; Depression Support</td>
<td>Healthy Solutions for Life is a disease-management program for members with asthma, COPD, diabetes, heart disease or high blood pressure. Members can enroll in any of these programs. Weight management is also available.</td>
</tr>
<tr>
<td></td>
<td>The program also helps members determine how emotions impact their condition. It helps with stress, poor sleep and appetite. As a part of the program, participants are assigned a health coach who works with the entire healthcare team to ensure members have everything they need to feel their best.</td>
</tr>
<tr>
<td>Caregiving Collaborations*</td>
<td>Caregivers are supported through various channels in the Caregiving Collaborations program. This benefit is available to one primary, informal support caregiver per member. Benefits include the Caregiver Resource Center and a Caregiver Journal. In addition to the program benefits, each member and caregiver will continue to receive coordination of respite services available through the individual care plan.</td>
</tr>
</tbody>
</table>
### Nursing Home-to-Community Transition Support

Sunflower offers nursing home transition support by partnering with providers to:

- Conduct pre-placement transition meetings and activities that may include finding and securing housing, securing house-hold items, confirming informal supports, completing in-home risk assessment and assisting with hiring of caregivers.
- Schedule follow-up visits to ensure services and equipment are in place and meeting the member’s needs, to confirm or set up a PCP appointment, among other personal support activities.
- Cover one week of home-delivered meals for each member transitioning out of a nursing facility regardless of waiver benefit coverage.

Members may be eligible for additional financial assistance or benefits, based upon need, when transitioning to independent living situations.

### Employment Support & Transportation

**Sunflower Transition to Employment Program (STEP)** is an employment support resource program. We help members identify and remove employment barriers through a discussion with an internal employment specialist. Benefits include enhanced transportation coverage, GED Ready and GED test vouchers, connection with career counseling services, and information on the STEP scholarship program. Members may be connected with a benefits specialist to learn how their income may impact their benefits.

### Members on the Frail & Elderly (F/E) and Physical Disability (PD) Waivers

**Dentures (F/E & PD Waivers)**
Dentures may be covered for eligible members receiving F/E and PD Waiver benefits. Eligibility is based on medical necessity.

**Internet Service (F/E & PD Waivers)**
Internet service for F/E & PD waiver members using telemonitoring services and home health coaching.

**Home-delivered Meals (F/E Waiver)**
Meals delivered to the home of F/E waiver members who are discharged from a nursing facility or inpatient stay. This covers 14 meals over a week. KanCare covers this service for PD and Brain Injury (BI) waiver members.

**Respite Care (F/E & PD Waivers)**
Up to 24 hours of respite care for non-paid caregivers who provide supports for persons on the F/E and PD waivers.

**Transportation to Community & Social Events (F/E & PD Waivers)**
Enhanced transportation to local community events and social activities for members receiving F/E and PD waiver benefits. Sunflower also assists members with finding events and activities. (Three round trips per year.)

**Home Modification & Assistive Services (F/E & PD Waivers)**
Home modification and assistive services for members on the F/E & PD waivers to enable individuals to remain living at home. Examples include wheelchair ramps, stair lifts, walk-in or wheelchair accessible bathtubs and showers.

**Peer Support Program (F/E & PD Waiver)**
Peer Support Program for members receiving F/E & PD waiver benefits, as well as members on the waiting list for PD waiver services. This social interaction includes monthly phone calls with other members, facilitated by a Sunflower Member Liaison.

**Hospital Companionship (F/E & PD Waiver)**
Up to 16 hours of hospital companionship for persons on the F/E and PD waivers.
Medical Management

Overview

Medical Management hours of operation are Monday through Friday from 8:00 a.m. to 5:00 p.m. CT (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.

Nurse advice line 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 (physical and behavioral health), 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 the Sunflower Medical Management Department at 1-877-644-4623.

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 (medical and behavioral). The UM program incorporates all care settings, including preventive care, emergency care, primary care, behavioral health 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 least restrictive, most clinically 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.

Additionally, Sunflower is committed to compliance with the Mental Health Parity and Addiction Equity Act (MHPAEA) of 2008 and the Interim Final Rule and subsequent Final Ruling. Sunflower will ensure compliance with MHPAEA requiring parity of both quantitative limits (QTLS) applied to MH/SUD benefits and non-quantitative limits (NQTLS). Sunflower administers benefits for substance use disorder (SUD) and/or behavioral health conditions as designated and approved by the state contract and plan benefits. MHPAEA does not preempt state law, unless law limits application of the act. We support access to care for individuals seeking treatment for behavioral health conditions as well as substance use disorders and believe in a “no wrong door” approach. Our strategies, evidentiary standards and processes for reviewing treatment services are no more stringent than those in use for medical/surgical benefits in the same classification when determining to what extent a benefit is subject to NQTLS.

Prior Authorization and Notifications

Prior authorization (PA) is a formal request to the Sunflower Utilization Management (UM) department through an approved mode, on the appropriate form, with clinical information for approval of certain
services before the service is rendered. This information will be used to allow Sunflower to make a medical necessity determination.

**Authorization must be obtained prior to the delivery of certain elective and scheduled services and failure to prior authorize those services may result in a denial of provider payment for the service.**

For Home & Community Based Services, prior authorization is provided through the person-centered planning process. A Sunflower care manager will schedule a visit with the member to complete an assessment and person-centered plan. The approved HCBS services will be listed within the plan.

For new members, this visit will occur within seven days of enrollment with Sunflower. For existing members, this visit occurs at least annually, and for certain HCBS programs, it occurs on a semiannual basis. The member or authorized representative and the providers listed within the plan are required to sign the plan.

Prior authorization should be requested prior to the scheduled service delivery date (keeping in mind a possible 14-day turnaround time) or as soon as the need for service is identified including weekdays, weekends and holidays.

If eligibility is determined while a member is receiving a covered benefit, contact Sunflower as soon as possible for authorization determination.

Some of the 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, but is not specific to an individual’s coverage. A full list of benefit coverage can be found on the KMAP website. (Please see elsewhere in this manual for authorization requirements related to retroactive eligibility and for home outpatient physical, occupational, and speech therapy.)

Use Sunflower’s Prior Authorization Pre-Screening Tool online at www.SunflowerHealthPlan.com/providers.html or contact a representative for additional information at 1-877-644-4623.

Failure to prior authorize services that require Sunflower authorization may result in a denial of the claim for the service.

### Examples of services that may require prior authorization at Sunflower Health Plan:

#### ANCILLARY SERVICES

- Air-ambulance transport (non-emergent fixed-wing airplane.)
- Certain biopharmaceuticals and specialty injections (please refer to website for complete list.)
- To find out which DME/orthotics/prosthetics require prior authorization, use Sunflower’s "Pre-Auth Check?" tool online at SunflowerHealthPlan.com/providers.html.
- Home healthcare services including home infusion, skilled nursing, personal care services, and therapy (occupational, physical and speech).
- Quantitative urine drug testing.
- Cochlear implants.
- Genetic testing.
- Behavioral health services.

#### HOME AND COMMUNITY BASED SERVICES (HCBS):

- All Home and Community Based Services provided under a HCBS waiver program.

For a list of HCBS services, please refer to the KMAP provider manuals, www.kmap-state-ks.us/public/providermanuals.asp and the Pre-Auth Needed tool on the Sunflower website.
**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, and reconstructive or plastic surgery
- Bariatric surgery
- Experimental or investigational
- High tech imaging (e.g., CT, MRI, — administered by NIA)
- Oral surgery that is potentially cosmetic
- Pain management

**INPATIENT AUTHORIZATION**

- Medical inpatient services
- All services performed in out-of-network facility
- Hospice care
- Rehabilitation facility
- Skilled nursing facility
- Transplants, including evaluation
- Acute medical detoxification
- Assisted living facility
- Head injury rehab facility
- Behavioral health inpatient services

**Hospitals serving Sunflower members are to notify the health plan within one business day (by 5 p.m. CT) of patient admission.**

Emergency room and post-stabilization services do not require prior authorization; however, providers should notify Sunflower of post-stabilization services including, but not limited to, home health, durable medical equipment, or urgent outpatient surgery, within one business day of the service initiation. This applies to services initiated at any time, including weekends or holidays.

Providers should notify Sunflower of urgent/emergent inpatient admissions within one business day (by 5 p.m. CT) of the admission for medical necessity review and ongoing concurrent review and discharge planning.

Maternity admissions without delivery complications require notification and information on the delivery outcome within one business day of delivery and must include birth outcomes, including Ballard score or equivalent.

Outpatient hospital days require authorization for any stay longer than two days. Clinical information is required for ongoing care authorization of the services.

**Sunflower Health Plan will deny coverage of services when notification requirements are not met.**

Inpatient brain injury rehab stays are approved in accordance with state policy regarding these facilities. They require notification by the facility to Sunflower of the eligibility of the member for the brain injury rehab and waiver level of care. The facility should fax a copy of the KDADS-signed Brain Injury Rehab Facility Referral Form indicating eligibility to the prior authorization fax number indicated below.

The PCP or requesting provider 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 same NPI number used when requesting an authorization. All out-of-network services (excluding emergency care) require prior authorization from Sunflower. Notification of potential need does not constitute a formal prior authorization request.

How to request a prior authorization review:

- **Phone:** Prior authorization requests may be called to Sunflower Health Plan, Prior Authorization Department at 1-877-644-4623.
- **Fax:** Prior authorization requests for medical services may be faxed to 1-888-453-4316. Prior authorization requests for behavioral health services may be faxed to 1-844-824-7705. The fax authorization request form can be found on our website at SunflowerHealthPlan.com.
- **Web:** Prior authorization requests may be submitted through the Secure Web Portal if the provider is a registered user. If the provider is not already a registered user on the Secure Web Portal and needs assistance or training on how to submit a prior authorization request through the portal, he or she may reach out to their dedicated Provider Relations Specialist.
Electronically: 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 Health Plan
c/o Centene EDI Department
1-800-225-2573, extension 607-5525
Or by e-mail at: EDIBA@centene.com

Radiology & 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’s interactive website (www.RadMD.com) 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.

Therapy Services

Sunflower offers our members access to all covered, medically necessary outpatient and home-based physical, occupational, and speech therapy services. We are partnering with NIA to ensure that the physical medicine services (physical, occupational and speech therapy) provided to our Sunflower Health Plan members are consistent with nationally recognized clinical guidelines.

Effective June 1, 2020, NIA provides utilization management services for outpatient physical, occupational and speech therapy services on behalf of Sunflower Health Plan (Medicaid) members.

HOW NIA’S PROGRAM WORKS:

Outpatient physical, occupational and speech therapy requests are reviewed by NIA’s peer consultants to determine whether the services meet policy criteria for medically necessary and appropriate care. The medical necessity determinations are based on a review of objective, contemporaneous, and clearly documented clinical records that may be requested to help support the appropriateness of care.

Clinical review helps determine whether such services are both medically necessary and eligible for coverage. Although prior authorization for the therapy evaluation alone is not required, additional services provided at the time of the evaluation and for any ongoing care is required through NIA.

There is no need to send patient records in advance. NIA will contact the provider via phone and fax if additional clinical information is needed to complete the request. If the clinical documentation fails to establish that care is medically necessary, is not received, or is not received in an appropriate amount of time, it may result in non-certification of the authorization request.

The purpose of NIA is to review medical necessity of PT/OT/ST services and not to manage the member’s benefits. Please verify member eligibility by using the Sunflower Secure Provider Portal or calling customer service at 1-877-644-4623.

For urgent authorization requests, please call 1-877-644-4623 and follow the prompt for therapy authorizations.

THERAPIES STILL MANAGED BY SUNFLOWER HEALTH PLAN:

- Therapies that are being provided under the Brain Injury (BI) waiver benefit, and/or
- Therapies that are being provided in the member’s home through the Medicaid state plan benefit.

Therapies provided under the Brain Injury waiver are approved by the Sunflower Care Manager through Person Centered Planning process. Pursuant to the approved Brain Injury waiver and KMAP Manual, the participant must meet the standards for making progress.
All home-based therapy services not provided through the BI waiver also require prior authorization regardless of provider type. Sunflower retains the right to review any services rendered for medical necessity and may alter a provider’s prior authorization requirements at any time.

If the service will be provided in the member’s home, it is the responsibility of the provider to obtain an approved prior authorization from the Utilization Management department at Sunflower Health Plan. You may submit your request via the portal, through fax at 888-453-4316, or you may contact the Prior Authorization department at 877-644-4623.

Please keep in mind you will need to ensure that the member has not exhausted his/her PT/OT/ST benefit and/or has a habilitative benefit prior to providing services.

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

**Behavioral Health Outpatient Treatment Request (OTR)**

When requesting sessions or additional sessions for behavioral health services that require authorization, the provider must complete an Outpatient Treatment Request (OTR) form for the level of care requested, found on Sunflower’s website and submit the completed form to Sunflower for clinical review prior to provision of services. 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 or is illegible.
  - Eligibility cannot be verified for the member with the information provided.
  - An authorization for the same service has already been issued to a different provider.
- Sunflower will not retroactively certify routine sessions. Exceptions:
  - Member did not have his or her 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.
- The dates of the authorization request must correspond to the dates of expected sessions. Treatment must occur within the dates of the authorization.
- Sunflower’s utilization management decisions are based on established medical necessity guidelines. Sunflower does not reimburse for unauthorized services, and each Provider Agreement precludes network providers from balance billing (billing a member directly) for covered services. An 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 of the request. Sunflower may extend the timeline by up to 14 additional 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 necessary information and explains how the extension is in the member’s interest.

“Necessary information” includes the results of any face-to-face clinical evaluations (including diagnostic testing) or a second opinion that may be required. Failure to submit the 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.

Urgent/expedited prior authorization requests must be submitted with the physician attestation of urgency and may be changed to a routine request (with provider notification) if it is found not to meet the urgent/expedited criteria. For urgent, concurrent review of an ongoing inpatient admission, decisions are made within 72 hours of receipt of the request. Written or electronic notification includes the
number of days of service approved and the next review date.

If service authorization decisions are not reached within the timeframes for either standard or expedited service authorizations, including extended timeframes, such untimely service authorizations constitute a denial and are adverse actions. In this case, Sunflower shall issue notice no later than the date that the timeframes expire.

Authorization determinations may be communicated to the requesting provider by fax, phone, letter, or secure web portal. Additionally, all adverse determinations will be provided in writing.

Second Opinion

A second opinion may be requested when there is a question concerning diagnosis or options for surgery or other treatment of a health condition, or when requested by any member of the member’s health care team, including the member, parent and/or guardian. A social worker exercising a custodial responsibility may also request a second opinion. Authorization for a second opinion will be granted to a qualified network practitioner or qualified out-of-network practitioner, if there is no qualified in-network practitioner available. The second opinion will be provided at no cost to the member.

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, letter, or secure web portal. All adverse determinations will be provided 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 (regardless of the level of payer – primary, secondary, or tertiary).
- For obstetrical admissions, the date and method of delivery, estimated date of confinement, and information related to the newborn or neonate (Ballard or equivalent).

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.

Failure to submit the necessary clinical information can result in a denial of the requested service.

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.

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.

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 or check KMAP to determine the status of the member.
- If a provider has reason to believe a Sunflower member is overutilizing or misusing his or her 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.
- E-mail referrals can be sent to pharmacy@sunflowerhealthplan.com
- Mailed referrals can be sent to Sunflower Health Plan, Attn: Pharmacy Department Lock-In Program, 8325 Lenexa Dr., Suite 410, Lenexa, KS 66214

Pharmacy Services

Sunflower Health Plan provides pharmacy benefits through its Pharmacy Benefits Manager, Envolve Pharmacy Solutions.

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. Please visit the KDHE (Kansas Department of Health and Environment) website for the PDL, clinical prior authorization criteria and PA forms.

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 are covered for eligible members within HCBS programs. Personal care services are approved in accordance with the person-centered assessment and service planning process and to meet the member’s needs related to completing activities of daily living and/or instrumental activities of daily living.

The services may be provided in the home or community. The person-centered process includes an assessment of functional need and other informal supports available to the member. Services are approved in accordance with the approved HCBS waiver for which the member is eligible. HCBS services do not replace the supports provided by a parent, foster parent or other legally responsible adult. The services must be provided by a qualified provider as defined within the approved HCBS waiver.

In accordance with state policy, for members eligible for brain injury rehabilitation in one of the state’s approved brain injury rehabilitation facilities, the facility will fax the Brain Injury Rehab Referral Form, signed by KDADS to Sunflower’s prior authorization number. The stay will then be approved in accordance with state policy.
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 who has appropriate clinical expertise in treating the member’s condition or disease reviews all potential adverse determinations 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 to be scheduled with the medical director from the Medical Management department. Information on the appeal process for members and providers is included in the Member Appeals or Provider Appeals 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, however InterQual® Smart Sheets can be found in the Sunflower Provider Portal under the Authorizations section for reference.

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 In-Home 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 Sunflower Utilization Review and Quality Improvement Committees and approved by physicians practicing in Kansas prior to implementation of said criteria.
MODALITY | GUIDELINES
--- | ---
Occupational Therapy | • Standards of Practice, the American Occupational Therapy Association

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)

Speech Therapy | • American Speech Language Hearing Association, Medical Review Guidelines for Speech-Language Pathology Services (2001)

Substance Abuse Criteria – Sunflower will use the American Society for Addiction Medicine (ASAM) Patient Placement Criteria as required in the contract. Our behavioral health and substance abuse reviewers have extensive experience in using ASAM criteria for placement, continued stay, and discharge of patients with addictive disorders.

Guidelines for Psychological Testing - Prior authorization is required for psychological testing and must be prior authorized for either inpatient or outpatient services. Testing, with prior authorization, may be used to clarify questions about a diagnosis as it directly relates to treatment.

It is important to note that:
- Testing will not be authorized by Sunflower for ruling out a medical condition.
- Testing is not used to confirm previous results that are not expected to change.

A comprehensive initial assessment (90791 and 90792) may be conducted by the requesting psychologist prior to requesting authorization for testing. No authorization is required for this assessment if the provider is contracted and credentialed with Sunflower.

Guidelines for the Autism Waiver Services - Providers who are requesting authorization for autism waiver services are to request these services via the Autism Waiver Outpatient Treatment Request Form, located on the Sunflower website.

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 review 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. Licensed ancillary healthcare professionals include 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 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 that 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 (medical and behavioral health) 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.

Providers are required to notify Sunflower of urgent or emergent inpatient admissions within one business day (by 5 p.m. CT) of the admission for medical necessity review and ongoing concurrent review and discharge planning.

Concurrent review decisions will be made within 72 hours of receipt of the initial 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. CT) of delivery with complete information regarding the delivery status and condition of the newborn, including Ballard score or equivalent (assessed gestational age) if available.

Behavioral Health Continuity of Care - When members are newly enrolled and have previously received behavioral health services, Sunflower will authorize care as needed to minimize disruption and promote continuity of care. Sunflower will work with non-participating providers (those that are not contracted and credentialed in Sunflower’s provider network) to continue treatment or create a transition plan to facilitate the transfer of a member’s care to a participating network provider.

In addition, if Sunflower determines that a member is in need of services that are not covered benefits, the member will be referred to an appropriate provider, and Sunflower will continue to coordinate care including discharge planning.

Sunflower will ensure appropriate post-discharge care when a member transitions from a state institution, and will ensure appropriate screening, assessment and crisis intervention services are available in support of members who are in the care and custody of the state.

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 (e.g., member was unconscious at presentation, member did not have his or her Sunflower ID card, services were 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 was not obtained due to a member being awarded retroactive eligibility with Sunflower Health Plan and a claim for services has been submitted, providers can submit a request for an optional reconsideration or appeal, including documentation indicating the member was retroactively enrolled to:

Sunflower Health Plan,
Attn: Reconsideration
P.O. Box 4070
Farmington, MO 63640-3833
All requests for optional reconsideration or appeal due to retroactive eligibility will be verified. If a claim has not been filed for the service, a request may be submitted to the Utilization Management department, indicating that retroactive eligibility was awarded and an authorization is being requested. Once verified that eligibility was granted retroactively and timely filing has occurred (providers have 180 calendar days from the date of the eligibility determination), an authorization will be created. The provider will be notified of the existence of the authorization so that they may proceed with billing for the service provided.

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. Our care managers are available to every member. They work closely with the member’s providers, including community service coordinators, independent living counselors and targeted case managers, to meet the needs of members accessing HCBS programs, WORK, 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 administrative work for the primary care physician’s (PCP) or specialist’s office.

The program includes a systematic approach for early identification of
eligible members, needs assessment, and development and implementation of a Person-Centered Service 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, behavioral, functional, social, employment and other needs. Our program focuses on improving social determinants of health, such as access to housing 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 whom 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 Envolve People Care (EPC) to administer services. EPC’s programs promote a coordinated, proactive, disease-specific approach to management that will improve members’ self-management of their conditions, improve clinical outcomes and control high costs associated with chronic medical and/or behavioral conditions. Sunflower programs include, but are not limited to, asthma, COPD, coronary artery disease, depression, 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 Care Management at**
1-877-644-4623

**Integrated Care Teams (IC Teams)**

Sunflower’s mission is to help members and providers access appropriate services to meet the needs of our members. This can include accessing services covered through Home and Community Based Services (HCBS), physical health services, behavioral health services, or even community and national resources.

Sunflower provides a holistic approach that includes integrated care management services through integrated care teams. Integrated care teams can consist of doctors, nurses, social workers, clinicians and other key professionals who work closely with providers and members to coordinate services on the member’s behalf. Teams are led by knowledgeable staff who are familiar with evidence-based practices, state and federal resources and best practice standards with the populations served.

These populations include members with severe and persistent mental illness or issues with substance abuse, children in foster care or other out-of-home placement, members who have aged out of foster care or have been adopted, those with complex medical needs, and members who meet medical necessity for HCBS waiver services.

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.
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 members’ privacy, medical records should be kept in a secure location.

Sunflower requires providers to maintain all records for members for at least 10 years for adult members and 13 years for minors; however, when an audit, litigation or other action involving records is initiated prior to the end of such period, records shall be maintained for not less than 10 years following the 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 (e.g., 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 (e.g., 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 is documented
- An up-to-date immunization record is established for pediatric members or an appropriate history is made in the 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, and 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 his or her parent/legal guardian, in accordance with state and federal laws and regulations. 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 found in 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 he or she obtained medical care, or he or she is 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 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 that the provider has negotiated a special agreement with Sunflower, please follow the section in that contract related to transfer or providing of medical records.

Access to Records and Audits by Sunflower Health Plan

Subject only to applicable state and federal confidentiality or privacy laws, provider shall permit Sunflower Health Plan or its designated representative access to provider’s records, at provider’s place of business in this state during normal business hours, or remote access of such records, in order to audit, inspect, review, perform chart reviews, and duplicate such records.

If performed on site, access to records for the purpose of an audit shall be scheduled at mutually agreed upon times, upon at least 30 business days prior written notice by Sunflower or its designated representative, but not more than 60 days following such written notice.

Electronic Medical Record Access

Provider will grant Sunflower Health Plan access to provider’s electronic medical record (EMR) system in order to effectively case manage members and capture medical record data for risk adjustment and quality reporting. There will be no other fees charged to Sunflower for this access.
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 laws and regulations.

Providers may not charge Sunflower Health Plan beneficiaries, or any financially responsible relatives or representatives of those individuals, 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. Please also review subsection “Billing the Member” for additional information on this topic.

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 the 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’s 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 from 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 a 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 time frame 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 180 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 time frame will be denied for untimely submission.
All corrected claims must be received within 365 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 his or her 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 that 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 red-and-white claim forms (UB-04 for hospitals and facilities; CMS 1500 for physicians or practitioners). Claims must be free of handwritten verbiage. Any Uniform Billing (UB)-04 or CMS 1500 forms that do not meet the Centers for Medicare and Medicaid Services (CMS) printing requirements will be rejected and sent back to the provider or facility upon receipt. 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).

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 Health Plan has a system restriction with a 97 Service Line Maximum for Institutional Claims (UB-04) and 50 Service Line Maximum for Professional Claims (CMS 1500).

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 or through the Kansas Medical Assistance Program (KMAP), or submit HIPAA 837 claims to us directly via our secure web-based provider portal. Providers may submit EDI using over 60 claims clearinghouses or through the Kansas Medical Assistance Program (KMAP), or submit HIPAA 837 claims to us directly via our secure web-based provider portal.

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

- Go to 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) 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 (behavioral health 68068), and we accept claims from the following clearinghouses:

- Emdeon
- SSI
- Gateway EDI
- 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 Envolve Vision can be found on their website at visionbenefits.envolvehealth.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 Envolve Vision.

Dental Providers (ADA or 837D):

- Dental claim forms can be submitted electronically. Information on submission of claims to Envolve Dental can be found on their website at dental.envolvehealth.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 Envolve Dental.

Electronic Secondary Claims

Sunflower has the ability to receive coordination of benefit (COB or secondary) claims electronically. Tertiary coverage must be billed on a paper claim. Tertiary coverage cannot be processed electronically through a clearinghouse. The field requirements for successful electronic COB submission are below (5010 format):
### COB FIELD NAME

<table>
<thead>
<tr>
<th>Field Name</th>
<th>Explanation</th>
<th>837I - INSTITUTIONAL EDI SEGMENT AND LOOP</th>
<th>837P - PROFESSIONAL EDI SEGMENT AND LOOP – COB INFORMATION MUST BE SUBMITTED AT DETAIL LINE LEVEL</th>
</tr>
</thead>
<tbody>
<tr>
<td>COB Paid Amount</td>
<td>If 2320/AMT01=D, MAP AMT02 or 2430/SVD02</td>
<td>If 2320/AMT01=D, MAP AMT02 or 2430/SVD02</td>
<td></td>
</tr>
<tr>
<td>COB Total Non-Covered Amount</td>
<td>If 2320/AMT01=A8, map AMT02</td>
<td>If 2320/AMT01=A8, map AMT02</td>
<td></td>
</tr>
<tr>
<td>COB Remaining Patient Liability</td>
<td>If 2300/CAS01 = PR, map CAS03</td>
<td>If 2320/AMT01=EAF, map AMT02</td>
<td></td>
</tr>
<tr>
<td>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</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>COB Patient Paid Amount</td>
<td>If 2320/AMT01 = F5, map AMT02</td>
<td></td>
<td></td>
</tr>
<tr>
<td>COB Patient Paid Amount Estimated</td>
<td>If 2300/AMT01=F3, map AMT02</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Claim Before Taxes Amount</td>
<td>If 2400/AMT01 = N8, map AMT02</td>
<td>If 2320/AMT01 = T, map AMT02</td>
<td></td>
</tr>
<tr>
<td>COB Claim Adjudication Date</td>
<td>If 2330B/DTP01 = 573, map DTP03</td>
<td>If 2330B/DTP01 = 573, map DTP03</td>
<td></td>
</tr>
<tr>
<td>COB Claim Adjustment Indicator</td>
<td>If 2330B/REF01 = T4, map REF02</td>
<td>If 2330B/REF01 = T4, map REF02 with a Y</td>
<td></td>
</tr>
</tbody>
</table>

### 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 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. Acknowledgments 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 resubmitted 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 resubmit these claims accurately.

Questions regarding electronically submitted claims should be directed to our EDI BA Support at 1-800-225-2573, ext. 607-5525, 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 SunflowerHealthPlan.com. Go to the section on electronic claim filing for more details.

Exclusions

<table>
<thead>
<tr>
<th>EXCLUDED CLAIM CATEGORIES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Excluded from EDI Submission Options</td>
</tr>
<tr>
<td>Must Be Filed Paper</td>
</tr>
<tr>
<td>Applies to Inpatient and Outpatient Claim Types</td>
</tr>
</tbody>
</table>

Claim records requiring supportive documentation or attachments (e.g., 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:

<table>
<thead>
<tr>
<th>ACTION</th>
<th>CONTACT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clearinghouses Submitting Directly to Sunflower</td>
<td>Emdeon, Availity, Gateway EDI, SSI, Smart Data Solutions</td>
</tr>
</tbody>
</table>
| Sunflower Payer ID                         | Medical: 68069  
 Behavioral health: 68068  
 NOTE: Please refer to the vendor provider manuals at SunflowerHealthPlan.com for their individual payer IDs. |
| General EDI Questions                      | Contact EDI Support at 1-800-225-2573, ext. 607-5525, 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. 607-5525, or via e-mail at EDIBA@centene.com |
| Remittance Advice Questions                | Contact Sunflower Provider Services at 1-877-644-4623 or through the secure provider portal at SunflowerHealthPlan.com |
| Provider Payee, UPIN, Tax ID, Payment Address Changes | Notify Provider Services in writing at:  
 Sunflower Health Plan  
 8325 Lenexa Drive  
 Lenexa, KS 66214  |
Important Steps to 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 show 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. Paper claims should be free of all handwritten verbiage and submitted on a standard red-and-white UB-04 or CMS 1500 claim form. Any UB-04 or CMS 1500 form received that does not meet the Centers for Medicare and Medicaid Services (CMS) printing requirements will be rejected and sent back to the provider or facility upon receipt.

Tertiary coverage must be billed on a paper claim. Tertiary coverage cannot be processed on the secure provider web portal or electronically through a clearinghouse.

Sunflower and its benefit managers will accept paper claims (initial, resubmissions, or corrected) at the following addresses:

<table>
<thead>
<tr>
<th>PAPER CLAIMS SUBMISSIONS</th>
<th>Sunflower Health Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Behavioral Health</td>
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<td>Farmington, MO 63640-3833</td>
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<td>LogistiCare Claims Dept.</td>
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<td>2552 West Erie Dr., Suite 101</td>
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<td>PO Box 4070</td>
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<td>Farmington, MO 63640-3833</td>
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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 claims 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 SunflowerHealthPlan.com.

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

**Correct Coding and Billing of Claims**

Providers should, at all times, document and code according to CMS regulations and follow all applicable coding guidelines for ICD-9 CM and, for dates of service on or after October 1, 2015, ICD-10-CM, CPT, and HCPCS code sets. Providers should note the following guidelines:

- Code all diagnoses to the highest level of specificity, which means assigning the most precise ICD code that most fully explains the narrative description in the medical chart of the symptom or diagnosis
- Ensure medical record documentation is clear, concise, consistent, complete and legible and meets CMS signature guidelines (each encounter must stand alone)
- Submit claims and encounter information in a timely manner
- Alert Sunflower Health Plan of any erroneous data submitted, and follow Sunflower’s policies to correct errors in a timely manner
- Provide medical records as requested in a timely manner
- Provide ongoing training to their staff regarding appropriate use of ICD coding for reporting diagnoses.

Accurate and thorough diagnosis coding is imperative to Sunflower’s ability to manage members, comply with state and federal audit requirements and effectively offer consumer products. Claims submitted with inaccurate or incomplete data may require retrospective chart reviews or medical records.

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 fourth or fifth 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: www.kmap-state-ks.us/Documents/Content/Forms/Consent/Sterilization.pdf
    - The physician must complete the Abortion...
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: 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.

### 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 SunflowerHealthPlan.com. A list of common upfront rejections can be found 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 in Appendix 2.

### Corrected Claims

#### Instructions for the Submission of Corrected Claims

If a provider has submitted a claim with incorrect or missing information (missing provider NPIs, submission of COB information, procedure, DRG or diagnosis codes, unit values, etc.), Sunflower Health Plan requires that providers submit a corrected claim.

#### Correction of Missing Provider Name and/or NPI

Claims missing or denied for the following information must be corrected electronically or by sending a corrected paper claim (using the instructions below):
- Attending Provider Name and NPI (box 76 on a CMS UB-04 claim form) and/or,
- Ordering, Referring or Prescribing Provider Name and NPI (box 17b on a CMS1500)

**Note:** Claims missing or denied for Attending, Ordering, Referring or Prescribing Provider may not be corrected using Sunflower Health Plan’s secure provider portal.

#### Correction of COB Claims

Providers needing to resubmit primary payer’s EOB must follow corrected claim process by submitting a corrected claim and attaching the primary EOB.

If a new primary EOB is submitted and that EOB does not match the original claim, submit a corrected claim and primary payer EOB using one of the following methods.

#### Correction of Electronic (EDI) Claims

Submit corrected claims electronically via your clearinghouse using the values specified for the fields below:
- **CMS 1500 / Professional Claims:**
  - FIELD CLM05-3 = 7
  - REF*F8 = Must contain the original claim number from the Explanation of Payment (EOP)
- **UB / Institutional Claims:**
  - FIELD CLM05-3 = 7
Correction of Paper Claims
All paper claims submissions should be free of handwritten verbiage and submitted on a standard red-and-white UB-04 or CMS1500 claim form. Any Uniform Billing (UB)-04 or CMS1500 forms received that do not meet the Centers for Medicare and Medicaid Services (CMS) printing requirements will be rejected and sent back to the provider or facility upon receipt.

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

Submit corrected claims to Sunflower Health Plan using the values specified for the fields below:

- CMS 1500 / Professional Claims:
  - Box 22
  - Medicaid Resubmission Code = 7 for Replacement or 8 for Void/Cancel of prior claim (left justified)
  - Original Ref No. = 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
  - Box 64 = Must contain the original claim number

Omission of these data elements may cause inappropriate denials or delays in processing and payment. The printing requirements are outlined in the Medicare Claims Processing Manual “Chapter 26 — Completing and Processing Form CMS-1500 Data Set (Pub.100-04).” Find the regulations online here: www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c26.pdf.

Mail corrected paper claims to:
Sunflower Health Plan
Attn: Corrected Claims
P.O. Box 4070
Farmington, MO 63640-3833
Or for behavioral health:
Sunflower Health Plan
P.O. Box 6400
Farmington, MO 63640-3807

Correction of Claims Using Sunflower Health Plan’s Secure Provider Portal
Submit corrected claims via the secure provider portal at SunflowerHealthPlan.com.

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

1. Click “Claims” at the top of the screen.
2. Select an individual paid claim to see the details.
3. The claim displays for you to correct as needed. Click “Correct Claim.”
4. Proceed through the claims screens, correcting the information that you may have omitted when the claim was originally submitted.
5. Continue clicking “Next” to move through the screens required to resubmit.

6. Review the claim information you have corrected before clicking “Submit.”
7. You will receive a success message confirming your submittal.

Timely Filing of Claims vs. Timely Correction of 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.
- When Sunflower is the secondary payer, claims must be received within 180 calendar days from the date of disposition (final determination) of the primary payer.
- Corrected claims must be received within 365 days of the date of Sunflower’s notification of payment or denial.

Contact a Sunflower customer service representative at 1-877-644-4623 if you need assistance or want to inquire about claim status, payment amounts or denial reasons.

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 EFTs and ERAs:
- **Reduce accounting expenses** – Electronic remittance advices can be imported directly into practice management or patient accounting systems, eliminating the need for manual rekeying.

- **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.

### Prospective and Retrospective Claim Reviews

Sunflower Health Plan is contractually obligated to have procedures in place to detect waste, abuse and fraud. This is achieved through:

- Claims editing
- Post-processing review of claims
- DRG Validation
- Payment Reviews of Hospital claims
- Cost Containment Projects

As accountable and fiscally responsible stewards of public funds, we take the prevention and detection of waste, fraud, and abuse very seriously. Sunflower Health Plan has a management contract with its parent organization, Centene Corporation (Centene), in which Centene conducts routine pre- and post-processing claims audits and reviews on behalf of Sunflower Health Plan. These audits are designed to ensure that billing codes and practices are correct and that Sunflower Health Plan has paid healthcare providers appropriately according to CMS and Kansas Medicaid billing guidelines.

#### Post Processing Claims Audit

A post-processing claims audit consists of a review of clinical documentation and claims submissions to determine whether the payment made was consistent with the services rendered. To start the audit, Centene auditors request medical records for a defined review period. Providers have two weeks to respond to the request; if no response is received, a second and final request for medical records is forwarded to the provider. If the provider fails to respond to the second and final request for medical records, or if services for which claims have been paid are not documented in the medical record, Sunflower Health Plan will recover all amounts paid for the services in question.

Centene auditors review cases for potential unbundling, upcoding, mutually exclusive procedures, incorrect procedures and/or diagnosis for member’s age, duplicates, incorrect modifier usage, and other billing irregularities. They consider state and federal laws and regulations, provider contracts, billing histories, and fee schedules in making determinations of claims payment appropriateness. If necessary, a clinician of like specialty may also review specific cases to determine if billing is appropriate. Auditors issue an audit results letter to each provider upon completion of the audit, which includes a claims report that identifies all records reviewed during the audit. If the auditor determines that clinical documentation does not support the claims payment in some or all circumstances, Sunflower Health Plan will seek recovery of all overpayments.

Depending on the number of services provided during the review period, Sunflower Health Plan may calculate the overpayment using an extrapolation methodology. Extrapolation is the use of statistical sampling to calculate and project overpayment amounts. It is used by Medicare Program Safeguard Contractors, CMS Recovery Audit Contractors, and Medicaid Fraud Control Units in calculating overpayments, and is recommended by the OIG in its Provider Self-Disclosure Protocol (63 Fed. Reg. 58,399; Oct. 30, 1998).

#### DRG Validation

DRG validation consists of a review of clinical documentation and claims submissions to determine whether an error in coding of a given hospital admission resulted in an incorrect underpayment or overpayment. To start the audit, Sunflower’s vendor, iCRS/Cotiviti, requests medical records for a specific date of service. Providers have 30 days to respond to the request; if no response is received, a second and final request for medical records, or if services for which claims have been paid are not documented in the medical record, Sunflower Health Plan will recover all amounts paid for the services in question.
Payment Reviews of Hospital Claims

Sunflower Health Plan will process and reimburse for inpatient hospital claims that qualify for additional outlier reimbursement as follows. This policy only affects inpatient hospital claims that qualify for outlier reimbursement based on billed amounts in excess of a predetermined payable calculation determined by Sunflower Health Plan: (1) claims that qualify for outlier reimbursement based on the billed amount, and (2) claims with an outlier payable calculation in excess of $25,000.

It is Sunflower’s policy to request an itemized bill for any inpatient claim that meets both criteria as detailed above. Upon receipt, the itemized bill will be reviewed for the appropriateness of all charges in accordance with CMS billing guidelines.

Eligible outlier claims will have their total claim reimbursement divided into two parts — the applicable DRG case rate and the potential calculated outlier portion. The DRG case rate will be calculated and released for payment immediately to the provider, but the outlier portion of the total reimbursement will be held until the requested documentation is received and reviewed in accordance with this policy. Once charges are reviewed and validated, the outlier portion of the reimbursement will be released and the total claims payment will have been adjudicated. For some contracted providers, the outlier payment will be processed at the same time as the DRG payment. The payment review will take place post-payment, and the overpayment will be recovered. Payment reviews are performed by Sunflower Health Plan’s contracted vendor, Equian.

Payment Review Process
1. DRG+Outlier are paid, and one line that doesn’t impact payment is denied
2. The EOP for the DRG payment requests an itemized bill
3. The itemized bill is sent to the Claims Department, which forwards the information to payment review vendor, Equian
4. Equian reviews the claim and itemized bill and informs the Claims Department of the results of the review, highlighting exceptions
5. The claim is adjusted based on the exceptions. You will be sent a Payment Review Report detailing all of the exceptions found in the review.

Cost Containment Projects

Sunflower Health Plan will review claims to identify and detect payment errors that are a result of undisclosed other primary or third-party insurers, as well as overpayments and underpayments that occurred due to Sunflower’s system error, provider billing practices, changes in state policy, misinterpretations of a contract, or other billing errors. These activities are performed by Sunflower Health Plan’s contracted vendors:
- Cotiviti Healthcare (formerly Connolly Healthcare)
- Optum (formerly AIM)
- HMS

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 are responsible for reporting overpayments or improper payments to Sunflower Health Plan. Providers have 60 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 offsets 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

Or for behavioral health:

Sunflower Health Plan
Attn: Claims Recovery Team
P.O. Box 3656
Carol Stream IL 60132-3809

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, 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
The provider should not adjust the
Sunflower Customer Service Department:  1-877-644-4623 (TTY 711)
Sunflower Customer Service Department:  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. Tertiary medical claims must be billed on paper claim forms and both the primary and secondary EOBs must be attached.

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 notify KanCare of potential third-party liability issues.

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, that 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 the 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 prepaid 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.

**Note:** 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) – Kansas AuthentiCare

Information about the state’s AuthentiCare system can be found at: www.aging.ks.gov/HCBSProvider/KS_AuthentiCare/KAC_Index.html. See Appendix IX in this provider manual for services requiring the use of Kansas 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

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 he or she 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 upon request.

*Statement is commonly referred to as an Advanced Beneficiary Notice (ABN).
Sunflower is committed to preventing, identifying and reporting all instances of suspected fraud, waste, and abuse. As an affiliate of Centene Corporation (Centene), Sunflower utilizes Centene’s Anti-Fraud Program to comply with state and federal laws. Centene created its Anti-Fraud Program to provide mechanisms for the prevention, detection, investigation, and recovery of suspected or actual fraud, waste, and abuse activities. As such, Sunflower partners with Centene’s Special Investigations Unit (SIU) to conduct routine audits of provider billing and coding practices to comply with Sunflower’s state contract requirements and other state and federal regulations, to include those contained in the Affordable Care Act.

Centene’s SIU performs both prepayment and retrospective reviews that, in some cases, may result in taking actions against providers who commit waste, abuse, and/or potential 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
- Referral for civil and/or criminal prosecution
- Any other remedies available

Some of the most common FWA 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

### Compliance Authority and Responsibility

Sunflower’s Compliance Officer has overall responsibility and authority for carrying out the provisions of the compliance program, including oversight of program integrity and FWA related activities.

Sunflower’s philosophy is that all employees, temporary employees, consultants, providers, members, and caregivers have the responsibility for program integrity including identification and reporting of potential fraud, waste or abuse.

All reports of suspected fraud, waste and abuse are taken seriously.

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

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

### 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 has steps for handling any problems you may have. We offer all of our members and providers the following processes to achieve satisfaction:

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

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

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

A member may file a grievance related to an extension of time proposed by Sunflower to make a Service Authorization decision, or if the member does not agree with Sunflower’s decision that an expedited appeal request does not meet criteria as expedited and moved to the standard appeal timeframe.

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 member grievance may be filed verbally by calling the plan or in writing.
- Written requests for member grievances are not required.
- Provider grievances can be filed verbally or in writing within 180 calendar days of the event being grieved.

- 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 a signed Authorized Representative Form to Sunflower, demonstrating that the member has authorized you to file and receive information about the grievance. To obtain this form, contact Customer Service or get it from the Sunflower website. You or the member can submit the form by mail or fax.
- 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.

Grievances are faxed or mailed to:

Sunflower Health Plan
Attn: Grievance Department
8325 Lenexa Drive
Lenexa, KS 66214
Fax: 888-453-4755
Grievance Timeline

**Step 1:**
Grievance filed by calling Customer Service, or by sending a fax or letter to Sunflower.

**Step 2:**
Sunflower sends a letter within 10 calendar days of receipt of a member grievance acknowledging the grievance has been received, unless the grievance is resolved on the same day it is received at Sunflower. Sunflower does not send an acknowledgment letter for provider grievances.

**Step 3:**
Sunflower resolves the grievance as expeditiously as the member condition warrants and sends a resolution notice within 30 calendar days of receipt of the grievance.

Appeal Process

An appeal is a request to review an action or adverse benefit determination by Sunflower. An adverse benefit determination is the denial or limiting of a member service or failure by Sunflower to provide service timely or to act within timeframes. An action is the denial, in whole or in part, of payment to a provider for a service. An appeal is a request for Sunflower to review the decision of concern, including existing or additional documentation, and make an appeal decision. There are two kinds of appeals described as follows:

- **Member appeals** – Examples include denial of prior authorization for a new service, reduction or termination of a previously authorized service, or actions by the plan that make a change to the member’s benefit or provider assignment, such as assignment to the lock-in program.

- **Provider appeals** – Examples include requests for review of a denied claim, request for review of a denial of authorization for a new health care service, 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 63 calendar days from the date of the Notice of Adverse Benefit Determination that is sent to you and the member. If you receive a letter and you don’t know if it is this type of letter, please contact us to review it with you.
- A member appeal may be filed by phone, by fax or in writing.

- Information on how to appeal will be included in the Notice of Adverse Benefit Determination.
- The member may allow someone to file an appeal for them including legal representation, provider, family member, etc. 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 adverse benefit determination letter or can be obtained from the Sunflower website. The member will need to fill it out and return by mail or fax in order for Sunflower to process the member appeal. If you submit an appeal with written consent from the member, this is considered a member appeal.
- Any appeal requested verbally regarding a denial of authorization will be treated as a member appeal; provider appeals must be submitted in writing.
- 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, which can include auxiliary aids and services like interpreters, toll-free number with TTY and interpreter capability.

- 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’s health or functioning at immediate risk, you may request an expedited appeal. Only member appeals can be expedited, and any request for an expedited appeal will be treated as a member appeal. These can be submitted verbally, and do not require a written request or member consent. Expedited appeals will be reviewed as quickly as the member condition warrants and no later than 72 hours from receipt. 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, reasonable attempts will be made to notify verbally, and a letter will be sent within 2 calendar days. The appeal will be processed in the standard member appeal timeframe and require the member consent/Authorized Representative Form.

- Sunflower wants to resolve appeal concerns quickly, and will resolve standard member appeals within 30 calendar days of filing with us. If we cannot resolve the appeal in 30 calendar days, we may extend the timeframe by up to 14 calendar days to gather more information to assist in our decision. You can also ask for an extension.

- 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 APPEALS

*Requires Authorized Rep form from member & information included in Member Appeals section

<table>
<thead>
<tr>
<th>TYPE OF SERVICE</th>
<th>SUNFLOWER SPECIALTY PARTNER</th>
<th>ADDRESS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical or HCBS Service</td>
<td>None</td>
<td>Sunflower Health Plan</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Attn: Appeals Department</td>
</tr>
<tr>
<td></td>
<td></td>
<td>8325 Lenexa Dr., Suite 410</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Lenexa, Kansas 66214</td>
</tr>
<tr>
<td>High Resolution Imaging</td>
<td>National Imaging Associate, Inc. (NIA)</td>
<td>Fax: 1-888-453-4755</td>
</tr>
<tr>
<td></td>
<td></td>
<td>OR Expedited Appeal Call:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1-877-644-4623</td>
</tr>
<tr>
<td>Behavioral Health Services</td>
<td>None</td>
<td></td>
</tr>
<tr>
<td>Vision</td>
<td>Envolve Vision</td>
<td></td>
</tr>
<tr>
<td>Dental</td>
<td>Envolve Dental</td>
<td></td>
</tr>
<tr>
<td>Pharmacy</td>
<td>Envolve Pharmacy Solutions</td>
<td></td>
</tr>
</tbody>
</table>

* Please use the Adverse Benefit 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 previously authorized services continue while they are waiting for Sunflower to make a decision, but this request must be made within 10 calendar days of the mailing date on notice of adverse benefit determination for non-HCBS services. HCBS services will continue automatically with appeal request.

**Step 3:** Sunflower sends a letter within 5 calendar 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 as expeditiously as member condition warrants and within 30 calendar days of receipt of the appeal. The notice will also include the date the appeal was completed.

**Step 5:** If a member is not satisfied with the Sunflower appeal decision, they have the right to request a state fair hearing within 123 calendar days from the date of the member appeal resolution notice from Sunflower.
What Happens to the Member’s Services While Appealing the Action with Sunflower or the Office of Administrative Hearings?

Non-HCBS Services:
Services may be continued during the appeal or state fair hearing if all of the following criteria are met:
- Sunflower Health plan’s action reduces, suspends or terminates previously authorized services.
- Request for appeal or state fair hearing is filed timely along with request for continuation of benefits, within 10 calendar days from the date the notice of adverse benefit determination was mailed or within 10 calendar days of the date the reduction, suspension, or termination of previously authorized services goes into effect.
- The services were ordered by an authorized provider.
- If you or the member do not know if the services related to the appeal are HCBS, please contact Customer Service at 1-877-644-4623.
- The original period covered by the authorization has not expired.
- A provider may not request continuation of benefits on behalf of a member, even if the provider is an authorized representative.

If your Sunflower appeal is denied or the action taken by Sunflower is approved by the Office of Administrative Hearings, the member may have to pay for service(s) provided during the Sunflower appeal and/or state fair hearing.

For members who receive non-HCBS services, the services and benefits continued pending the outcome of the appeal process shall end 10 calendar days following the notice containing the appeal decision for the termination, suspension or reduction of previously authorized services. If a state fair hearing is requested within 123 calendar days from the date on the notice of appeal resolution, the services and benefits will be continued through the date of the state fair hearing decision.

HCBS Services:
Services will be continued during the appeal or state fair hearing process if all of the following criteria are met:
- Sunflower Health Plan’s action reduces, suspends or terminates previously authorized HCBS program services or benefits.
- Request for appeal is filed timely within 63 calendar days from the date of the notice of adverse benefit determination. Or in the case of a state fair hearing, the request for state fair hearing is filed timely within 123 calendar days from the date the notice of appeal resolution.
- The services were ordered by an authorized provider.
- The original period covered by the authorization has not expired.
- If you requested different HCBS program services to replace your previously authorized HCBS program services, and Sunflower authorized the new HCBS program services, your previously authorized HCBS program services must be terminated to allow your new HCBS program services to begin. If your new HCBS program services will begin within 63 days of the date of the Notice of Adverse Benefit Determination terminating your previously authorized HCBS program services, your previously authorized HCBS program services will be continued only until your new HCBS program services begin.

If you ask for a Sunflower appeal or a state fair hearing, your current HCBS program services will continue for the duration of the Sunflower Health Plan appeal, the date of the decision in your state fair hearing, or until the time period or service limits of the previously authorized service has expired or been met.

If your Sunflower appeal results in approval or the action taken by Sunflower is reversed by the Office of Administrative Hearings, you will not have to repay Sunflower for service(s) provided during the Sunflower appeal and/or state fair hearing, unless fraud has occurred.

For members who receive HCBS services, the services and benefits continued pending the outcome of the appeal process shall end 123 calendar days following the notice containing the appeal decision for the termination, suspension or reduction of previously authorized services. If a state fair hearing is requested within 123 calendar days from the date on the notice of the appeal decision, the services and benefits will be continued through the date of the state fair hearing decision.

Requests for future services are not included in continuation of services.

If you or the member do not know if the services related to the appeal are 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 after the Sunflower appeal process has been completed. A member must complete the plan expedited appeal process before filing an expedited state fair hearing.

The request for a state fair hearing must be received within 123 calendar days from the date of the member appeal.
resolution notice from Sunflower. In the event a provider has completed an external independent third party review (EITPR), the request for a state fair hearing must be received within 33 calendar days from the date of the EITPR resolution notice from Sunflower.

A member state fair hearing request can be 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 appeal resolution notice and mail it to Office of Administrative Hearings (OAH), 1020 Kansas Avenue, Topeka, KS, 66612.

If the state fair hearing request is sent to Sunflower, we will forward it to the Office of Administrative Hearings within one business day.

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 Notice of Member Appeal Resolution letter sent to the member and provider.

**Provider Appeals**

Providers have the right to initiate the reconsideration step, which is optional, to have a decision made by Sunflower Health Plan reviewed. The provider will receive a written letter or EOP noting payment amount, denial or adjustment and receive appeal instructions in that notification. This is the notice of action.

**Reconsideration Basics** (optional step):
- The reconsideration step is only available for review of payment decisions; reconsideration is not available for review of prior authorization decisions.
- Requests may be made by phone, email, in person or in writing to Sunflower or specialty partner address on EOP/letter.
- Include the claim number, reason for request, supporting documentation and other items requested. Any written materials must be sent via mail to the address on the EOP/letter.
- Must be requested within 120 calendar days of the date of the Notice of Action. Three (3) additional calendar days will be allowed for mailing time.
- Reconsiderations will be resolved within 30 calendar days from the date of receipt and notification will be a revised EOP for same claim number.
- If a request for review does not clearly specify that the provider is requesting a reconsideration, the request will be treated as an appeal.

**Provider Appeal Basics**:
- Sunflower will not treat you differently if you file an appeal.
- Provider appeal request must be filed in writing, within 60 calendar days of the date of the notice action. Three (3) additional calendar days will be allowed for mailing time.
- Information or documents that support the appeal can be sent by mail as noted in the notice of action or EOP.
- Information on how and where to appeal will be included in the EOP or notice of action you receive; general guides are provided below.
- The member may not file a provider appeal.
- Providers may not charge Sunflower beneficiaries, or any financially responsible relative or representative of that individual, any amount in excess of the Sunflower paid amount. Section 1902(a) (25)(C) of the Social Security Act prohibits Sunflower providers from directly billing Sunflower beneficiaries.
- The provider may not balance bill a member. 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.
- Sunflower will acknowledge appeal requests within 10 calendar days of receiving the request.
- Sunflower wants to resolve appeal concerns quickly, and will resolve provider appeals within 30 calendar days of appeal request receipt.
- The provider will receive a notice of provider appeal resolution letter with the appeal decision, rationale, and date of resolution/decision.
- A state fair hearing or external independent third-party review can only be requested after the provider has completed the Sunflower provider appeal process.
- The process for provider appeals and state fair hearing is the same for both participating and non-participating providers.

**External Independent Third-Party Review (EITPR) - Optional**

Effective for denials issued on or after January 1, 2020:

After completing the Sunflower Health Plan provider appeal process, the treating provider may request
that Sunflower’s appeal decision be reviewed by an external independent third party. Only the treating provider may request this review – the member may not make this request.

To request an external independent third-party review, the treating provider must complete the EITPR request form, which is available on Sunflower’s website. The request must be sent to the address below. EITPR requests sent to any other address will not be processed:

Sunflower Health Plan
Attn.: Appeals Department
8325 Lenexa Drive, Suite 410
Lenexa, KS 66214

- The provider may request an external review regarding a claim payment decision made by Sunflower Health Plan or regarding denial of authorization for a new health care service. New health care service is defined as a service that Sunflower has not previously authorized or a service that Sunflower has previously authorized but the authorization period for that service has expired at the time of the request for additional services.
- The provider must request EITPR within 60 calendar days from the date on the Notice of Provider Appeal Resolution. 3 additional days are allowed for mailing.
- For denials of authorization for new health care services, the provider must complete a provider appeal prior to requesting an EITPR. If the provider filed a member appeal on behalf of the member with the member’s written consent, then a separate provider appeal is not required.
- Sunflower will acknowledge EITPR requests within 5 business days of receiving the request. Sunflower will forward the request and all applicable appeal documentation to the Kansas Department of Health and Environment (KDHE) within 15 business days of receipt. KDHE will assign the review to an external agency for review within 5 business days. The external reviewer will make a decision within 30 calendar days of their receipt of all information from KDHE. In certain cases, the external reviewer may request a 14-day extension for more time to complete the review.
- KDHE will deny the request for EITPR for the following reasons:
  - The request is related to a reduction/suspension/termination of previously authorized services.
  - The provider has not completed the internal appeal process.
  - The provider did not include all of the required information in their EITPR request.
- The external reviewer will review the documentation that was submitted during the Sunflower appeal, medical necessity criteria applied in the appeal decision for denials of a healthcare service, the notice of appeal resolution and the providers request for an external review. Additional documentation submitted with the external review request will not be considered.
- If you wish to submit additional information beyond the information provided during the appeal process, you should not request an EITPR but instead proceed to state fair hearing.
- After the external review is completed, the reviewer will send a letter to you and to Sunflower regarding their decision. Following receipt of this letter, Sunflower Health Plan will send the provider a Notice of EITPR Resolution.
- If the reviewer agrees with Sunflower’s decision, the provider who requested the review will be responsible for paying for the cost of the review. If the reviewer disagrees with Sunflower’s decision, then Sunflower will be responsible for paying for the cost of the review. The member cannot be held responsible for the cost of the external review.
- If the reviewer agrees with Sunflower’s decision, the provider may request a state fair hearing. After an EITPR has been completed, the provider must request state fair hearing within 30 calendar days from the date on Sunflower’s Notice of EITPR Resolution. 3 additional days are allowed for mailing.

State Fair Hearing for Provider Appeals

Providers can only request a state fair hearing after completing the provider appeal process, with a determination received from Sunflower. The reconsideration and EITPR steps are optional and not required in order to file a request for state fair hearing. If an EITPR is requested, then it is recommended that the provider wait until the EITPR is finished prior to requesting a state fair hearing.

If a provider disagrees with the decision made in Sunflower’s appeal resolution, you may request a state fair hearing within 120 calendar days of the date of the Provider Appeal Resolution Notice. Three (3) additional
calendar days will be allowed for mailing time. If an EITPR has been completed, you must request a state fair hearing within 30 calendar days from the date on Sunflower’s Notice of EITPR Resolution. 3 additional days are allowed for mailing. The provider or their representative can ask the Kansas Office of Administrative Hearings to review Sunflower’s decision only after the Sunflower appeal process has been completed. Your request must be submitted in writing to the Office of

### Provider Appeal Process Steps and Timelines

<table>
<thead>
<tr>
<th><strong>RECONSIDERATION</strong></th>
<th></th>
</tr>
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<tbody>
<tr>
<td><strong>Send Where</strong></td>
<td>Call Customer Service: 1-877-644-4623  &lt;br&gt;Mail to the address listed in EOP or letter</td>
</tr>
<tr>
<td><strong>Send What</strong></td>
<td>- Claim number  &lt;br&gt;  - Reason for request  &lt;br&gt;  - Supporting documentation  &lt;br&gt;  - Other items requested</td>
</tr>
<tr>
<td><strong>Deadline to Submit</strong></td>
<td>Within 120 calendar days from the date of the notice of action. Three (3) additional calendar days will be allowed for mailing time.</td>
</tr>
<tr>
<td><strong>Expected Timeline for Response</strong></td>
<td>Within 5 business days from date of reconsideration resolution, a revised or unrevised EOP will be sent.</td>
</tr>
<tr>
<td><strong>Rules and Prerequisites</strong></td>
<td>- This step is optional.  &lt;br&gt;  - Provider appeal rights are preserved throughout this step, and provider may terminate this step at any time.</td>
</tr>
<tr>
<td><strong>Resolution/Decision Notification Type</strong></td>
<td>Revised or unrevised EOP (for same claim number).</td>
</tr>
<tr>
<td><strong>Expected Timeline for Resolution Notice</strong></td>
<td>The reconsideration will be resolved within 30 calendar days of receipt.</td>
</tr>
</tbody>
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<thead>
<tr>
<th><strong>PROVIDER APPEAL</strong></th>
<th></th>
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<tbody>
<tr>
<td><strong>Send Where</strong></td>
<td>Mail to the address listed in EOP or letter</td>
</tr>
<tr>
<td><strong>Send What</strong></td>
<td>Provider Reconsideration and Appeal Form found here: sunflowerhealthplan.com/providers/resources/forms-resources.html or additional form provided with EOP or letter  &lt;br&gt;Pharmacy MAC Pricing Inquiry: Please submit MAC Inquiry Form to CVS Caremark. Form &amp; MAC info can be accessed via the pharmacy portal at rxservices.cvscaremark.com. For portal assistance or questions, contact CVS Caremark Network Services at 866-488-4708.</td>
</tr>
<tr>
<td><strong>Deadline to Submit</strong></td>
<td>Within 60 calendar days from date of the Notice of Action. Three (3) additional calendar days will be allowed for mailing time.</td>
</tr>
<tr>
<td><strong>Expected Timeline for Response</strong></td>
<td>Five (5) business days from the date of resolution of the appeal, the Provider Appeal Resolution notice will be sent.</td>
</tr>
<tr>
<td><strong>Rules and Prerequisites</strong></td>
<td>Within 10 calendar days, provider will receive a written acknowledgment of their appeal request.</td>
</tr>
<tr>
<td><strong>Resolution/Decision Notification Type</strong></td>
<td>Written Provider Appeal Resolution Notice</td>
</tr>
<tr>
<td><strong>Expected Timeline for Resolution Notice</strong></td>
<td>Within 30 calendar days from date of receipt, a resolution decision</td>
</tr>
</tbody>
</table>
### EXTERNAL INDEPENDENT THIRD PARTY REVIEW (EITPR)

| **Send Where** | Sunflower Health Plan Appeals Dept., 8325 Lenexa Drive, Suite 410. Lenexa, KS 66214  
Fax: 1-888-453-4755 |
<table>
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<tr>
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<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Send What</strong></td>
<td>Providers must submit the request in writing using the EITPR Request form available on Sunflower’s website. The form must be signed and completed entirely in order to be processed.</td>
</tr>
<tr>
<td><strong>Deadline to Submit</strong></td>
<td>Within 60 calendar days from the date of the notice of appeal resolution. Three (3) additional calendar days will be allowed for mailing time.</td>
</tr>
<tr>
<td><strong>Rules and Prerequisites</strong></td>
<td>Provider must complete the provider appeal step and receive a determination from Sunflower prior to requesting EITPR. In the case of an EITPR request related to a denial of authorization for a new health care service: if the provider completed a member appeal on behalf of the member, then a separate provider appeal is not required.</td>
</tr>
<tr>
<td><strong>Resolution/Decision Notification Type</strong></td>
<td>Written resolution notice from Sunflower Health Plan.</td>
</tr>
</tbody>
</table>

Providers can only file for a state fair hearing after completing the provider appeal process, with a determination received from Sunflower. If a provider disagrees with the decision made in the appeal resolution, it may then be appealed to the Office of Administrative Hearings as a request for a state fair hearing within 120 calendar days of the date of the Provider Appeal Resolution Notice. Three (3) additional calendar days will be allowed for mailing time. The reconsideration step is optional and not required to file an appeal or state fair hearing.

### STATE FAIR HEARING

| **Send Where** | Office of Administrative Hearings (OAH) 1020 Kansas Avenue, Topeka, KS 66612  
Phone: 1-785-296-2433 |
<table>
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<tr>
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<th></th>
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</thead>
<tbody>
<tr>
<td><strong>Send What</strong></td>
<td>Providers must submit the request in writing. If the request is submitted to Sunflower, Sunflower will forward the state fair hearing request to OAH within one business day. Applicable forms found here: oah.ks.gov/Home/Forms</td>
</tr>
<tr>
<td><strong>Deadline to Submit</strong></td>
<td>Within 120 calendar days from the date of the notice of action. Three (3) additional calendar days will be allowed for mailing time.</td>
</tr>
<tr>
<td><strong>Expected Timeline for Response</strong></td>
<td>Varies at discretion of OAH</td>
</tr>
<tr>
<td><strong>Rules and Prerequisites</strong></td>
<td>Provider must complete the appeal step and receive a determination from Sunflower prior to requesting state fair hearing.</td>
</tr>
<tr>
<td><strong>Resolution/Decision Notification Type</strong></td>
<td>Written communication from OAH</td>
</tr>
</tbody>
</table>
### WHERE TO SEND PROVIDER CLAIM APPEALS

<table>
<thead>
<tr>
<th>TYPE OF SERVICE</th>
<th>SUNFLOWER SPECIALTY PARTNER</th>
<th>PROVIDER APPEALS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical, NF/LTC, or HCBS Services</td>
<td>None</td>
<td>Sunflower Health Plan, Attn: Provider Appeals</td>
</tr>
<tr>
<td></td>
<td></td>
<td>PO Box 4070</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Farmington, MO 63640-3833</td>
</tr>
<tr>
<td>High Resolution Imaging</td>
<td>National Imaging Associate, Inc. (NIA)</td>
<td>Sunflower Health Plan, Attn: Provider Appeals</td>
</tr>
<tr>
<td></td>
<td></td>
<td>PO Box 4070</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Farmington, MO 63640-3833</td>
</tr>
<tr>
<td>Behavioral Health Services</td>
<td>Sunflower Health Plan</td>
<td>Sunflower Health Plan, BH Claim Appeals</td>
</tr>
<tr>
<td></td>
<td></td>
<td>P.O. Box 6000</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Farmington, MO 63640-3809</td>
</tr>
<tr>
<td>Physical Therapy (PT), Occupational Therapy (OT), and Speech Therapy (ST)</td>
<td>National Imaging Associate, Inc. (NIA)</td>
<td>Sunflower Health Plan, Attn: Provider Appeals</td>
</tr>
<tr>
<td></td>
<td></td>
<td>PO Box 4070</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Farmington, MO 63640-3833</td>
</tr>
<tr>
<td>Vision</td>
<td>Envolve Vision</td>
<td>Envolve Vision, Attn: Claims Appeal Committee</td>
</tr>
<tr>
<td></td>
<td></td>
<td>PO Box 7548</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Rocky Mount, NC 27804</td>
</tr>
<tr>
<td>Dental</td>
<td>Envolve Dental</td>
<td>Envolve Dental, Kansas Appeals &amp; Corrected Claims</td>
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<tr>
<td></td>
<td></td>
<td>PO Box 25857</td>
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<tr>
<td></td>
<td></td>
<td>Tampa, FL 33622-5857</td>
</tr>
<tr>
<td>Pharmacy</td>
<td>CVS Caremark</td>
<td>MAC pricing info can be found on CVS Caremark</td>
</tr>
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<td></td>
<td></td>
<td>questions: 1-866-488-4708</td>
</tr>
</tbody>
</table>

*Note: This chart is only a guide; please use the EOP/Notice of Action letter for mailing address and information requested. Claim documentation submitted to Sunflower’s administrative offices in Lenexa, Wichita or Topeka will be returned to the provider.*
Quality Improvement Program

Overview

Sunflower culture, systems, and processes are structured around our purpose to transform the health of the community, one person at a time. 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 those 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 following goals are integrated throughout Sunflower departments and committees as a part of the QAPI Program include but are not limited to:

- Improve the delivery of holistic, integrated, person-centered and culturally appropriate care;
- Improve member experience and quality of life by promoting the highest level of member independence, productivity, wellness and functional ability in the least restrictive environment;
- Improve provider experience and network relationships;
- Increase access to and availability of services;
- Increase the use of evidence-based practices for member with mental health, substance abuse disorders and chronic physical health conditions;
- Provide integrated and coordinated care across the whole spectrum of health, including physical health, behavioral health, which includes mental health and substance use disorders, and LTSS;
- Implement initiatives aimed to improve the quality of care members receive through integrated care coordination and financial incentives paid for performance (quality and outcomes);
- Implement activities to control costs by emphasizing health, wellness, prevention and early detection, as well as integration and coordination of care;
- Establish long-lasting reforms that sustain the improvements in quality of health and wellness for members and provide a model for other states for Medicaid payment and delivery system reforms;
- Meet established performance targets for Preventive and Clinical Practice Guideline compliance. This includes, but is not limited to, compliance with immunizations, prenatal care, diabetes, asthma, early detection of chronic kidney disease and EPSDT guidelines. (Early Periodic Screening, Diagnosis and Treatment Program);
Compliance with all applicable regulatory requirements and accreditation standards will be maintained; and

- Adopt innovative and strategic partnerships with participating providers to improve delivery of quality care and services to all members

Additionally, Sunflower uses the Plan Do Study Act (PDSA) method of rapid cycle process improvement across its departments and committees to drive continuous quality improvement in care and services provided to members and providers.

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 recredentialing programs.

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

- Credentialing Committee
- Grievance and Appeals Committee
- Utilization Management Committee
- Performance Improvement Team
- Peer Review Committee (Ad Hoc Committee)
- Long Term Support Services (LTSS) Quality Assurance Committee
- HEDIS Steering Committee
- Pharmacy & Therapeutics 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 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
- Enrollment and disenrollment
- 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 recredentialing)
- Utilization management, including under- and overutilization

- Selection and retention of providers (credentialing and recredentialing)
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, grievance 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. Another method of identifying adverse events is through claims-based reporting and analyses by responsible parties.

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.

Sunflower also inputs and addresses Adverse Incident Reports (AIRs) that are a part of the KDADS system used for reporting of these types of critical events or those that have potential to harm HCBS members. This includes reports of matters that are actual or potential risks to the member.

Reviews of the situations are completed by Sunflower in a collaborative fashion with Quality Improvement, Medical Management and other health plan departments as appropriate to address and resolve any matters that can improve the situation and/or outcome for the member. Sunflower submits back to the KDADS system details on the resolution to allow for tracking and reporting within their system.

Additionally, Sunflower tracks, trends and reports AIRs data to the Grievance and Appeals Committee, LTSS Quality Assurance Committee and QIC as appropriate.

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 nonclinical 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 the principles of sound research design and appropriate statistical analysis. Results of these studies are used to evaluate the appropriateness, quality of care and services delivered against established standards and guidelines for the provision of that care or service. Each QI initiative is 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, responsible parties 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 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. Providers agree to allow Sunflower to use their performance data for quality improvement activities.
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 mammograms, annual chlamydia screenings, 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-10, 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 exams 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 from March through May each year. At that time, if any of your patients’ 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. Please note that medical records may be uploaded to the secure provider portal.

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 and meets the HEDIS technical specification requirements.
- **Provide medical records to health plan when requested.**
- **Submit claims and encounter data using CPT codes related to HEDIS** measures such as diabetes, eye exams, blood pressure and immunizations/vaccinations.

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. This survey allows for inclusion of various Sunflower network providers, including but not limited to, family practice, specialists, nursing facilities, home and community based and behavioral health providers. The survey is conducted by an external vendor.

Provider participants are randomly selected by the vendor, meeting specific requirements outlined by Sunflower, and the participants are kept anonymous. We encourage you to respond promptly to the survey, as the results 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 through Sunflower also have the opportunity to respond to a behavioral health member experience survey that allows them to provide feedback and input into the quality oversight of the behavioral health program.

Sunflower follows the NCQA and CMS sampling requirements for all CAHPS surveys, including Title XIX and Title XXI.

**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
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 provider directories, as well as being eligible for applicable financial incentive programs. Additionally, Sunflower offers several financial incentive programs, such as HEDIS measure-based incentive programs.

Sunflower evaluates opportunities to expand incentive programs on an ongoing basis for the potential to incorporate other elements and which include elements demonstrating performance on KanCare quality management goals.

More information on our incentive programs can be found on the provider web portal or by contacting the Sunflower Contracting and/or Provider Engagement 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, 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 percent 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 engagement specialist.
Appendices

Appendix I: Common Causes of Upfront Rejections

- Admission Type is missing (Inpatient Facility Claims – UB-04, field 14)
- 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
- CPT/Procedure Code is missing or invalid
- Date of Service is not prior to the received date of the claim (future date of service)
- Date of Service is prior to member’s effective date
- Date of Service or Date Span is missing from required fields. Example: “Statement From” or “Service From” dates
- Diagnosis Code is missing, invalid, or incomplete
- Incorrect Form Type is used
- Institutional Claim (UB-04) exceeded the maximum 97 service line limit
- Member Date of Birth is missing
- Member Name or Identification Number is missing or incomplete
- Modifiers are missing or invalid
- Occurrence Code/Date is missing or invalid
- Patient Status is missing (Inpatient Facility Claims – UB-04, field 17)
- Professional Claim (CMS-1500) exceeded the maximum 50 service line limit
- Provider Name, Taxpayer Identification Number (TIN), or National Practitioner Identification (NPI) Number is missing or does not match the records on file
- Provider not valid on DOS
- Revenue Code is missing or invalid
- Service Line Detail is missing
- Type of Bill is invalid
- 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

Appendix II: Common Causes of Claim Processing Delays and Denials

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

<table>
<thead>
<tr>
<th>CODE</th>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>07</td>
<td>DENY: THE PROCEDURE CODE IS INCONSISTENT WITH THE PATIENT’S SEX</td>
</tr>
<tr>
<td>09</td>
<td>DENY: THE DIAGNOSIS CODE IS INCONSISTENT WITH THE PATIENT’S AGE</td>
</tr>
<tr>
<td>10</td>
<td>DENY: THE DIAGNOSIS CODE IS INCONSISTENT WITH THE PATIENT’S SEX</td>
</tr>
<tr>
<td>18</td>
<td>DENY: DUPLICATE CLAIM/SERVICE</td>
</tr>
<tr>
<td>28</td>
<td>DENY: COVERAGE NOT IN EFFECT WHEN SERVICE PROVIDED</td>
</tr>
<tr>
<td>29</td>
<td>DENY: THE TIME LIMIT FOR FILING HAS EXPIRED</td>
</tr>
<tr>
<td>35</td>
<td>DENY: BENEFIT MAXIMUM HAS BEEN REACHED</td>
</tr>
<tr>
<td>46</td>
<td>DENY: THIS SERVICE IS NOT COVERED</td>
</tr>
<tr>
<td>50</td>
<td>DENY: NOT A MCO COVERED BENEFIT</td>
</tr>
<tr>
<td>86</td>
<td>DENY: THIS IS NOT A VALID MODIFIER FOR THIS CODE</td>
</tr>
<tr>
<td>99</td>
<td>DENY: MISC/UNLISTED CODES CAN NOT BE PROCESSED W/O DESCRIPTION/REPORT</td>
</tr>
<tr>
<td>1K</td>
<td>DENY: CPT OR DX CODE IS NOT VALID FOR AGE OF PATIENT</td>
</tr>
</tbody>
</table>
| 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 |
| KS   | PROVIDER MEDICAID ID REQUIRED FROM MEMBER STATE; OBTAIN ID & RESUBMIT |
| 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 |
| St   | DENY: RESUBMIT CLAIM TO THE STATE FOR CONSIDERATION |
| U1   | CLAIM CANNOT BE PROCESSED WITHOUT MEDICAL RECORDS |
| VI   | GLOBAL FEE PAID |
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)

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

- Anesthesia information
- Narrative description of unspecified/miscellaneous/unlisted codes
- Product Number Healthcare Uniform Code Council—Global Trade Item Number (GTIN)
- 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 unshaded 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**

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<tr>
<th>Procedure</th>
<th>Description</th>
<th>Notes</th>
</tr>
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<tbody>
<tr>
<td>7E214</td>
<td>Laparoscopic Hernia Repair w/ Note Attached</td>
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**Unlisted, Non-Specific, or Miscellaneous CPT or HCPC Code**

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<th>Description</th>
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**Vendor Product Number – HIBCC**

<table>
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</table>

**Product Number Healthcare Uniform Code Council – GTIN**

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### 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.

<table>
<thead>
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<tr>
<td>02</td>
<td>INVALID MBR</td>
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<tr>
<td>06</td>
<td>INVALID PRV</td>
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<tr>
<td>07</td>
<td>INVALID MBR DOB &amp; PRV</td>
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<tr>
<td>08</td>
<td>INVALID MBR &amp; PRV</td>
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<td>09</td>
<td>MBR NOT VALID AT DOS</td>
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<td>INVALID MBR; PRV NOT VALID AT DOS</td>
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<tr>
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<td>INVALID DIAG</td>
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<td>32</td>
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</tr>
<tr>
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</tr>
<tr>
<td>34</td>
<td>INVALID PROC</td>
</tr>
<tr>
<td>35</td>
<td>INVALID DOB; INVALID PROC</td>
</tr>
<tr>
<td>36</td>
<td>INVALID MBR; INVALID PROC</td>
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<tr>
<td>37</td>
<td>INVALID OR FUTURE DATE</td>
</tr>
<tr>
<td>38</td>
<td>MBR NOT VALID AT DOS; PRV NOT VALID AT DOS; INVALID DIAG</td>
</tr>
<tr>
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<td>ERROR DESC</td>
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</tr>
<tr>
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</tr>
<tr>
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</tr>
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<td>63</td>
<td>PRV NOT VALID AT DOS; INVALID DIAG; INVALID PROC</td>
</tr>
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<td>64</td>
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</tr>
<tr>
<td>65</td>
<td>INVALID MBR; PRV NOT VALID AT DOS; INVALID DIAG; INVALID PROC</td>
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<td>72</td>
<td>MBR NOT VALID AT DOS; PRV NOT VALID AT DOS; INVALID DIAG; INVALID PROC</td>
</tr>
<tr>
<td>73</td>
<td>INVALID MBR DOB; MBR NOT VALID AT DOS; PRV NOT VALID AT DOS; INVALID DIAG; INVALID PROC</td>
</tr>
<tr>
<td>74</td>
<td>REJECT. DOS PRIOR TO 6/1/2006</td>
</tr>
<tr>
<td>75</td>
<td>INVALID UNIT</td>
</tr>
<tr>
<td>76</td>
<td>ORIGINAL CLAIM NUMBER REQUIRED</td>
</tr>
<tr>
<td>77</td>
<td>INVALID CLAIM TYPE</td>
</tr>
<tr>
<td>81</td>
<td>INVALID UNIT; INVALID PRV</td>
</tr>
<tr>
<td>83</td>
<td>INVALID UNIT; INVALID MBR &amp; PRV</td>
</tr>
<tr>
<td>89</td>
<td>INVALID PRV; MBR NOT VALID AT DOS; INVALID DOS</td>
</tr>
<tr>
<td>92</td>
<td>INVALID REFERRING PROVIDER NPI</td>
</tr>
<tr>
<td>93</td>
<td>INVALID ADMISSION TYPE</td>
</tr>
<tr>
<td>A2</td>
<td>CLAIM EXCEEDED THE MAXIMUM 97 SERVICE LINE LIMIT</td>
</tr>
<tr>
<td>A2</td>
<td>DIAGNOSIS POINTER INVALID</td>
</tr>
<tr>
<td>ZZ</td>
<td>CLAIM NOT PROCESSED</td>
</tr>
</tbody>
</table>

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.

Tertiary coverage must be billed on a paper claim and mailed to the address below.

**Coordination of Benefits (COB)**

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 with Sunflower. 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.
Tertiary medical claims must be billed on paper claim forms and both the primary and secondary EOBs must be attached. Paper submissions should be mailed to:

Sunflower Health Plan
PO Box 4070
Farmington, MO 63640-3833

Behavioral health paper claims should be mailed to:

Sunflower Health Plan
PO Box 6400
Farmington, MO 63640-3807

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 other 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 a 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 and Fields 58-62 must be completed.
- 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’s paid amount

When Sunflower’s allowed amount is equal to or less than the other insurance’s 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:

- Noncovered 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 insurer and, after 30 days, has not received a written or electronic response to the claim from the third-party insurer, 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 insurer 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 insurer 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 insurer 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 insurer has not received payment or denial from the third-party insurer, 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 insurer 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. Providers are not required to submit paper documentation for claims billed using electronic submissions, 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 another insurer 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 another insurer 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
<table>
<thead>
<tr>
<th>FIELD #</th>
<th>FIELD DESCRIPTION</th>
<th>INSTRUCTIONS OR COMMENTS</th>
<th>REQUIRED OR CONDITIONAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>INSURANCE PROGRAM IDENTIFICATION</td>
<td>Check only the type of health coverage applicable to the claim. This field indicates the payer to whom the claim is being filed. Enter “X” in the box marked “Other”</td>
<td>R</td>
</tr>
<tr>
<td>1a</td>
<td>INSURED’S ID NUMBER</td>
<td>The 9-digit identification number on the member’s Sunflower ID card</td>
<td>R</td>
</tr>
<tr>
<td>2</td>
<td>PATIENT’S NAME (Last Name, First Name, Middle Initial)</td>
<td>Enter the patient’s name as it appears on the member’s Sunflower ID card. Do not use nicknames.</td>
<td>R</td>
</tr>
<tr>
<td>3</td>
<td>PATIENT’S BIRTH DATE / SEX</td>
<td>Enter the patient’s 8-digit date of birth (MM/DD/YYYY) and mark the appropriate box to indicate the patient’s sex/gender. M= Male F= Female</td>
<td>R</td>
</tr>
<tr>
<td>4</td>
<td>INSURED’S NAME</td>
<td>Enter the patient’s name as it appears on the member’s Sunflower ID card.</td>
<td>C</td>
</tr>
<tr>
<td>5</td>
<td>PATIENT’S ADDRESS (Number, Street, City, State, Zip code) Telephone (include area code)</td>
<td>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 code), include the hyphen. Do not use a hyphen or space as a separator within the telephone number (e.g., (803)5551414). Note: Patient’s Telephone does not exist in the electronic 837 Professional 4010A1.</td>
<td>C</td>
</tr>
<tr>
<td>6</td>
<td>PATIENT’S RELATION TO INSURED</td>
<td>Always mark to indicate self.</td>
<td>C</td>
</tr>
<tr>
<td>7</td>
<td>INSURED’S ADDRESS (Number, Street, City, State, Zip code) Telephone (include area code)</td>
<td>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 code), include the hyphen. Do not use a hyphen or space as a separator within the telephone number (e.g., (803)5551414). Note: Patient’s Telephone does not exist in the electronic 837 Professional 4010A1.</td>
<td>C</td>
</tr>
<tr>
<td>FIELD #</td>
<td>FIELD DESCRIPTION</td>
<td>INSTRUCTIONS OR COMMENTS</td>
<td>REQUIRED OR CONDITIONAL</td>
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</tr>
<tr>
<td>8</td>
<td>PATIENT STATUS</td>
<td></td>
<td>Not Required</td>
</tr>
<tr>
<td>9</td>
<td>OTHER INSURED’S NAME (Last Name, First Name, Middle Initial)</td>
<td>Refers to someone other than the patient. REQUIRED if patient is covered by another insurance plan. Enter the complete name of the insured.</td>
<td>C</td>
</tr>
<tr>
<td>9a</td>
<td>OTHER INSURED’S POLICY OR GROUP NUMBER</td>
<td>REQUIRED if field 9 is completed. Enter the policy or group number of the other insurance plan.</td>
<td>C</td>
</tr>
<tr>
<td>9b</td>
<td>RESERVED FOR NUCC USE</td>
<td></td>
<td>Not Required</td>
</tr>
<tr>
<td>9c</td>
<td>RESERVED FOR NUCC USE</td>
<td></td>
<td>Not Required</td>
</tr>
<tr>
<td>9d</td>
<td>INSURANCE PLAN NAME OR PROGRAM NAME</td>
<td>REQUIRED if field 9 is completed. Enter the other insured’s (name of person listed in field 9) insurance plan or program name.</td>
<td>C</td>
</tr>
<tr>
<td>10a, b, c</td>
<td>IS PATIENT’S CONDITION RELATED TO:</td>
<td>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.</td>
<td>R</td>
</tr>
<tr>
<td>10d</td>
<td>CLAIM CODES (Designated by NUCC)</td>
<td>When reporting more than one code, enter three blank spaces and then the next code.</td>
<td>C</td>
</tr>
<tr>
<td>11</td>
<td>INSURED’S POLICY OR FECA NUMBER</td>
<td>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.</td>
<td>C</td>
</tr>
<tr>
<td>11a</td>
<td>INSURED’S DATE OF BIRTH / SEX</td>
<td>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.</td>
<td>C</td>
</tr>
<tr>
<td>11b</td>
<td>OTHER CLAIM ID (Designated by NUCC)</td>
<td>The following qualifier and accompanying identifier has been designated for use: Y4 Property Casualty Claim Number FOR WORKERS’ COMPENSATION OR PROPERTY &amp; CASUALTY: Required if known. Enter the claim number assigned by the payer.</td>
<td>C</td>
</tr>
<tr>
<td>11c</td>
<td>INSURANCE PLAN NAME OR PROGRAM NUMBER</td>
<td>Enter name of the insurance health plan or program.</td>
<td>C</td>
</tr>
<tr>
<td>11d</td>
<td>IS THERE ANOTHER HEALTH BENEFIT PLAN</td>
<td>Mark Yes or No. If Yes, complete fields 9a-d and 11c.</td>
<td>R</td>
</tr>
<tr>
<td>12</td>
<td>PATIENT’S OR AUTHORIZED PERSON’S SIGNATURE</td>
<td>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.</td>
<td>C</td>
</tr>
<tr>
<td>FIELD #</td>
<td>FIELD DESCRIPTION</td>
<td>INSTRUCTIONS OR COMMENTS</td>
<td>REQUIRED OR CONDITIONAL</td>
</tr>
<tr>
<td>---------</td>
<td>------------------</td>
<td>--------------------------</td>
<td>-------------------------</td>
</tr>
<tr>
<td>13</td>
<td>PATIENT’S OR AUTHORIZED PERSON’S SIGNATURE</td>
<td>Obtain signature if appropriate.</td>
<td>Not Required</td>
</tr>
<tr>
<td>14</td>
<td>DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)</td>
<td>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</td>
<td>C</td>
</tr>
<tr>
<td>15</td>
<td>IF PATIENT HAS SAME OR SIMILAR ILLNESS, GIVE FIRST DATE</td>
<td>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</td>
<td>C</td>
</tr>
<tr>
<td>16</td>
<td>DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION</td>
<td></td>
<td>C</td>
</tr>
<tr>
<td>17</td>
<td>NAME OF REFERRING PHYSICIAN OR OTHER SOURCE</td>
<td>Enter the name of the referring physician or professional (first name, middle initial, last name, and credentials). Required for home health, therapy, pharmacy, laboratory and radiology services.</td>
<td>C</td>
</tr>
<tr>
<td>17a</td>
<td>ID NUMBER OF REFERRING PHYSICIAN</td>
<td>Required if field 17 is completed. Use ZZ qualifier for taxonomy code</td>
<td>C</td>
</tr>
<tr>
<td>17b</td>
<td>NPI NUMBER OF REFERRING PHYSICIAN</td>
<td>Required if field 17 is completed. If unable to obtain referring NPI, servicing NPI may be used.</td>
<td>C</td>
</tr>
<tr>
<td>18</td>
<td>HOSPITALIZATION DATES RELATED TO CURRENT SERVICES</td>
<td></td>
<td>C</td>
</tr>
<tr>
<td>19</td>
<td>RESERVED FOR LOCAL USE – NEW FORM: ADDITIONAL CLAIM INFORMATION</td>
<td></td>
<td>C</td>
</tr>
<tr>
<td>20</td>
<td>OUTSIDE LAB / CHARGES</td>
<td></td>
<td>C</td>
</tr>
<tr>
<td>21</td>
<td>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</td>
<td>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.</td>
<td>R</td>
</tr>
<tr>
<td>FIELD #</td>
<td>FIELD DESCRIPTION</td>
<td>INSTRUCTIONS OR COMMENTS</td>
<td>REQUIRED OR CONDITIONAL</td>
</tr>
<tr>
<td>---------</td>
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<td>---------------------------</td>
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</tr>
<tr>
<td>22</td>
<td>RESUBMISSION CODE / ORIGINAL REF.NO.</td>
<td>For resubmissions or adjustments, enter the claim number of the original claim. New form – for resubmissions only: 7 – Replacement of Prior Claim 8 – Void/Cancel Prior Claim</td>
<td>C</td>
</tr>
<tr>
<td>23</td>
<td>PRIOR AUTHORIZATION NUMBER or CLIA NUMBER</td>
<td>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</td>
<td>If auth = C If CLIA = R (If both, always submit the CLIA number)</td>
</tr>
<tr>
<td>24a-j</td>
<td>General Information</td>
<td>Box 24 contains six claim lines. Each claim line is split horizontally into shaded and unshaded areas. Within each unshaded 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 24a–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 unshaded area of a claim line is for the entry of claim line item detail.</td>
<td></td>
</tr>
<tr>
<td>24a-g</td>
<td>SUPPLEMENTAL INFORMATION</td>
<td>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.</td>
<td>C</td>
</tr>
<tr>
<td>24a</td>
<td>DATE(S) OF SERVICE</td>
<td>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.</td>
<td>R</td>
</tr>
<tr>
<td>24b</td>
<td>PLACE OF SERVICE</td>
<td>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.</td>
<td>R</td>
</tr>
<tr>
<td>24c</td>
<td>EMG</td>
<td>Enter Y (Yes) or N (No) to indicate if the service was an emergency.</td>
<td>Not Required</td>
</tr>
<tr>
<td>FIELD #</td>
<td>FIELD DESCRIPTION</td>
<td>INSTRUCTIONS OR COMMENTS</td>
<td>REQUIRED OR CONDITIONAL</td>
</tr>
<tr>
<td>---------</td>
<td>-------------------</td>
<td>--------------------------</td>
<td>------------------------</td>
</tr>
<tr>
<td>24d</td>
<td>PROCEDURES, SERVICES OR SUPPLIES CPT/HCPCS MODIFIER</td>
<td>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.</td>
<td>R</td>
</tr>
<tr>
<td>24e</td>
<td>DIAGNOSIS CODE</td>
<td>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. Up to four diagnosis pointers are allowed per line. 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.</td>
<td>R</td>
</tr>
<tr>
<td>24f</td>
<td>CHARGES</td>
<td>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 (e.g., 199,999.99). Do not enter a dollar sign ($). If the dollar amount is a whole number (e.g., 10.00), enter 00 in the area to the right of the vertical line.</td>
<td>R</td>
</tr>
<tr>
<td>24g</td>
<td>DAYS OR UNITS</td>
<td>Enter quantity (days, visits, units). If only one service provided, enter a numeric value of one.</td>
<td>R</td>
</tr>
<tr>
<td>24h</td>
<td>EPSDT (Family Planning)</td>
<td>Leave blank or enter “Y” if the services were performed as a result of an EPSDT referral.</td>
<td>C</td>
</tr>
<tr>
<td>24i</td>
<td>EPSDT (Family Planning)</td>
<td>Enter the appropriate qualifier for EPSDT visit.</td>
<td>C</td>
</tr>
<tr>
<td>24j</td>
<td>ID QUALIFIER</td>
<td>Use ZZ qualifier for taxonomy Use 1D qualifier for ID if an atypical provider.</td>
<td>R</td>
</tr>
<tr>
<td>24j</td>
<td>NON-NPI PROVIDER ID#</td>
<td>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.</td>
<td>R</td>
</tr>
<tr>
<td>24j</td>
<td>NPI PROVIDER ID</td>
<td>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.).</td>
<td>R</td>
</tr>
<tr>
<td>FIELD #</td>
<td>FIELD DESCRIPTION</td>
<td>INSTRUCTIONS OR COMMENTS</td>
<td>REQUIRED OR CONDITIONAL</td>
</tr>
<tr>
<td>--------</td>
<td>------------------------------------</td>
<td>----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>-------------------------</td>
</tr>
<tr>
<td>25</td>
<td>FEDERAL TAX ID NUMBER SSN/EIN</td>
<td>Enter the provider or supplier 9-digit Federal Tax ID number and mark the box labeled EIN</td>
<td>R</td>
</tr>
<tr>
<td>26</td>
<td>PATIENT’S ACCOUNT NO.</td>
<td>Enter the provider’s billing account number</td>
<td>C</td>
</tr>
<tr>
<td>27</td>
<td>ACCEPT ASSIGNMENT</td>
<td>Enter an X in the YES box. Submission of a claim for reimbursement of services provided to an Sunflower 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.</td>
<td>C</td>
</tr>
<tr>
<td>28</td>
<td>TOTAL CHARGES</td>
<td>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 (e.g., 1999999.99). Do not use commas. Do not enter a dollar sign ($). If the dollar amount is a whole number (e.g., 10.00), enter 00 in the area to the right of the vertical line. When more than one claim page is used for the same beneficiary and for the same date of service, follow the instructions below: 1. Ensure that multiple pages of the claims are sent to Sunflower together. 2. Do not total the charges in Field 28 on each claim form. Only total all itemized charges (on all claim forms) on the last claim page. 3. Enter “Continued. Page ___ of ___” in Field 28. For example, when 10 procedures were provided for the same beneficiary on the same date of service enter, “Continued. Page 1 of 2.” 4. Enter the total charge in Field 28 of the last page of the claim form.</td>
<td>R</td>
</tr>
<tr>
<td>29</td>
<td>AMOUNT PAID</td>
<td>REQUIRED when another carrier is the primary payer. Enter the payment received from the primary payer prior to invoicing Sunflower. Sunflower 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 (e.g., 1999999.99). Do not use commas. Do not enter a dollar sign ($). If the dollar amount is a whole number (e.g., 10.00), enter 00 in the area to the right of the vertical line.</td>
<td>C</td>
</tr>
<tr>
<td>30</td>
<td>BALANCE DUE</td>
<td>REQUIRED when field 29 is completed. Enter the balance due (total charges minus the amount of payment received from the primary payer). Dollar amounts to the left of the vertical line should be right justified. Up to eight characters are allowed (e.g., 1999999.99). Do not use commas. Do not enter a dollar sign ($). If the dollar amount is a whole number (e.g., 10.00), enter 00 in the area to the right of the vertical line.</td>
<td>C</td>
</tr>
<tr>
<td>FIELD #</td>
<td>FIELD DESCRIPTION</td>
<td>INSTRUCTIONS OR COMMENTS</td>
<td>REQUIRED OR CONDITIONAL</td>
</tr>
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<td>-------------------------</td>
</tr>
<tr>
<td>31</td>
<td>SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS</td>
<td>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.</td>
<td>R</td>
</tr>
<tr>
<td>32a</td>
<td>NPI – SERVICES RENDERED</td>
<td>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.</td>
<td>C</td>
</tr>
<tr>
<td>FIELD #</td>
<td>FIELD DESCRIPTION</td>
<td>INSTRUCTIONS OR COMMENTS</td>
<td>REQUIRED OR CONDITIONAL</td>
</tr>
<tr>
<td>--------</td>
<td>----------------------------------</td>
<td>------------------------------------------------------------------------------------------</td>
<td>-------------------------</td>
</tr>
<tr>
<td>33a</td>
<td>GROUP BILLING NPI</td>
<td>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.</td>
<td>R</td>
</tr>
<tr>
<td>33b</td>
<td>GROUP BILLING OTHERS ID</td>
<td>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.</td>
<td>R</td>
</tr>
</tbody>
</table>
Sunflower Customer Service Department: 1-877-644-4623 (TTY 711)

**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. Hospitals 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 form 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**
<table>
<thead>
<tr>
<th>FIELD #</th>
<th>FIELD DESCRIPTION</th>
<th>INSTRUCTIONS OR COMMENTS</th>
<th>REQUIRED OR CONDITIONAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>(Unlabeled Field)</td>
<td>LINE 1: Enter the complete provider name. LINE 2: Enter the complete mailing address. LINE 3: Enter the city, state, and zip+4 code (include hyphen). NOTE: The 9-digit zip (zip+4 code) is a requirement for paper and EDI claims. LINE 4: Enter the area code and phone number.</td>
<td>R</td>
</tr>
<tr>
<td>2</td>
<td>(Unlabeled Field)</td>
<td>Enter the pay-to name and address.</td>
<td>Not Required</td>
</tr>
<tr>
<td>3a</td>
<td>PATIENT CONTROL NO.</td>
<td>Enter the facility patient account/control number.</td>
<td>Not Required</td>
</tr>
<tr>
<td>3b</td>
<td>MEDICAL RECORD NUMBER</td>
<td>Enter the facility patient medical or health record number.</td>
<td>R</td>
</tr>
<tr>
<td>4</td>
<td>TYPE OF BILL</td>
<td>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).</td>
<td>R</td>
</tr>
<tr>
<td>5</td>
<td>FED. TAx NO.</td>
<td>Enter the 9-digit number assigned by the federal government for tax reporting purposes.</td>
<td>R</td>
</tr>
<tr>
<td>6</td>
<td>STATEMENT COVERS PERIOD FROM/THROUGH</td>
<td>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).</td>
<td>R</td>
</tr>
<tr>
<td>7</td>
<td>(Unlabeled Field)</td>
<td>Not used</td>
<td>Not Required</td>
</tr>
<tr>
<td>8a</td>
<td>PATIENT NAME</td>
<td>8a – Enter the first 9 digits of the identification number on the member’s Sunflower ID card.</td>
<td>R</td>
</tr>
<tr>
<td>8b</td>
<td>PATIENT NAME</td>
<td>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.</td>
<td>R</td>
</tr>
<tr>
<td>9</td>
<td>PATIENT ADDRESS</td>
<td>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)</td>
<td>R (except line 9e)</td>
</tr>
<tr>
<td>FIELD #</td>
<td>FIELD DESCRIPTION</td>
<td>INSTRUCTIONS OR COMMENTS</td>
<td>REQUIRED OR CONDITIONAL</td>
</tr>
<tr>
<td>---------</td>
<td>-------------------</td>
<td>--------------------------</td>
<td>------------------------</td>
</tr>
<tr>
<td>10</td>
<td>BIRTHDATE</td>
<td>Enter the patient’s date of birth (MMDDYYYY).</td>
<td>R</td>
</tr>
<tr>
<td>11</td>
<td>SEX</td>
<td>Enter the patient’s sex. Only M or F is accepted.</td>
<td>R</td>
</tr>
<tr>
<td>12</td>
<td>ADMISSION DATE</td>
<td>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.</td>
<td>R</td>
</tr>
</tbody>
</table>
| 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                     |
<table>
<thead>
<tr>
<th>FIELD #</th>
<th>FIELD DESCRIPTION</th>
<th>INSTRUCTIONS OR COMMENTS</th>
<th>REQUIRED OR CONDITIONAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>15</td>
<td>ADMISSION SOURCE</td>
<td>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</td>
<td>R</td>
</tr>
<tr>
<td>16</td>
<td>DISCHARGE HOUR</td>
<td>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</td>
<td>C</td>
</tr>
</tbody>
</table>
### Patient Status

**Field # 17**

**Description:** 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 Veterans Administration [VA] hospital)
- **50** - Hospice – home
- **51** - Hospice – medical facility
- **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)

### Condition Codes

**Fields # 18-28**

**Description:** 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.

### Accident State

**Field # 29**

**Description:** Not Required.
<table>
<thead>
<tr>
<th>FIELD #</th>
<th>FIELD DESCRIPTION</th>
<th>INSTRUCTIONS OR COMMENTS</th>
<th>REQUIRED OR CONDITIONAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>30</td>
<td>(Unlabeled Field)</td>
<td>Not Used</td>
<td>Not Required</td>
</tr>
<tr>
<td>31-34</td>
<td>OCCURRENCE CODE and OCCURRENCE DATE</td>
<td>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.</td>
<td>C</td>
</tr>
<tr>
<td>35-36</td>
<td>OCCURRENCE SPAN CODE and OCCURRENCE DATE</td>
<td>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.</td>
<td>C</td>
</tr>
<tr>
<td>37</td>
<td>(Unlabeled Field)</td>
<td>REQUIRED for resubmissions or adjustments. Enter the DCN (Document Control Number) of the original claim.</td>
<td>C</td>
</tr>
<tr>
<td>38</td>
<td>RESPONSIBLE PARTY NAME AND ADDRESS</td>
<td>Not Required</td>
<td>Not Required</td>
</tr>
<tr>
<td>FIELD #</td>
<td>FIELD DESCRIPTION</td>
<td>INSTRUCTIONS OR COMMENTS</td>
<td></td>
</tr>
<tr>
<td>---------</td>
<td>-------------------</td>
<td>--------------------------</td>
<td></td>
</tr>
<tr>
<td>39-41 a-d</td>
<td>VALUE CODES CODES and AMOUNTS</td>
<td>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 (e.g., 199,999.99). Do not enter a dollar sign ($) or a decimal. A decimal is implied. If the dollar amount is a whole number (e.g., 10.00), enter 00 in the area to the right of the vertical line.</td>
<td></td>
</tr>
<tr>
<td>General Information Fields 42-47</td>
<td>SERVICE LINE DETAIL</td>
<td>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.</td>
<td></td>
</tr>
<tr>
<td>42 Lines 1-22</td>
<td>REV CD</td>
<td>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.</td>
<td></td>
</tr>
<tr>
<td>42 Line 23</td>
<td>Rev CD</td>
<td>Enter 0001 for total charges.</td>
<td></td>
</tr>
<tr>
<td>43 Lines 1-22</td>
<td>DESCRIPTION</td>
<td>Enter a brief description that corresponds to the revenue code entered in the service line of field 42.</td>
<td></td>
</tr>
<tr>
<td>43 Line 23</td>
<td>PAGE _______ OF _________</td>
<td>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 (e.g., PAGE “1” OF “1”). (Limited to 4 pages per claim).</td>
<td></td>
</tr>
<tr>
<td>44</td>
<td>HCPCS/RATES</td>
<td>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/HCPCS 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/HCPCS 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.</td>
<td></td>
</tr>
<tr>
<td>FIELD #</td>
<td>FIELD DESCRIPTION</td>
<td>INSTRUCTIONS OR COMMENTS</td>
<td>REQUIRED OR CONDITIONAL</td>
</tr>
<tr>
<td>---------</td>
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</tr>
<tr>
<td>45</td>
<td>SERVICE DATE</td>
<td>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.</td>
<td>C</td>
</tr>
<tr>
<td>45</td>
<td>CREATION DATE</td>
<td>Enter the date the bill was created or prepared for submission on all pages submitted (MMDDYY).</td>
<td>R</td>
</tr>
<tr>
<td>46</td>
<td>SERVICE UNITS</td>
<td>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.</td>
<td>R</td>
</tr>
<tr>
<td>47</td>
<td>TOTAL CHARGES</td>
<td>Enter the total charges for each service line.</td>
<td>R</td>
</tr>
<tr>
<td>47</td>
<td>TOTALS</td>
<td>Enter the total charges for all service lines.</td>
<td>R</td>
</tr>
<tr>
<td>48</td>
<td>NON-COVERED CHARGES</td>
<td>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.</td>
<td>C</td>
</tr>
<tr>
<td>48</td>
<td>TOTALS</td>
<td>Enter the total non-covered charges for all service lines.</td>
<td>C</td>
</tr>
<tr>
<td>49</td>
<td>(Unlabeled Field)</td>
<td>Not Used</td>
<td>Not Required</td>
</tr>
<tr>
<td>50 A-C</td>
<td>PAYER</td>
<td>Enter the name of each payer from which reimbursement is being sought in the order of the payer liability.</td>
<td>R</td>
</tr>
<tr>
<td>51</td>
<td>HEALTH PLAN IDENTIFICATION NUMBER</td>
<td></td>
<td>Not Required</td>
</tr>
<tr>
<td>52 A-C</td>
<td>REL. INFO</td>
<td>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.”</td>
<td>R</td>
</tr>
<tr>
<td>53</td>
<td>ASG. BEN.</td>
<td>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.</td>
<td>R</td>
</tr>
<tr>
<td>54</td>
<td>PRIOR PAYMENTS</td>
<td>Enter the amount received from the primary payer on the appropriate line when Sunflower is listed as secondary or tertiary.</td>
<td>C</td>
</tr>
<tr>
<td>55</td>
<td>EST. AMOUNT DUE</td>
<td></td>
<td>Not Required</td>
</tr>
<tr>
<td>56</td>
<td>NATIONAL PROVIDER IDENTIFIER or PROVIDER ID</td>
<td>Required: Enter provider’s 10-character NPI ID.</td>
<td>R</td>
</tr>
<tr>
<td>57</td>
<td>OTHER PROVIDER ID</td>
<td>Enter the numeric provider identification number. Enter the TPI number (non-NPI number) of the billing provider.</td>
<td>R</td>
</tr>
<tr>
<td>FIELD #</td>
<td>DESCRIPTION</td>
<td>INSTRUCTIONS OR COMMENTS</td>
<td>REQUIRED OR CONDITIONAL</td>
</tr>
<tr>
<td>--------</td>
<td>-------------</td>
<td>--------------------------</td>
<td>-------------------------</td>
</tr>
<tr>
<td>58</td>
<td>INSURED’S NAME</td>
<td>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.</td>
<td>R</td>
</tr>
<tr>
<td>59</td>
<td>PATIENT RELATIONSHIP</td>
<td>Not Required</td>
<td></td>
</tr>
<tr>
<td>60</td>
<td>INSURED’S UNIQUE ID</td>
<td>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.</td>
<td>R</td>
</tr>
<tr>
<td>61</td>
<td>GROUP NAME</td>
<td>Not Required</td>
<td></td>
</tr>
<tr>
<td>62</td>
<td>INSURANCE GROUP NO.</td>
<td>Not Required</td>
<td></td>
</tr>
<tr>
<td>63</td>
<td>TREATMENT AUTHORIZATION CODES</td>
<td>Enter the prior authorization or referral when services require pre-certification.</td>
<td>Not Required</td>
</tr>
<tr>
<td>64</td>
<td>DOCUMENT CONTROL NUMBER</td>
<td>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 Sunflower Health Plan from field 50. Applies to claims 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.</td>
<td>C</td>
</tr>
<tr>
<td>65</td>
<td>EMPLOYER NAME</td>
<td>Not Required</td>
<td></td>
</tr>
<tr>
<td>66</td>
<td>DX VERSION QUALIFIER</td>
<td>Enter an appropriate qualifier of 9 or 0. The following qualifiers indicate the edition of the ICD being used: 9 - Ninth Revision (ICD-9), 0 - Tenth Revision (ICD-10).</td>
<td>R</td>
</tr>
<tr>
<td>67</td>
<td>PRINCIPAL DIAGNOSIS CODE</td>
<td>Enter the principal/primary diagnosis or condition using the appropriate release/update of ICD-9/10-CM Volumes 1 &amp; 3 for the date of service.</td>
<td>R</td>
</tr>
<tr>
<td>67 A-Q</td>
<td>OTHER DIAGNOSIS CODE</td>
<td>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 &amp; 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. Note: Claims with incomplete or invalid diagnosis codes will be denied.</td>
<td>C</td>
</tr>
<tr>
<td>68</td>
<td>PRESENT ON ADMISSION INDICATOR</td>
<td></td>
<td>R</td>
</tr>
<tr>
<td>FIELD #</td>
<td>FIELD DESCRIPTION</td>
<td>INSTRUCTIONS OR COMMENTS</td>
<td>REQUIRED OR CONDITIONAL</td>
</tr>
<tr>
<td>---------</td>
<td>--------------------------------------</td>
<td>------------------------------------------------------------------------------------------</td>
<td>-------------------------</td>
</tr>
<tr>
<td>69</td>
<td>ADMITTING DIAGNOSIS CODE</td>
<td>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 &amp; 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. Note: Claims with missing or invalid diagnosis codes will be denied.</td>
<td>R</td>
</tr>
<tr>
<td>70</td>
<td>PATIENT REASON CODE</td>
<td>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. NOTE: Claims with missing or invalid diagnosis codes will be denied.</td>
<td>R</td>
</tr>
<tr>
<td>71</td>
<td>PPS/DRG CODE</td>
<td>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 &amp; 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. Note: Claims with missing or invalid diagnosis codes will be denied.</td>
<td>Not Required</td>
</tr>
<tr>
<td>72 a, b, c</td>
<td>EXTERNAL CAUSE CODE</td>
<td>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. NOTE: Claims with missing or invalid diagnosis codes will be denied.</td>
<td>Not Required</td>
</tr>
<tr>
<td>73</td>
<td>(UNLABELED)</td>
<td>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).</td>
<td>Not Required</td>
</tr>
<tr>
<td>74</td>
<td>PRINCIPAL PROCEDURE CODE/DATE</td>
<td>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).</td>
<td>C</td>
</tr>
<tr>
<td>74 a-e</td>
<td>OTHER PROCEDURE CODE DATE</td>
<td>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. Date: Enter the date the principal procedure was performed (MMDDYY).</td>
<td>C</td>
</tr>
<tr>
<td>75</td>
<td>(UNLABELED)</td>
<td>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: OB – 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.</td>
<td>Not Required</td>
</tr>
<tr>
<td>76</td>
<td>ATTENDING PHYSICIAN</td>
<td>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: OB – 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.</td>
<td>R</td>
</tr>
<tr>
<td>FIELD #</td>
<td>FIELD DESCRIPTION</td>
<td>INSTRUCTIONS OR COMMENTS</td>
<td>REQUIRED OR CONDITIONAL</td>
</tr>
<tr>
<td>---------</td>
<td>-------------------</td>
<td>--------------------------</td>
<td>-------------------------</td>
</tr>
<tr>
<td>77</td>
<td>OPERATING PHYSICIAN</td>
<td>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.</td>
<td>C</td>
</tr>
<tr>
<td>78 &amp; 79</td>
<td>OTHER PHYSICIAN</td>
<td>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 numbers: 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.</td>
<td>C</td>
</tr>
<tr>
<td>80</td>
<td>REMARKS</td>
<td>Not Required</td>
<td></td>
</tr>
<tr>
<td>81</td>
<td>CC</td>
<td>R: Taxonomy of billing provider. Use B3 qualifier.</td>
<td>R</td>
</tr>
<tr>
<td>82</td>
<td>ATTENDING PHYSICIAN</td>
<td>Enter name or 7-digit provider number of ordering physician.</td>
<td>R</td>
</tr>
</tbody>
</table>
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.

<table>
<thead>
<tr>
<th>BENEFIT</th>
<th>HCPCS</th>
<th>DIAGNOSIS</th>
<th>LIMITS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family Adjustment Counseling</td>
<td>S9482 – Individual</td>
<td>ASD</td>
<td>Max 48 units per calendar year</td>
</tr>
<tr>
<td></td>
<td>S9482HQ – Group</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Parent Support and Training</td>
<td>T1027 – Individual</td>
<td>ASD</td>
<td>Max 120 units per calendar year</td>
</tr>
<tr>
<td></td>
<td>T1027HQ – Group</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Respite Care</td>
<td>T1005</td>
<td>ASD</td>
<td>Max 672 units per calendar year</td>
</tr>
</tbody>
</table>

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.

<table>
<thead>
<tr>
<th>BENEFIT</th>
<th>HCPCS</th>
<th>DIAGNOSIS</th>
<th>LIMITS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult Day Care – &lt;5 hours</td>
<td>S5101</td>
<td>*R68.89</td>
<td>1 unit equals 1-5 hours. Max 1 unit in 24 hours</td>
</tr>
<tr>
<td>Adult Day Care – &gt; 5 hours</td>
<td>S5102</td>
<td>*R68.89</td>
<td>1 unit equals &gt;5 hours. Max 1 unit in 24 hours</td>
</tr>
<tr>
<td>Assistive Technology</td>
<td>T2029</td>
<td>*R68.89</td>
<td>1 unit equals 1 purchase. $7,500 lifetime max</td>
</tr>
<tr>
<td>Attendant Care Level II – Provider Directed</td>
<td>S5125</td>
<td>*R68.89</td>
<td>1 unit equals 15 minutes. Combined max 48 units/12 hours per day for any combination of attendant care.</td>
</tr>
<tr>
<td>Attendant Care Level III – Provider Directed</td>
<td>S5125UA</td>
<td>*R68.89</td>
<td>1 unit equals 15 minutes. Combined max 48 units/12 hours per day for any combination of attendant care.</td>
</tr>
<tr>
<td>Attendant Care Level I – Provider Directed</td>
<td>S5130</td>
<td>*R68.89</td>
<td>1 unit equals 15 minutes. Combined max 48 units/12 hours per day for any combination of attendant care.</td>
</tr>
<tr>
<td>Attendant Care – Self Directed</td>
<td>S5125UD</td>
<td>*R68.89</td>
<td>1 unit equals 15 minutes. Combined max 48 units/12 hours per day for any combination of attendant care.</td>
</tr>
<tr>
<td>Comprehensive Support – Provider Directed</td>
<td>S5135</td>
<td>*R68.89</td>
<td>Max 48 units (12 hours) per day. Cannot exceed 24 hours with other program combo. Cannot be provided at same time as Attendant Care or Enhanced Care</td>
</tr>
<tr>
<td>BENEFIT</td>
<td>HCPCS</td>
<td>DIAGNOSIS</td>
<td>LIMITS</td>
</tr>
<tr>
<td>----------------------------------------</td>
<td>---------------</td>
<td>-----------</td>
<td>---------------------------------------------</td>
</tr>
<tr>
<td>Assistive Services</td>
<td>S5165</td>
<td>*R68.89</td>
<td>Max $7,500 lifetime</td>
</tr>
<tr>
<td>Financial Management Services</td>
<td>T2040U2</td>
<td>*R68.89</td>
<td>1 unit equals 1 month</td>
</tr>
<tr>
<td>Home-Delivered Meals</td>
<td>S5170</td>
<td>*R68.89</td>
<td>1 unit equals 1 meal. Max 2 meals per day</td>
</tr>
<tr>
<td>Medication Reminder Call/Alarm</td>
<td>S5185</td>
<td>n/a</td>
<td>1 unit equals 1 month</td>
</tr>
<tr>
<td>Medication Reminder Dispenser</td>
<td>T1505U6</td>
<td>n/a</td>
<td>1 unit equals 1 month</td>
</tr>
<tr>
<td>Medication Reminder – Install</td>
<td>T1505</td>
<td>n/a</td>
<td>1 unit equals install. Max 1 per year</td>
</tr>
<tr>
<td>Personal Emergency Response System – Install</td>
<td>S5160</td>
<td>n/a</td>
<td>1 unit equals install. Max 2 per year</td>
</tr>
<tr>
<td>Personal Emergency Response System – Rental</td>
<td>S5161</td>
<td>n/a</td>
<td>1 unit equals 1 month</td>
</tr>
</tbody>
</table>

**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.
<table>
<thead>
<tr>
<th>Benefit</th>
<th>HCPCS</th>
<th>Diagnosis</th>
<th>Limits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Personal Services – Agency Directed</td>
<td>S5125U9</td>
<td>R68.89</td>
<td>1 unit equals 15 minutes. Max 10 hours/day, 1,240 units per month</td>
</tr>
<tr>
<td>Personal Services – Self Directed</td>
<td>S5125U6</td>
<td>R68.89</td>
<td>1 unit equals 15 minutes. Max 10 hours/day, 1,240 units per month</td>
</tr>
<tr>
<td>Enhanced Care Services</td>
<td>T2025</td>
<td>n/a</td>
<td>1 unit equals 6-12 hours. Only 1 unit in 24-hour period</td>
</tr>
</tbody>
</table>

**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.

<table>
<thead>
<tr>
<th>Benefit</th>
<th>HCPCS</th>
<th>Diagnosis</th>
<th>Limits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assistive Services (Home Mods)</td>
<td>S5165</td>
<td>R68.89</td>
<td>Max $7,500 lifetime</td>
</tr>
<tr>
<td>Financial Management Services</td>
<td>T2040U2</td>
<td>R68.89</td>
<td>1 unit equals 1 month</td>
</tr>
<tr>
<td>Health Maintenance Monitoring</td>
<td>T1001</td>
<td>R68.89</td>
<td>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 T1002, T1000, or T1005</td>
</tr>
<tr>
<td>Intermittent Intensive Medical Care</td>
<td>T1002</td>
<td>R68.89</td>
<td>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</td>
</tr>
<tr>
<td>Personal Care Services – Agency Directed</td>
<td>T1004</td>
<td>R68.89</td>
<td>1 unit equals 15 minutes. Max 12 hours per day (48 units) or 372 hours equating to 1,488 units/month</td>
</tr>
<tr>
<td>Personal Service Attendant–Self Directed</td>
<td>T1019</td>
<td>R68.89</td>
<td>1 unit equals 15 minutes. Max 12 hours per day (48 units) or 372 hours equating to 1,488 units/month</td>
</tr>
<tr>
<td>Medical Respite</td>
<td>T1005</td>
<td>R68.89</td>
<td>1 unit equals 15 minutes. Max of 168 hours (672 units) per year. T1005 cannot be billed on same day as T1000</td>
</tr>
<tr>
<td>Specialized Medical Care RN/LPN</td>
<td>T1000</td>
<td>R68.89</td>
<td>1 unit equals 15 minutes. Max 32 units/8 hours per day, not to exceed 160 units/40 hours per week. T1000 cannot be billed on same day as T1005</td>
</tr>
</tbody>
</table>
The Home and Community Based Services (HCBS) Brain Injury (BI) program is designed to meet the needs of beneficiaries who have a documented medical diagnosis of a Traumatic Brain Injury or Acquired Brain Injury (TBI or ABI). Brain injuries due to a chromosomal or congenital diagnosis do not qualify for the BI waiver.

<table>
<thead>
<tr>
<th>Benefit Description</th>
<th>HCPCS Code</th>
<th>Diagnosis Code</th>
<th>Limits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assistive Services (Home Mods)</td>
<td>S5165</td>
<td>n/a</td>
<td>Max $7,500 lifetime</td>
</tr>
<tr>
<td>Behavior Therapy</td>
<td>H0004</td>
<td>n/a</td>
<td>1 unit equals 15 minutes. Combined max of 780 hours (3,120 units) per calendar year for the following: H0004, 97532, G0151, G0152, &amp; G0153</td>
</tr>
<tr>
<td>Cognitive Rehabilitation</td>
<td>97532</td>
<td>n/a</td>
<td>1 unit equals 15 minutes. Combined max of 780 hours (3,120 units) per calendar year for the following: H0004, 97532, G0151, G0152, &amp; G0153</td>
</tr>
<tr>
<td>Occupational Therapy</td>
<td>G0152</td>
<td>n/a</td>
<td>1 unit equals 15 minutes. Combined max of 780 hours (3,120 units) per calendar year for the following: H0004, 97532, G0151, G0152, &amp; G0153</td>
</tr>
<tr>
<td>Physical Therapy</td>
<td>G0151</td>
<td>n/a</td>
<td>1 unit equals 15 minutes. Combined max of 780 hours (3,120 units) per calendar year for the following: H0004, 97532, G0151, G0152, &amp; G0153</td>
</tr>
<tr>
<td>Speech Therapy</td>
<td>G0153</td>
<td>n/a</td>
<td>1 unit equals 15 minutes. Combined max of 780 hours (3,120 units) per calendar year for the following: H0004, 97532, G0151, G0152, &amp; G0153</td>
</tr>
<tr>
<td>Enhanced Care Services</td>
<td>T2025</td>
<td>R68.89</td>
<td>1 unit equals one sleep cycle. Max 1 unit in 24-hour period. Combined HCBS program services will not exceed 24 hours</td>
</tr>
<tr>
<td>Personal Services – Agency Directed</td>
<td>S5125U9</td>
<td>R68.89</td>
<td>1 unit equals 15 minutes. Max 10 hours/day, 1,240 units per month. Not to be overlapped with other services without plan approval</td>
</tr>
<tr>
<td>Personal Services – Self Directed</td>
<td>S5125UB</td>
<td>R68.89</td>
<td>1 unit equals 15 minutes. Max 10 hours/day, 1,240 units per month. Not to be overlapped with other services without plan approval</td>
</tr>
<tr>
<td>Personal Emergency Response System – Install</td>
<td>S5160</td>
<td>n/a</td>
<td>1 unit equals install. Max 2 per year</td>
</tr>
<tr>
<td>Personal Emergency Response System – Rental</td>
<td>S5161</td>
<td>n/a</td>
<td>1 unit equals 1 month</td>
</tr>
<tr>
<td>Financial Management Services</td>
<td>T2040U2</td>
<td>R68.89</td>
<td>1 unit equals 1 month</td>
</tr>
<tr>
<td>Home-Delivered Meals</td>
<td>S5170</td>
<td>R68.89</td>
<td>1 unit equals 1 meal. Max of 2 meals per day</td>
</tr>
<tr>
<td>Medication Reminder Call/Alarm</td>
<td>S5185</td>
<td>n/a</td>
<td>1 unit equals 1 month</td>
</tr>
<tr>
<td>Medication Reminder Dispenser</td>
<td>T1505UB</td>
<td>n/a</td>
<td>1 unit equals 1 month</td>
</tr>
<tr>
<td>Medication Reminder Install</td>
<td>T1505</td>
<td>n/a</td>
<td>1 unit equals 1 install. Max 1 unit per calendar year</td>
</tr>
<tr>
<td>Transitional Living Skills</td>
<td>H2014</td>
<td>n/a</td>
<td>1 unit equals 15 min.</td>
</tr>
</tbody>
</table>
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.

<table>
<thead>
<tr>
<th>BENEFIT</th>
<th>HCPCS</th>
<th>DIAGNOSIS</th>
<th>LIMITS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Residential Regular Tier 1-5</td>
<td>T2016</td>
<td>n/a</td>
<td>1 unit = 1 day. Max of 31 per month. (Cannot be billed with S5125, H0045, &amp; T2025/deny)</td>
</tr>
<tr>
<td>Residential Super Tier 1-5</td>
<td>T2016</td>
<td>n/a</td>
<td>1 unit = 1 day. Max of 31 per month. (Cannot be billed with S5125, H0045, T1000, and T1000TD &amp; T2025/deny)</td>
</tr>
<tr>
<td>Day Service Regular Tier 1-5</td>
<td>T2021</td>
<td>n/a</td>
<td>1 unit = 15 minutes. Max of 23 days (460 units a month)</td>
</tr>
<tr>
<td>Day Service Super Tier 1-5</td>
<td>T2021</td>
<td>n/a</td>
<td>1 unit = 15 minutes. Max of 23 days (460 units a month)</td>
</tr>
<tr>
<td>Supportive Home Care – Agency Directed</td>
<td>S5125</td>
<td>n/a</td>
<td>1 unit = 15 minutes. Max of 12 hours or 48 units/day or 1,488 units per month</td>
</tr>
<tr>
<td>Personal Assistant Services – Self Directed</td>
<td>T1019</td>
<td>n/a</td>
<td>1 unit = 15 minutes. Max of 12 hours or 48 units/day or 1,488 units per month</td>
</tr>
<tr>
<td>Respite Overnight</td>
<td>H0045</td>
<td>n/a</td>
<td>1 unit = 1 day, 60 days per calendar year. Not allowable with T2016 in same day</td>
</tr>
<tr>
<td>Supported Employment</td>
<td>H2023</td>
<td>n/a</td>
<td>1 unit = 15 minutes</td>
</tr>
<tr>
<td>Enhanced Care Services</td>
<td>T2025</td>
<td>n/a</td>
<td>1 unit = 1 day (minimum of 6 hours). Max of 31 per month</td>
</tr>
<tr>
<td>Specialized Medical Care (RN)</td>
<td>T1000TD</td>
<td>n/a</td>
<td>1 unit = 15 minutes, limited to 12 hours/day (48 units) and 372 hours/month (1,488 units)</td>
</tr>
<tr>
<td>Specialized Medical Care (LPN)</td>
<td>T1000</td>
<td>n/a</td>
<td>1 unit = 15 minutes, limited to 12 hours/day (48 units) and 372 hours/month (1,488 units)</td>
</tr>
<tr>
<td>Medical Alert Rental</td>
<td>S5161</td>
<td>n/a</td>
<td>1 unit = 1 month. Max of 12 per year</td>
</tr>
<tr>
<td>Financial Management Services</td>
<td>T2040U2</td>
<td>*R68.89</td>
<td>1 unit = 1 month. Max of 12 per year</td>
</tr>
<tr>
<td>Wellness Monitoring</td>
<td>S5190</td>
<td>n/a</td>
<td>1 unit equals 1 visit. Max 1 per 60 days</td>
</tr>
<tr>
<td>Assistive Services</td>
<td>S5165</td>
<td>n/a</td>
<td>Lifetime max $7,500</td>
</tr>
<tr>
<td>Targeted Case Management (State Plan Services)</td>
<td>T1017</td>
<td>n/a</td>
<td>1 unit = 15 minutes. Max of 240 units per year</td>
</tr>
</tbody>
</table>

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)

<table>
<thead>
<tr>
<th>DATES OF SERVICE</th>
<th>PROCEDURE CODE</th>
<th>BILLED UNITS</th>
</tr>
</thead>
<tbody>
<tr>
<td>1/1/16 – 1/31/16</td>
<td>T2016</td>
<td>31 units</td>
</tr>
<tr>
<td>1/1/16 – 1/5/16</td>
<td>T2016</td>
<td>5 units</td>
</tr>
<tr>
<td>1/1/16 – 1/1/16</td>
<td>T2016</td>
<td>1 unit</td>
</tr>
<tr>
<td>1/6/15 – 1/12/16</td>
<td>T2016</td>
<td>3 units</td>
</tr>
<tr>
<td>1/1/16 – 1/31/16</td>
<td>T2016</td>
<td>27 units</td>
</tr>
</tbody>
</table>

- You must bill within the same calendar month, and you cannot overlap any given calendar month, e.g., 01/15/16 through 02/10/16 – this would be two claims, one for January and one for February.

- Day Supports (T2020/T2021) – Effective with dates of service January 1, 2016, 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 seven days), 460 units per month (a month is defined as the first 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 eight hours a day for Day Supports with a limit of 25 hours per week. Therefore, a person can work up to eight 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) – Kansas AuthentiCare

Information regarding implementation of the state’s AuthentiCare System can be found at [www.kdads.ks.gov/provider-home/home-and-community-based-services-provider-information/authenticare-kansas-information](http://www.kdads.ks.gov/provider-home/home-and-community-based-services-provider-information/authenticare-kansas-information).

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

<table>
<thead>
<tr>
<th>SERVICE CODE</th>
<th>SERVICE NAME</th>
</tr>
</thead>
<tbody>
<tr>
<td>HCFES5125</td>
<td>FE - Level 2 Attendant Care</td>
</tr>
<tr>
<td>HCFES5125UD</td>
<td>FE - Self-Directed Attendant Care</td>
</tr>
<tr>
<td>HCFES5130</td>
<td>FE - Level 1 Attendant Care</td>
</tr>
<tr>
<td>HCFES5101</td>
<td>FE - Adult Day Care</td>
</tr>
<tr>
<td>HCFES5160</td>
<td>FE - Personal Emergency Response – Install</td>
</tr>
<tr>
<td>HCFES5190</td>
<td>FE - Wellness Monitoring</td>
</tr>
<tr>
<td>HCFET1001</td>
<td>FE - Nurse Evaluation Visit</td>
</tr>
<tr>
<td>HCFET2025</td>
<td>FE - Enhanced Care Services</td>
</tr>
<tr>
<td>HCFES5135</td>
<td>FE - Provider-Directed Comprehensive Support</td>
</tr>
<tr>
<td>HCFES5135UD</td>
<td>FE - Self-Directed Comprehensive Support</td>
</tr>
<tr>
<td>HCFET2040U2</td>
<td>FE - Financial Management Service</td>
</tr>
<tr>
<td>HCFES5161</td>
<td>FE - Personal Emergency Response – Rental</td>
</tr>
<tr>
<td>HCFET2029</td>
<td>FE - Assistive Technology</td>
</tr>
<tr>
<td>HCFES0315</td>
<td>FE - Home Telehealth – Install</td>
</tr>
<tr>
<td>HCFES0317</td>
<td>FE - Home Telehealth – Rental</td>
</tr>
<tr>
<td>HCFES5185</td>
<td>FE - Medication Reminder</td>
</tr>
</tbody>
</table>

### Intellectual/Developmental Disability (I/DD) HCBS Programs

<table>
<thead>
<tr>
<th>SERVICE CODE</th>
<th>SERVICE NAME</th>
</tr>
</thead>
<tbody>
<tr>
<td>HCDT1019</td>
<td>IDD - Self-Directed Personal Assistant Services</td>
</tr>
<tr>
<td>HCDT2025</td>
<td>IDD - Enhanced Care Services</td>
</tr>
<tr>
<td>HCDHH0045</td>
<td>IDD - Overnight Respite</td>
</tr>
<tr>
<td>HCDT1000</td>
<td>IDD - LPN Specialized Medical Care</td>
</tr>
<tr>
<td>HCDT1000TD</td>
<td>IDD - RN Specialized Medical Care</td>
</tr>
<tr>
<td>HCDSS5125</td>
<td>IDD - Supportive Home Care</td>
</tr>
<tr>
<td>HCDSS5161</td>
<td>IDD - Medical Alert Rental</td>
</tr>
<tr>
<td>HCDT2040U2</td>
<td>IDD - Financial Management Service</td>
</tr>
</tbody>
</table>
Physical Disability (PD) HCBS Programs

<table>
<thead>
<tr>
<th>SERVICE CODE</th>
<th>SERVICE NAME</th>
</tr>
</thead>
<tbody>
<tr>
<td>HCPDS5125U6</td>
<td>PD - Self-Directed Personal Services</td>
</tr>
<tr>
<td>HCPDT2025</td>
<td>PD - Enhanced Care Services</td>
</tr>
<tr>
<td>HCPDS5125U9</td>
<td>PD - Agency-Directed Personal Services</td>
</tr>
<tr>
<td>HCPDS5160</td>
<td>PD - Personal Emergency Response – Install</td>
</tr>
<tr>
<td>HCPDS5161</td>
<td>PD - Personal Emergency Response – Rental</td>
</tr>
<tr>
<td>HCPDS5185</td>
<td>PD - Medication Reminder (call/alarm)</td>
</tr>
<tr>
<td>HCPDT1505U6</td>
<td>PD - Medication Reminder/Dispenser</td>
</tr>
<tr>
<td>HCPDT1505</td>
<td>PD - Medication Reminder/Dispenser – Install</td>
</tr>
<tr>
<td>HCPDT2040U2</td>
<td>PD - Financial Management Service</td>
</tr>
</tbody>
</table>

Brain Injury HCBS Programs

<table>
<thead>
<tr>
<th>SERVICE CODE</th>
<th>SERVICE NAME</th>
</tr>
</thead>
<tbody>
<tr>
<td>HCHIS5125UB</td>
<td>BI - Self-Directed Personal Services</td>
</tr>
<tr>
<td>HCHIT2025</td>
<td>BI - Enhanced Care Services</td>
</tr>
<tr>
<td>HCHIS5125U9</td>
<td>BI - Agency-Directed Personal Services</td>
</tr>
<tr>
<td>HCHIS5160</td>
<td>BI - Personal Emergency Response – Install</td>
</tr>
<tr>
<td>HCHIS5161</td>
<td>BI - Personal Emergency Response – Rental</td>
</tr>
<tr>
<td>HCHIS5185</td>
<td>BI - Medication Reminder (call/alarm)</td>
</tr>
<tr>
<td>HCHIT1505UB</td>
<td>BI - Medication Reminder/Dispenser</td>
</tr>
<tr>
<td>HCHIT1505</td>
<td>BI - Medication Reminder/Dispenser – Install</td>
</tr>
<tr>
<td>S5170</td>
<td>BI - Home-Delivered Meals</td>
</tr>
</tbody>
</table>

Technology-Assisted HCBS Programs

<table>
<thead>
<tr>
<th>SERVICE CODE</th>
<th>SERVICE NAME</th>
</tr>
</thead>
<tbody>
<tr>
<td>HCTAT1019</td>
<td>TA - Personal Service Attendant</td>
</tr>
<tr>
<td>HCTAT2040U2</td>
<td>TA - Financial Management Service</td>
</tr>
</tbody>
</table>

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 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 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: 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/for individuals with intellectual disabilities (ICF/IID), 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 a detail line. If no modifier is included, the claim will deny.
- All hearing aid replacements require the use of modifier RA.
- 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 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).
- Effective with dates of service on or after March 1, 2018, the ET modifier will be informational only. Hospitals will no longer need to bill the ET modifier with procedures codes 99281-99285 or 99291-99292.

EPSDT/KBH

- Beneficiaries must be 20 years of age and under.
- 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

When a provider does not complete total OB care and only partial antepartum care has been provided, the following guidelines apply when billing services:
- The following guidelines must be followed to avoid claim denials when billing for obstetrical services:
  - One to three prenatal visits
    - Bill using E&M office visit codes
  - Four to six prenatal visits only
    - Bill using code 59425
  - 7 or more antepartum care visits only – Bill using code 59426
  - Delivery only - Bill using code 59409 or 59514
  - Delivery and postpartum care only - Bill using code 59410 or 59515
  - Postpartum care only - Bill using code 59430
  - Four to six antepartum care visits, delivery & postpartum care only - Bill using codes 59425 and 59410 or 59515
  - Total OB care; seven or more antepartum care visits, delivery and postpartum care - Bill using codes 59400 or 59510
- 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.

GLOBAL OB BILLING

Use the KMAP professional manual for a reference. In instances when a patient’s pregnancy is not covered by a single MCO, split bill between 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).
- The following guidelines must be followed to avoid claim denials when billing for obstetrical services:
  - One to three prenatal visits
    - Bill using E&M office visit codes
  - Four to six prenatal visits only
    - Bill using code 59425
  - 7 or more antepartum care visits only – Bill using code 59426
  - Delivery only - Bill using code 59409 or 59514
  - Delivery and postpartum care only - Bill using code 59410 or 59515
  - Postpartum care only - Bill using code 59430
  - Four to six antepartum care visits, delivery & postpartum care only - Bill using codes 59425 and 59410 or 59515
  - Total OB care; seven or more antepartum care visits, delivery and postpartum care - Bill using codes 59400 or 59510
- Codes 59425 and 59426

FLUORIDE BILLING BY HEALTH DEPARTMENTS

Fluoride services provided by RNs at health departments must be billed through Envolve Dental 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, they must pre-register their information with Envolve Dental at dental.envolvehealth.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 Envolve Dental are sent to the following address:

Envolve Dental
Kansas Claims
P.O. Box 25857
Tampa, FL 33622-5857

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

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: www.kmap-state-ks.us/Documents/Content/Provider/Coding%20Modifiers%20Table.pdf.

Missed Appointments
- Missed appointments should never be billed and will not be reimbursed.

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

Newborn Billing
- Effective with processing dates on or after February 15, 2016, claims for newborn services billed
under the mother’s beneficiary ID will be pended for 45 days from date of birth pending receipt of the newborn’s beneficiary ID number. If a newborn ID is received, the claim will be denied **ExNb — Deny:** 

**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**
- For dates of service before April 1, 2015, code 99218ET should be billed for any service which requires monitoring a patient’s condition beyond the usual amount of time in an outpatient setting. This code shall not be used to bill for the recovery room.
- For dates of service on or after April 1, 2015, code G0378 should be used to bill for outpatient services. This code replaces 99218ET.
- 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.
  - Medical supplies and injections (99070, J7030-J7130) are considered content of service of the observation room services.

**Obstetrics & Gynecology**
- Sunflower requests all OB-GYN 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 G0463 for use of room and supplies, where appropriate.

**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 audited, 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.

### 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 15 days with the same DRG or similar diagnosis at the same hospital, only the DRG payment for the first stay will be reimbursed.
- When a KanCare beneficiary is discharged and subsequently readmitted within 15 days with the same DRG or similar diagnosis at the same hospital or hospitals within the same hospital system, only the DRG payment for the first stay will be reimbursed.
- Medical records shall be reviewed to determine if the readmission was the result of an inappropriate discharge from the initial admission based on one of the following criteria:
  - A medical readmission for a continuation or recurrence for the initial admission or closely related condition (e.g. readmission for diabetes following an initial admission for diabetes).
  - A medical complication related to an acute medical complication related to a care during the initial admission (e.g. patient discharged with urinary catheter readmitted for treatment of a urinary tract infection).
  - An unplanned readmission for a surgical procedure to address a complication resulting from care from the primary admission (e.g. readmitted for appendectomy following a primary admission for abdominal pain and fever).
  - An unplanned readmission for a surgical procedure to address a complication resulting from care from the primary admission (e.g. readmission for drainage of a post-operative wound abscess following an initial admission for a bowel resection).
  - The unplanned readmission is the result of a need that could have reasonably been prevented by the provision of appropriate care consistent with accepted standards prior to discharge or during the post-discharge follow-up period.
  - An issue caused by a premature discharge from the same facility.
  - Readmission is medically unnecessary.
- The following are excluded from readmission review:
  - Readmission that is planned (such as for repetitive treatments, i.e. cancer chemotherapy, transfusions for chronic anemia, or other similar repetitive treatments).
  - Readmission due to malignancies, burns, cystic fibrosis, or anemia.
  - Readmission due to bone marrow transplants.
  - Obstetrical admission.
- Readmission that stems from an initial stay discharge status of “left against medical advice”.
- Admission to a skilled nursing facility (SNF), long-term acute care facility (LTAC), or inpatient rehabilitation facility (IRF).
- Admission for treatment when the primary diagnosis is psychiatric.
- Transfer of patient to receive care not available at the first facility.

Supplies
- For dates of service before April 1, 2015, hospitals may bill 99070ET for supplies.
- For dates of service on or after April 1, 2015 hospitals may bill code 99070 without the modifier ET for supplies. Modifier ET is no longer a valid modifier for 99070. Only one supply is allowed per day.

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.
- 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: 837 Companion Guide (October 2016)

Refers to the Implementation Guides based on the HIPAA Transaction ASC X12N. Standards for Electronic Data Interchange X12N/005010x222 Health Care Claim: Professional (837P) and ASC X12N/005010x223 Health Care Claim: Institutional (837I). Approved by KDHE 3/16/17.

Overview
The Companion Guide provides Sunflower trading partners with guidelines for submitting the ASC X12N/005010x222 Health Care Claim: Professional (837P) and ASC X12N/005010x223 Health Care Claim: Institutional (837I). The Sunflower Companion Guide documents any assumptions, conventions, or data issues that may be specific to Sunflower business processes when implementing the HIPAA ASC X12N 5010A Technical Reports Type 3 (TR3). As such, this Companion Guide is unique to Sunflower and its affiliates.

This document does NOT replace the HIPAA ASC X12N 5010A Technical Reports Type 3 (TR3) for electronic transactions, nor does it attempt to amend any of the rules therein or impose any mandates on any trading partners of Sunflower. This document provides information on Sunflower-specific code handling and situation handling that is within the parameters of the HIPAA administrative Simplification rules. Readers of this Companion Guide should be acquainted with the HIPAA Technical Reports Type 3, their structure and content. Information contained within the HIPAA TR3s has not been repeated here although the TR3s have been referenced when necessary. The HIPAA ASC X12N 5010A Technical Reports Type 3 (TR3) can be purchased at http://store.x12.org.

The Companion Guide provides supplemental information to the Trading Partner Agreement (TPA) that exists between Sunflower and its trading partners. Refer to the TPA for guidelines pertaining to Sunflower legal conditions surrounding the implementations of EDI transactions and code sets. Refer to the Companion Guide for information on Sunflower business rules or technical requirements regarding the implementation of HIPAA compliant EDI transactions and code sets.

Nothing contained in this guide is intended to amend, revoke, contradict, or otherwise alter the terms and conditions of the Trading Partner Agreement. If there is an inconsistency with the terms of this guide and the terms of the Trading Partner Agreement, the terms of the Trading Partner Agreement shall govern.

Express permission to use X12 copyrighted materials within this document has been granted.
Rules of Exchange

The Rules of Exchange section details the responsibilities of trading partners in submitting or receiving electronic transactions with Sunflower.

Transmission Confirmation

Transmission confirmation may be received through one of two possible transactions: the ASC X12C/005010X231 Implementation Acknowledgment For Health Care Insurance (TA1, 999). A TA1 Acknowledgment is used at the ISA level of the transmission envelope structure, to confirm a positive transmission or indicate an error at the ISA level of the transmission. The 999 Acknowledgment may be used to verify a successful transmission or to indicate various types of errors.

Confirmations of transmissions, in the form of TA1 or 999 transactions, should be received within 24 hours of batch submissions, and usually sooner. Senders of transmissions should check for confirmations within this time frame.

Batch Matching

Senders of batch transmissions should note that transactions are unbundled during processing, and rebundled so that the original bundle is not replicated. Trace numbers or patient account numbers should be used for batch matching or batch balancing.

TA1 Interchange Acknowledgment

The TA1 Interchange Acknowledgment provides senders a positive or negative confirmation of the transmission of the ISA/IEA Interchange Control.

999 Functional Acknowledgment

The 999 Functional Acknowledgment reports on all Implementation Guide edits from the Functional Group and transaction Sets.

277CA Health Care Claim Acknowledgment

The X12N005010X214 Health Care Claim Acknowledgment (277CA) provides a more detailed explanation of the transaction set. Sunflower also provides the Pre-Adjudication rejection reason of the claim within the STC12 segment of the 2220D loop. **NOTE: The STC03 – Action Code will only be a “U” if the claim failed on HIPAA validation errors, NOT Pre-Adjudication errors.**

Duplicate Batch Check

To ensure that duplicate transmissions have not been sent, Sunflower checks five values within the ISA for redundancy:
- ISA06, ISA08, ISA09, ISA10, ISA13

Collectively, these numbers should be unique for each transmission. A duplicate ISA/IEA receives a TA1 response of “025” (Duplicate Interchange Control Number).

To ensure that Transaction Sets (ST/SE) have not been duplicated within a transmission, Sunflower checks the ST02 value (Transaction Set Control Number), which should be a unique ST02 within the Functional Group transmitted.

Note: ISA08 & GS03 could also be the Single Payer ID

New Trading Partners

New trading partners should access https://sites.edifecs.com/index.jsp?centene, register for access, and perform the steps in the Sunflower trading partner program. The EDI Support Desk (EDIBA@Centene.com) will contact you with additional steps necessary upon completing your registration.

Claims Processing

Acknowledgments

Senders receive four types of Acknowledgment transactions: the TA1 transaction to acknowledge the Interchange Control Envelope (ISA/IEA) of a transaction, the 999 transaction to acknowledge the Functional Group (GS/GE) and Transaction Set (ST/SE), the 277CA transaction to acknowledge health care claims, and the Sunflower Audit Report. At the claim level of a transaction, the only Acknowledgment of receipt is the return of the Claim Audit Report and/or a 277CA.

Coordination of Benefits (COB) Processing

To ensure the proper processing of claims requiring coordination of benefits, Sunflower recommends that providers validate the patient’s Membership Number and supplementary or primary carrier information for every claim.

Code Sets

Only standard codes, valid at the time of the date(s) of service, should be used.
Corrections and Reversals

The 837 defines what values submitters must use to signal payers that the Inbound 837 contains a reversal or correction to a claim that has previously been submitted for processing. For both Professional and Institutional 837 claims, 2300 CLM05-3 (Claim Frequency Code) must contain a value for the National UB Data Element Specification Type List Type of Bill Position 3.

Data Format/Content

Sunflower accepts all compliant data elements on the 837 Professional Claim. The following points outline consistent data format and content issues that should be followed for submission.

Dates The following statements apply to any dates within an 837 transaction:
- All dates should be formatted according to Year 2000 compliance, CCYYMMDD, except for ISA segments where the date format is YYMMDD.
- The only values acceptable for “CC” (century) within birthdates are 18, 19, or 20.
- Dates that include hours should use the following format: CCYYMMDDHHMM.
- Use Military format, or numbers from 0 to 23, to indicate hours.
- For example, an admission date of 201006262115 defines the date and time of June 26, 2010 at 9:15 PM.
- No spaces or character delimiters should be used in presenting dates or times.
- Dates that are logically invalid (e.g. 20011301) are rejected.
- Dates must be valid within the context of the transaction. For example, a patient’s birth date cannot be after the patient’s service date.

Decimals All percentages should be presented in decimal format. For example, a 12.5% value should be presented as .125.

Dollar amounts should be presented with decimals to indicate portions of a dollar; however, no more than two positions should follow the decimal point. Dollar amounts containing more than two positions after the decimal point are rejected.

Monetary and Unit Amount Values
Sunflower accepts all compliant data elements on the 837 Professional Claim; however, monetary or unit amount values that are in negative numbers are rejected.

Delimiters Delimiters are characters used to separate data elements within a data string. Delimiters suggested for use by Sunflower are specified in the Interchange Header segment (the ISA level) of a transmission; these include the tilde (~) for segment separation, the asterisk (*) for element separation, and the colon (:) for component separation.

Phone Numbers Phone numbers should be presented as contiguous number strings, without dashes or parenthesis markers. For example, the phone number (336) 555-1212 should be presented as 3365551212. Area codes should always be included. Sunflower requires the phone number to be AAAABBBCCCC where AAA is the Area code, BBB is the telephone number prefix, and CCCC is the telephone number.

Additional Items
- Sunflower will not accept more than 97 service lines per UB-04 claim.
- Sunflower will not accept more than 50 service lines per CMS 1500 claim.
- Sunflower will only accept single digit diagnosis pointers in the SV107 of the 837P.
- The Value Added Network Trace Number (2300-REF02) is limited to 30 characters.

Identification Codes and Numbers

General Identifiers

Federal Tax Identifiers Any Federal Tax Identifier (Employer ID or Social Security Number) used in a transmission should omit dashes or hyphens. Sunflower sends and receives only numeric values for all tax identifiers.

Sender Identifier The Sender Identifier is presented at the Interchange Control (ISA06) of a transmission. Sunflower expects to see the sender’s Federal Tax Identifier (ISA05, qualifier 30) for this value. In special circumstances, Sunflower will accept a “Mutually Defined” (ZZ) value. Senders wishing to submit a ZZ value must confirm this identifier with Sunflower EDI.

Payer Identifier Single Payer IDs are used for all Health Plans. Please verify directly with the Health Plan and/or Clearinghouse the Payer ID that should be used or contact the EDI Support Desk at 800-225-2573, x6075525 or EDIBA@centene.com.
Sunflower Customer Service Department: 1-877-644-4623 (TTY 711)

### Provider Identifiers

**National Provider Identifiers (NPI)** HIPAA regulation mandates that providers use their NPI for electronic claims submission. The NPI is used at the record level of HIPAA transactions; for 837 claims, it is placed in the 2010AA loop. See the 837 Professional Data Element table for specific instructions about where to place the NPI within the 837 Professional file. The table also clarifies what other elements must be submitted when the NPI is used.

**Billing Provider** The Billing Provider Primary Identifier should be the group/organization ID of the billing entity, filed only at 2010AA. This will be a Type 2 (Group) NPI unless the Billing provider is a sole proprietor and processes all claims and remittances with a Type 1 (Individual) NPI.

**Rendering Provider** When providers perform services for a subscriber/patient, the service will need to be reported in the Rendering Provider Loop (2310B or 2420A). You should only use 2420A when it is different than Loop 2310B/NM1*82.

**Referring Provider** Sunflower has no specific requirements for Referring Provider information.

**Atypical Provider** Atypical providers are not always assigned an NPI number, however, if an Atypical provider has been assigned an NPI, then they need to follow the same requirements as a medical provider. An Atypical provider which provides non-medical services is not required to have an NPI number (i.e. carpenters, transportation, etc). Existing Atypical providers need only send the Provider Tax ID in the REF segment of the billing provider loop.

**NOTE:** If an NPI is billed in any part of the claim, it will not follow the Atypical Provider Logic.

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### Submitter Identifiers

Submitters must use the entire identification code as it appears on the subscriber’s card in the 2010BA element.

### Claim Identifiers

Sunflower issues a claim identification number upon receipt of any submitted claim. The ASC X12 Technical Reports (Type 3) may refer to this number as the Internal Control Number (ICN), Document Control Number (DCN), or the Claim Control Number (CCN). It is provided to senders in the Claim Audit Report and in the CLP segment of an 835 transaction. Sunflower returns the submitter’s Patient Account Number (2300, CLM01) on the Claims Audit Report and the 835 Claim Payment/Advice (CLP01).

### Connectivity Media for Batch Transactions

#### Secure File Transfer

Sunflower encourages trading partners to consider a secure File Transfer Protocol (FTP) transmission option. Sunflower offers two options for connectivity via FTP.

- **Method A** – the trading partner will push transactions to the Sunflower FTP server and Sunflower will push outbound transactions to the Sunflower FTP server.
- **Method B** – The Trading partner will push transactions to the Sunflower FTP server and Sunflower will push outbound transactions to the trading partner’s FTP server.

#### Encryption

Sunflower offers the following methods of encryption SSH/SFTP, FTPS (Auth TLS), FTP w/PGP, HTTPS (Note this method only applies with connecting to Sunflower’s Secure FTP. Sunflower does not support retrieve files automatically via HTTPS from an external source at this time.) If PGP or SSH keys are used they will be shared with the trading partner. These are not required for those connecting via SFTP or HTTPS.

### Direct Submission

Sunflower also offers posting an 837 batch file directly on the Provider Portal website for processing.

### Edits and Reports

Incoming claims are reviewed first for HIPAA compliance and then for Sunflower business rules requirements. The business rules that define these requirements are identified in the 837 Professional Data Element Table below, and are also available as a comprehensive list in the 837 Professional Claims – Sunflower Business Edits Table. HIPAA TR3 implementation guide errors may be returned on either the TA1 or 999 while Sunflower business edit errors are returned on the Sunflower Claims Audit Report.

### Reporting

The following table indicates which transaction or report to review for problem data found within the 837 Professional Claim Transaction.
<table>
<thead>
<tr>
<th>TRANSACTION STRUCTURE LEVEL</th>
<th>TYPE OF ERROR OR PROBLEM</th>
<th>TRANSACTION OR REPORT RETURNED</th>
</tr>
</thead>
<tbody>
<tr>
<td>ISA/IEA Interchange Control</td>
<td>HIPAA Implementation Guide violations</td>
<td>TA1</td>
</tr>
<tr>
<td>GS/GE Functional Group</td>
<td>HIPAA Implementation Guide violations</td>
<td>999 Sunflower Claims Audit Report (a proprietary confirmation &amp; error report)</td>
</tr>
<tr>
<td>ST/SE Segment</td>
<td>Sunflower Business Edits (see audit report rejection reason codes and explanation.)</td>
<td>Sunflower Claims Audit Report (a proprietary confirmation and error report)</td>
</tr>
<tr>
<td>Detail Segments</td>
<td>HIPAA Implementation Guide violations &amp; Sunflower Business Edits.</td>
<td>277CA</td>
</tr>
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### 277CA/Audit Report Rejection Codes

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<th>REJECTION REASON</th>
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</tr>
<tr>
<td>02</td>
<td>Invalid Mbr</td>
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<td>06</td>
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<td>07</td>
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<tr>
<td>08</td>
<td>Invalid Mbr &amp; Provider</td>
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<td>09</td>
<td>Mbr not valid at DOS</td>
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<tr>
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<td>Invalid Mbr DOB; Mbr not valid at DOS</td>
</tr>
<tr>
<td>12</td>
<td>Provider not valid at DOS</td>
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<td>14</td>
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<tr>
<td>15</td>
<td>Mbr not valid at DOS; Invalid Prv</td>
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<tr>
<td>16</td>
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<td>Invalid Mbr DOB; Mbr not valid at DOS; Invalid Diag; Invalid Proc</td>
</tr>
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<td>63</td>
<td>Prv not valid at DOS; Invalid Diag; Invalid Proc</td>
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<td>66</td>
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<td>Mbr not valid at DOS; Prv not valid at DOS; Invalid Diag; Invalid Proc</td>
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<td>Invalid Mbr DOB; Mbr not valid at DOS; Prv not valid at DOS; Invalid Diag; Invalid Proc</td>
</tr>
<tr>
<td>74</td>
<td>Services performed prior to Contract Effective Date</td>
</tr>
<tr>
<td>75</td>
<td>Invalid units of service</td>
</tr>
<tr>
<td>76</td>
<td>Original Claim Number Required</td>
</tr>
<tr>
<td>77</td>
<td>Invalid Claim Type</td>
</tr>
<tr>
<td>78</td>
<td>Diagnosis Pointer- Not in sequence or incorrect length</td>
</tr>
<tr>
<td>81</td>
<td>Invalid units of service, Invalid Prv</td>
</tr>
<tr>
<td>83</td>
<td>Invalid units of service, Invalid Prv, Invalid Mbr</td>
</tr>
<tr>
<td>89</td>
<td>Invalid Mbr DOB; Mbr not valid at DOS; Prv not valid at DOS; Invalid Diag</td>
</tr>
<tr>
<td>91</td>
<td>Invalid Missing Taxonomy or NPI/Invalid Prov</td>
</tr>
<tr>
<td>92</td>
<td>Invalid Referring/Ordering NPI</td>
</tr>
<tr>
<td>ERROR CODE</td>
<td>REJECTION REASON</td>
</tr>
<tr>
<td>------------</td>
<td>-----------------</td>
</tr>
<tr>
<td>93</td>
<td>Mbr not valid at DOS; Invalid Proc</td>
</tr>
<tr>
<td>96</td>
<td>GA OPR. NPI Registration-State</td>
</tr>
<tr>
<td>A2</td>
<td>Diagnosis Pointer Invalid</td>
</tr>
<tr>
<td>A3</td>
<td>Service Lines - Greater than 97 Service lines submitted- Invalid</td>
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<tr>
<td>B1</td>
<td>Rendering and Billing NPI are not tied on State File - IN rejection</td>
</tr>
<tr>
<td>B2</td>
<td>Not enrolled with MHS IN and/or State with rendering NPI/TIN on DOS. Enroll with MHS and Resubmit claim</td>
</tr>
<tr>
<td>B5</td>
<td>Invalid CLIA</td>
</tr>
<tr>
<td>C7</td>
<td>NPI Registration - State GA OPR</td>
</tr>
<tr>
<td>C9</td>
<td>Invalid/Missing Attending NPI</td>
</tr>
<tr>
<td>HP/H1/H2</td>
<td>ICD9 after end date/ICD10 sent before Eff Date/Mixed ICD versions</td>
</tr>
</tbody>
</table>

### Appendix XII: Provider Manual Updates

<table>
<thead>
<tr>
<th>REVISION DATE</th>
<th>PROVIDER MANUAL SECTION</th>
<th>REVISION DESCRIPTIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>April 14, 2015</td>
<td>New Provider Manual</td>
<td>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</td>
</tr>
<tr>
<td>October 2015</td>
<td>Appendix VIII: HCBS Programs Billing Information</td>
<td>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. Appendix heading includes ICD-9 code for dates of service prior to 10/1/2015.</td>
</tr>
<tr>
<td>October 2015</td>
<td>Provider Appeal Process Timeline</td>
<td>Step 4 was updated from 5 business days to 10 business days to acknowledge receipt</td>
</tr>
<tr>
<td>October 2015</td>
<td>Appendix I: Common Causes of Upfront Rejections</td>
<td>Attending provider box 48 was updated to box 76 on the paper UB claim form</td>
</tr>
<tr>
<td>October 2015</td>
<td>Sunflower Health Plan Benefits Grid: Enteral and Parenteral</td>
<td>Oral Supplements Nutrition was changed to Oral Supplemental Nutrition</td>
</tr>
<tr>
<td>October 2015</td>
<td>Health Homes Program</td>
<td>“Chronic conditions” was replaced with “serious mental illness” 11th bullet “problems” was replaced with “conditions”</td>
</tr>
<tr>
<td>October 2015</td>
<td>Provider Types That May Serve As PCPs</td>
<td>The definition of PCP was updated to reflect the definition found on the KMAP site</td>
</tr>
<tr>
<td>October 2015</td>
<td>Coding of Claims/Billing Codes</td>
<td>ICD-10 diagnosis code-related rejection or denial reasons added</td>
</tr>
<tr>
<td>October 2015</td>
<td>Appendix II: Common Causes of Claim Procession Delays and Denials</td>
<td>First bullet point was updated to include ICD-10 diagnosis code-related delays or denials</td>
</tr>
<tr>
<td>REVISION DATE</td>
<td>PROVIDER MANUAL SECTION</td>
<td>REVISION DESCRIPTIONS</td>
</tr>
<tr>
<td>---------------</td>
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</tr>
<tr>
<td>October 2015</td>
<td>Appendix III: Common EOP Denial Codes and Descriptions</td>
<td>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</td>
</tr>
<tr>
<td>October 2015</td>
<td>Appendix X: Billing Tips and Reminders</td>
<td>ICD-10 was added to the last bullet on the POA Indicator definition</td>
</tr>
<tr>
<td>October 2015</td>
<td>Benefit Explanation and Limitations</td>
<td>Benefit limitation for Oxygen and Respiratory Services entry was updated to: some limitations, exclusions, and quantity limits may apply</td>
</tr>
<tr>
<td>October 2015</td>
<td>Appendix III Common EOP Denial Codes and Descriptions</td>
<td>Code ym 30 DAY READMISSION. SUBMIT ALL MEDICAL RECORDS FOR 30 DAY PERIOD, was added.</td>
</tr>
<tr>
<td>October 2015</td>
<td>Appendix X: Billing Tips and Reminders</td>
<td>Readmissions section added</td>
</tr>
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<td>January 2016</td>
<td>Provider Rights and Responsibilities</td>
<td>Sixth bullet point updated to “To file a grievance or appeal with Sunflower”</td>
</tr>
<tr>
<td>October 2016</td>
<td>Contracting and Network Development</td>
<td>Renamed, reorganized and updated</td>
</tr>
<tr>
<td>October 2016</td>
<td>Welcome &amp; Provider Rights and Responsibilities</td>
<td>Reorganized and updated throughout</td>
</tr>
<tr>
<td>October 2016</td>
<td>Medical Management</td>
<td>Lock-In, other changes</td>
</tr>
<tr>
<td>October 2016</td>
<td>Billing and Claims Submission; Billing-Related Appendices (III, VII, X)</td>
<td>Numerous updates</td>
</tr>
<tr>
<td>October 2016</td>
<td>Health Homes</td>
<td>Section removed</td>
</tr>
<tr>
<td>December 2016</td>
<td>Various</td>
<td>Updated Timely Filing deadlines</td>
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<tr>
<td>December 2016</td>
<td>Various</td>
<td>Clarified discharge coordination language</td>
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<td>December 2016</td>
<td>Performance Improvement Process</td>
<td>Added contract language</td>
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<td>December 2016</td>
<td>Member Rights</td>
<td>Updated to match Member Handbook</td>
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<tr>
<td>December 2016</td>
<td>Miscellaneous</td>
<td>Additional minor corrections and updates throughout manual</td>
</tr>
<tr>
<td>June 2017</td>
<td>Medical Management</td>
<td>Prior authorization updates</td>
</tr>
<tr>
<td>June 2017</td>
<td>Value Added Services</td>
<td>Updated for 2017 changes</td>
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<td>June 2017</td>
<td>Provider &amp; Member Rights and Responsibilities</td>
<td>Various updates</td>
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<td>June 2017</td>
<td>Provider Appeals</td>
<td>Changes throughout manual</td>
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<tr>
<td>June 2017</td>
<td>Appendix XI</td>
<td>Addition of 837 Companion Guide</td>
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<tr>
<td>June 2017</td>
<td>Benefit Explanation and Limitations</td>
<td>Various updates</td>
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<td>December 2017</td>
<td>Provider Network Development</td>
<td>Specialty companies &amp; facilities types</td>
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<tr>
<td>December 2017</td>
<td>Medical Management</td>
<td>Second Opinions updated</td>
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<tr>
<td>December 2017</td>
<td>Grievance and Appeal Process</td>
<td>Grievance Basics, Member Appeal Basics &amp; Member Standard Appeal Process Timeline, various updates</td>
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<td>December 2017</td>
<td>Appendix X: Billing Tips and Reminders</td>
<td>Obstetrical and Gynecological Billing Guidelines</td>
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<td>December 2017</td>
<td>Provider Rights and Responsibilities</td>
<td>Travel Distances and Access Standards</td>
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<td>REVISION DATE</td>
<td>PROVIDER MANUAL SECTION</td>
<td>REVISION DESCRIPTIONS</td>
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<td>December 2017</td>
<td>Provider Rights and Responsibilities</td>
<td>Appointment Availability and Wait Times</td>
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<tr>
<td>March 2018</td>
<td>Provider Rights and Responsibilities</td>
<td>Appointment Availability and Wait Times</td>
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<tr>
<td>March 2018</td>
<td>Grievances and Appeals</td>
<td>Updates throughout</td>
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<tr>
<td>March 2018</td>
<td>Appendix X: Billing Tips and Reminders</td>
<td>Multiple updates from state policies</td>
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<td>January 2019</td>
<td>All Sections</td>
<td>Integrated behavioral health and other changes.</td>
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<td>May 2019</td>
<td>Grievance and Appeal Process</td>
<td>Updated grievances section</td>
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<tr>
<td>January 2020</td>
<td>Grievance and Appeal Process</td>
<td>Added EITPR process</td>
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<td>January 2020</td>
<td>Various</td>
<td>Updated Brain Injury Waiver info</td>
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<td>January 2020</td>
<td>Contracting &amp; Network Development</td>
<td>Added KMAP Enrollment info</td>
</tr>
<tr>
<td>January 2020</td>
<td>Quality Improvement</td>
<td>Updated QAPI goals &amp; HEDIS recommendations</td>
</tr>
<tr>
<td>January 2020</td>
<td>Appendices</td>
<td>Various updates to match state and procedural accuracy</td>
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<tr>
<td>January 2020</td>
<td>Provider Rights &amp; Responsibilities</td>
<td>Updated Travel Distance &amp; Access Standards, Appointment Availability &amp; Wait Times</td>
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<tr>
<td>May 2020</td>
<td>Grievance and Appeal Process</td>
<td>Updated EITPR verbiage to match bulletins</td>
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<tr>
<td>June 2020</td>
<td>Medical Management</td>
<td>Updating information for NIA and PT/OT/ST</td>
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<td>June 2020</td>
<td>Billing and Claims</td>
<td>Updated extrapolated methodology language</td>
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<tr>
<td>August 2020</td>
<td>Medical Records</td>
<td>Updated retention requirements</td>
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<tr>
<td>August 2020</td>
<td>Grievances and Appeals</td>
<td>Updated KDHE EITPR denial reasons</td>
</tr>
<tr>
<td>October 2020</td>
<td>Provider Rights &amp; Responsibilities</td>
<td>Added Dismissing a Member from Your Practice</td>
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