KanCare | sunflower health plan



Provider Manual

November 17, 2026

Current as of 11/17/2026. Please see **sunflowerhealthplan.com/providers/resources/forms-resources.html** *for updates.*

1-877-644-4623
TTY 711

SunflowerHealthPlan.com

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Welcome to Sunflower Health Plan

On behalf of everyone at Sunflower Health Plan, welcome and thank you for your commitment to the members and communities we serve across Kansas.

At Sunflower, we believe that strong partnerships with providers are essential to improving health outcomes and creating a better healthcare experience for our members. Whether you are a longstanding network partner or are newly joining our provider community, we are grateful for the expertise, compassion and dedication you bring to those who rely on us for their care.

Every day, providers like you help make a difference in the lives of Kansans by delivering quality, person-centered care. Your work is critical to helping members access preventive services, manage chronic conditions, address behavioral health needs and achieve their best possible health. Together, we share a commitment to improving access to care, supporting healthier communities and ensuring members receive the right care at the right time and in the right setting.

This Provider Manual is designed to serve as a resource for working with Sunflower Health Plan. Within these pages, you will find information about our programs, policies, procedures and tools that support our partnership and help you navigate interactions with our health plan. We encourage you to use these resources and connect with our Provider Relations team whenever assistance is needed.

We value the trust you place in Sunflower as your partner. We look forward to working alongside you to deliver high-quality, coordinated care and to continue improving the health of the communities we serve, one person at a time.

Thank you for all that you do on behalf of our members.

Sincerely,

Michael R. Stephens
President and Chief Executive Officer
Sunflower Health Plan

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 serves 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.

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 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 sent to providers who have signed up for **Sunflower Email Alerts**. If you need further explanation of any topics discussed in this manual, please contact the Customer Service department toll free at 1-877-644-4623.

Key Contacts and Important Phone Numbers

The following table includes several important toll-free 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

For general Provider Relations questions, please visit SunflowerHealthPlan.com/contact-us.

HEALTH PLAN INFORMATION		
Website	SunflowerHealthPlan.com	
Main Address	Sunflower Health Plan 8325 Lenexa Dr., Ste. 410, Lenexa, KS 66214	
DEPARTMENT	**PHONE**	**FAX**
Contracting (SunflowerStateHealth@centene.com**)**	1-877-644-4623	1-877-285-8469
Customer Service	1-877-644-4623	1-866-491-1824
Prior Authorization Requests for Inpatient and Outpatient Medical Services – visit SunflowerHealthPlan.com to submit prior authorization online.	1-877-644-4623	Medical: 1-888-453-4316 Behavioral: 1-844-824-7705 Transplant: 1-833-590-1588
Concurrent Review/Clinical Information	1-877-644-4623	1-877-213-7732
Admissions/Census Reports/Face Sheets	1-877-644-4623	1-866-965-5433
Care Management (CM)	1-877-644-4623	1-866-694-3649
24/7 Nurse Advice Line	1-877-644-4623	N/A
Pharmacy Services	1-877-644-4623	1-833-645-2740 Pharmacy 1-888-453-4756 Medical
Centene Dental Services (formerly Envolve Dental) – centened-ental.com	1-855-434-9245	N/A
Centene Vision Services (formerly Envolve Vision) – centenevi-sion.com	1-877-644-4623	1-877-865-1077
Evolent – TTY: 711	1-877-517-9179	N/A
Oncology Authorizations, my.newcenturyhealth.com	1-888-999-7713	N/A
High-Tech Imaging, www.radmd.com	1-877-644-4623	N/A
Outpatient Physical Therapy, www.radmd.com	1-877-644-4623	N/A
Musculoskeletal Surgical Services, www.radmd.com	1-877-644-4623	N/A
SafeRide Health – Non-Emergent Medical Transportation, www.saferidehealth.com	1-877-917-8162	N/A
Voiance – Interpreter Services	1-877-644-4623	N/A
Language Line	1-877-644-4623	N/A
Report suspected waste, fraud and abuse to Sunflower	1-866-685-8664	N/A
Ethics and Compliance Helpline	1-800-345-1642	N/A
EDI CLAIMS		
Sunflower Health Plan, c/o Centene EDI Dept 1-800-225-2573, ext. 607-5525 or by email to EDIBA@centene.com		

Behavioral Health Crisis

- **Emergencies.** If a member is experiencing a medical or behavioral health emergency, is in immediate danger, or poses an immediate risk to themselves or others, call 911 immediately or assist the member in accessing the nearest emergency department or emergency services provider. No prior authorization is required for emergency services or for treatment of a behavioral health crisis.
- **Crisis support / 988.** If a member, caregiver, guardian, authorized representative, or provider is concerned that a member may be experiencing a behavioral health, emotional, substance use, or mental health crisis, they may call or text 988 or visit the 988 Suicide & Crisis Lifeline online. The 988 Lifeline is available 24 hours a day, 7 days a week, and provides access to trained crisis counselors.
- Trained counselors can assist with:
  - Suicidal thoughts or behaviors
  - Mental health crisis or severe emotional distress
  - Substance use concerns or crises
  - Thoughts of self-harm or harm to others
  - Support for family, caregivers, guardians and other individuals concerned about someone in crisis
- **Additional crisis resources.** Members may also contact their local Community Mental Health Center (CMHC), Certified Community Behavioral Health Clinic (CCBHC), crisis provider, or other behavioral health provider for crisis intervention, mobile crisis response, and behavioral health support services.
- **Non-emergency concerns.** For non-emergency behavioral health or substance use concerns, members may contact a participating behavioral health provider or contact Sunflower Customer Service at 1-877-644-4623 for help accessing services and supports.

Sunflower Website

SunflowerHealthPlan.com

The Sunflower website was designed to reduce administrative burdens for providers and their staff and optimize their ability to access information quickly so they can provide efficient service for members. Using the website allows immediate access to current provider and member information at all times. Please call your provider relations representative or our Customer Service department toll free at 1-877-644-4623 with any questions or concerns regarding the website.

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

- Provider Manual
- Quick Reference Guides
- Tool for determining whether services require authorization using CPT, HCPCS® or revenue codes
- Provider Portal access and training materials
- Administrative, clinical and prior authorization forms
- Provider newsletters, announcements, bulletins and notices
- Clinical practice guidelines and medical policies
- Quality Improvement and Population Health resources
- Credentialing and recredentialing information
- Provider/practitioner demographic change requests and updates
- New contract and amendment requests
- Claims, billing and payment information
- Electronic transactions and EDI information
- Pharmacy and prescription drug resources
- Provider Directory and Find a Provider information
- Member eligibility and benefits resources
- Contact information for provider support staff

SECURE PROVIDER PORTAL

Using the **Sunflower Secure Provider Portal** or **Availity Essentials***, participating providers can:

- Check member eligibility and renewal dates
- 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 register. 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.

**Some functionality is limited to the Sunflower Secure Provider Portal. Additional Availity Essentials functionality is in developed.*

Kansas Medicaid Program Summary

The KanCare program is administered by the Kansas Department of Health and Environment, Division of Health Care Finance (KDHE-DHCF) in coordination with the Kansas Department for Aging and Disability Services (KDADS) for certain long-term services and supports (LTSS) and behavioral health programs.

KDHE contracts with Sunflower to manage access to covered services and provider networks for those who qualify for the state's KanCare program. Most Medicaid members and Children's Health Insurance Program (CHIP) beneficiaries are enrolled in KanCare managed care organizations unless excluded from managed care under state or federal requirements. KDHE-DHCF oversees eligibility requirements, access standards, covered services and program policies for KanCare beneficiaries. Sunflower administers covered services and provider networks in accordance with applicable state and federal requirements.

Below are the eligible populations that can enroll in the KanCare program.

- Adults and children eligible under the Caretaker Medical program.
- Pregnant and postpartum individuals and eligible children, subject to applicable Medicaid and CHIP eligibility requirements.
- Certain children over the age of 1 year and through the month of their 6th birthday.
- Certain children over the age of 6 years and through the month of their 19th birthday.
- Children under the age of 19 years who are not eligible for Medicaid, but are living in families with incomes less than 255% of the federal poverty level (CHIP).
- Aged and disabled individuals receiving Supplemental Security Income (SSI).
- Adults under the age of 26 who are aged out of the foster care program in any state.
- Medically needy aged and disabled individuals (spend-down populations).
- Employed persons with disabilities receiving coverage under the Medicaid Buy-In (Working Healthy).
- Children and youth in foster care.
- Children whose families receive adoption support.
- Beneficiaries receiving long-term care, including institutional care or Home and Community Based Services (HCBS), including applicable waiver and state plan services.

Beneficiaries who are not eligible for managed care include:

- Tuberculosis medical.
- Incarcerated individuals.
- Beneficiaries receiving state-funded assistance: MediKan, the KDHE Division of Public Health-run programs and state-only institutional care.
- Ineligible noncitizens receiving time-limited coverage of certain emergency medical conditions (SOBRA).
- Persons whose only coverage is under a Medicare Savings Program.
- Persons enrolled in the Program for All Inclusive Care for the Elderly (PACE).

Long-Term Services and Supports (LTSS)

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 assists with coordinating all care a Sunflower member receives. These members may reside in nursing facilities, intermediate care facilities for individuals with intellectual disabilities (ICF/IID), psychiatric residential treatment facilities (PRTFs) or receive services in community settings through HCBS providers and other LTSS providers.

The goals of the KanCare program are to improve overall health outcomes, promote independence and community integration, enhance care coordination and slow the rate of healthcare cost growth over time. These goals are supported through the delivery of right services, in the right amount, in the most appropriate setting and at the right time.

Sunflower focuses 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 HCBS waiver and community-based service programs currently administered through KanCare include, but are not limited to:

- Autism (AU)
- Brain Injury (BI)
- Frail Elderly (FE)
- Intellectual/Developmental Disability (I/DD)
- Physical Disability (PD)
- Technology Assistance (TA)
- Community Support Waiver (CSW)
- Serious Emotional Disturbance (SED) and other applicable behavioral health community-based services

For more information about these services, please refer to Appendices VIII and IX of this manual and the KMAP manuals at **portal.kmap-state-ks.us/PublicPage/Public/Index/**.

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. Our goal is to meet the healthcare needs of our members by having adequate numbers of providers of all specialty types and comply with KanCare's access and availability requirements.

Sunflower continually evaluates provider capacity, geographic distribution, appointment availability, quality measures, member utilization patterns and access-to-care concerns when making network development decisions. Ongoing network adequacy assessments may result in targeted provider recruitment, network expansion initiatives or alternative access arrangements to ensure members have timely access to covered services.

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 are responsible for supervising, coordinating and providing primary healthcare to members and maintaining the continuity of care for members. PCPs include, but are not limited to, family and general practitioners, internists, pediatricians, nurse practitioners, physician assistants and other practitioner specialties approved by Sunflower and participating in accordance with applicable state and federal requirements. In certain circumstances and in accordance with applicable program requirements, Sunflower may designate a specialist to serve as a member's PCP when clinically appropriate.

Authorization is required for services from providers that are not contracted as participating in the Sunflower network. If you refer a member for out-of-network care, you must have authorization prior to initiating the referral. Referrals are not required for in-network care.

Lock-in members must receive services from specified lock-in providers. If members need to see specialists, they will need a written referral from assigned primary care providers. Members may have to pay for medical services if they do not receive a referral from their PCP. Services obtained outside of established lock-in program requirements may not be covered except as otherwise required by applicable state or federal requirements. The referral

form is located on the **Sunflower website**.

Lock-in members do not need permission from a PCP to see the following providers. However, a referral is required for prescriptions from these providers to be covered:

- Dentist
- Optometrist (eye doctor)
- Mental health care provider
- Drug or alcohol treatment provider
- Family planning services provider

If medically necessary covered services are not available through participating providers within the Sunflower network or if the network is otherwise unable to meet applicable KanCare access and availability requirements, Sunflower will arrange for services to be provided by a qualified nonparticipating provider. Sunflower will coordinate any required authorization, care coordination and payment arrangements to ensure members have timely access to covered services.

For assistance locating a participating provider or specialist, please contact Sunflower Customer Service at 1-877-644-4623.

Kansas Medical Assistance Program (KMAP) Enrollment

All providers wishing to participate in the Sunflower KanCare network must first enroll with KMAP. To learn more about enrollment or to manage your KMAP application, visit the **KMAP Provider Portal**.

KMAP enrollment is a prerequisite for participation in the Sunflower network; however, KMAP approval does not guarantee participation. Providers must complete Sunflower's contracting and credentialing requirements and receive an effective participation date before rendering covered services to Sunflower members.

Credentialing approval alone does not constitute active participation in the Sunflower network. **Providers will be notified separately of their effective participation date once all contracting, credentialing and system implementation activities have been completed.**

Credentialing

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.

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) will be required to submit the following to KMAP:

- 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 may be used in lieu of completing CAQH data forms for each practitioner. (Roster in the required format can be found on the **Sunflower website**.)

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

- Completed Participating Provider Agreement
- Completed Ownership and Controls Disclosure Form (for independent physician groups, a Disclosure of Ownership Form is required for each practitioner in the IPG)
- Completed 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 or CAQH data form for each practitioner employed by the provider. (Roster in the required format can be found on the **Sunflower website**.)
- Copy of current malpractice insurance policy face sheet
- Copy of facility license
- Copy of all Community Developmental Disability Organization (CDDO) Affiliate Agreements (I/DD providers)

Upon receipt of a complete credentialing application and all required supporting documentation, the Sunflower Credentialing Committee will render a final decision on acceptance at 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 notification of application decision is mailed or faxed to the provider.

Providers must be credentialed and active in the Sunflower network prior to accepting or treating Sunflower members unless otherwise authorized by Sunflower. PCPs may not accept member assignments until credentialing has been completed and the provider has received an effective participation date.

Credentialing Committee

The Sunflower Credentialing Committee, which includes the medical director or the medical director's physician designee, has the responsibility to establish and adopt necessary criteria for provider participation, termination and direction of the credentialing procedures. The credentialing committee includes health plan medical directors and community providers representing a variety of clinical disciplines and meets monthly to support a timely credentialing process.

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

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

For further information about contracting, credentialing or provider participation requirements with Sunflower Health Plan, contact Sunflower Provider Services at 1-877-644-4623.

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.

Between credentialing cycles, Sunflower conducts ongoing provider performance and compliance monitoring activities. These activities include regular review of state licensure information to identify newly disciplined providers or providers experiencing adverse licensure actions.

Sunflower also reviews federal exclusion and sanction reports, including information published by Office of Inspector General (OIG) and other applicable federal databases, to identify providers who have become sanctioned or excluded from participation in Medicare, Medicaid or other federal healthcare programs.

A provider's Participating Provider Agreement may be terminated if, at any time, the Sunflower Credentialing Committee determines that credentialing requirements, participation standards or applicable regulatory requirements 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 if 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 applied to join the Sunflower network have the right to be informed of the status of their application upon request. To request 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 the Contracting team at sunflowerstatehealth@centene.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. When an 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.

Sunflower will send the applicant a written response to his/her request within two weeks of the final decision. Send written requests for appeal 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. Send written requests for such administrative fair hearing 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 Sunflower's criteria, as well as government regulations and standards of accrediting agencies. The provider is contractually obligated to 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 Representatives

As a participating provider, you and your office staff will have a provider relations representative who will provide education and training regarding Sunflower's administrative processes. Your provider relations representative 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 representative is to ensure you and your staff receive support from Sunflower Health Plan.

Providers and their office staff are encouraged to call or email the provider relations representative to access:

- Provider onboarding and education, including:
  - Onboarding, orientation, implementation activities following contracting and credentialing and ongoing education and training for new and existing staff.
  - Clarification of state Medicaid, KanCare, KMAP and Sunflower Health Plan policies and procedures and information about provider communications, newsletters, notices, bulletins, policy updates, regulatory changes and training opportunities.
  - Location of provider manuals, forms, reference materials and other provider resources available through the **Sunflower website** and provider portal.

- Operational and administrative support, including:
  - Assistance with membership list (patient panel) inquiries, provider demographic updates, provider directory information, panel status and other provider record maintenance activities.
  - Education and assistance regarding provider portal functions, eligibility verification, prior authorization submissions, claims and billing processes, electronic transactions and other operational processes.
  - Understanding the Participating Provider Agreement between Sunflower Health Plan and the provider. Questions regarding the Participating Provider Agreement may also be directed to Sunflower's Contracting Department at **sunflowerstatehealth@centene.com**.
- Quality, Care Management and Clinical programs, including:
  - Support for quality improvement initiatives, HEDIS®, clinical quality measures, population health programs, care management programs, clinical practice guidelines, value-based care initiatives, provider resources, delegated vendor resources, behavioral health resources, LTSS resources, and other programs intended to improve member outcomes and healthcare quality.

Provider and Practitioner Change Requests

Providers are required to maintain accurate enrollment and provider information through the applicable Kansas Medicaid provider enrollment processes and promptly notify Sunflower of changes affecting provider records, participation, credentialing or directory information.

Provider updates may include demographic and practice changes, such as office address changes, phone/fax number changes, office hours, telehealth availability, accessibility accommodations, languages spoken, practitioner additions, terminations or other changes affecting provider operations. Certain changes, including tax identification number (TIN), national provider indicator number (NPI), ownership, location or organizational changes, may require additional enrollment, credentialling, contracting or approval processes.

Sunflower receives provider enrollment and demographic information through state-approved data exchange processes and will update provider records in accordance with applicable contractual, regulatory and operational requirements.

Some changes may require a new Participating Provider Agreement, an amendment to an existing Participating Provider Agreement, updated credentialing documentation or additional supporting information.

Please refer to the **Provider Resources** section of the Sunflower website for additional information and required materials, or contact the Contracting and Provider Relations departments 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 a minimum of 180 days of the expected termination date, unless otherwise stated in their 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
Attn.: President
8325 Lenexa Dr., Ste. 410
Lenexa, KS 66214
Fax: 877-285-8469

Providers may also initiate contract terminations through the KDHE provider enrollment portal.

Member Impact from Provider Termination

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 Population Health 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 90 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 expect members to follow their healthcare instructions and directions and their support plans for long-term services.
- To file a grievance or appeal with Sunflower.
- To file a grievance on behalf of a member, with the member's consent.
- To have access to information about Sunflower quality improvement programs, including program goals, processes and outcomes that relate to member care and services.
- To contact Customer Service with any questions, comments, or problems.
- To collaborate with other healthcare or long-term support professionals who are involved in the care of members.
- To not be excluded, penalized or terminated from participating with Sunflower for having developed or accumulated a substantial number of members in the Sunflower plan with high-cost medical conditions or long-term support needs.
- To request an administrative state fair hearing to appeal actions of Sunflower Health Plan.

Sunflower Provider Responsibilities

Participating providers play an integral role in the delivery of high-quality, accessible and coordinated healthcare services to Sunflower members. Providers are expected to collaborate with members, caregivers, authorized representatives, care managers, state agencies, community organizations and other healthcare professionals to support member choice, person-centered care, continuity of care, quality outcomes and timely access to medically necessary services. Providers serving members receiving Long-Term Services and Supports (LTSS) and Home and Community Based Services (HCBS) should support person-centered planning, interdisciplinary care coordination, community integration and services delivered in the least restrictive setting appropriate to the member's needs.

MEMBER RIGHTS, PRIVACY AND ACCESSIBILITY

All participating providers have the responsibilities:

- To inform members, and when applicable their parent, guardian, healthcare agent or designated representa-

tive, of applicable privacy rights and responsibilities and provide:
  - Access to inspect and receive copies of personal health information, as permitted by law.
  - An accounting of disclosures of personal health information, as permitted by law.
  - The opportunity to request restrictions on the use and disclosure of personal health information.
- To comply with all applicable federal and state laws, regulations and contractual requirements governing member rights, quality of care, confidentiality, nondiscrimination, accessibility, person-centered care and the delivery of medically necessary services.
- To provide members, upon request, information regarding the provider's qualifications, training, experience, licensure, certification, specialty, board certification status and other relevant credentials applicable to the services being provided.
- To inform members when a provider is unable to furnish a medically necessary service because of religious or other conscientious objections and, consistent with applicable law, assist members in obtaining timely access to another qualified provider or service resource without disrupting care or services.
- To advocate for or assist members in making informed decisions regarding medically necessary healthcare services, treatment options and supports within the provider's scope of practice, including the right to discuss treatment alternatives, support service options, risks, benefits, consequences of treatment decisions and the option to decline treatment or services.
- To provide members with clear and complete information in a language, format and manner they can understand, regarding their health conditions, treatment options, support needs, available services and alternatives regardless of cost or benefit coverage and to encourage member participation in decision-making to the extent possible.
- To inform members when proposed treatment, procedures, services or supports are part of a research study or experimental intervention and respect a member's right to refuse participation.
- To respect a member's right to refuse or discontinue treatment, services or supports after being informed of the potential risks and consequences of such decisions, consistent with applicable law and professional standards.
- To allow members to obtain a second opinion and provide information regarding how to access covered healthcare services and supports.

CARE COORDINATION AND CONTINUITY OF CARE

All participating providers have the responsibilities:

- To cooperate and coordinate with Sunflower, members, parents, guardians, healthcare agents, authorized representatives, caregivers, care managers, case managers, Community Developmental Disability Organizations (CDDOs), Targeted Case Managers, state agencies, community organizations and other providers involved in a member's care to support person-centered planning, discharge planning, care coordination, service integration, transitions of care, continuity of care, continuity of LTSS and HCBS services and the delivery of medically necessary and authorized services.
- To provide appropriate notice and continuity of care when discontinuing services to a member, consistent with professional standards, applicable state and federal requirements and the terms of the Participating Provider Agreement.
- To participate in care transition activities and coordinate with members, caregivers, care managers, authorized representatives and other providers when services are reduced, discontinued, transferred or terminated.
- To treat members with fairness, dignity, respect and without discrimination on the basis of race, color, national origin, limited English proficiency, religion, age, sex, disability, health status, anticipated need for healthcare services, claims experience, medical history, genetic information or other protected characteristics.
- To collaborate with Sunflower to support safe and appropriate discharge planning and continuity of care regardless of Sunflower's level of financial responsibility or payer status.

LTSS, HCBS WAIVERS AND RELATED SERVICE PROVIDER RESPONSIBILITIES

Providers serving members receiving LTSS, HCBS waiver and other applicable waiver or community-based services have the responsibilities:

- To support and facilitate members' participation in person-centered planning and service planning activities; respect member choice, informed decision-making, independence, dignity and self-determination; and provide services in a manner that promotes community integra-

tion and delivery in the least restrictive setting appropriate to the member's needs, consistent with applicable Medicaid, KanCare, state and federal requirements.

- To recognize and involve parents, guardians, family members, designated representatives, caregivers and supported decision-making resources, as appropriate and consistent with applicable law, member preferences and person-centered planning requirements.
- To respect members' advance directives, document the existence of such directives as applicable and maintain person-centered service plans, assessments and related documentation in accordance with applicable state and federal requirements.
- To provide services in accordance with applicable Home and Community Based Services (HCBS) Final Rule requirements, including principles of member choice, community integration, privacy, dignity, respect, independence, autonomy and the opportunity for members to receive services in the most integrated setting appropriate to their needs.
- To comply with applicable federal and state laws, regulations, KanCare requirements, KDADS policies, HCBS requirements, CDDO requirements where applicable, member rights provisions, service transition requirements and continuity-of-care obligations.
- To comply with applicable federal and state requirements for reporting, documenting, investigating and cooperating with reviews of critical incidents, abuse, neglect, exploitation, suspected fraud, health and welfare concerns and other reportable events as required by KDADS, KanCare, CMS, HCBS waiver requirements and other applicable program requirements.
- To ensure that all employees, contractors, volunteers, direct support workers, caregivers and other individuals furnishing HCBS waiver services satisfy applicable criminal background check, exclusion screening, registry verification, training, staffing and provider qualification requirements prior to furnishing services and throughout service delivery, consistent with applicable federal and state laws, regulations, KanCare requirements, KDADS policies, HCBS waiver requirements and other applicable program requirements.
- To maintain documentation demonstrating compliance with applicable provider qualification, training, background screening, exclusion screening, registry verification, health and welfare, service delivery and waiver program requirements and provide such documentation upon request as permitted by applicable law.
- To cooperate in the development, implementation and maintenance of backup plans and contingency plans necessary to support member health, safety, welfare, continuity of care, continuity of services and continuity of support.
- To cooperate and coordinate with Sunflower Health Plan, Targeted Case Managers (TCMs), Community Developmental Disability Organizations (CDDOs), waiver service providers, caregivers, authorized representatives, care managers, healthcare providers, behavioral health providers, community organizations and other members of the Interdisciplinary Care Team (ICT) to support person-centered planning, service coordination, continuity of care, continuity of services and the delivery of medically necessary and authorized services.
- To participate in person-centered service planning, interdisciplinary care planning, care transitions, discharge planning, continuity-of-care activities and service coordination activities, as applicable.
- To comply with applicable federal and state EVV requirements and program guidance if furnishing services subject to Electronic Visit Verification (EVV) requirements.
- To maintain ongoing compliance with all applicable federal and state laws, regulations, KanCare requirements, KDADS policies, HCBS waiver requirements, provider qualification requirements, member rights provisions, health and welfare requirements and all other applicable program requirements.

Failure to comply with applicable criminal background check, exclusion screening, registry verification, training, staffing, provider qualification, health and welfare, HCBS waiver or other applicable program requirements may result in monitoring activities, audits, corrective action plans, retraining requirements, suspension of referrals, recovery or recoupment of payments for services that were not properly provided or documented, referral to KDADS or other oversight entities, contract action, termination of participation, or other actions consistent with applicable contractual, regulatory, credentialing and program requirements.

QUALITY IMPROVEMENT AND POPULATION HEALTH

All participating providers have the responsibilities:

- To participate in Sunflower quality improvement, quality reporting, accreditation, medical record review and regulatory activities, including HEDIS®, NCQA, CMS, state contractual requirements and other quality and

performance initiatives.
- To review and consider clinical practice guidelines distributed by Sunflower.
- To participate in Sunflower Population Health programs and care management initiatives that are applicable to the provider's practice, specialty, services and member population.

ADMINISTRATIVE RESPONSIBILITIES

All participating providers have the responsibilities:
- To promptly report and return identified overpayments or improper payments in accordance with applicable federal and state laws, regulations and contractual requirements.
- To identify, collect and report to known or suspected third-party liability, coordination of benefits, subrogation matters, casualty claims, workers' compensation claims, liability insurance coverage and other health insurance coverage information, and to cooperate with Sunflower and the Kansas Medical Assistance Program (KMAP) in the identification and recovery of liable third-party resources.
- To notify Sunflower of any actual or proposed change in ownership, control, legal entity status, tax identification number or other reportable organizational change and comply with all related notification, disclosure and approval requirements set forth in the Participating Provider Agreement and applicable regulatory requirements.
- To verify member eligibility, enrollment, benefits, coordination of benefits information, and coverage status through Sunflower, KMAP and other applicable eligibility verification resources, as appropriate.
- To provide Sunflower and KMAP, as applicable, timely notice of changes affecting provider participation, enrollment, credentialing, practice operations, demographic information, services offered, office locations, telehealth availability, hours of operation, accessibility accommodations, panel status, practitioner additions or terminations and other information necessary to maintain accurate provider records, directory information and provider listings.
- To maintain and provide accurate and current information to members and Sunflower regarding office locations, appointment availability, hours of operation, after-hours coverage, accessibility accommodations, telehealth services, languages spoken by practitioners and office staff, interpreter and translation services, auxiliary aids and services, and other information necessary to support timely access to care and services and ensure the accuracy of Sunflower's provider directory and Find a Provider resources.

PCP RESPONSIBILITIES

PCPs are responsible for the provision of primary care services for Sunflower's members, including but not limited to:
- Screening for behavioral health and substance use disorder needs during preventive health visits and, when appropriate, initiating referrals, coordinating care and facilitating follow-up services.
- Collaborating with Sunflower Care Management regarding member screening, assessment, care planning, care coordination, risk management and access to support services, as appropriate.
- Notifying Sunflower Care Management of members with complex medical, behavioral health, LTSS, HCBS, transplant, high-risk pregnancy or other significant care coordination needs when additional care management support may benefit the member.
- Maintaining procedures for monitoring missed appointments and, when appropriate, making reasonable efforts to contact and re-engage members in preventive, primary care and recommended follow-up service, 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 for 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 KBH).
- 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 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.

Beneficiary and Attorney Requests and Subpoenas

Occasionally a Medicaid beneficiary or representative acting on the beneficiary's behalf may request records, billing information or itemized statements. Such requests may be related to a potential third-party liability (TPL) matter. Federal and state Medicaid requirements obligate providers to cooperate in identifying, reporting and assisting with the recovery of third-party liability, coordination of benefits, subrogation matters and other liable resources to ensure Medicaid remains the payer of last resort.

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:

HMS
6021 Southwest 29th St., Ste. A, #373
Topeka, KS 66614
Phone: 785-271-9300
Fax: 785-271-9318
Email: ksmedsub@hms.com

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)

This allows providers to comply with HIPAA privacy rules. Under that rule, when Medicaid members request to see or obtain a copy of their billing records, covered providers must provide this to the member within 30 days, under 45 C.F.R. Sec. 164.524(b)(2).

You do not need to notify the Kansas Medicaid subrogation contractor if:

- The member wants treatment records only.
- The member needs the bill to meet a spenddown.

portal.kmap-state-ks.us/PublicPage/ProviderPricing/ProviderPublications

Provider Types That May Serve as PCPs

Primary care providers generally include physicians and other qualified practitioners whose specialty designation and services meet applicable Kansas Medicaid program requirements. Reimbursement for services provided by advanced practice clinicians, Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) is determined in accordance with applicable state and federal Medicaid reimbursement methodologies.

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 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

Once members are assigned to Sunflower, they are given the opportunity to select a PCP from the health plan's list of participating PCPs. When a member is assigned to Sunflower Health Plan, Sunflower must ensure members have selected a PCP within 10 business days of their enrollment. For those members who have not selected a PCP during enrollment, Sunflower 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 member is a returning member and

attempt to match them to their previous PCP. If the member is new to Sunflower, claim history provided by the state will be used to match the member to a PCP that the member had a previous relationship with, where possible. If the member joins Sunflower and has an established relationship with a provider who is not participating in the Sunflower network, Sunflower will evaluate available continuity-of-care options in accordance with applicable contractual, regulatory and continuity-of-care requirements.

2. **If the member has no previous relationship with a PCP, the algorithm will try to assign the member to the same PCP as another family member enrolled with Sunflower, such as a parent or sibling, when appropriate**.
3. **Geographic proximity of PCP to member residence.** The auto-assignment logic considers current KanCare access standards and is designed to assign members to PCP located within 20 miles or 40 minutes in urban areas and 30 miles or 45 minutes in rural areas, where available.
4. **Appropriate PCP type.** The algorithm will consider the member's age, clinical needs, provider specialty and other relevant factors to support assignment to an appropriate PCP, such as assigning children to pediatric providers.
5. **Language Preference.** The algorithm will consider the member's preferred language when known.

Pregnant women are encouraged to select a pediatrician or other appropriate PCP for their newborn before last trimester of pregnancy. If a PCP is not selected, Sunflower may assign a PCP for the newborn in accordance with its member assignment procedures.

The member may change his or her PCP at any time. PCP changes will be processed in accordance with Sunflower member assignment procedures and applicable KanCare requirements. Please call your provider relations representative 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 guarantee that any provider will receive a certain number of assigned 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 who want to change their panel status (open, closed, existing members only) must notify Sunflower by calling Customer Service at 1-877-644-4623 or contact Provider Relations at **providerrelations@sunflowerhealthplan.com**. Sunflower prefers that PCPs submit panel status changes using the **Sunflower-approved roster** located on the Sunflower Health Plan website.

Please note that PCPs 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, except 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 laws governing self-referrals and conflicts of interest, participating providers shall not refer members for designated health services to entities with which the referring provider or immediate family member of the referring provider has a prohibited financial relationship, unless an applicable exception is met.

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 Population Health 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.
- For services ordered by the specialist that require prior authorization, it is the responsibility of the ordering physician to facilitate the prior authorization process.

Providers are encouraged to contact their dedicated provider relations representative 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 Population Health Department of all inpatient admissions within one business day following the admission. Clinical information must be submitted with the admission to support medical necessity criteria.
- Partner with Sunflower's Population Health department by providing discharge dispositions or additional documentation on admissions where Sunflower may not be the primary payer.

- Notify Sunflower's Population Health Department of all admissions via the ER within one business day.
- Notify Sunflower's Population Health Department of all newborn deliveries within one day of the delivery.

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

24-Hour Access to Providers

Sunflower providers must ensure continuous access to necessary healthcare services for members, 24 hours a day, 365 days a year. This includes the following requirements:

- **During Normal Business Hours:** Provider office phones must be answered by staff during regular business hours.
- **After-Hours and Weekend Access:** Providers must ensure that members can reach a qualified individual after hours and on weekends. Acceptable methods include:
  - Intended provider, on-call provider or a covering physician.
  - An answering service or system that will page provider or physician.
  - Answering system with option to page the provider or physician.
  - A triage/nurse/crisis line with access to the provider or physician.
  - Answering service that will page the provider or physician after a message is left.
  - Answering system triage service or voicemail that provides a secondary phone number to access the provider, which is actively answered.
  - Outgoing message states a call back will be received within 30 minutes for urgent calls or 24 hours for non-urgent calls.
- **All after-hours systems must:**
  - Connect the caller to someone who can make or facilitate a clinical decision.
  - Be accessible via the provider's regular daytime phone number.
- **Voicemail and Recorded Messages:** If a recorded message is used, it must be:
  - High-quality and informative.
  - Clearly identify the provider's practice.
  - Provided in both English and Spanish if the provider serves a significant Spanish-speaking population.
  - Include instructions for leaving a message and an expected timeframe for a return call.
- **Unacceptable After-Hours Coverage:** The following are not compliant:
  - Recordings that only instruct callers to leave a message without further guidance.
  - Recordings that only recommend calling back during business hours
  - Recordings that direct all callers to an urgent care center or the emergency room that does not give any other directions to receive after-hours assistance.
- **Monitoring and Compliance:** Sunflower will monitor provider compliance through both scheduled and unscheduled visits and audits.

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 urgent 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.

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 full list of access standards requirements can be viewed at **KS Medicaid Network Adequacy Standards**. Below is a sample of the list (not all-inclusive):

- 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:
  - 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
  - Urban Areas: 30 miles or 60 minutes
- Behavioral Health:
  - Rural Areas: 60 miles or 90 minutes
  - Urban Areas: 30 miles or 60 minutes
- Optometry
  - Rural Areas: 60 miles or 90 minutes
  - Urban Areas: 30 miles or 60 minutes
- Psychiatrist
  - Rural Areas: 60 miles or 90 minutes
  - Urban Areas: 15 miles or 30 minutes
- Pharmacy
  - Rural Areas: 30 miles or 45 minutes
  - Urban Areas: 10 miles or 20 minutes
- Occupational Therapy
  - Rural Areas: 60 miles or 90 minutes
  - Urban Areas: 30 miles or 60 minutes
- Physical Therapy
  - Rural Areas: 60 miles or 90 minutes
  - Urban Areas: 30 miles or 60 minutes
- Speech Therapy
  - Rural Areas: 60 miles or 90 minutes
  - Urban Areas: 30 miles or 60 minutes

Please refer to Table 2: **Description of Timely Access Standards to Initiation of HCBS Services** in KDHE's Network Adequacy standards for other timeliness requirements for HCBS services.

Participating providers must provide covered services to Sunflower members without regard to payer source and may not intentionally segregate members based on participation in Medicaid, CHIP or other government-sponsored healthcare programs. Sunflower monitors compliance with applicable access and non-discrimination requirements and may implement corrective actions when warranted.

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:

PRIMARY CARE & PEDIATRIC PROVIDERS

TYPE OF APPOINTMENT	APPOINTMENT STANDARDS
Routine Care	Not to exceed three weeks (21 calendar day) from date of member request
Urgent Care/Sick Visits	Within 48 hours of request for services

PRENATAL CARE OBSTETRICIAN

TYPE OF APPOINTMENT	APPOINTMENT STANDARDS
First Trimester	Within three weeks of request
Second Trimester	Within two weeks of request
Third Trimester	Within one week of request
Urgent Care	Within 48 hours of member's call
Routine Care	Within 15 business days of request

SUBSTANCE USE DISORDER (SUD) PROVIDERS

TYPE OF APPOINTMENT	APPOINTMENT STANDARDS
Emergent	On-demand service. No prior authorization is required, and members go directly to an emergency room. Members are seen immediately.
Urgent Care	Assessment conducted within 24 hours of the initial contact, and services delivered within 24 hours of the date and time of assessment.
Person Who Injects Drugs	Assessment and admitted to treatment no later than 10 business days of request.
Routine Care	Members are assessed within 10 business days of initial contact.
Pregnant SUD and Person Who Injects Drugs	Provide services within 24 hours of assessment or 48 hours of initial contact to include prenatal care.

MENTAL HEALTH ACCESS STANDARDS

TYPE OF APPOINTMENT	APPOINTMENT STANDARDS
Post-Stabilization Services	Referral within one hour. Assessment and/or treatment within one hour of referral for post-stabilization services (both inpatient and outpatient) in an emergency.
Emergent	Referral immediately.
Urgent Care	Assessment within 72 hours from request for services.
Routine Outpatient	Initial assessment or follow up within 10 business days.
Non-Life-Threatening Emergency	Referral made within six hours.

SPECIALTY AND URGENT CARE (INCLUDES SPECIALTY PHYSICIAN SERVICES, HOSPICE CARE, HOME HEALTHCARE, SUD TREATMENT, REHABILITATION SERVICES, ETC.)

TYPE OF APPOINTMENT	APPOINTMENT STANDARDS
Routine Care	Not to exceed 30 calendar days.
Urgent Care	Not to exceed 48 hours of member's call.

EMERGENCY CARE

TYPE OF APPOINTMENT	APPOINTMENT STANDARDS
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.

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 a 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.
  - Patients with long-term chronic conditions prefer to have primary-care services managed by their specialist.
  - Women of childbearing age prefers to have primary care services managed by their OBGYN.
- LTSS and HCBS Services: If a member no longer meets the criteria for the LTSS, HCBS, waiver or community-based services being provided, or the provider is unable to safely and appropriately meet the member's service needs, include a description of the member's condition, service needs and the reason for the decision. Examples include:
  - Member no longer meets eligibility criteria for the service.
  - Member's needs exceed the provider's scope, staffing, training, licensure or service capabilities.
  - Member requires a different level of care, service setting or provider specialization.
  - Member elects to receive services from another provider.
  - Repeated unsuccessful attempts to contact the member or provide authorized services despite documented outreach efforts.

Providers delivering LTSS or HCBS services should coordinate with Sunflower Care Management, applicable care coordinators, Community Developmental Disability Organizations (CDDOs) and other members of the interdisciplinary care team, as appropriate, before discontinuing services when member health, safety, welfare or continuity of care may be impacted. Providers must comply with applicable federal and state requirements, KanCare policies, HCBS waiver requirements, CDDO requirements where applicable, member rights provisions, service transition requirements and continuity-of-care obligations

To dismiss a member from your practice, complete the **Provider Request for Member Dismissal Cover Sheet** located on our *Manuals, Forms and Resources* web page in the *Forms > Medical Forms* section. 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. Additional continuity-of-care requirements may apply for members receiving LTSS, HCBS, behavioral health or other ongoing services.

Cultural Competency

Sunflower views cultural competency as the ability of individuals and organizations to effectively understand, communicate with and respond to the diverse cultural, linguistic, social and healthcare needs of the populations they serve. Cultural competency, cultural humility and cultural responsiveness require an ongoing commitment to learning, self-assessment and continuous improvement.

Sunflower values diversity and is committed to promoting equitable access to healthcare services for all members, regardless of race, color, national origin, ethnicity, language, religion, disability, age, sex, sexual orientation, gender identity, socioeconomic status, veteran status, geographic location or other characteristics that contribute to an individual's unique experiences and healthcare needs. In the delivery of healthcare services, cultural competency includes recognizing and respecting each member's beliefs, preferences, communication needs, health literacy level and cultural values while supporting person-centered care, effective communication, informed decision-making and improved health outcomes.

Providers serving members receiving Long-Term Services and Supports (LTSS) and Home and Community Based Services (HCBS) should also recognize and accommodate individual accessibility, support and decision-making needs while promoting member choice, independence, community integration and care in the least restrictive setting appropriate to the member's needs.

Sunflower is committed to developing, strengthening and sustaining positive provider-member relationships. Members are entitled to respectful, appropriate, accessible and high-quality care. When healthcare services are delivered without consideration of cultural, linguistic, communication, accessibility or individual needs, members may experience barriers to care and less effective health outcomes. Members may be unable or unwilling to communicate their healthcare needs in an environment that does not promote trust, understanding and mutual respect, which can negatively affect the delivery of care and the member experience.

Providers should recognize that a member's experience begins with their first interaction with the practice. Failure to incorporate culturally and linguistically appropriate services and person-centered practices may result in:

- Feelings of being disrespected or treated unfairly.
- Reluctance to seek future care or communicate healthcare needs.
- Confusion or misunderstanding regarding healthcare instructions or treatment plans.
- Reduced adherence to recommended treatment plans.
- Feelings of isolation, exclusion or lack of support.
- Caregivers or family members becoming reluctant to seek care or services.
- Unfilled prescriptions or delayed treatment.
- Missed appointments.

- Misdiagnosis due to lack of information sharing.
- Miscommunication that may contribute to inappropriate or delayed care.
- Increased complaints, grievances or appeals.

Providing culturally and linguistically responsive care begins with recognizing, respecting and valuing the unique backgrounds, experiences, preferences and needs of each member. Sunflower is committed to supporting providers in delivering person-centered, equitable and culturally responsive care.

Providers are encouraged to consider the following as they serve Sunflower members:

- How might your own experiences, perspectives,and assumptions influence interactions with members and families?
- How can cultural, linguistic, religious, social or accessibility differences influence communication, trust, treatment planning and healthcare outcomes?
- How well do you understand and respond to your members' cultural backgrounds, preferred language, communication needs, health literacy levels and support systems?
- Does your approach to care consider individual values, beliefs, communication styles, spirituality, family structures, decision-making preferences and accessibility needs?
- How can you foster an environment that promotes respect, inclusion, member choice, shared decision-making and effective communication?
- How can cultural differences and individual experiences be recognized as strengths that support improved health outcomes and member engagement?
- Providers serving members receiving Long-Term Services and Supports (LTSS) and Home and Community Based Services (HCBS) should also consider each member's functional needs, communication preferences, support systems, goals and desired outcomes in order to promote person-centered planning, community integration, independence and care in the least restrictive setting appropriate to the member's needs.

The U.S Department of Health and Human Services' Office of Minority Health has developed educational resources to support health equity and the delivery of culturally and linguistically appropriate services (CLAS). Providers are encouraged to visit Think Cultural Health at **thinkculturalhealth.hhs.gov** to access free training and educational resources.

As part of Sunflower's Cultural Competency Program, providers and their staff should support culturally and linguistically responsive, person-centered care by ensuring the following:

- Members are informed of the availability of qualified medical interpreters, sign language interpreters, telecommunications relay services, TTY services and other communication accommodations at no cost to the member.
- Healthcare services are delivered with consideration of the members' cultural background, preferred language, communication needs, health literacy, accessibility needs, beliefs, values and individual circumstances.
- Providers and office staff who routinely interact with members are encouraged to participate in cultural competency, health equity, accessibility and related educational opportunities offered by Sunflower.
- Treatment plans are developed in partnership with members and, when appropriate, their caregivers or representatives, with consideration given to factors such as culture, language, country of origin, health literacy, religion, disability status, age, sex, sexual orientation, gender identity, socioeconomic factors, family structure and other characteristics that may influence healthcare decision-making and treatment preferences.
- Provider offices maintain appropriate language assistance resources and communications that comply with applicable federal and state language access requirements.
- Providers establish appropriate mechanisms to comply with the Americans with Disabilities Act (ADA) and other applicable accessibility requirements. Facilities and services must be accessible to individuals with disabilities, and no individual may be excluded from participation in, denied the benefits of, or otherwise subjected to discrimination in the provision of healthcare services.
- Providers serving members receiving Long-Term Services and Supports (LTSS) and Home and Community Based Services (HCBS) should consider individual communication preferences, support needs, accessibility requirements and person-centered goals when delivering services.

Sunflower provider agreements require compliance with applicable federal and state nondiscrimination, accessibility, language access and cultural competency requirements, including the appropriate use of professional interpreter

services and reasonable accommodations for members with disabilities.

Find Sunflower's full Cultural Competency policy at **www.SunflowerHealthPlan.com**.

Mainstreaming

Sunflower considers the integration of members into the same healthcare settings, services and service delivery systems as other patients an important component of quality care. Participating providers are expected to treat members with dignity, respect and without discrimination based on race, color, national origin, ancestry, religion, creed, age, sex, sexual orientation, gender identity, disability, health status, income status, program participation or any other characteristic protected by applicable federal or state law, except when medically necessary and clinically appropriate.

Examples of prohibited practices include:

- Denying a member access to a covered service or healthcare facility.
- Providing a Sunflower member with a covered service in a manner that differs from services provided to other patients solely because of the member's participation in Medicaid, CHIP, LTSS, HCBS or other government-sponsored healthcare programs.
- Segregating members from other patients through the use of separate waiting areas, appointment schedules, treatment locations or other discriminatory practices.
- Delaying access to medically necessary services or appointments based on a member's payer source, program participation, disability status or other protected characteristic

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 call Customer Service at 1-877-644-4623 immediately.

Below is a sample member identification card.

sunflower health plan | KanCare

Pharmacy:
RXBIN: 003858
RXPCN: MA
RXGROUP: 2ELA

NAME:

#: **DOB:**

PCP Name:

PCP Phone:

Effective Date: **Copay: $0**

If you have an emergency, call 911 or go to the nearest emergency room (ER). If you are not sure if you need to go to the ER, call your PCP or Sunflower's 24/7 nurse line at 877-644-4623 (TTY 711).

8325 Lenexa Drive, Suite 410, Lenexa, KS 66214
www.SunflowerHealthPlan.com

IMPORTANT CONTACT INFORMATION

Members:
Customer Service: 877-644-4623 (TTY 711)
Transportation: 877-917-8162
Vision: 877-644-4623
Dental: 877-644-4623
Behavioral Health: 877-644-4623
Pharmacy: 877-644-4623

Providers:
Provider Services & IVR Eligibility Inquiry - Prior Auth: 877-644-4623
Pharmacists Only: 833-750-4447

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

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

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

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

Member Rights and Responsibilities

SUNFLOWER 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 provided health care services in accordance with 42 CFR §§ 438.206-438.210.
- 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 languages.
- To be notified that free interpretation services are available and how to access them.
- To get adequate and timely information on Sunflower's Physician Incentive Plan upon request.
- To exercise their rights and that the exercise of those rights does not adversely affect the way Sunflower, its providers or the state treat the member.
- To use any hospital or other setting for emergency care.
- To request a State Fair Hearing.

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 participate in care planning and coordination activities, including LTSS, HCBS, behavioral health and other support services, when applicable.
- 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 make reasonable efforts to follow healthy lifestyle practices and treatment recommendations that support their health and well-being.
- 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 use available grievance, appeal and complaint processes when concerns arise regarding service or care.
- To choose a primary care provider (PCP).
- To treat providers and staff with dignity and respect.

Member Interpreter Services

All Sunflower members or potential members whose preferred language is not English, as well as members who are deaf, hard of hearing or have other communnication needs, are entitled to receive interpreter and communication services at no cost.

Interpreter services are available to facilitate communication interactions related to a member's healthcare and benefits, including but not limited to:

- Processes
- Customer service interactions
- Receipt of covered healthcare services from participating providers
- Emergency services
- Care management and care coordination activities
- Grievance and appeal processes

Sunflower provides access to qualified interpreter services including oral interpretation, sign language interpretation, TTY/telecommunications relay services and other communication accommodations as appropriate.

Providers may contact Sunflower to arrange interpreter services. Advance notice is generally not required for telephonic services; however, advance scheduling may be necessary for certain in-person, virtual or sign language interpreter requests.

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 Population Health staff are trained on our policies and procedures related to advance directives.

PCPs and providers delivering care to Sunflower members must ensure members ages 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.

Providers serving members receiving Long-Term Services and Supports (LTSS) and Home and Community Based Services (HCBS) should honor member choice and incorporate advance directive information into person-centered planning and care coordination activities when appropriate and consistent with applicable law.

Sunflower recommends that PCPs, physicians, LTSS providers, HCBS providers and other providers:

- At the earliest appropriate point of contact, PCP's office staff should ask if the member has executed an advance directive and whether a healthcare agent, legal guardian or other legally authorized representative has been designated to make healthcare decisions on the member's behalf, when applicable. The response should be documented in the medical record.
- LTSS and HCBS providers should encourage members to communicate the existence of an advance directive and to identify any healthcare agent, legal guardian, durable power of attorney for healthcare or other legally authorized representative, where applicable. Providers should incorporate this information into care coordination, person-centered planning and service delivery activities, consistent with applicable state and federal requirements
- If the member has executed an advance directive, the provider should request a copy for inclusion in the member's medical record or service record, as applicable. The date of the request should be documented. If a requested copy is not received within 30 days, the provider should make a reasonable follow-up attempt to obtain the advance directive.
- Any advance directive provided by the member's designated representative, healthcare agent, legal guardian or other legally authorized representative, including Mental Health Treatment Declaration or other mental health advance directive recognized under Kansas law should be maintained as part of the member's medical record or service record as appropriate.
- If an advance directive exists, the treating physician should discuss potential medical emergencies and treatment preferences with the member and, when appropriate and authorized, member's designated representative, family member, significant other or other individual identified in the advance directive. The physician should also discuss the advance directive with referring provider when appropriate for care coordination and continuity of care. Any such discussion should be documented in the medical record.
- Providers are prohibited from discriminating against the member based on whether the member has or has not executed an advance directive.

Kansas law permits providers to decline to implement certain advance directive instructions based on conscientious objection. Providers who are unable or unwilling to comply with a member's advance directive must promptly inform the member or member's representative and facilitate transfer of care to another provider upon request, consistent with applicable law. Sunflower Health Plan does not restrict coverage of services based on provider's conscientious objections.

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 visit SunflowerHealthPlan.com or call 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 help you understand 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.

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. Sunflower members may not be charged or balance billed for covered services.

For information regarding which services require prior authorization, see the *Population Health* section of this provider manual for a summary listing, visit our website at SunflowerHealthPlan.com, or call Customer Service at 1-877-644-4623.

SERVICE	COVERAGE	BENEFIT LIMITATION	COMMENTS
Alternative Medicine	Not Covered		Examples are acupuncture, Christian Science, faith healing, herbal therapy, homeopathy, massage, massage therapy or naturopathy.
Abortions	Not Covered – See *exception	Only covered when a member suffers from a rape or incest, or the life of the mother is threatened.	Abortion necessity form is required at the time the claim is submitted
Adult Care Home Services	Covered		
Allergy Services	Covered	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.	
Ambulance (Emergency Transportation)	Covered	Ground, rotary and fixed wing	
Ambulatory Surgery Center	Covered		
All services are subject to benefit coverage, limitations and exclusions, some of which are described here. Call Customer Service at 877-644-4623 or visit SunflowerHealthPlan.com to learn more about benefit coverage.			

Sunflower Customer Service Department: 1-877-644-4623 (TTY 711)

SERVICE	COVERAGE	BENEFIT LIMITATION	COMMENTS
Anesthesia Services	Covered		
Audiology Services	Covered		
Bariatric Surgery	Covered		A member must meet certain medical criteria
B-12 Injections	Covered		
Behavioral Health Svcs	Covered		
Birthing Centers	Covered		
Cardiac Rehabilitation	Covered		
Chemical Dependency Treatment	Covered		
Chemotherapy	Covered		
Chiropractor Services	Not Covered		Only covered if member has Medicare coverage in a Qualified Medicare Beneficiary program plan.
Circumcisions (Routine/ Elective)	Covered		
Cosmetic or Plastic Surgery	Not Covered		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.
Dental Services	Covered		
Dentures or Partials	Covered		Prior authorization is required by Centene Dental Services.
Developmental Testing	Covered		
Diabetic Education	Not Covered		Provided by the Healthy Solutions for Life Program
Diagnosis and Treatment of Infertility, Impotence and Sexual Dysfunction	Not Covered		
Dialysis	Covered		
Dietitian Services	Covered	Services limited to members ages 20 and under.	
Doula Services	Covered		
Durable Medical Equipment	Covered		For non-covered DME services, a prior authorization needs to be submitted first. If extra steps are needed to get these services covered, UM will reach out to your office. Invoices are required for DME services.
Early Periodic Screening Diagnosis and Treatment	Covered	Members under 21 years old	
All services are subject to benefit coverage, limitations and exclusions, some of which are described here. Call Customer Service at 877-644-4623 or visit **SunflowerHealthPlan.com** to learn more about benefit coverage.			

SERVICE	COVERAGE	BENEFIT LIMITATION	COMMENTS
Emergency Room Svcs	Covered		
Experimental Procedures, Drugs and Equipment	Not Covered		
Family Planning	Covered		
Fluoride Application	Covered	Limited to three per calendar year for children under 21 meeting EPSDT criteria.	
Gender Reassignment Surgery	Not Covered		
Hearing Aids	Covered	Some limitations apply for ages over 20.	Batteries are limited to six per month for monaural hearing aids and 12 per month for binaural hearing aids. Hearing aids are covered, one every four years.
Hearing Aid Repairs	Covered	Charges for hearing aid repairs under $15 are not covered.	
Hearing Aids (Bone Anchored)	Covered	Limited to members 5-20 years of age.	
HIV Testing & Counseling	Covered		
Home Births	Not Covered		
Home Healthcare Svcs	Covered		
Hospice Care	Covered		
Hospital Services: Inpatient	Covered		
Hospital Services: Outpatient	Covered		
Hyperbaric Oxygen Therapy	Covered		
Hysterectomy	Covered	Not covered if only to prevent pregnancy.	Sterilization consent form is no longer required for hysterectomies performed for medical reasons.
Laboratory Services – Outpatient	Covered		
Laboratory Services – Inpatient	Covered		
Maternity (OB Routine Ultrasounds)	Covered	One routine OB sonogram covered per fetus per pregnancy.	
Maternity Care Services	Covered		Examples are: Nurse midwife services; Pregnancy-related services; Care for conditions that might complicate pregnancy
Medical Nutrition (through stomach or veins)	Covered	Some limitations apply.	Oral supplements excluded. See the KMAP Provider Manual for nutritional supplement requirements.
All services are subject to benefit coverage, limitations and exclusions, some of which are described here. Call Customer Service at 877-644-4623 or visit SunflowerHealthPlan.com to learn more about benefit coverage.			

Sunflower Customer Service Department: 1-877-644-4623 (TTY 711)

SERVICE	COVERAGE	BENEFIT LIMITATION	COMMENTS
Non-Emergency Medical Transportation (Ambulance)	Covered		Examples are transportation for non-ambulatory patients, patient home to hospital or hospital to patient's home, transfers between hospitals. Prior authorization required for fixed wing transportation.
Non-Emergency Medical Transportation (NEMT)	Covered		For transportation call: 1-877-917-8162
Non-Medical Equipment	Not Covered		
Outpatient Hospital/ Outpatient Surgery	Covered		
Oxygen and Respiratory Services	Covered	Some limitations apply.	
Pain Management	Covered		
Personal Comfort Items	Not Covered		
Physician and Nurse Practitioner Services	Covered		
Physical Exam Required for Insurance or Licensing	Not Covered		
Physical, Occupational and Speech Therapy	Covered		
Podiatrist Services	Covered	For members ages 20 and under.	For EPSDT additional visits may be provided with prior authorization.
Prescription Drugs	Covered		
Preventive Care	Covered	Certain limitations may apply.	
Prosthetic & Orthotic Devices	Covered		
Psychotherapy	Covered		
Psychological Testing	Covered		
Radial Keratotomy	Not Covered		
Radiology and X-rays	Covered		
Radiology (High Tech Imaging)	Covered		
Reconstructive Surgery after Mastectomy	Covered	Related to diagnosis of breast cancer only.	
School-Based Services	Not Covered		School-Based Services are covered through the State's Fee-for-Service program.
School and Employment Physicals	Covered		Some exclusions apply. Please see the KMAP Professional Manual for details.
Screening and Treatment for STD	Covered		
All services are subject to benefit coverage, limitations and exclusions, some of which are described here. Call Customer Service at 877-644-4623 or visit SunflowerHealthPlan.com to learn more about benefit coverage.			

SERVICE	COVERAGE	BENEFIT LIMITATION	COMMENTS
Services Not Allowed by Federal or State Law	Not Covered		
Sleep Studies	Covered	For members ages 20 and under or as part of the pre-operative work-up for bariatric surgery.	
Transplant Services	Covered	Covered for certain organs. Limitations apply. Confirm with the plan during prior authorization or by calling customer service.	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.
Transportation (See Non-Emergency Medical Transportation)	Covered		
Urgent Care Services	Covered		
Vision and Eye Exams	Covered	One complete eye exam and one pair of glasses are covered for members 21 years and older each year. Eyeglasses, repairs and exams as needed for members under 21, up to three pairs per calendar year. Additional coverage for exams following eye surgeries or for monitoring of certain medical conditions may be covered.	For coverage questions, call Centene Vision Services. 1-877-644-4623
All services are subject to benefit coverage, limitations and exclusions, some of which are described here. Call Customer Service at 877-644-4623 or visit **SunflowerHealthPlan.com** to learn more about 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 ages 16-64 with Physical Disability (PD)
- Technology Assisted (TA) — Medically fragile children ages 0-22
- Individuals ages 0-64 with Brain Injury (BI)
- Individuals 65 and older who are Frail Elderly (FE)
- Community Support Waiver (CSW)
- Children with Severe Emotional Disturbance (SED)
- Community-Based Alternatives to Psychiatric Residential Treatment Facility (PRTF) — ages 4-18

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

The Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit provides comprehensive and preventive healthcare services for children under age 21 who are enrolled in Medicaid. EPSDT is key to ensuring that children and adolescents receive appropriate preventive, dental, mental health, and developmental and specialty services.

- **Early:** Assessing and identifying problems early
- **Periodic:** Checking children's health at periodic, age-appropriate intervals
- **Screening:** Providing physical, mental, developmental, dental, hearing, vision and other screening tests to detect potential problems
- **Diagnostic:** Performing diagnostic tests to follow up when a risk is identified, and
- **Treatment:** Control, correct or reduce health problems found.

Sunflower and participating providers will provide or arrange the full range of EPSDT screening, diagnostic and treatment services in accordance with federal EPSDT requirements, Kansas state regulationsMedicaid requirements and KanCare policies and procedures for EPSDT. These services include periodic health screenings, age-appropriate immunizations based on the Advisory Committee on Immunization Practices (ACIP) recommended schedule and preventive care consistent with the American Academy of Pediatrics periodicity schedule. For members under age 21, medically necessary services covered under federal Medicaid law must be provided when needed to correct or ameliorate identified physical or behavioral health conditions, even when the service is not otherwise covered for adults or exceeds an otherwise applicable amount, duration or scope limit.

In accordance with CMS guidelines, dental services follow a separate pediatric periodicity schedule. EPSDT also covers medically necessary services needed to correct or ameliorate identified physical or behavioral health conditions, whether those services are otherwise included in the state's Medicaid benefits.

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 use 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 – First examination at the eruption of the first tooth and no later than 12 months. Repeat every six months or as indicated by child's risk status/susceptibility to disease. Includes assessment of pathology and injuries.
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 is 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.

Page 8 of CMS's *Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Guide for States* says "States may encourage providers to perform all five components of the EPSDT well-child visit but cannot exclude providers who perform only partial screenings from being paid for the parts they do provide."

Providers must follow the most current Kansas-approved KAN Be Healthy/EPSDT periodicity schedule and applicable screening requirements. Current guidance, schedules, forms and provider resources are available on the KMAP Provider Publications page under *"KAN Be Healthy – Early and Periodic Screening, Diagnostic, and Treatment."*

Sunflower requires providers to fully cooperate with Sunflower's 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 coop-

erate 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.

Scope of EPSDT Treatment Services

In addition to screening services, coverage of certain treatment services may also be approved under EPSDT.

COVERAGE OF MEDICALLY NECESSARY SERVICES

Any service, supply or equipment that has been determined to be medically necessary for a child and is not covered (for adults) under the state Medicaid plan will be approved for the child under EPSDT guidelines.

A treatment service need not cure a condition in order to be approved under EPSDT. Services that maintain or improve the child's current health condition are also covered in EPSDT because they "ameliorate" a condition (that is to say, they make a condition more tolerable to the child). Maintenance services are defined as services that sustain or support, rather than those that cure or improve health problems.

Services are covered when they prevent a condition from worsening or prevent development of additional health problems. Thus, services such as physical and occupational therapy are covered when they have an ameliorative, maintenance purpose. This is particularly important for children with disabilities, because such services can prevent conditions from worsening, reduce pain and avert the development of more costly illnesses and conditions.

Other, less common examples include items of durable medical equipment, such as decubitus cushions, bed rails and augmentative communication devices. Such services are a crucial component of a good, comprehensive child-focused health benefit. See the **HHS EPSDT coverage guide**.

Some examples of services that if medically necessary would be available under EPSDT include (**Mandatory and Optional Medicaid Benefits**):

- Physical therapy
- Occupational therapy
- Speech, hearing and language disorder services
- Other licensed practitioner services
- Private duty nursing services
- Personal care
- Clinic services
- Dental services
- Prescription drugs
- Dentures
- Prosthetics
- Eyeglasses
- Other diagnostic, screening, preventive and rehabilitative services

IMPORTANT CONSIDERATIONS:

- Providers should ensure that all billed services are medically necessary and documented appropriately.
- For services not typically covered under the state's Medicaid plan, providers can submit the **EPSDT Medical Necessity Form (PDF)** to Sunflower following the prior authorization process as documented in the **Prior Authorizations section** of the Sunflower website.

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 call 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 required 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 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 and a plan physician is not available for consultation. In this situation, Sunflower will give the treating physician the opportunity to consult with a plan physician and the treating physician may continue with care of the patient until a plan physician is reached or one of the criteria described below is met.

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

- A plan physician with privileges at the treating hospital assumes responsibility for the member's care;
- A plan physician assumes responsibility for the member's care through transfer;
- A Sunflower representative and the treating physician 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 to render 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 on the **KMAP publications page** 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.

Obstetric Care

Sunflower members who are pregnant have direct access to prenatal/maternal (obstetric) care providers and do not need to obtain a referral from Sunflower or their PCP to seek care from an obstetric 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. The form can be found and downloaded under **Forms > Medical Forms > Pregnancy and Birth Forms**.

Providers can notify us via fax, mail or telephone as soon as they become aware of a pregnancy. Early notification of pregnancy allows us to assist the member with prenatal care and coordination of services. Pregnant members identified as high risk will be referred to our Maternal Health Integrated Care Team (ICT) for follow up and management.

Members may also complete the NOP form by calling the Customer Service department. We also encourage our members to notify us when they are pregnant through ongoing educational programs and member outreach efforts to keep members informed about the importance of early prenatal care and the benefits of the Start Smart for Your Baby® Program. Any Population Health 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 coordi-

nation 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 mailers 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 has 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.

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 prepaid card. Rewards can be used for utilities, transportation, telecommunications, childcare services, education, rent or everyday items at Walmart or Hy-Vee.

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.

HEALTH ACTIVITY	REWARD
Complete an annual Health Risk Screening – One per calendar year.	$25
Participate in a **Member Advisory Committee** meeting.	$10
Annual Child Well Visit – Ages 3-20.	$10
Infant Well Visits – Ages 15-30 months.	$5 each. (Max. $10)
Blood Lead Test Screening – Ages 0-24 months. One per member.	$10
Breast Cancer Screening – Ages 40-74.	$20
Colorectal Cancer Screening – Ages 45-75.	$10
Follow-Up Visit within Seven Days of Intensitive Substance Use Treatment	$10
Diabetes Management – HbA1c tests. Ages 18-75.	$20 per test (max. $40)
Submit **Notice of Pregnancy**	$10
Postpartum Visit – 7-84 days after delivery.	$10

Some rewards 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 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 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 techniques, including health screenings, educational literature and books 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.

Also, Start Smart offers an enhanced breastfeeding educational program for members. For more information about the Sunflower Start Smart program, please call Customer Service at 1-877-644-4623 or the member's assigned case manager.

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.

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.

Value-Added Services

Sunflower offers extra benefits to support members' health and well-being—at no extra cost. These are in addition to their regular Medicaid benefits. Members can learn more or access these services, by visiting www.sunflowerhealthplan.com or calling Customer Service toll free at 1-877-644-4623 (TTY 711).

Please note: Value-Added Benefits are optional extras. They don't include grievance or appeal rights.

BENEFIT HIGHLIGHTS

- **Enhanced Transportation –** Up to 12 round trips per year for the member and their caregiver. They can use these for things like pharmacy visits, support groups, food access, housing services and employment support.
- **My Health Pays® Rewards –** Members earn $5-$25 for completing health checkups, screenings and other activities. See the My Health Pays section for details.
- **Cell Phones –** Through Lifeline providers like Assurance, eligible members can receive free voice, data and text services. Assurance and SafeLink calls to Sunflower's toll-free number don't deplete member minutes.
- **Start Smart® for Your Baby –** Support for pregnant members and families, including:
  - Free nursing support and education
  - Community resource help
  - Texting programs for moms
  - Free baby showers with gifts and health education
  - Rides to WIC appointments
- **First Years of Life Program –** Care coordinators help families with babies (ages 0-24 months) schedule well-child visits and access resources like food, housing and childcare.
- **Community Programs for Children**
  - $50 annual credit for programs like YMCA, Boys & Girls Clubs, Girl Scouts or Scouting America (ages 5-18). Members can see their local club to request this benefit.
  - Sunny's Kids Club for children under 12 includes a membership card, activity book and online resources.
  - Strong Youth Strong Communities™ (SYSC) offers youth-focused resources in partnership with the Pro Football Hall of Fame.
- **Teladoc Digital Mental Health –** Online tools to help manage depression and anxiety, including exercises, mood tracking and inspirational content.
- **Farmers Market Vouchers –** Members get a $10 produce voucher at select events—one per member, no household limit.
- **Healthy Solutions for Life –** Health coaching programs for weight management, stress, nutrition, quitting tobacco and chronic condition support. Some programs have age or other requirements.
- **Caregiving Collaborations®** – Support for one caregiver per member, including stress-reduction resources, support group referrals and access to a Caregiver Journal and Resource Center.
- **Mobile Clinics –** Twice a year, Sunflower brings a mobile clinic to rural communities so members can get dental and vision care close to home. We help with checkups, glasses if needed, and scheduling follow-up visits.
- **Employment Support & Transportation (GROW (GED, Rides, Opportunities, Work) Program) –** Help with employment barriers, GED prep vouchers, extra transportation for job fairs and interviews and career counseling. Members can also speak with a

Benefits Specialist to understand how income affects coverage.

Value-Added Benefits for Waiver Members and Other Groups

- **Practice Dental Visits (I/DD Waiver) –** Up to two practice visits to help members feel more comfortable with dental care.
- **Respite Care (FE & PD Waivers, members on HCBS waiting lists) –** Up to 60 hours per year for unpaid caregivers. No more than 48 hours can be used in one month.
- **Transition Services –** Support for members returning home from jail or nursing facilities (who are not receiving other transition help), including:
  - Transition planning
  - Home health wellness checks
  - Up to $500 for household and personal items
- **Home-Delivered Meals (FE Waiver) –** Up to two meals per day for seven days after returning home from a nursing home or hospital stay. PD and BI waiver members may also qualify through KanCare.
- **Peer Support Program –** In-person and virtual training for waiver members focused on self-direction and independent living.
- **Hospital Companionship –** Up to 16 hours of companionship for waiver members during hospital stays.
- **Behavioral Health & Foster Care Support –** Includes peer-support calls, recorded and live training for foster/adoptive families via Fostercare.com and provider education.
- **Healthy Living (Harvey County) –** Incentive for diabetes education classes, cooking lessons, weekly food boxes and other tools to support healthy lifestyle changes.

Population Health

Overview

Population Health is here to help you Monday through Friday from 8:00 a.m. to 5:00 p.m. CT (excluding holidays). Calls made to our Population Health 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. Population Health 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 Population Health has responsibility for direct supervision and operation of the department. To reach the medical director or VP of Population Health, call the Sunflower Population Health 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) 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 at least five days prior to the scheduled service delivery date (keeping in mind a possible 7-day turnaround time) or as soon as the need for service is identified including weekdays, weekends and holidays.

Once identified notification should occur within one business day, even if the initiation occurs on a weekday, weekend or holiday.

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 therapy.)

Use the Sunflower **Prior Authorization Pre-Screening Tool online** or call a representative for additional information at 1-877-644-4623 and select the Prior Authorization option.

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

Authorization is not required for services in order for coordination of benefits to occur on claims if another health insurance carrier is the primary payer. Sunflower will not coordinate benefits when primary insurer denies for the following reasons: no authorization or lack of medical necessity, untimely filing and duplicate denial. If the primary payer denies due to lack of benefits, i.e., the service is not covered or benefits have been exhausted. This does not apply to Psychiatric Residential Treatment Facilities, as an

auth is required for this service regardless of existence of a primary insurance coverage.

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.)
- Some DME/orthotics/prosthetics require prior authorization. Use **Sunflower's "Pre-Auth Check?" tool** online.
- Home healthcare services, including home infusion, skilled nursing, personal care services and physical therapy.
- 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**.

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 Evolent
- Oral surgery that is potentially cosmetic
- Pain management

INPATIENT AUTHORIZATION

- Medical inpatient services
- All inpatient elective procedures
- 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 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 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. Notification is required regardless of Sunflower's status as secondary or tertiary payer. For your convenience, Sunflower offers an optional **Birth Event Outcomes Notification form** on its website.

Clinical information is required for ongoing care authorization of the services. Currently, the observation stay is limited to 48 hours. Anything over 48 hours requires an inpatient authorization request.

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 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 may be requested by calling 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.
- **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 representative.
- **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
  800-225-2573, ext. 607-5525
  Or by email at EDIBA@centene.com

Home Health Services

Sunflower will authorize up to six home health visits following an inpatient hospital admission, without requirement of clinical documentation. The provider must notify Sunflower of the need for a home health authorization in accordance with timeframes stated above. If more than six visits are required, the provider must request prior authorization as soon as the need is identified and submit clinical documentation for determination of medical necessity.

Radiology & Diagnostic Imaging Services

As part of a continued commitment to further improve the quality of advanced imaging and radiology services, Sunflower is using Evolent to provide prior authorization services and utilization. Evolent 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
- PET

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.

Evolent'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

Some therapy services services require prior authorization. Check the Sunflower Pre-Auth Check tool for current requirements.

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

Evolent provides utilization management services for outpatient physical therapy services on behalf of Sunflower members.

HOW EVOLENT'S PROGRAM WORKS:

Outpatient physical therapy requests are reviewed by Evolent'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 Evolent.

We will automatically approve eight physical therapy visits per member per calendar year. Prior authorization to obtain these eight visits must still be submitted and registered via the **Evolent RadMD website**. The initial evaluation continues to not require prior authorization unless treatment is also rendered during that visit. Subsequent visit requests for physical therapy authorizations will continue the same process currently in place and will be reviewed for medical necessity.

There is no need to send patient records in advance. Evolent 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 Evolent is to review medical necessity of physical therapy 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, by fax at 888-453-4316 or by calling 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**.

Interventional Pain Management (IPM)

Sunflower has partnered with Evolent to manage non-emergent outpatient prior authorizations for Intervention Pain Management (IPM) procedures for Sunflower. It is the responsibility of the ordering physician to obtain authorization for all IPM procedures outlined below.

Outpatient IPM procedures requiring prior authorization include:

- Spinal epidural injections
- Paravertebral facet injections or blocks
- Paravertebral facet joint denervation (radiofrequency neurolysis)
- Sacroiliac joint injections
- Sympathetic nerve blocks
- Spinal cord stimulators

Note: Separate prior authorization number is required for each procedure ordered above. Prior authorization is not required through Evolent for services performed in the emergency department, on an inpatient basis, or in conjunction with a surgery. Prior authorization and/or notification of admission is still required through Sunflower.

Musculoskeletal Care Management (MSK)

In keeping with our commitment tof promote continuous quality improvement for services provided to Sunflower members, Sunflower has partnered with Evolent to implement a Musculoskeletal Care Management (MSK) program.

This program includes prior authorization for non-emergent MSK procedures for Sunflower members. This decision is consistent with industry-wide efforts to ensure clinically appropriate quality of care and to manage the increasing utilization of these services.

HOW THE PROGRAM WORKS

MSK Surgeries: Prior authorization will be required for the following non-emergent inpatient and outpatient hip, knee, shoulder, lumbar and cervical surgeries:

Hip
- Revision/conversion hip arthroplasty
- Total hip arthroplasty/resurfacing
- Femoroacetabular impingement (FAI) hip surgery (includes CAM/pincher & labral repair)
- Hip surgery – Other (includes synovectomy, loose body removal, debridement, diagnostic hip arthroscopy and extra-articular arthroscopy knee)

Knee
- Revision knee arthroplasty
- Total knee arthroplasty (TKA)
- Partial-unicompartmental knee arthroplasty (UKA)
- Knee manipulation under anesthesia (MUA)
- Knee ligament reconstruction/repair
- Knee meniscectomy/meniscal repair/meniscal transplant
- Knee surgery – Other (includes synovectomy, loose body removal, diagnostic knee arthroscopy, debridement with or without chondroplasty, lateral release/patellar realignment, articular cartilage restoration)

Shoulder
- Revision shoulder arthroplasty
- Total/reverse shoulder arthroplasty or resurfacing
- Partial shoulder arthroplasty/hemiarthroplasty
- Shoulder rotator cuff repair
- Shoulder labral repair
- Frozen shoulder/adhesive capsulitis repair
- Shoulder surgery – Other (includes debridement, manipulation, decompression, tenotomy, tenodesis, synovectomy, claviculectomy, diagnostic shoulder arthroscopy)

Cervical
- Cervical anterior decompression with fusion – single & multiple levels
- Cervical posterior decompression with fusion – single & multiple levels
- Cervical posterior decompression (without fusion)
- Cervical artificial disc replacement – single & two levels
- Cervical anterior decompression (without fusion)

Lumbar
- Lumbar microdiscectomy
- Lumbar decompression (laminotomy, laminectomy, facetectomy & foraminotomy)
- Lumbar spine fusion (arthrodesis) with or without decompression – single & multiple levels
- Lumbar artificial disc – single & multiple levels

Sacroiliac
- Sacroiliac joint fusion

As a part of the Evolent clinical review process, actively practicing, orthopedic surgeon specialists (hip, knee and shoulder) or neurosurgeons (spine) will conduct the medical necessity reviews and determinations of musculoskeletal surgery cases.

Please refer to the "Solutions" tab on the Evolent home page (**www.RadMD.com**) for additional information on the MSK program. Checklists and tip sheets are available there to help providers ensure surgical procedures are delivered according to national clinical guidelines.

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 7 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.
- 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 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.

National Performance-Based Gold Card Program

Sunflower may offer a Performance-Based Gold Card Program for select participating providers who consistently demonstrate high prior authorization approval rates for selected outpatient services. Providers participating in the program will not be required to wait for an authorization determination before rendering Gold Card eligible services following submission of the required pre-notification.

Pre-notifications must be submitted through Availity, or for services managed by Evolent through the Evolent portal. The program applies only to specifically identified outpatient services and does not apply to inpatient services or services outside the designated Gold Card scope.

Participation in the program is limited to providers who meet established eligibility criteria and performance standards determined by the health plan. Eligibility is assessed at the Ordering/Referring Tax Identification Number (TIN) level and may be reviewed periodically to ensure ongoing compliance with utilization management, billing and program integrity expectations. Participation does not waive medical necessity, member eligibility, coverage, benefit or network requirements, and the health plan retains the right to conduct utilization review, audit and program integrity activities in accordance with applicable federal and state requirements. Additional operational guidance, including eligible services and implementation details, will be communicated to participating providers as applicable.

Providers may be removed from the program if monitoring or audit activities identify concerns related to utilization patterns, billing practices, fraud, waste, abuse or noncompliance with program requirements.

Lock-In

The administrative lock-in program is designed to help members get consistent care from providers in the Sunflower Health Plan network. Members are identified for the lock-in program through utilization analysis, provider referrals and various other 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 email. When making a referral, please include the member's name, date of birth and Medicaid ID number.
- To make a referral by phone or for questions about the Lock-in program, providers may call 1-877-644-4623.
- To make a referral by fax, send your request to: Sunflower Health Plan, Attn: Pharmacy Department Lock-In Program. Fax 1-833-950-3295.
- Email 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.

Sunflower adheres to the State of Kansas formulary and 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 or behavioral 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 used 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 Population Health 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

Providers may find Sunflower's Medical Necessity Criteria on **Sunflower's website**.

High-Tech Imaging – Sunflower will use an internally developed criteria set to determine medical necessity of CT scan or MRI/MRA, as developed by Evolent, our high-technology imaging subcontractor. Evolent 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.

Evolent 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 **Evolent's public website**.

Oncology Prior Authorizations - All oncology-related infused and oral chemotherapeutic drugs/supportive agents listed on the KDHE Prior Authorization Criteria for Oncology Agents and Oncology – Auxiliary Treatment Agents will require a prior authorization from Evolent before being administered in either the provider's office, outpatient hospital, ambulatory setting or infusion center. Authorizations for Medicaid members ages 21 and over will be reviewed by NCH.

NCH uses clinical criteria based on nationally recognized guidelines to promote evidence-based cancer care. NCH providers increase collaboration with physician offices to foster a team approach through physician discussions with true peer, medical oncologists who can understand and better discuss treatment plans.

Authorizations may be submitted to the NCH provider web portal at **my.newcenturyhealth.com** or by calling 1-888-999-7713.

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

Substance Use Criteria – Sunflower will use the American Society for Addiction Medicine (ASAM) Patient Placement Criteria as required in the contract. Our behavioral health and substance use 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.

Peer-to-Peer Discussions

Medical directors in Sunflower's Medical Affairs and Population Health departments may conduct a peer-to-peer review with providers following a denied request for KanCare services. Peer-to-peer discussions are conducted at the request of the ordering provider. A peer-to-peer review can be conducted with physicians, nurse practitioners, attending/hospitalist physicians or specialists. Further, Sunflower will conduct peer-to-peer discussions with physical therapy providers when necessary.

Behavioral health peer-to-peer discussions can be conducted with a psychiatrist, APRN, social worker, therapist or substance use disorder counselor. Ordering providers may delegate peer-to-peer rights to a resident physician when permitted by facility contract, registered nurse, physician assistant or a licensed ancillary healthcare professional, including 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 med-

ical officer. The CPC will develop or revise criteria based on a new technology or procedure, a new use for existing technology, or a negative trend in length of stay or utilization. The Sunflower CMD will work with the CPC and KDADS to ensure 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 call the Population Health department at 1-877-644-4623.

Concurrent Review and Discharge Planning

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 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 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 needs 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 a member was awarded retroactive eligibility and has a denied claim, 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 Sunflower confirms that the member was retroactively enrolled, an authorization will be created upon receipt of the reconsideration/appeal request.

- Sunflower will require an authorization request in order to pay a claim where retrospective eligibility covered the entire length of stay. **Example:** Member is inpatient from 1/1/2021-1/5/2021, the state determines the member eligible on 1/8/2021 back-dating to 1/1/2021.
- **Example:** Member receives home health services from 2/3/2021-3/3/2021, the state determines the member eligible on 4/1/2021 back-dating to 2/1/2021.

Provider should be aware of the 180-day timely filing from date of eligibility determination. Claim will be denied if not submitted timely.

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
- Substance Abuse and Mental Health Services of America (SAMHSA)
- American Academy of Child and Adolescent Psychiatry (AACAP)
- American Psychological Association
- American Psychiatric Association (APA)
- United States Department of Veteran Affairs and the Department of Defense (VA/DoD)

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

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, employment support programs or behavioral health services.

The program is based upon a Sunflower model that uses a multidisciplinary, integrated care management team and fosters a holistic approach to care to yield better outcomes. The goal of our program is to help members achieve the highest possible levels of wellness, functionality and quality of life, while decreasing the 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 and removing barriers that may impact member's ability to achieve optimal health outcomes.

Members receiving Long-Term Services and Supports (LTSS) and Home and Community Based Services (HCBS) may be assigned enhanced care management based on their assessed needs. These members may receive care coordination through an Interdisciplinary Care Team (ICT) that may include the member, caregivers, authorized representatives, primary care providers, specialists, behavioral health providers, HCBS providers, community-based organizations and other individuals involved in the member's care.

Members receiving services through the Community Support Waiver (CSW) may also be eligible for enhanced care management and care coordination based on their assessed needs. Care management activities may include coordination with the member, caregivers, authorized representatives, primary care providers, behavioral health providers, Targeted Case Managers, Community Developmental Disability Organizations (CDDOs), waiver service providers and other members of the Interdisciplinary Care Team (ICT). Care management supports person-centered planning, member choice, community integration, continuity of care and access to services and supports designed to promote independence and successful participation in home and community-based settings.

Members in Foster Care (custody of the Kansas Department for Children and Families (DCF) may be assigned enhanced care management based on their assessed needs. Care management may include coordination with the member, foster parents or placement caregivers, DCF, foster care case management providers, primary care and behavioral health providers and other members of the Interdisciplinary Care Team (ICT). Care management supports trauma-informed planning, placement stability, continuity of care during transitions and timely access to physical and behavioral health services.

Targeted Case Management (TCM) Responsibilities for I/DD Waiver Members

TCMs support members receiving Intellectual and Developmental Disability (I/DD) Waiver services by facilitating person-centered planning, coordinating services and supports, promoting member choice and self-determination and monitoring member health, safety, welfare and progress toward identified goals.

For members receiving I/DD Waiver services, TCM responsibilities include:

- Identifying and documenting member strengths, needs, preferences, priorities, risks and goals.

- Facilitating, developing, implementing, maintaining, monitoring and updating the Person-Centered Service Plan (PCSP).
- Ensuring the Person-Centered Service Plan is reviewed and updated no less than every 365 days and more frequently when there is a significant change in the member's needs, services, supports, goals, health, safety, welfare or living situation.
- Coordinating with members, caregivers, authorized representatives, Community Developmental Disability Organizations (CDDOs), healthcare providers, behavioral health providers, waiver providers, educational supports, employment supports and other members of the Interdisciplinary Care Team (ICT).
- Assisting members in accessing medically necessary services, waiver services, educational supports, employment supports, transportation resources, housing resources and other available community supports.
- Monitoring service utilization, service delivery, member health and welfare, access to services and progress toward identified goals.
- Facilitating communication among providers, caregivers, CDDOs and other members of the care team.
- Supporting community integration, independence, self-determination, informed choice and continuity of care.

All I/DD Waiver TCM activities shall be conducted in accordance with applicable federal and state laws, regulations, CMS requirements, Medicaid requirements, KanCare requirements, KDADS policies, HCBS requirements, I/DD Waiver requirements, member rights provisions, person-centered planning requirements, health and welfare standards, conflict-of-interest requirements and all other applicable program requirements.

Failure to perform required TCM activities, including but not limited to: development, implementation, review, monitoring and updating of Person-Centered Service Plans (PCSPs); completion of required annual and interim reviews; health and welfare monitoring; service coordination; required member contacts; documentation; service monitoring; coordination with providers and Community Developmental Disability Organizations (CDDOs); or compliance with applicable waiver, KanCare, KDADS, state or federal requirements may result in monitoring activities, audit findings, corrective action plans, retraining requirements, referral to KDADS or other oversight entities, suspension of referrals, recovery or recoupment of payments for services that were not properly performed or documented, contract action or other actions consistent with applicable contractual, regulatory, credentialing and program requirements.

Targeted Case Management (TCM) Responsibilities for Comprehensive I/DD Waiver and Community Support Waiver (CSW) Members

TCMs support members enrolled in the Community Support Waiver (CSW) by facilitating person-centered planning, supporting participant direction and informed choice, coordinating services and supports, assisting with budget planning and resource allocation, monitoring member health and welfare and promoting community integration, independence, employment and self-sufficiency.

For members receiving Comprehensive I/DD Waiver and Community Support Waiver (CSW) services, TCM responsibilities include:

- Identifying and documenting member strengths, needs, preferences, priorities, risks, goals, desired outcomes and support needs.
- Facilitating, developing, implementing, maintaining, monitoring and updating the Person-Centered Support and Service Plan (PCSP).
- Ensuring the PCSP is reviewed and updated no less than every 365 days and more frequently when there is a significant change in the member's goals, supports, services, employment activities, health, safety, welfare or living situation.
- Assisting members in understanding available waiver services, supports, provider options, participant-direction opportunities, community resources and employment-related supports.
- Developing, coordinating, maintaining and monitoring Budget Authority Worksheets, individual budget planning activities, service authorization requests, spending plans, backup planning requirements and other documentation required under Comprehensive I/DD Waiver and Community Support Waiver (CSW) requirements.
- Assisting members in selecting providers and supports consistent with the member's goals, preferences and approved PCSP.

- Monitoring utilization of waiver services and supports to ensure services remain consistent with the approved PCSP, authorized budget, health and welfare requirements and waiver requirements.
- Coordinating with members, caregivers, authorized representatives, Community Developmental Disability Organizations (CDDOs), waiver providers, healthcare providers, behavioral health providers, employment support providers, community organizations and other members of the Interdisciplinary Care Team (ICT).
- Facilitating communication among providers and coordinating transitions between services, employment supports, providers, waiver programs and community-based resources.
- Monitoring member health, safety, welfare, access to services, backup planning, continuity of support systems and progress toward identified goals and outcomes.
- Assisting members in identifying and addressing barriers that impact employment, independence, self-direction, community integration, access to services, health, safety, welfare or successful participation in home and community-based settings.

All TCM activities shall be conducted in accordance with applicable federal and state laws, regulations, CMS requirements, Medicaid requirements, KanCare requirements, KDADS policies, HCBS Final Rule requirements, waiver requirements, approved budget requirements, member rights provisions, person-centered planning standards, conflict-of-interest requirements, health and welfare standards and all other applicable program requirements.

Failure to perform required TCM activities, including but not limited to development, implementation, review, monitoring, and updating of PCSPs; completion of required annual and interim reviews; development, maintenance, monitoring, or documentation of Budget Authority Worksheets, CSW only; individual budget planning; spending plans; backup plans; service authorizations; health and welfare monitoring; service coordination; required member contacts; documentation; monitoring of approved services and expenditures; compliance with applicable budget requirements; or compliance with waiver requirements, KanCare, KDADS, state, or federal requirements may result in monitoring activities, audit findings, corrective action plans, retraining requirements, referral to KDADS or other oversight entities, recovery or recoupment of payments for services that were not properly performed or documented, suspension of referrals, contract action or other actions consistent with applicable contractual, regulatory, credentialing and program requirements.

Care management activities support person-centered planning, care coordination, community integration, continuity of care and access to medically necessary services and supports designed to help members achieve their individual goals and remain in the least restrictive setting appropriate to their needs.

Providers are encouraged to refer members who may benefit from care management, including members with complex medical conditions, behavioral health needs, LTSS, HCBS Waiver needs, members experiencing barriers related to social determinants of health and members who may benefit from additional care coordination and support services.

To contact a care manager, call **Sunflower Care Management at 1-877-644-4623.**

Disease Management Programs

Disease management is the concept of reducing healthcare costs and improving quality of life, for people 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.

Sunflower's disease management 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, 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 the need and level of intervention most appro-

priate 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 may include members with serious mental illness (SMI), including severe and persistent behavioral/mental illness (SMPI) or issues with substance use, children in foster care or other out-of-home placement, members who have aged out of foster care or have been adopted, members with complex medical needs and members who meet medical necessity for HCBS waiver services or other Long-term Services and Supports (LTSS) programs.

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 shall maintain clinical and medical records in a manner that is current, detailed, organized and that permits effective and confidential patient care and quality review, administrative, civil and/or criminal investigations and/or prosecutions. Clinical and medical records shall be consistent with 42 CFR §456 and current National Committee for Quality Assurance (NCQA) standards, as well as all other related state and federal laws for medical record documentation.

Providers must maintain the confidentiality of clinical and medical record information and release the information only in the following manner:

- All clinical and medical records of members shall be confidential and shall only be released in compliance with HIPAA and other applicable record-protection laws.
- Written consent of the member is only required for the transmission of clinical and medical record information of a former enrolled member for "sensitive conditions" or as otherwise specified by HIPAA and other applicable record-protection laws. Authorization is not required when Sunflower is transitioning the member's care to another KanCare MCO.
- The extent of clinical or medical record information to be released in each instance shall be based upon tests of medical necessity and a "need to know" on the part of the provider requesting the information.
- All releases of information for SUD specific clinical or medical records must meet federal guidelines at 42 CFR Part 2.

Sunflower requires providers to maintain all member clinical and medical records and claim forms for at least 10

years from the date of termination of the contract. Records involving matters that are the subject of litigation shall be retained for a period of not less than 10 years following the termination of such litigation, if the litigation is not terminated within the normal retention period. 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 use 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-/underutilization 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.

If 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 may 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 beneficiaries or any financially responsible relatives or representatives of those individuals any amount in excess of the Sunflower-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

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: 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 KDHE.
- 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 representative 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 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 **Sunflowerstatehealth@centene.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 used 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 any of more than 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 enter claims directly online in HIPAA Direct Data Entry (DDE) compliant fashion via our online claims entry feature — another component of our secure provider portal.

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**.

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

- Go to **SunflowerHealthPlan.com**.
- Click "Login" and follow the instructions.

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

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

Electronic Claims Submission

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

Sunflower Health Plan, c/o Centene EDI Department 1-800-225-2573, ext. 607-5525 or by email at **EDI-BA@centene.com**

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

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

The Sunflower payer ID is 68069 (behavioral health 68068), and we accept claims from Availity.

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

- Claims submitted by optometrists or ophthalmologists can be submitted electronically.
- Information on submission of claims to Centene Vision Services can be found on their website at **centenevision.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 Centene Vision Services.

Dental Providers (ADA or 837D):

- Dental claim forms can be submitted electronically. Information on submission of claims to Centene Dental Services can be found on their website at **centenedental.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 can 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 The below should come from the primary payer's Explanation of Payment	**837I - INSTITUTIONAL EDI SEGMENT AND LOOP**	**837P - PROFESSIONAL EDI SEGMENT AND LOOP – COB INFORMATION MUST BE SUBMITTED AT DETAIL LINE LEVEL**
COB Paid Amount	If 2320/AMT01=D, MAP AMT02 or 2430/SVD02	If 2320/AMT01=D, MAP AMT02 or 2430/SVD02
COB Total Non-Covered Amount	If 2320/AMT01=A8, map AMT02	If 2320/AMT01=A8, map AMT02
COB Remaining Patient Liability	If 2300/CAS01 = PR, map CAS03 Note: Segment can have 6 occurrences. Loop2320/AMT01=EAF, map AMT02, which is the sum of all of CAS03 with CAS01 segments presented with a PR	If 2320/AMT01=EAF, map AMT02
COB Patient Paid Amount		If 2320/AMT01 = F5, map AMT02
COB Patient Paid Amount Estimated	If 2300/AMT01=F3, map AMT02	
Total Claim Before Taxes Amount	If 2400/AMT01 = N8, map AMT02	If 2320/AMT01 = T, map AMT02
COB Claim Adjudication Date	IF 2330B/DTP01 = 573, map DTP03	IF 2330B/DTP01 = 573, map DTP03
COB Claim Adjustment Indicator	IF 2330B/REF01 = T4, map REF02	IF 2330B/REF01 = T4, map REF02 with a Y

Specific Data Record Requirements

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

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 email 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 in the appendices of this manual. Go to the section on electronic claim filing for more details.

Exclusions

Excluded Claim Categories

- Excluded from EDI Submission Options
- Must Be Filed Paper
- Applies to Inpatient and Outpatient Claim Types

Claim records requiring supportive documentation or attachments (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:

ACTION	CONTACT
Clearinghouses Submitting Directly to Sunflower	Availity
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 email 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 email at **EDIBA@centene.com**
Remittance Advice Questions	Call 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 Dr., Ste. 410 Lenexa, KS 66214

Important Steps to Successful Submission of EDI Claims

1. Select a clearinghouse to use 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 in the appendices of this manual 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 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:

PAPER CLAIMS SUBMISSIONS	
Behavioral Health	Sunflower Health Plan PO Box 6400 Farmington, MO 63640-3807
Dental	Centene Dental Services Kansas Claims P.O. Box 25857 Tampa, FL 33622-5857
Pharmacy	Sunflower Health Plan PO Box 4070 Farmington, MO 63640-3833
SafeRide	Member Claims: 106 Jefferson, Suite 300, San Antonio, TX 78205 Fax: 888-453-5398 or email Sunflower_Claims@Saferidehealth.com
Vision	Centene Vision Services PO Box 7548 Rocky Mount, NC 27804
Medical, NF/LTC and HCBS Services	Sunflower Health Plan PO Box 4070 Farmington, MO 63640-3833

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, call Customer Service at 1-877-644-4623.

Sunflower encourages all providers to submit claims electronically.

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

Correct Coding and Billing of Claims

Providers should always document and code according to CMS regulations and follow all applicable coding guidelines for 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 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.
  - ICD 10 diagnosis code billed with decimal.
- 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:
  - Sterilization and Abortion Necessity forms are located on the **KMAP website**.
- Abortions are only covered under the following conditions:
  - In the case where a woman suffers from a physical disorder, physical injury, or physical illness, includ-

ing 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.**

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 in the appendices of this manual. 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
  - REF*F8 = Must contain the original claim number from the Explanation of Payment (EOP)

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)."

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**.

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.*

Corrected claims submitted via the portal cannot be submitted at the header level. The "header level" provides an overview of the bill. The header details give basic information that includes, but is not limited to, member ID, NPI, date of service, etc. Claim header-level adjustments cannot be applied to a line item because they are not specific to an individual procedure.

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.

Call 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.
- *Get copies of Explanations of Payment (EOPs).*
- *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 call our Customer Service department at 1-877-644-4623.

Zelis® Electronic Payments & Remittance

Effective Q1 2027, Sunflower will transition from PaySpan® to Zelis® for electronic payment and remittance services.

Providers enrolled with PaySpan may be required to take action to maintain electronic payment delivery and access to remittance information. Providers are encouraged to review available payment options and enrollment requirements prior to the transition date.

ZELIS OVERVIEW

Zelis is a secure electronic payment and remittance solution that allows providers to receive claim payments and access remittance information electronically. Through Zelis, providers can select from available electronic payment options, access payment information and reduce administrative burden associated with paper checks and mailed Explanation of Payments (EOPs).

Available payment options may include Electronic Funds Transfer (EFT), ZAPP Edge, Virtual Credit Card (VCC) or paper check, depending on provider enrollment status and payment preferences.

BENEFITS TO PROVIDERS

- Faster access to claim payments through electronic payment options
- Online access to payment and remittance information
- Reduced reliance on paper checks and mailed remittance documents
- Enhanced payment security
- Simplified payment reconciliation and reporting
- Support from Zelis for payment enrollment and payment delivery questions

AVAILABLE PAYMENT OPTIONS

ZAPP Edge

ZAPP Edge is an electronic payment solution offered through Zelis that allows providers to receive payments and remittance information from multiple participating payers through a single connection.

Benefits may include:

- Consolidated payment delivery from multiple participating payers.
- Access to payment information and 835 files.
- Centralized payment management and reporting.
- Access to Zelis payment support resources.

Providers interested in enrolling in ZAPP Edge should contact Zelis directly. Fees may apply.

Virtual Credit Card (VCC)

Virtual Credit Card is an electronic payment option offered through Zelis that provides a unique, single-use credit card number for claim payments.

Important information regarding Virtual Credit Card payments:

- A unique card number is generated for each payment.
- Standard merchant processing fees may apply.
- Fees are determined by the provider's merchant services agreement.
- Providers may contact Zelis to change payment preferences or opt out of this payment method.

Paper Checks

Providers who do not enroll in an available electronic payment option may receive claim payments by paper check. Paper checks may result in longer delivery times and additional administrative handling compared to electronic payment methods.

ENROLLMENT

Providers interested in receiving electronic payments through Zelis should contact Zelis to review available payment options and complete any required enrollment steps.

Enrollment requirements may include:

- Verification of Tax Identification Number (TIN) and National Provider Identifier (NPI) information.
- Submission of banking information, if applicable.
- Selection of payment preferences.
- Establishment of user account and security settings.

Providers should have recent payment or provider information available when completing the enrollment process.

SUPPORT & ASSISTANCE

For questions regarding enrollment, payment preferences, payment delivery or technical support, providers may contact Zelis:

- **Phone:** 877-828-8770
- **Email:** csdept@zelis.com

Prospective and Retrospective Claim Reviews

Sunflower is contractually obligated to have procedures 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 has a management contract with its parent organization, Centene Corporation, in which Centene conducts routine pre- and post-processing claims audits and reviews on behalf of Sunflower. These audits are designed to ensure that billing codes and practices are correct and that Sunflower 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 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 will seek recovery of all overpayments.

Depending on the number of services provided during the review period, Sunflower 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 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 will recover all amounts paid for the services in question.

PAYMENT REVIEWS OF HOSPITAL CLAIMS

Sunflower Health Plan will process and reimburse for inpatient hospitals 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: (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'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 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 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's contracted vendors:

- Cotiviti Healthcare (formerly Connolly Healthcare)
- Optum (formerly AIM)
- HMS

Refunds and Overpayments

Sunflower 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. 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 and complete information regarding third-party liability. If a provider becomes aware of third-party liability not known by Sunflower, the provider shall notify Sunflower Customer Service at 1-877-644-4623 or follow the procedure 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 uses the services of a third party for post-payment review of potential third-party liability issues. The third party analyzes post-payment claims data, investigates potential third-party liability situations and pursues any potential recoveries. Any identified third-party liability will be reported to KanCare.

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

Note: *Sunflower requires that providers submit COB information at the line level for each claim detail line when billed on a HCFA 1500. Sunflower will honor the KDHE TPL non-covered list as published on the KMAP website in the form of a* ***provider bulletin*** *each year.*

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 *even though you have already been paid for providing these services.*

It is mandatory for all PCPs to submit encounter data. Each month, Sunflower generates an encounter report to evaluate all aspects of provider compliance, quality and utilization management related to encounter data submission. Both the state and federal governments have strict requirements regarding the timely and accurate submission of encounter data. If you are unsure of these requirements or of your ability to comply with these requirements, please call Sunflower at 1-877-644-4623 for further assistance. Encounter claims do not generate an EOP.

Providers must submit a claim for each service 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 on the **KDADS website**. 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).*

Anti-Fraud, Waste & Abuse (FWA)

Sunflower is committed to preventing, identifying and reporting all instances of suspected fraud, waste and abuse.

As an affiliate of Centene Corporation, Sunflower uses 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 are responsible 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 Dr., Ste. 410
  Lenexa, KS 66214
- You can also report suspected provider fraud, waste and abuse and fraud to the Kansas Medicaid Fraud and Abuse Division by mail, phone or online submission:
  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

Complaints also may be submitted at www.ag.ks.gov/file-a-complaint/medic-aid-fraud-abuse.

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.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 at least 10 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, 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, but a written request is 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.
- 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.
- You can send information or documents that support the grievance to Sunflower by mail or fax.
- We will provide you documentation used to make the decision about the grievance on your request.
- Sunflower will help with filling out any forms needed for the process.
- Fax or mail rievances to:
  Sunflower Health Plan
  Attn: Grievance Department
  PO Box 10287
  Van Nuys, CA 91410-0287
  Fax: 888-453-4755

GRIEVANCE TIMELINE

Step 1: Grievance filed by calling Customer Service at 1-877-644-4623 (TTY 711) 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. If we cannot resolve the grievance in 30 calendar days, we may extend the timeframe by up to 14 calendar days to gather more information for a resolution.

If we extend the timeframe for a member grievance, we will attempt to contact the requestor by phone and will send a written notice within two calendar days to notify of the

reason for extension. The notice will inform the member of a right to file a grievance if the member disagrees with that decision to extend the timeframe.

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 or adjustment of payment amount of a claim.

A provider, or other member designated person, may represent a member and request a member or pre-service appeal with the written 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 do not 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.
- Information or documents that support the appeal can be sent to Sunflower by mail or fax.
- Sunflower will help fill out any forms needed for the process, which can include auxiliary aids and services like interpreters, toll-free number with TTY and interpreter capability.
- For appeals that require medical necessity review, the final decision to uphold an appeal must be made by a physician with appropriate clinical expertise who was not involved in the initial denial decision and is not subordinate to the practitioner who made the initial denial decision.
- Sunflower wants to resolve appeal concerns quickly and will resolve standard member appeals within 30 calendar days of filing with us. For appeals related to services that put the member's health or functioning at immediate risk, you may request an expedited appeal. 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. You may also submit an expedited appeal request via fax. 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 two calendar days. The appeal will be processed in the standard member appeal timeframe.
- If we cannot resolve the appeal in the expected timeframe (30 days for a standard appeal, 72 hours for an expedited appeal), 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 time to resolve the appeal, we will attempt to contact the requestor by phone and will send a written notice within two calendar days to notify of the reason for extension. The notice will inform the member of their right to file a grievance if the member disagrees with that decision to extend the timeframe.

WHERE TO SEND MEMBER APPEALS

*Requires **Authorized Representative Designation form** from member & information included in Member Appeals section.

ADDRESS

- Sunflower Health Plan
  Attn: Appeals Department
  P.O. Box 10287
  Van Nuys, CA 91410-0287

Fax: 1-888-453-4755 OR
Call: 1-877-644-4623

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?

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 call Customer Service at 1-877-644-4623 (TTY 711).

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 a previously authorized course of treatment.
- 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 authorized provider.
- 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 the member's appeal is denied or the action taken by Sunflower is affirmed 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 and request for continuation of benefits is requested within 10 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.

HCBS SERVICES:

Services will be continued during the appeal or state fair hearing process if all of the following criteria are met:

- Sunflower'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 authorized provider.
- The original period covered by the authorization has not expired.

If the member requested different HCBS program services to replace your previously authorized HCBS program services, and Sunflower authorized the new HCBS program ser vices, yourservices, their previously authorized HCBS program services must be terminated to allow their new HCBS program services to begin. If their new HCBS program services will begin within 63 days of the date of the Notice of Adverse Benefit Determination terminating their previously authorized HCBS program services, their previously authorized HCBS program services will be continued only until their new HCBS program services begin.

If a member asks for a Sunflower appeal or a state fair hearing, the current HCBS program services will continue for the duration of the Sunflower appeal and/or until the date of the decision in the state fair hearing (if one is requested).

If a member's appeal results in denial or the action taken by Sunflower is affirmed by the Office of Administrative Hearings, the member 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.

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:

- Call Sunflower and ask us to file a state fair hearing request.
- Send a letter to Sunflower and ask us to file a state fair hearing request.
- 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, followed by a provider appeal step, to have a decision made by Sunflower 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:

- This step is optional and not required in order to request an appeal or state fair hearing.
- 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 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 (including provider portal submission) within 60 calendar days of the date of the notice of action. Three 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. If payment was denied due to failure to timely submit an authorization request or notification, provide information regarding any extenuating circumstances. If sufficient evidence is provided demonstrating an extenuating circumstance, Sunflower will perform a medical necessity review as applicable.
- Information on how and where to appeal will be included in the EOP or notice 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 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*

After completing the Sunflower Health Plan 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 Dr., Suite 410
Lenexa, KS 66214

- The provider may request an external review regarding a claim payment decision made by Sunflower 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 Appeal Resolution. Three additional days are allowed for mailing.
- For denials of authorization for new health care services, the provider must complete a member appeal on behalf of the member with the member's written consent.
- Sunflower will acknowledge EITPR requests within five business days of receiving the request. Sunflower may reverse their decision upon receipt of the EITPR request. In those instances, Sunflower will send an approval notice to the provider and affected member, if applicable, within five business days of receiving the EITPR. Otherwise, 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 five 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 submit the EITPR request with the EITPR request form.
  - The provider did not sign the EITPR request form.
- The external reviewer will only 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. Regardless of outcome, 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 a state fair hearing within 30 calendar days from the date on Sunflower's Notice of EITPR Resolution. Three additional days are allowed for mailing.

State Fair Hearing for Provider Appeals

Providers can only request state fair hearings after completing the Sunflower internal provider appeal, including receipt of the Provider Appeal Resolution Notice. Seeking an EITPR is optional and not required in order to file a request for a state fair hearing. If an EITPR is requested, the provider should wait until the EITPR is resolved before requesting a state fair hearing.

If no EITPR is sought, any state fair hearing request must be made within 120 calendar days of the date of the Provider Appeal Resolution Notice. Three additional calendar days will be allowed for mailing time. If an EITPR has been sought and completed, a request for any state fair hearing must be made within 30 calendar days from the date on Sunflower Health Plan's Notice of EITPR Resolution. Three additional days are allowed for mailing. Providers must comply with the state fair hearing process.

A request for a state fair hearing must be submitted in writing to the Office of Administrative Hearings:

Office of Administrative Hearings
1020 Kansas Avenue
Topeka, KS, 66612

Provider Appeal Process Steps and Timelines

RECONSIDERATION	
Send Where	**Call Customer Service:** 1-877-644-4623. Mail to the address listed in EOP or letter or submit via the provider portal.
Send What	■ Claim number ■ Reason for request ■ Supporting documentation ■ Other items requested
Deadline to Submit	Within 120 calendar days from the date of the notice of action. Three additional calendar days will be allowed for mailing time.
Expected Timeline for Response	Within five business days from date of reconsideration resolution, a revised or unrevised EOP will be sent.
Rules and Prerequisites	**This step is optional.** Provider appeal rights are preserved, and provider may terminate this step and request an appeal instead within 60 calendar days from the date of the notice of action. Three additional calendar days will be allowed for mailing.
Resolution/Decision Notification Type	Revised or unrevised EOP (for same claim number).
Expected Timeline for Resolution Notice	The reconsideration will be resolved within 30 calendar days of receipt.
PROVIDER APPEAL	
Send Where	Mail to the address listed in EOP or letter or submit via the provider portal.
Send What	Provider Reconsideration and Appeal Form or additional form provided with EOP or letter. **Pharmacy MAC Pricing Inquiry:** For assistance or questions, contact Express Scripts at 800-717-6630 or https://prc.express-scripts.com.
Deadline to Submit	Within 60 calendar days from date of the EOP or notice of action. Three additional calendar days will be allowed for mailing time.
Expected Timeline for Acknowledgment	Provider appeals will be acknowledged within 10 calendar days of receipt.
Resolution/Decision Notification Type	Written Provider Appeal Resolution Notice.
Expected Timeline for Resolution Notice	Provider appeals will be resolved within 30 calendar days of receipt. Notice of Appeal Resolution will be sent within five business days from the date of resolution.

Sunflower Customer Service Department: 1-877-644-4623 (TTY 711)

EXTERNAL INDEPENDENT THIRD PARTY REVIEW (EITPR)	
Send Where	Sunflower Health Plan, Appeals Dept., 8325 Lenexa Dr., Ste. 410. Lenexa, KS 66214 Fax: 1-888-453-4755
Send What	Providers must submit the request in writing using the **EITPR Request form** available on Sunflower's website or attached to the appeal resolution notice. The form must be signed and completed entirely in order to be processed.
Deadline to Submit	Within 60 calendar days from the date of the notice of appeal resolution. Three additional calendar days will be allowed for mailing time.
Rules and Prerequisites	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: the provider must complete a member appeal on behalf of the member with written member consent.
Resolution/Decision Notification Type	Written resolution notice from Sunflower Health Plan.
STATE FAIR HEARING	
Send Where	**Office of Administrative Hearings (OAH)** 1020 Kansas Avenue, Topeka, KS 66612 **Phone:** 1-785-296-2433
Send What	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.**
Deadline to Submit	▪ Within 120 calendar days from the date of the Notice of Appeal Resolution. Three additional calendar days will be allowed for mailing time. **OR** ▪ Within 30 calendar days from the date of the Notice of EITPR Resolution. Three additional calendar days will be allowed for mailing time.
Expected Timeline for Response	Varies at discretion of OAH.
Rules and Prerequisites	Provider must complete the appeal step and receive a determination from Sunflower prior to requesting a state fair hearing.
Resolution/Decision Notification Type	Written communication from OAH.

WHERE TO SEND PROVIDER CLAIM APPEALS

TYPE OF SERVICE	SUNFLOWER SPECIALTY PARTNER	PROVIDER APPEALS *Requires info found in Provider Appeal section
▪ Medical, NF/LTC, or HCBS Services ▪ High Resolution Imaging ▪ Physical Therapy (PT)		Sunflower Health Plan Attn: Provider Appeals PO Box 4070 Farmington, MO 63640-3833
Behavioral Health Services	Sunflower Health Plan	Sunflower Health Plan BH Claim Appeals P.O. Box 6400 Farmington, MO 63640-3809
Vision	Centene Vision Services	Centene Vision Services Attn: Claims Appeal Committee PO Box 7548 Rocky Mount, NC 27804
Dental	Centene Dental Services	Centene Dental Services Kansas Appeals & Corrected Claims PO Box 25857 Tampa, FL 33622-5857
Pharmacy	Express Scripts	Express Scripts Provider Portal 1-800-717-6630
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 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 uses 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 underutilization, 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.

Sunflower Health Plan's primary goal is to improve members' health status through meaningful quality improvement activities implemented across all care settings and aimed at improving the quality of care and services delivered. The Quality Program focuses on the health priorities defined by a combination of the CDC 6|18 Initiative, Healthy People 2030, the National Institutes of Health and other evidence-based sources. Performance measures are aligned to specific priorities and SMART goals used to drive quality improvement and operational excellence.

The following goals, which are aligned with the state's Quality Management Strategy (QMS), are integrated throughout Sunflower departments and committees as a part of the QAPI Program and include but are not limited to:

- Promoting an organizational culture focused on continuous quality improvement, innovation and service excellence at all levels of quality program design and implementation.
- Empowering staff excellence through hiring staff who are experienced and knowledgeable in Medicaid and investing in their development through relevant ongoing training, education and mentorship.
- Harnessing data from information systems and engaging data analytics approaches to produce actionable information that is consistent, timely, valid and reliable and supports evidence-based decision making.
- Using rapid-cycle process improvement methods to quickly identify, analyze and resolve operational inefficiency to improve the member experience, provider experience and quality of care.
- Focusing on achieving year-over-year quantitative and qualitative improvements.
- Implementing a system of measurement and monitoring that assures the health, safety and welfare of members.
- Pursuing innovative approaches to expand access to quality care and services.
- Developing a transparent and collaborative environment with members, providers and other stakeholders to promote best in class healthcare service delivery to

members and improve access to care, the quality of care and member outcomes.
- Employing strategies to evaluate the ongoing efficiency and effectiveness of participating providers and fostering innovative partnerships to improve the delivery of quality care and services.
- Improving the delivery of holistic, integrated, person-centered and culturally appropriate care;
- Maximizing the quality of life of all members by addressing social determinants of health (SDOH) through delivery of culturally appropriate, integrated, holistic and evidence-based care and services;
- Promoting the highest level of independence, dignity, productivity, community inclusion and individuality based on member and representative choice, rights and goals of care;
- Increasing employment and independent living support to increase independence and health outcomes for members;
- Using person-centered models to collaborate with members, caregivers and family to achieve the highest level of member self-actualization and success.
- Improving the overall health and safety of 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 leadership 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 care and services delivered and to continuously enhance and improve the quality of care and services provided to members. This is accomplished through a comprehensive, health plan-wide system of ongoing, objective and systematic monitoring of activities and outcomes using the quality process.

The following plan-level subcommittees report directly to the Quality Improvement Committee (QIC):
- Credentialing Committee
- Population Health & Clinical Outcomes Committee
- Performance Improvement Committee
- Peer Review Committee
- Patient Safety / Quality of Care Committee
- Long Term Support Services (LTSS) Quality Assurance Committee
- Delegated Vendor Oversight 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 & Goals

The scope of the Quality Program is comprehensive and addresses both the quality and safety of clinical care and quality of services provided to Sunflower members, including medical, behavioral health, dental and vision care as applicable to the health plan's benefit package. Sunflower incorporates all demographic groups, lines of business, benefit packages, care settings and services in its quality management and improvement activities.

Areas addressed by the Quality Program include preventive health, emergency care, acute and chronic care, population health management, health disparity reduction, behavioral health, episodic care, long-term services and supports, ancillary services, continuity and coordination of care, patient safety, social determinants of health, and administrative, member and network services as applicable.

To that end, the Sunflower QAPI Program monitors the following:
- Behavioral healthcare
- Care management
- Complaints, grievances and appeals
- Continuity and coordination of care
- Cultural competency
- Customer service
- Delegated entity oversight
- Enrollment and disenrollment
- Health equity
- HEDIS performance measures
- Long-Term Services and Support
- Member satisfaction

- NCQA accreditation
- Patient safety
- Peer review activities
- Performance improvement projects
- Pharmacy initiatives
- Provider access and accessibility
- Population health
- Provider satisfaction
- Records management
- Selection and retention of providers (credentialing and recredentialing)
- Social determinants of health
- Utilization management, including under- and overutilization

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 Population Health 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 to make a determination of severity and need for corrective action, up to and including review by the Peer Review Committee as indicated. Quality of care issues received in the QI department are tracked and monitored for trends in occurrence, regardless of the outcome or severity level.

Sunflower also enters 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 and those in PRTFs. 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, Population Health 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 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). The QAPI work plan 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 advisory committees, provider joint operating committees, provider bulletins, the Sunflower website and Sunflower web portal.

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 quality-driven healthcare industry, HEDIS rates are becoming 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 quality" 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 are calculated using data collected from multiple sources, including administrative claims and encounters, supplemental data and medical record documentation when applicable.

Administrative data consists of claims and encounter data submitted to Sunflower by participating providers, facilities and ancillary service providers. Accurate and timely submission of claims and encounters using appropriate CPT, HCPCS, ICD-10-CM and other applicable coding standards is critical to ensuring services are captured correctly for quality measurement and reporting purposes.

Supplemental data may be used to identify services, test results, assessments, screenings, immunizations or other clinical information that may not be available through claims or encounter submissions alone. Supplemental data may be obtained from electronic health records (EHRs), health information exchanges, laboratory vendors, immunization registries, pharmacy data sources, provider medical records and other approved sources. Providers are encouraged to submit complete and accurate clinical documentation to support quality measurement activities.

For select HEDIS measures, medical record review may be conducted to validate services rendered or capture clinical information not available through administrative or supplemental data sources. Complete, accurate and timely medical record documentation helps ensure appropriate recognition of the care provided to members and may reduce the need for additional provider outreach.

See the Sunflower website for more information regarding HEDIS resources, coding guidance, medical record documentation requirements and supplemental data submission information.

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 approximately January through May each year. At that time, if any of your patients' medical records are selected for review, you will receive a call, letter or other outreach from a medical record review representative. Your prompt cooperation with the representative is greatly needed and appreciated. Several methods of retrieval are available and will be outlined in the medical record request.

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 Sun-

flower, authorizing the vendor to collect PHI on Sunflower's behalf for HEDIS and other healthcare operations activities.

Consistent with the requirements of the Sunflower Provider Agreement, providers are required to cooperate in the timely provision of requested medical records to Sunflower and its authorized representatives, including contracted medical record review vendors, when records are requested for quality improvement, healthcare operations, regulatory, accreditation, audit or other authorized purposes. Requested records must be provided at no charge when required under applicable contractual, regulatory or accreditation requirements.

If a provider has negotiated a separate agreement with Sunflower that contains different provisions regarding the transfer or provision of medical records, the terms of that agreement shall govern.

How Can Providers Improve Their HEDIS Scores?

- ***Understand the specifications*** established for each HEDIS measure.
- ***Submit claims and encounter data for 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.
- ***Submit claims and encounter data using CPT codes related to HEDIS*** measures such as diabetes, eye exams, blood pressure and immunizations/vaccinations.
- ***Establish an automated Supplemental Data Feed or EMR Bi-Directional Feed*** to share HEDIS measure data from your EMR (electronic medical record).
- ***Provide medical records to health plan when requested.***

For further information related to the annual HEDIS project or the medical record reviews, please contact the Quality Improvement department by email at **SM_HEDIS_OPS@sunflowerhealthplan.com**.

Provider Satisfaction Survey

You are essential to providing the highest-quality healthcare possible for our members, and your satisfaction is important to us. As your partner, we want to ensure that your experience with us is positive and rewarding. We assess your experience with the health plan through an annual provider satisfaction survey conducted by an external vendor. Survey questions request your feedback around finance, utilization and quality management, network coordination of care, pharmacy, health plan call center, provider relations and overall satisfaction.

Provider participants are randomly selected by the vendor, meeting specific requirements outlined by Sunflower. We encourage you to respond promptly to the survey, as the results are analyzed and used as a basis for forming provider-related improvement initiatives.

Results of the **Provider Satisfaction Survey** can be found on our website along with other helpful details.

We strive for providers to be Completely Satisfied and consider us Well Above Average. If we are not meeting your expectations and needs, please let us know by contacting us at **ProviderRelations@sunflowerhealthplan.com**.

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 can 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-quality (P4Q) 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 quality monitoring program to capture data relating to healthcare access, costs and quality of care that Sunflower members receive.

The P4Q program promotes efforts that are consistent with the Institute of Medicine's aims for advancing quality (safe, timely, patient-centered, efficient and equitable) as well as recommendations from other national agencies such as the CMS, AMA Physician Consortium for Performance Improvement (PCPI), NCQA and National Quality Forum (NQF). Additionally, Sunflower Health Plan may offer financial incentives to PCPs and specialists that encourage accurate and timely submission of preventive health and disease monitoring services in accordance with evidence-based clinical practice guidelines.

The goals of **Sunflower's P4Q program** are to:

- Increase provider awareness of their performance in key, measurable areas.
- Motivate providers to establish measurable quality 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.

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 may offer other 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 Quality Provider Engagement departments.

Physician Incentive Programs

Annually 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 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 Quality Practice Advisor or **providerengagement@sunflowerhealthplan.com**.

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 that require additional characters. ICD 10 Diagnosis Codes only allowed as secondary "manifestation" codes
- 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.

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

HQ	DENY: EDI CLAIM MUST BE SUBMITTED IN HARD COPY WITH CONSENT FORM
IM	DENY: RESUBMIT WITH CORRECT MODIFIER
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
x3	PROCEDURE CODE UNBUNDLED FROM GLOBAL PROCEDURE CODE
x4	PROCEDURE CODE/ICD-9 CODE INCONSISTENT WITH MEMBER'S GENDER
x5	PROCEDURE CODE CONFLICTS WITH MEMBER'S AGE
x6	ADD-ON CODE REQUIRED WITH PRIMARY CODE FOR QUANTITY GREATER THAN ONE
x7	ADD-ON CODE CANNOT BE BILLED WITHOUT PRIMARY CODE
x8	MODIFIER INVALID FOR PROCEDURE OR MODIFIER NOT REPORTED
x9	PROCEDURE CODE PAIRS INCIDENTAL, MUTUALLY EXCLUSIVE, OR UNBUNDLED
xa	CODE IS A COMPONENT OF A MORE COMPREHENSIVE CODE
xb	PROCEDURE CODE NOT ELIGIBLE FOR ANESTHESIA
xc	PROCEDURE/DIAGNOSIS CODE DELETED, INCOMPLETE, OR INVALID
xd	PROCEDURE CODE APPENDED WITH BILATERAL 50 MODIFIER
xe	PROCEDURE CODE INCONSISTENT WITH MEMBER'S AGE
xf	MAXIMUM ALLOWANCE EXCEEDED
xh	PROCEDURE CODE EXCEEDS MAXIMUM ALLOWED PER DATE OF SERVICE
xp	PROCEDURE CODE PREVIOUSLY BILLED ON HISTORICAL CLAIM
xq	PROCEDURE CODE EXCEEDS MAXIMUM ALLOWED PER DATE OF SERVICE
Y6	DENY: INSUFFICIENT INFO FOR PROCESSING, RESUBMIT W/ PRIME'S ORIGINAL EOB
ye	CLAIM CANNOT BE PROCESSED WITHOUT MEDICAL RECORDS
ym	30 DAY READMISSION. SUBMIT ALL MEDICAL RECORDS FOR 30 DAY PERIOD
ZC	DENY: PROCEDURE IS INAPPROPRIATE FOR PROVIDER SPECIALTY

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

CMS-1500 Form, Shaded Field 24A-G

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

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

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

7 Anesthesia information

ZZ Narrative description of unspecified/miscellaneous/unlisted codes

OZ Product Number Healthcare Uniform Code Council – Global Trade Item Number (GTIN)

VP Vendor Product Number – Health Industry Business Communications Council (HIBCC) Labeling Standard

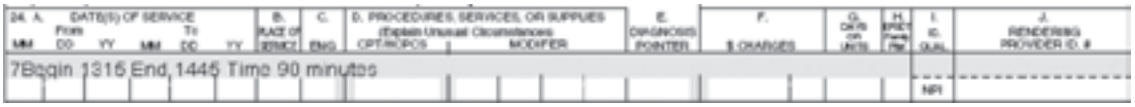
To enter supplemental information, begin at 24A by entering the qualifier and then the information. Do not enter a space between the qualifier and the supplemental information.

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

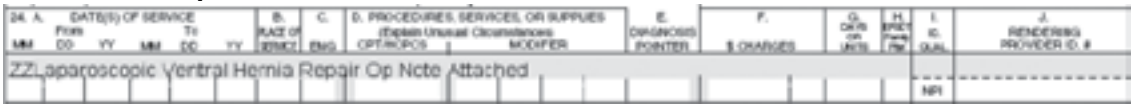
More than one supplemental item can be reported in a single shaded claim line IF the information is related to the unshaded claim line item it is entered on. When entering more than one supplemental item, enter the first qualifier at the start of 24A, followed by the number, code, or other information. 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:

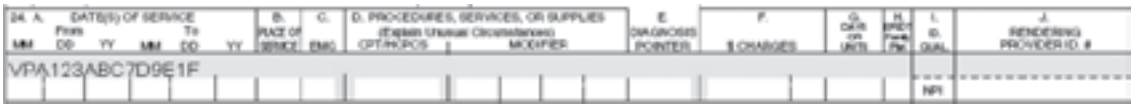
Anesthesia



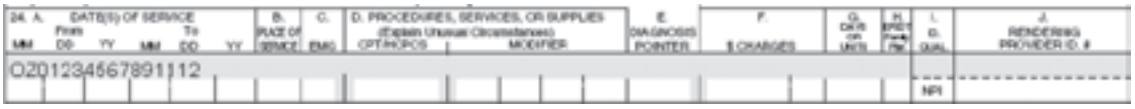
Unlisted, Non-Specific, or Miscellaneous CPT or HCPC Code



Vendor Product Number – HIBCC



Product Number Healthcare Uniform Code Council – GTIN



Appendix V: Common HIPAA-Compliant EDI Rejection Codes

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

ID	ERROR DESCRIPTION
01	INVALID MBR DOB
02	INVALID MBR
06	INVALID PRV
07	INVALID MBR DOB & PRV
08	INVALID MBR & PRV
09	MBR NOT VALID AT DOS
10	INVALID MBR DOB; MBR NOT VALID AT DOS
12	PRV NOT VALID AT DOS

ID	ERROR DESCRIPTION
13	INVALID MBR DOB; PRV NOT VALID AT DOS
14	INVALID MBR; PRV NOT VALID AT DOS
15	MBR NOT VALID AT DOS; INVALID PRV
16	INVALID MBR DOB; MBR NOT VALID AT DOS; INVALID PRV
17	INVALID DIAG
18	INVALID MBR DOB; INVALID DIAG
19	INVALID MBR; INVALID DIAG
21	MBR NOT VALID AT DOS; PRV NOT VALID AT DOS
22	INVALID MBR DOB; MBR NOT VALID AT DOS; PRV NOT VALID AT DOS
23	INVALID PRV; INVALID DIAG
24	INVALID MBR DOB; INVALID PRV; INVALID DIAG
25	INVALID MBR; INVALID PRV; INVALID DIAG
26	MBR NOT VALID AT DOS; INVALID DIAG
27	INVALID MBR DOB; MBR NOT VALID AT DOS; INVALID DIAG
29	PRV NOT VALID AT DOS; INVALID DIAG
30	INVALID MBR DOB; PRV NOT VALID AT DOS; INVALID DIAG
31	INVALID MBR; PRV NOT VALID AT DOS; INVALID DIAG
32	MBR NOT VALID AT DOS; PRV NOT VALID; INVALID DIAG
33	INVALID MBR DOB; MBR NOT VALID AT DOS; PRV NOT VALID; INVALID DIAG
34	INVALID PROC
35	INVALID DOB; INVALID PROC
36	INVALID MBR; INVALID PROC
37	INVALID OR FUTURE DATE
38	MBR NOT VALID AT DOS; PRV NOT VALID AT DOS; INVALID DIAG
39	INVALID MBR DOB; MBR NOT VALID AT DOS; PRV NOT VALID AT DOS; INVALID DIAG
40	INVALID PRV; INVALID PROC
41	INVALID PRV; INVALID PROC; INVALID MBR DOB
42	INVALID MBR; INVALID PRV; INVALID PROC
43	MBR NOT VALID AT DOS; INVALID PROC
44	INVALID MBR DOB; MBR NOT VALID AT DOS; INVALID PROC
46	PRV NOT VALID AT DOS; INVALID PROC
48	INVALID MBR; PRV NOT VALID AT DOS; INVALID PROC
49	INVALID PROC; INVALID PRV; MBR NOT VALID AT DOS
51	INVALID DIAG; INVALID PROC
52	INVALID MBR DOB; INVALID DIAG; INVALID PROC
53	INVALID MBR; INVALID DIAG; INVALID PROC
55	MBR NOT VALID AT DOS; PRV NOT VALID AT DOS; INVALID PROC
57	INVALID PRV; INVALID DIAG; INVALID PROC
58	INVALID MBR DOB; INVALID PRV; INVALID DIAG; INVALID PROC
59	INVALID MBR; INVALID PRV; INVALID DIAG; INVALID PROC
60	MBR NOT VALID AT DOS; INVALID DIAG; INVALID PROC
61	INVALID MBR DOB; MBR NOT VALID AT DOS; INVALID DIAG; INVALID PROC
63	PRV NOT VALID AT DOS; INVALID DIAG; INVALID PROC
64	INVALID MBR DOB; PRV NOT VALID AT DOS; INVALID DIAG; INVALID PROC
65	INVALID MBR; PRV NOT VALID AT DOS; INVALID DIAG; INVALID PROC

ID	ERROR DESCRIPTION
66	MBR NOT VALID AT DOS; INVALID PRV; INVALID DIAG; INVALID PROC
67	INVALID MBR DOB; MBR NOT VALID AT DOS; INVALID PRV; INVALID DIAG; INVALID PROC
72	MBR NOT VALID AT DOS; PRV NOT VALID AT DOS; INVALID DIAG; INVALID PROC
73	INVALID MBR DOB; MBR NOT VALID AT DOS; PRV NOT VALID AT DOS; INVALID DIAG; INVALID PROC
74	REJECT. DOS PRIOR TO 6/1/2006
75	INVALID UNIT
76	ORIGINAL CLAIM NUMBER REQUIRED
77	INVALID CLAIM TYPE
81	INVALID UNIT; INVALID PRV
83	INVALID UNIT; INVALID MBR & PRV
89	INVALID PRV; MBR NOT VALID AT DOS; INVALID DOS
92	INVALID REFERRING PROVIDER NPI
93	INVALID ADMISSION TYPE
A2	CLAIM EXCEEDED THE MAXIMUM 97 SERVICE LINE LIMIT
A2	DIAGNOSIS POINTER INVALID
ZZ	CLAIM NOT PROCESSED

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

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

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

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 Victims 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

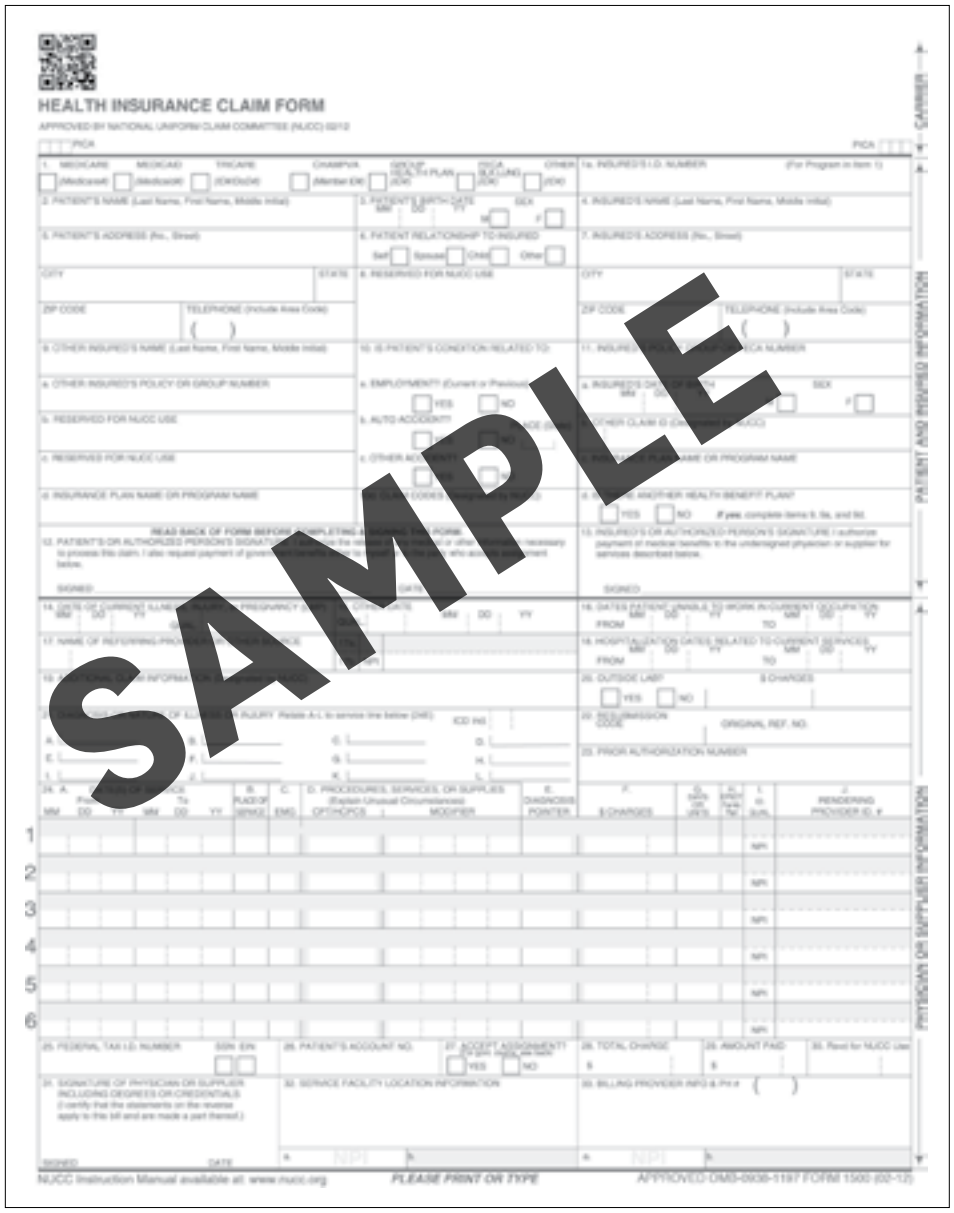
Billing Guide for a CMS-1500 and CMS UB-04

A CMS-1500 should be used by ambulance services, clinical social workers, physicians and their assistants, nurses including clinical nurse specialists and practitioners, psychologists, ambulatory surgery centers, or durable medical equipment providers.

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



Sunflower Customer Service Department: 1-877-644-4623 (TTY 711)

FIELD #	FIELD DE SCRIPTION	INSTRUCTIONS OR COMMENTS	REQUIRED OR CONDITIONAL
1	Insurance Program Identification	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"	R
1a	Insured's ID Number	The 9-digit identification number on the member's Sunflower ID card	R
2	Patient's Name (Last Name, First Name, Middle Initial)	Enter the patient's name as it appears on the member's Sunflower ID card. Do not use nicknames.	R
3	Patient's Birth Date / Sex	Enter the patient's 8-digit date of birth (MM/DD/YYYY) and mark the appropriate box to indicate the patient's sex/gender. **M**= Male **F**= Female	R
4	Insured's Name	Enter the patient's name as it appears on the member's Sunflower ID card.	C
5	Patient's Address (Number, Street, City, State, Zip code) Telephone (include area code)	Enter the patient's complete address and telephone number, including area code, on the appropriate line. ■ First line – Enter the street address. Do not use commas, periods or other punctuation in the address (e.g., 123 N Main Street 101 instead of 123 N. Main Street, #101). ■ Second line – In the designated block, enter the city and state. ■ Third line – Enter the zip code and phone number. When entering a 9-digit zip code (zip+4 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.	C
6	Patient's Relation to Insured	Always mark to indicate self.	C
7	Insured's Address (Number, Street, City, State, Zip Code) Telephone (Include Area Code)	Enter the patient's complete address and telephone number, including area code, on the appropriate line. ■ First line – Enter the street address. Do not use commas, periods, or other punctuation in the address (e.g., 123 N Main Street 101 instead of 123 N. Main Street, #101). ■ Second line – In the designated block, enter the city and state. ■ Third line – Enter the zip code and phone number. When entering a 9-digit zip code (zip+4 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.	C
8	Patient Status		Not Required
9	Other Insured's Name (Last Name, First Name, Middle Initial)	Refers to someone other than the patient. REQUIRED if patient is covered by another insurance plan. Enter the complete name of the insured.	C

FIELD #	FIELD DE SCRIPTION	INSTRUCTIONS OR COMMENTS	REQUIRED OR CONDITIONAL
9a	*Other Insured's Policy or Group Number	REQUIRED if field 9 is completed. Enter the policy or group number of the other insurance plan.	C
9b	Reserved For NUCC Use		Not Required
9c	Reserved For NUCC Use		Not Required
9d	Insurance Plan Name or Program Name	REQUIRED if field 9 is completed. Enter the other insured's (name of person listed in field 9) insurance plan or program name.	C
10a, b, c	Is Patient's Condition Related To:	Enter a Yes or No for each category/line (a, b and c). Do not enter a Yes and No in the same category/line. When marked Yes, primary insurance information must then be shown in Item Number 11.	R
10d	Claim Codes (Designated By NUCC)	When reporting more than one code, enter three blank spaces and then the next code.	C
11	Insured's Policy or Feca Number	REQUIRED when other insurance is available. Enter the policy, group, or FECA number of the other insurance. If Item Number 10abc is marked Y, this field should be populated.	C
11a	Insured's Date of Birth / Sex	Enter the 8-digit date of birth (MM/DD/YYYY) of the insured and an X to indicate the sex (gender) of the insured. Only one box can be marked. If gender is unknown, leave blank.	C
11b	Other Claim ID (Designated By NUCC)	The following qualifier and accompanying identifier has been designated for use: ■ Y4 Property Casualty Claim Number ■ FOR WORKERS' COMPENSATION OR PROPERTY & CASUALTY: Required if known. Enter the claim number assigned by the payer.	C
11c	Insurance Plan Name or Program Number	Enter name of the insurance health plan or program.	C
11d	Is There Another Health Benefit Plan	Mark Yes or No. If Yes, complete fields 9a-d and 11c.	R
12	Patient's or Authorized Person's Signature	Enter "Signature on File," "SOF," or the actual legal signature. The provider must have the member's or legal guardian's signature on file or obtain their legal signature in this box for the release of information necessary to process and/or adjudicate the claim.	C
13	Patient's or Authorized Person's Signature	Obtain signature if appropriate.	Not Required

FIELD #	FIELD DE SCRIPTION	INSTRUCTIONS OR COMMENTS	REQUIRED OR CONDITIONAL
14	Date of Current: Illness (First Symptom) or Injury (Accident) or Pregnancy (LMP)	Enter the 6-digit (MM/DD/YY) or 8-digit (MM/DD/YYYY) date of the first date of the present illness, injury, or pregnancy. For pregnancy, use the date of the last menstrual period (LMP) as the first date. Enter the applicable qualifier to identify which date is being reported. 431 Onset of Current Symptoms or Illness 484 Last Menstrual Period	C
15	If Patient Has Same or Similar Illness, Give First Date	Enter another date related to the patient's condition or treatment. Enter the date in the 6-digit (MM/DD/YY) or 8-digit (MM/DD/YYYY) format	C
16	Dates Patient Unable to Work in Current Occupation		C
17	Name of Referring Physician or Other Source	Enter the name of the referring physician or professional (first name, middle initial, last name and credentials). Required for home health, therapy, pharmacy, laboratory, DME, hospice and radiology services. If multiple providers are involved, enter one provider using this priority order: 1. Referring Provider 2. Ordering Provider 3. Supervising Provider Do not use periods or commas. A hyphen can be used for hyphenated names. Enter the applicable qualifier to identify which provider is being reported. DN - Referring Provider DK - Ordering Provider DQ - Supervising Provider	C
17a	ID Number of Referring Physician	Required if field 17 is completed. Use ZZ qualifier for taxonomy code	C
17b	NPI Number of Referring Physician	Required if field 17 is completed. If unable to obtain referring NPI, servicing NPI may be used.	C
18	Hospitalization Dates Related to Current Services		C
19	Reserved for Local Use – New Form: Additional Claim Information		C

FIELD #	FIELD DE SCRIPTION	INSTRUCTIONS OR COMMENTS	REQUIRED OR CONDITIONAL
20	Outside Lab / Charges		C
21	Diagnosis or Nature of Illness or Injury. (Relate Items A-L to Item 24e by Line). New Form Allows up to 12 Diagnoses and ICD Indicator	Enter the codes to identify the patient's diagnosis and/or condition. List no more than 12 ICD-9-CM or ICD-10-CM diagnosis codes. Relate lines A – L to the lines of service in 24E by the letter of the line. Use the highest level of specificity. Do not provide narrative description in this field. Note: Claims missing or with invalid diagnosis codes will be rejected or denied for payment.	R
22	Resubmission Code / Original Ref. No.	For 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	C
23	Prior Authorization Number or CLIA Number	Enter the authorization or referral number. Refer to the Provider Manual for information on services requiring referral and/or prior authorization. CLIA number for CLIA-waived or CLIA-certified laboratory services	If auth = C If CLIA = R (If both, always submit the CLIA number)
24a-j General Information		Box 24 contains six claim lines. Each claim line is split horizontally into shaded and 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.	
24a-g shaded	Supplemental Information	The shaded top portion of each service claim line is used to report supplemental information for: NDC Narrative description of unspecified codes Contract rate For detailed instructions and qualifiers, refer to Appendix IV of this guide.	C
24a unshaded	Date(s) of Service	Enter the date the service listed in field 24D was performed (MMDDYYYY). If there is only one date, enter that date in the "From" field. The "To" field may be left blank or populated with the "From" date. If identical services (identical CPT/HCPC code(s)) were performed, each date must be entered on a separate line.	R

FIELD #	FIELD DE SCRIPTION	INSTRUCTIONS OR COMMENTS	REQUIRED OR CONDITIONAL
24b unshaded	Place of Service	Enter the appropriate 2-digit CMS Standard Place of Service (POS) Code. A list of current POS Codes may be found on the CMS website.	R
24c unshaded	EMG	Enter Y (Yes) or N (No) to indicate if the service was an emergency.	Not Required
24d unshaded	Procedures, Services or Supplies CPT/ HCPCS Modifier	Enter the 5-digit CPT or HCPC code and 2-character modifier, if applicable. Enter the 5-digit CPT or HCPC code and 2-character modifier, if applicable. Only one CPT or HCPC and up to four modifiers may be entered per claim line. Codes entered must be valid for date of service. Missing or invalid codes will be denied for payment. Only the first modifier entered is used for pricing the claim. Failure to use modifiers in the correct position or combination with the procedure code, or invalid use of modifiers, will result in a rejected, denied, or incorrectly paid claim.	R
24e unshaded	Diagnosis Code	In 24E, enter the diagnosis code reference letter (pointer) as shown in Item Number 21 to relate the date of service and the procedures performed to the primary diagnosis. When multiple services are performed, the primary reference letter for each service should be listed first, other applicable services should follow. The reference letter(s) should be A – L or multiple letters as applicable. Up to four diagnosis pointers are allowed per line. ICD-10-CM diagnosis codes must be entered in Item Number 21 only. Do not enter them in 24E. Do not use commas or decimals between the diagnosis pointer numbers. Diagnosis codes must be valid ICD-10 Codes for the date of service or the claim will be rejected/denied.	R
24f unshaded	Charges	Enter the charge amount for the claim line item service billed. Dollar amounts to the left of the vertical line should be right justified. Up to eight characters are allowed (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.	R
24g unshaded	Days or Units	Enter quantity (days, visits, units). If only one service provided, enter a numeric value of one.	R
24h shaded	EPSDT (Family Planning)	Leave blank or enter "Y" if the services were performed as a result of an EPSDT referral.	C
24h unshaded	EPSDT (Family Planning)	Enter the appropriate qualifier for EPSDT visit.	C
24i shaded	ID Qualifier	Use ZZ qualifier for taxonomy Use 1D qualifier for ID if an atypical provider.	R
24j shaded	Non-NPI Provider ID#	**Typical providers:** Enter the provider taxonomy code that corresponds to the qualifier entered in field 24I shaded. Use ZZ qualifier for taxonomy code. **Atypical providers:** Enter the provider ID number.	R
24j unshaded	NPI Provider ID	Typical providers ONLY: Enter the 10-character NPI ID of the provider who rendered services. If the provider is billing as a member of a group, the rendering individual provider's 10-character NPI ID may be entered. Enter the billing NPI if services are not provided by an individual (e.g., DME, independent lab, home health, RHC/FQHC general medical exam, etc.).	R

FIELD #	FIELD DE SCRIPTION	INSTRUCTIONS OR COMMENTS	REQUIRED OR CONDITIONAL
25	Federal Tax ID Number SSN/ EIN	Enter the provider or supplier 9-digit Federal Tax ID number and mark the box labeled EIN	R
26	Patient's Account No.	Enter the provider's billing account number	C
27	Accept Assignment	Enter an X in the YES box. Submission of a claim for reimbursement of services provided to an 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.	C
28	Total Charges	Enter the total charges for all claim line items billed – claim line 24F. Dollar amounts to the left of the vertical line should be right justified. Up to 8 characters are allowed (e.g., 199999.99). Do not use commas. Do not enter a dollar sign ($). If the dollar amount is a whole number (e.g., 10.00), enter 00 in the area to the right of the vertical line. When more than one claim page is used for the same beneficiary and for the same date of service, follow the instructions below: 1. Ensure that multiple pages of the claims are sent to Sunflower together. 2. Do not total the charges in Field 28 on each claim form. Only total all itemized charges (on all claim forms) on the last claim page. 3. Enter "Continued. Page __ of __ " in Field 28. For example, when 10 procedures were provided for the same beneficiary on the same date of service enter, "Continued. Page 1 of 2." 4. Enter the total charge in Field 28 of the last page of the claim form.	R
29	Amount Paid	REQUIRED when another carrier is the primary payer. Enter the payment received from the primary payer prior to invoicing Sunflower. Sunflower programs are always the payers of last resort. Dollar amounts to the left of the vertical line should be right justified. Up to eight characters are allowed (e.g., 199999.99). Do not use commas. Do not enter a dollar sign ($). If the dollar amount is a whole number (e.g., 10.00), enter 00 in the area to the right of the vertical line.	C
30	Balance Due	REQUIRED when field 29 is completed. Enter the balance due (total charges minus the amount of payment received from the primary payer). Dollar amounts to the left of the vertical line should be right justified. Up to eight characters are allowed (e.g., 199999.99). 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.	C
31	Signature of Physician or Supplier Including Degrees or Credentials	If there is a signature waiver on file, you may stamp, print, or computer-generate the signature; otherwise, the practitioner or practitioner's authorized representative MUST sign the form. If signature is missing or invalid, the claim will be returned unprocessed. Note: Does not exist in the electronic 837P.	R

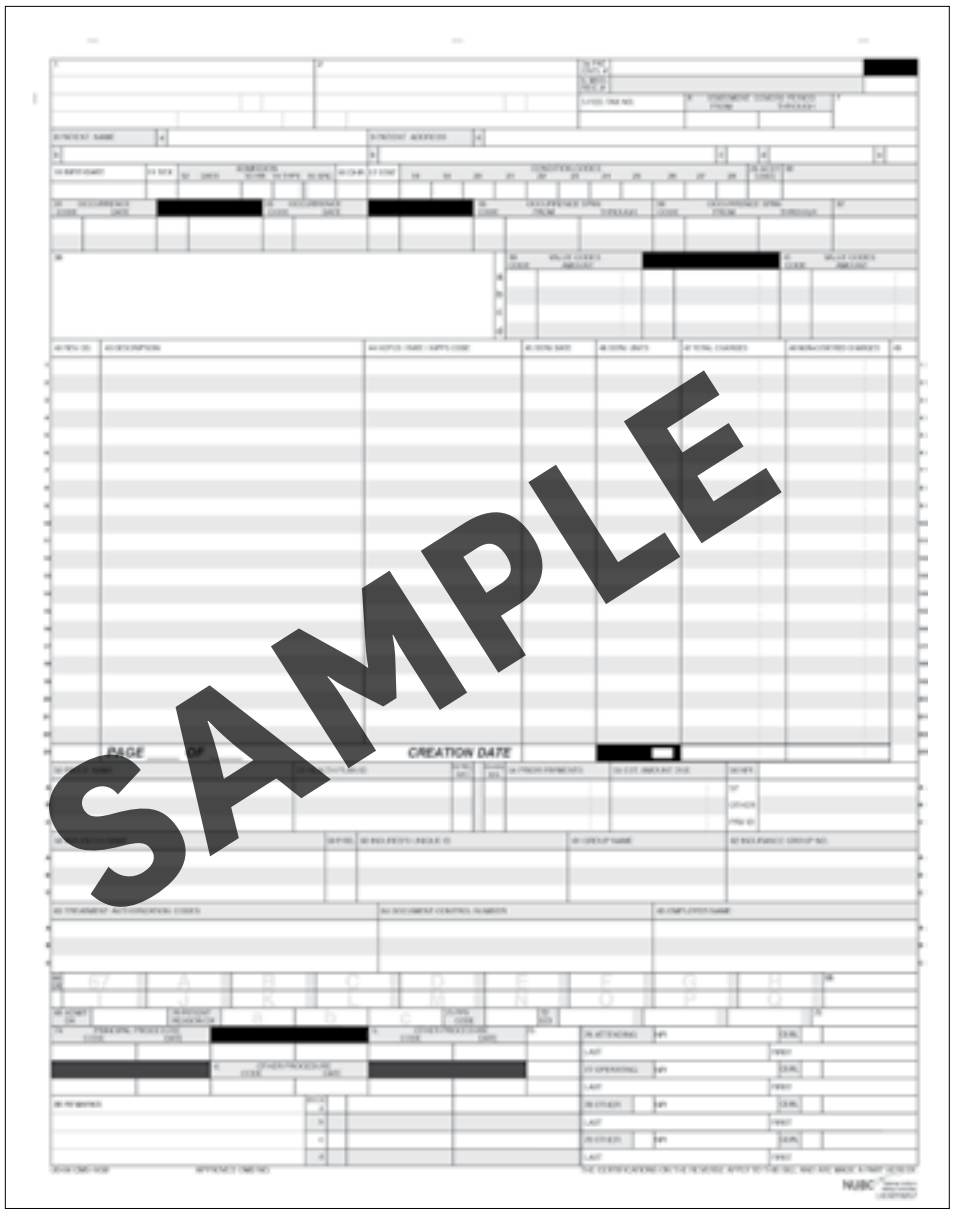
FIELD #	FIELD DE SCRIPTION	INSTRUCTIONS OR COMMENTS	REQUIRED OR CONDITIONAL
32	Service Facility Location Information	REQUIRED if the location where services were rendered is different from the billing address listed in field 33. Enter the name and physical location. (P.O. box numbers are not acceptable here.) ■ First line – Enter the business/facility/practice name. ■ Second line – Enter the street address. Do not use commas, periods, or other punctuation in the address (e.g., 123 N Main Street 101 instead of 123 N. Main Street, #101). ■ Third line – In the designated block, enter the city and state. ■ Fourth line – Enter the zip code and phone number. When entering a 9-digit zip code (zip+4 code), include the hyphen.	C
32a	NPI – Services Rendered	Typical providers ONLY: REQUIRED if the location where services were rendered is different from the billing address listed in field 33. Enter the 10-character NPI ID of the facility where services were rendered.	C
32b	Other Provider ID	REQUIRED if the location where services were rendered is different from the billing address listed in field 33. ■ Typical providers: Enter the 2-character qualifier ZZ followed by the taxonomy code (no spaces). ■ Atypical providers: Enter the 2-character qualifier ID (no spaces).	C
33	Billing Provider Info & Ph #	Enter the billing provider's complete name, address (include the zip+4 code) and phone number. ■ First line – Enter the business/facility/practice name. ■ Second line – Enter the street address. Do not use commas, periods, or other punctuation in the address (e.g., 123 N Main Street 101 instead of 123 N. Main Street, #101). ■ Third line – In the designated block, enter the city and state. ■ Fourth line – Enter the zip code and phone number. ■ When entering a 9-digit zip code (zip+4 code), include the hyphen. Do not use a hyphen or space as a separator within the telephone number (e.g., (555)555-5555). NOTE: The 9-digit zip code (zip+4 code) is a requirement for paper and EDI claim submission.	R
33a	Group Billing NPI	Typical providers ONLY: REQUIRED if the location where services were rendered is different from the billing address listed in field 33. Enter the 10-character NPI ID.	R
33b	Group Billing Others ID	Enter as designated below the billing group taxonomy code. ■ Typical providers: Enter the provider taxonomy code. Use ZZ qualifier. ■ Atypical providers: Enter the provider ID number.	R

UB-04 Claim Form

A UB-04 is the only acceptable claim form for submitting inpatient or outpatient hospital claim charges for reimbursement by Sunflower. 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 from will be returned to the provider.

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

Completing a CMS UB-04 Form



Sunflower Customer Service Department: 1-877-644-4623 (TTY 711)

FIELD #	FIELD DE SCRIPTION	INSTRUCTIONS OR COMMENTS	REQUIRED OR CONDITIONAL
1	(Unlabeled Field)	LINE 1: Enter the complete provider name. LINE 2: Enter the complete mailing address. LINE 3: Enter the city, state and zip+4 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.	R
2	(Unlabeled Field)	Enter the pay-to name and address.	Not Required
3a	Patient Control No.	Enter the facility patient account/control number.	Not Required
3b	Medical Record Number	Enter the facility patient medical or health record number.	R
4	Type of Bill	Enter the appropriate Type of Bill (TOB) Code as specified by the NUBC UB-04 Uniform Billing Manual minus the leading "0" (zero). A leading "0" is not needed. Digits should be reflected as follows: ■ 1st Digit – Indicating the type of facility. ■ 2nd Digit – Indicating the type of care. ■ 3rd Digit – Indicating the bill sequence (frequency code).	R
5	Fed. Tax No.	Enter the 9-digit number assigned by the federal government for tax reporting purposes.	R
6	Statement Covers Period From/ Through	Enter begin and end, or admission and discharge, dates for the services billed. Inpatient and outpatient observation stays must be billed using the admission date and discharge date. Outpatient therapy, chemotherapy, laboratory, pathology, radiology and dialysis may be billed using a date span. All other outpatient services must be billed using the actual date of service (MMDDYY).	R
7	(Unlabeled Field)	Not used	Not Required
8a	Patient Name	8a – Enter the first 9 digits of the identification number on the member's Sunflower ID card.	R
8b	Patient Name	8b – Enter the patient's last name, first name and middle initial as it appears on the Sunflower ID card. Use a comma or space to separate the last and first names. ■ Titles (Mr., Mrs., etc.) should not be reported in this field. ■ Prefix: No space should be left after the prefix of a name (e.g., McKendrick, H). ■ Hyphenated names: Both names should be capitalized and separated by a hyphen (no space). ■ Suffix: A space should separate a last name and suffix.	R
9	Patient Address	Enter the patient's complete mailing address. Line a: Street address Line b: City Line c: State Line d: Zip code Line e: Country code (NOT REQUIRED)	R (except line 9e)
10	Birthdate	Enter the patient's date of birth (MMDDYYYY).	R
11	Sex	Enter the patient's sex. Only M or F is accepted.	R
12	Admission Date	Enter the date of admission for inpatient claims and date of service for outpatient claims. Enter the time using 2-digit military time (00-23) for the time of inpatient admission or time of treatment for outpatient services.	R

FIELD #	FIELD DE SCRIPTION	INSTRUCTIONS OR COMMENTS	REQUIRED OR CONDITIONAL
13	Admission Hour	00 - 12:00 midnight to 12:59 01 - 01:00 to 01:59 02 - 02:00 to 02:59 03 - 03:00 to 03:59 04 - 04:00 to 04:59 05 - 05:00 to 05:59 06 - 06:00 to 06:59 07 - 07:00 to 07:59 08 - 08:00 to 08:59 09 - 09:00 to 09:59 10 - 10:00 to 10:59 11 - 11:00 to 11:59 12 - 12:00 noon to 12:59 13 - 01:00 to 01:59 14 - 02:00 to 02:59 15 - 03:00 to 03:59 16 - 04:00 to 04:59 17 - 05:00 to 05:59 18 - 06:00 to 06:59 19 - 07:00 to 07:59 20 - 08:00 to 08:59 21 - 09:00 to 09:59 22 - 10:00 to 10:59 23 - 11:00 to 11:59	R
14	Admission Type	Require for inpatient and outpatient admissions (Enter the 1-digit code indicating the nature of the admission using the appropriate following codes): 1 - Emergency 2 - Urgent 3 - Elective 4 - Newborn 5 - Trauma	R
15	Admission Source	Required for inpatient and outpatient admissions. Enter the 1-digit code indicating the source of the admission or outpatient service using one of the following codes. For type of admission 1,2,3, or 5: 1 - Physician Referral 2 - Clinic Referral 3 - Health Maintenance Referral (HMO) 4 - Transfer from a Hospital 5 - Transfer from Skilled Nursing Facility 6 - Transfer from Another Health Care Facility 7 - Emergency Room 8 - Court/Law Enforcement 9 - Information Not Available For type of admission 4 (newborn): 1 - Physician Referral 2 - Not Available	R
16	Discharge Hour	Enter the time using 2-digit military times (00-23) for the time of the inpatient or outpatient discharge. 00 - 12:00 midnight to 12:59 01 - 01:00 to 01:59 02 - 02:00 to 02:59 03 - 03:00 to 03:59 04 - 04:00 to 04:59 05 - 05:00 to 05:59 06 - 06:00 to 06:59 07 - 07:00 to 07:59 08 - 08:00 to 08:59 09 - 09:00 to 09:59 10 - 10:00 to 10:59 11 - 11:00 to 11:59 12 - 12:00 noon to 12:59 13 - 01:00 to 01:59 14 - 02:00 to 02:59 15 - 03:00 to 03:59 16 - 04:00 to 04:59 17 - 05:00 to 05:59 18 - 06:00 to 06:59 19 - 07:00 to 07:59 20 - 08:00 to 08:59 21 - 09:00 to 09:59 22 - 10:00 to 10:59 23 - 11:00 to 11:59	C

FIELD #	FIELD DE SCRIPTION	INSTRUCTIONS OR COMMENTS	REQUIRED OR CONDITIONAL
17	Patient Status	REQUIRED for inpatient claims. Enter the 2-digit disposition of the patient as of the "through" date for the billing period listed in field 6 using one of the following codes: 01 - Routine discharge 02 - Discharged/transferred to another short-term general hospital for inpatient care 03 - Discharged to SNF 04 - Discharged to ICF 05 - Discharged to another type of institution 06 - Discharged to care of home health service organization 07 - Left against medical advice 08 - Discharged/transferred to home under care of a home IV provider 09 - Admitted as an inpatient to this hospital (only for use on Medicare outpatient hospital claims) 20 - Expired or did not recover 30 - Still patient (to be used only when the client has been in the facility for 30 consecutive days if payment is based on DRG) 40 - Expired at home (hospice use only) 41 - Expired in a medical facility (hospice use only) 42 - Expired – place unknown (hospice use only) 43 - Discharged/transferred to a federal hospital (such as a 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 64 - Discharged/transferred to a nursing facility certified under Medicaid but not certified under Medicare 65 - Discharged/transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital 66 - Discharged/transferred to a critical access hospital (CAH)	R
18 – 28	Condition Codes	REQUIRED when applicable. Condition codes are used to identify conditions relating to the bill that may affect payer processing. Each field (18-24) allows entry of a 2-character code. Codes should be entered in alphanumeric sequence (numbered codes precede alphanumeric codes). For a list of codes and additional instructions, refer to the NUBC UB-04 Uniform Billing Manual.	C
29	Accident State		Not Required
30	(Unlabeled Field)	Not Used	Not Required

FIELD #	FIELD DE SCRIPTION	INSTRUCTIONS OR COMMENTS	REQUIRED OR CONDITIONAL
31-34 a-b	Occurrence Code and Occurrence Date	Occurrence code: REQUIRED when applicable. Occurrence codes are used to identify events relating to the bill that may affect payer processing. Each field (31-34a) allows for entry of a 2-character code. Codes should be entered in alphanumeric sequence (numbered codes precede alphanumeric codes). For a list of codes and additional instructions, refer to the NUBC UB-04 Uniform Billing Manual. Occurrence date: REQUIRED when applicable or when a corresponding occurrence code is present on the same line (31a-34a). Enter the date for the associated occurrence code in MMDDYYYY format.	C
35-36 a-b	Occurrence Span Code and Occurrence Date	Occurrence span code: REQUIRED when applicable. Occurrence codes are used to identify events relating to the bill that may affect payer processing. Each field (31-34a) allows for entry of a 2-character code. Codes should be entered in alphanumeric sequence (numbered codes precede alphanumeric codes). For a list of codes and additional instructions, refer to the NUBC UB-04 Uniform Billing Manual. Occurrence span date: REQUIRED when applicable or when a corresponding occurrence span code is present on the same line (35a-36a). Enter the date for the associated occurrence code in MMDDYYYY format.	C
37	(Unlabeled Field)	REQUIRED for resubmissions or adjustments. Enter the DCN (Document Control Number) of the original claim.	C
38	Responsible Party Name And Address		Not Required
39-41 a-d	Value Codes Codes and Amounts	Code: REQUIRED when applicable. Value codes are used to identify events relating to the bill that may affect payer processing. Each field (39-41) allows for entry of a 2- character code. Codes should be entered in alphanumeric sequence (numbered codes precede alphanumeric codes). Up to 12 codes can be entered. All “a” fields must be completed before using “b” fields, all “b” fields before using “c” fields and all “c” fields before using “d” fields. For a list of codes and additional instructions, refer to the NUBC UB-04 Uniform Billing Manual. Amount: REQUIRED when applicable or when a value code is entered. Enter the dollar amount for the associated value code. Dollar amounts to the left of the vertical line should be right justified. Up to eight characters are allowed (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.	C
General Information Fields 42-47	Service Line Detail	The following UB-04 fields – 42-47 have a total of 22 service lines for claim detail information. Fields 42, 43, 45, 47, 48 include separate instructions for the completion of lines 1-22 and line 23.	

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FIELD #	FIELD DE SCRIPTION	INSTRUCTIONS OR COMMENTS	REQUIRED OR CONDITIONAL
42 Lines 1-22	Rev Cd	Enter the appropriate revenue codes itemizing accommodations, services and items furnished to the patient. Refer to the NUBC UB-04 Uniform Billing Manual for a complete listing of revenue codes and instructions. Enter accommodation revenue codes first followed by ancillary revenue codes. Enter codes in ascending numerical value.	R
42 Line 23	Rev Cd	Enter 0001 for total charges.	R
43 Lines 1-22	Description	Enter a brief description that corresponds to the revenue code entered in the service line of field 42.	R
43 Line 23	Page _____ of _____	Enter the number of pages. Indicate the page sequence in the "PAGE" field and the total number of pages in the "OF" field. If only one claim form is submitted, enter a "1" in both fields (e.g., PAGE "1" OF "1"). (Limited to 4 pages per claim).	C
44	HCPCS/Rates	REQUIRED for outpatient claims when an appropriate CPT/HCPCS code exists for the service line revenue code billed. The field allows up to 9 characters. Only one CPT/HCPC and up to two modifiers are accepted. When entering a CPT/HCPCS with a modifier(s), do not use spaces, commas, dashes, or the like between the CPT/HCPC and modifier(s). Refer to the NUBC UB-04 Uniform Billing Manual for a complete listing of revenue codes and instructions. Please refer to your current provider contract.	C
45 Lines 1-22	Service Date	REQUIRED on all outpatient claims. Enter the date of service for each service line billed. (MMDDYY) Multiple dates of service may not be combined for outpatient claims.	C
45 Line 23	Creation Date	Enter the date the bill was created or prepared for submission on all pages submitted (MMDDYY).	R
46	Service Units	Enter the number of units, days, or visits for the service. A value of at least "1" must be entered. For inpatient room charges, enter the number of days for each accommodation listed.	R
47 - Lines 1-22	Total Charges	Enter the total charges for each service line.	R
47 Line 23	Totals	Enter the total charges for all service lines.	R
48 Lines 1-22	Non-Covered Charges	Enter the non-covered charges included in field 47 for the revenue code listed in field 42 of the service line. Do not list negative amounts.	C
48 Line 23	Totals	Enter the total non-covered charges for all service lines.	C
49	(Unlabeled Field)	Not Used	Not Required
50 A-C	Payer	Enter the name of each payer from which reimbursement is being sought in the order of the payer liability. Line A refers to the primary payer; B, secondary; and C, tertiary	R

FIELD #	FIELD DE SCRIPTION	INSTRUCTIONS OR COMMENTS	REQUIRED OR CONDITIONAL
51	Health Plan ID Number		Not Required
52 A-C	Rel. Info	REQUIRED for each line (A, B, C) completed in field 50. Release of Information Certification Indicator. Enter "Y" (yes) or "N" (no). Providers are expected to have necessary release information on file. It is expected that all released invoices contain "Y."	R
53	Asg. Ben.	Enter "Y" (yes) or "N" (no) to indicate a signed form is on file authorizing payment by the payer directly to the provider for services.	R
54	Prior Payments	Enter the amount received from the primary payer on the appropriate line when Sunflower is listed as secondary or tertiary.	C
55	Est. Amt Due		Not Required
56	National Provider Identifier or Provider ID	Required: Enter provider's 10-character NPI ID.	R
57	Other Provider ID	Enter the numeric provider identification number. Enter the TPI number (non-NPI number) of the billing provider.	R
58	Insured's Name	For each line (A, B, C) completed in field 50, enter the name of the person who carries the insurance for the patient. In most cases, this will be the patient's name. Enter the name as last name, first name, middle initial.	R
59	Patient Relationship		Not Required
60	Insured's Unique ID	REQUIRED: Enter the patient's insurance ID exactly as it appears on the patient's ID card. Enter the insurance ID in the order of liability listed in field 50.	R
61	Group Name		Not Required
62	Insurance Group No.		Not Required
63	Treatment Authorization Codes	Enter the prior authorization or referral when services require pre-certification.	Not Required
64	Document Control Number	Enter the 12-character original claim number of the paid/denied claim when submitting a replacement or void on the corresponding A, B, C line reflecting 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.	C
65	Employer Name		Not Required
66	Dx Version Qualifier	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).	R
67	Principal Diagnosis Code	Enter the principal/primary diagnosis or condition using the appropriate release/update of ICD-10-CM Volumes 1 & 3 for the date of service. Do not include the decimal in the diagnosis; it is implied.	R

FIELD #	FIELD DE SCRIPTION	INSTRUCTIONS OR COMMENTS	REQUIRED OR CONDITIONAL
67 A-Q	Other Diagnosis Code	Enter additional diagnosis or conditions that coexist at the time of admission or that develop subsequent to the admission and have an effect on the treatment or care received using the appropriate release/update of ICD-10-CM Volumes 1 & 3 for the date of service. Diagnosis codes submitted must be valid ICD- 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. Do not include the decimal in the diagnosis; it is implied.	C
68	Present on Admission Indicator		R
69	Admitting Diagnosis Code	Enter the diagnosis or condition provided at the time of admission as stated by the physician using the appropriate release/update of ICD-10-CM Volumes 1 & 3 for the date of service. Diagnosis codes submitted must be valid ICD-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. Do not include the decimal in the diagnosis; it is implied.	R
70	Patient Reason Code	Enter the ICD-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-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.	R
71	PPS/DRG Code		Not Required
72 a, b, c	External Cause Code		Not Required
73	(Unlabeled)		Not Required
74	Principal Procedure Code/ Date	CODE: Enter the ICD-10 procedure code that identifies the principal/primary procedure performed. Do not enter the decimal between the 2nd or 3rd digits of code; it is implied. DATE: Enter the date the principal procedure was performed (MMDDYY).	C
74 a-e	Other Procedure Code Date	REQUIRED on inpatient claims when a procedure is performed during the date span of the bill. CODE: Enter the ICD-10 procedure code(s) that identify a significant procedure(s) performed other than the principal/primary procedure. Up to five ICD-10 procedure codes may be entered. DATE: Enter the date the principal procedure was performed (MMDDYY).	C
75	(Unlabeled)		Not Required

FIELD #	FIELD DE SCRIPTION	INSTRUCTIONS OR COMMENTS	REQUIRED OR CONDITIONAL
76	Attending Physician	Enter the NPI and name of the physician in charge of the patient's care. ■ NPI: Enter the attending physician's 10-character NPI ID. ■ Taxonomy code: Enter valid taxonomy code. ■ QUAL: Enter one of the following qualifiers and ID number: - 0B – State License #. - 1G – Provider UPIN. - G2 – Provider Commercial #. - B3 – Taxonomy Code. ■ LAST: Enter the attending physician's last name. ■ FIRST: Enter the attending physician's first name.	R
77	Operating Physician	REQUIRED when a surgical procedure is performed. Enter the NPI and name of the physician in charge of the patient's care. ■ NPI: Enter the attending physician's 10-character NPI ID. ■ Taxonomy code: Enter valid taxonomy code. ■ QUAL: Enter one of the following qualifiers and ID number: - 0B - State License #. - 1G - Provider UPIN. - G2 - Provider Commercial #. - B3 - Taxonomy Code. ■ LAST: Enter the attending physician's last name. ■ FIRST: Enter the attending physician's first name.	C
78 & 79	Other Physician	Enter the provider type qualifier, NPI and name of the physician in charge of the patient's care. (Blank Field): Enter one of the following provider type qualifiers: DN – Referring Provider ZZ – Other Operating MD 82 – Rendering Provider NPI: Enter the other physician 10-character NPI ID. QUAL: Enter one of the following qualifier and ID 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.	C
80	Remarks		Not Required
81	CC	A: Taxonomy of billing provider. Use B3 qualifier.	R
82	Attending Physician	Enter name or 7-digit provider number of ordering physician.	R

Appendix VIII: HCBS Programs Billing Information

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

Visit **https://portal.kmap-state-ks.us/PublicPage/ProviderPricing/ProviderPublications** to see the most up-to-date information about HCBS services and procedure codes.

DATE SPAN BILLING WITH EXAMPLES

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

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

DATES OF SERVICE	PROCEDURE CODE	BILLED UNITS
1/1/25 – 1/31/25	T2016	31 units
1/1/25 – 1/5/25	T2016	5 units
1/1/25 – 1/1/25	T2016	1 unit
1/6/25 – 1/12/25	T2016	3 units
1/1/25 – 1/31/25	T2016	27 units

- You must bill within the same calendar month, and you cannot overlap any given calendar month, e.g., 01/15/25 through 02/10/25 – this would be two claims, one for January and one for February.
- Day Supports – 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 **kdads.ks.gov**.

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

FRAIL ELDERLY HCBS PROGRAMS

SERVICE CODE	SERVICE
HCFES5125	FE - Level 2 Personal Care Services
HCFES5125UD	FE - Self-Directed Personal Care Services
HCFES5130	FE - Level 1 Personal Care Services
HCFES5190	FE - Wellness Monitoring
HCFET1001	FE - Nurse Evaluation Visit
HCFET2025	FE - Agency Directed Enhanced Care Services
HCFET2025U2	FE - Self Directed Enhanced Care Services
HCFES5135	FE - Provider-Directed Comprehensive Support
HCFES5135UD	FE - Self-Directed Comprehensive Support
HCFET2040U2	FE - Financial Management Service

INTELLECTUAL/DEVELOPMENTAL DISABILITY (I/DD) HCBS PROGRAMS

SERVICE CODE	SERVICE NAME
HCDDT1019	IDD - Self-Directed Personal Care Services
HCDDT2025	IDD - Agency Directed Enhanced Care Services
HCDDT2025U1	IDD - Self Directed Enhanced Care Services
HCDDH0045	IDD - Overnight Respite
HCDDT1000	IDD - Specialized Medical Care
HCDDS5125	IDD - Agency-Directed Personal Care Services
HCDDS5161	IDD - Medical Alert Rental
HCDDT2040U2	IDD - Financial Management Service
HCDDS5125U1	IDD Children's Integrated Community Supports Ratio 1:3
HCDDS5125U2	IDD Children's Integrated Community Supports Ratio 1:2
HCDDS5190	IDD Wellness Monitoring

PHYSICAL DISABILITY (PD) HCBS PROGRAMS

SERVICE CODE	SERVICE NAME
HCPDS5125U6	PD - Self-Directed Personal Services
HCPDT2025	PD - Agency Directed Enhanced Care Services
HCPDT2025U5	PD - Self Directed Enhanced Care Services
HCPDS5125U9	PD - Agency-Directed Personal Services
HCPDT2040U2	PD - Financial Management Service

BRAIN INJURY HCBS PROGRAMS

SERVICE CODE	SERVICE NAME
HCBIS5125UB	BI - Self-Directed Personal Services
HCBIT2025	BI - Agency Directed Enhanced Care Services
HCBIT2025U3	BI - Self Directed Enhanced Care Services
HCBIS5125U9	BI - Agency-Directed Personal Services
HCBIT2040U2	BI - Financial Management Service
HCBIH2014	BI - Transition Living Skills
HCBI97129	BI - Cognitive Rehabilitation
HCBIH0004	BI - Behavioral Therapy
HCBIG0151, G0152, G0153	BI - Therapies: Physical Therapy, Occupational Therapy, Speech Therapy

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TECHNOLOGY-ASSISTED HCBS PROGRAMS

SERVICE CODE	SERVICE NAME
HCTAT1019	TA - Self-Directed Personal Care Services
HCTAT2040U2	TA - Financial Management Services
HCTAT1000	TA - Specialized Medical Care
HCTAT1001	TA - Health Maintenance Monitoring
HCTAT1002	TA - Intermittent Intensive Medical Care
HCTAT1004	TA - Agency-Directed Personal Care Services
HCTAT1005	TA - Respite Services

SERIOUS EMOTIONAL DISTURBANCE HCBS PROGRAMS

SERVICE CODE	SERVICE NAME
HCSEDT1019HK	SED - Attendant Care

AUTISM HCBS PROGRAMS

SERVICE CODE	SERVICE NAME
HCAUT1005	AU - Respite
HCAUT1005U6	AU - Self-Directed Respite
HCAU2040U2	AU -Financial Management Services

COMMUNITY SUPPORT HCBS PROGRAMS

SERVICE CODE	SERVICE NAME
CSS0315U8	CSW – Telemonitoring Installation
CSS0317U8	CSW – Home Telehealth – Rental
CST1505U3	CSW – Medication Reminder - Dispenser Installation
CST1505U8	CSW – Medication Reminder – Dispenser
CSS5185U8	CSW – Medication Reminder - Call – Alarm

As mentioned previously, Sunflower will use 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 an invoice and MSRP. Without submission of an invoice and MSRP, manually priced claims will pend.

Drug Pricing Program – 340 B

- Sunflower 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 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'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

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).
- 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.

FLUORIDE BILLING BY HEALTH DEPARTMENTS

Fluoride services provided by RNs at health departments must be billed through Centene Dental Services 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 **Centene Dental Services**.

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 Centene Dental Services are sent to the following address:

Centene Dental Services
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.

Interim Billing

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

Locum Tenens

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

Modifiers

- GN, GO, GP Modifiers – therapy modifiers required for speech, occupational and physical therapy.
- For all other rules around modifiers, please refer to **https://portal.kmap-state-ks.us**.

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 December 31, 2020, claims for newborn services billed under the mother's beneficiary ID may be suspended for 30 days pending receipt of the newborn's beneficiary ID number from the eligibility system. If a newborn ID is received, the claim will be denied ***EXnB — Deny: Rebill with Newborn Medicaid ID#, Name and DOB*** notifying the provider they must submit a corrected claim using the newborn's ID number, name and DOB.

- If no newborn ID is received and the date of service is within 45 days of the newborn's date of birth, the claim may be paid using the mother's ID number. If the date of service is not within 45 days of the newborn's date of birth, the claim will be denied.

Billing Guidelines When Using the Mother's Beneficiary ID Number

- Newborn services are considered procedure codes that specifically state "newborn" in the code description according to the CPT® manual or revenue codes 170–179. These services must be billed with a newborn diagnosis code in order to receive payment.
- When billing newborn services for a newborn that does not have a beneficiary ID number, use "Newborn," "Baby Girl," or "Baby Boy" in the first name field and enter the last name. Use the newborn's date of birth and the mother's beneficiary ID number.

NDC Requirements

- Sunflower has mirrored the NDC requirements that the State of Kansas has in place. We download the NDC/procedure code crosswalk file from the KMAP website monthly and update our configuration accordingly.

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, 101 or 110 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.

Professional Fees

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

Prosthetic and Orthotic

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

Readmissions

- When a KanCare beneficiary is discharged prematurely and subsequently readmitted within 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 continuation or a recurrence of a problem causing the initial 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 the **x12 Store** (**https://x12.org/products**).

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.

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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 **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 AAABBBCCCC 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.

PLAN	RECEIVER ID	PAYER ID
All	***ISA08/GS03 837P/837I***	***NMN109 when NM101 = PR***
Medical	68069	68069
Behavioral Health	68068	68068
Centurion	42140	42140

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. Providers should follow the state policy related to 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.***

Subscriber 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 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 avail-

able 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.

TRANSACTION STRUCTURE LEVEL	TYPE OF ERROR OR PROBLEM	TRANSACTION OR REPORT RETURNED
ISA/IEA Interchange Control		TA1
GS/GE Functional Group ST/SE Segment Detail Segments	HIPAA Implementation Guide violations	999 Sunflower Claims Audit Report (a proprietary confirmation & error report)
Detail Segments	Sunflower Business Edits (see audit report rejection reason codes and explanation.)	Sunflower Claims Audit Report (a proprietary confirmation and error report)
Detail Segments	HIPAA Implementation Guide violations & Sunflower Business Edits.	277CA

277CA/Audit Report Rejection Codes

ERROR CODE	REJECTION REASON
01	Invalid Mbr DOB
02	Invalid Mbr
06	Invalid Provider
07	Invalid Mbr DOB & Provider
08	Invalid Mbr & Provider
09	Mbr not valid at DOS
10	Invalid Mbr DOB; Mbr not valid at DOS
12	Provider not valid at DOS
13	Invalid Mbr DOB; Prv not valid at DOS
14	Invalid Mbr; Prv not valid at DOS
15	Mbr not valid at DOS; Invalid Prv
16	Invalid Mbr DOB; Mbr not valid at DOS; Invalid Prv
17	Invalid Diag Code
18	Invalid Mbr DOB; Invalid Diag
19	Invalid Mbr; Invalid Diag
21	Mbr not valid at DOS; Prv not valid at DOS
22	Invalid Mbr DOB; Mbr not valid at DOS; Prv not valid at DOS
23	Invalid Prv; Invalid Diagnosis Code
24	Invalid Mbr DOB; Invalid Prv; Invalid Diag Code
25	Invalid Mbr; Invalid Prv; Invalid Diag Code
26	Mbr not valid at DOS; Invalid Diag Code
27	Invalid Mbr DOB; Mbr not valid at DOS; Invalid Diag Code
29	Provider not valid at DOS; Invalid Diag Code
30	Invalid Mbr DOB; Prv not valid at DOS; Invalid Diag
31	Invalid Mbr; Prv not valid at DOS; Invalid Diag

ERROR CODE	REJECTION REASON
32	Mbr not valid at DOS; Prv not valid; Invalid Diag
33	Invalid Mbr DOB; Mbr not valid at DOS; Invalid Prv; Invalid Diag
34	Invalid Proc
35	Invalid Mbr DOB; Invalid Proc
36	Invalid Mbr; Invalid Proc
37	Invalid Future Service Date
38	Mbr not valid at DOS; Prv not valid at DOS; Invalid Diag
39	Invalid Mbr DOB; Mbr not valid at DOS; Prv not valid at DOS; Invalid Diag
40	Invalid Prv; Invalid Proc
41	Invalid Mbr DOB, Invalid Prv; Invalid Proc
42	Invalid Mbr; Invalid Prv; Invalid Proc
43	Mbr not valid at DOS; Invalid Proc
44	Invalid Mbr DOB; Mbr not valid at DOS; Invalid Proc
46	Prv not valid at DOS; Invalid Proc
48	Invalid Mbr; Prv not valid at DOS; Invalid Proc
49	Mbr not valid at DOS; Invalid Prv; Invalid Proc
51	Invalid Diag; Invalid Proc
52	Invalid Mbr DOB; Invalid Diag; Invalid Proc
53	Invalid Mbr; Invalid Diag; Invalid Proc
55	Mbr not valid at DOS; Prv not valid at DOS; Invalid Proc
57	Invalid Prv; Invalid Diag; Invalid Proc
58	Invalid Mbr DOB; Invalid Prv; Invalid Diag; Invalid Proc
59	Invalid Mbr; Invalid Prv; Invalid Diag; Invalid Proc
60	Mbr not valid at DOS;Invalid Diag;Invalid Proc
61	Invalid Mbr DOB; Mbr not valid at DOS; Invalid Diag; Invalid Proc
63	Prv not valid at DOS; Invalid Diag; Invalid Proc
64	Invalid Mbr DOB; Prv not valid at DOS; Invalid Diag; Invalid Proc
65	Invalid Mbr; Prv not valid at DOS; Invalid Diag; Invalid Proc
66	Mbr not valid at DOS; Invalid Prv; Invalid Diag; Invalid Proc
67	Invalid Mbr DOB; Mbr not valid at DOS; Invalid Prv; Invalid Diag; Invalid Proc
72	Mbr not valid at DOS; Prv not valid at DOS; Invalid Diag; Invalid Proc
73	Invalid Mbr DOB; Mbr not valid at DOS; Prv not valid at DOS; Invalid Diag; Invalid Proc
74	Services performed prior to Contract Effective Date
75	Invalid units of service
76	Original Claim Number Required
77	Invalid Claim Type
78	Diagnosis Pointer- Not in sequence or incorrect length
81	Invalid units of service, Invalid Prv
83	Invalid units of service, Invalid Prv, Invalid Mbr
89	Invalid Mbr DOB; Mbr not valid at DOS; Prv not valid at DOS; Invalid Diag
91	Invalid Missing Taxonomy or NPI/Invalid Prov
92	Invalid Referring/Ordering NPI
93	Mbr not valid at DOS; Invalid Proc
96	GA OPR NPI Registration-State

ERROR CODE	REJECTION REASON
A2	Diagnosis Pointer Invalid
A3	Service Lines- Greater than 97 Service lines submitted- Invalid
B1	Rendering and Billing NPI are not tied on State File- IN rejection
B2	Not enrolled with MHS IN and/or State with rendering NPI/TIN on DOS. Enroll with MHS and Resubmit claim
B5	Invalid CLIA
C7	NPI Registration- State GA OPR
C9	Invalid/Missing Attending NPI
HP/H1/H2	ICD9 after end date/ICD10 sent before Eff Date/Mixed ICD versions

Appendix XII: Common Acronyms

Acronym	Definition
ABD	Aged, Blind, Disabled
ABA	Applied Behavioral Analysis
ABN	Advanced Beneficiary Notice
ACA	Affordable Care Act
ACIP	Advisory Commission on Immunization Practices
ADA	American Dental Association
ADA	Americans with Disabilities Act
ADAP	AIDS Drug Assistance Program
ADT	Admission Discharge Transfer
AIMS	Automated Information Management System
AIR	Adverse Incident Report
AMA	American Medical Association
ANSI	The American National Standards Institute
API	Active Pharmaceutical Ingredient
APM	Alternative Payment Model
APN	Advanced Practice Nursing
APRN	Advanced Practice Registered Nurse
APS	Adult Protective Services
ARRA	American Recovery and Reinvestment Act
ASAM	American Association of Addiction Medicine
AVRS	Automated Voice Response System
BAA	Business Associate Agreement
BC-DR	Business Continuity/Disaster Recovery
BH	Behavioral Health
BH-CMO	Behavioral Health Medical Officer/Medical Director
BI	Brain Injury Waiver

Acronym	Definition
BSRB	Behavioral Sciences Regulatory Board
CAH	Critical Access Hospital
CAHPS®	Consumer Assessment of Healthcare Providers and Systems
CAP	Corrective Action Plan
CAQH	Council for Affordable Quality Healthcare
CARC	Claim Adjustment Reason Codes
CCBHC	Certified Community Behavioral Health Clinic
CDC	Centers for Disease and Control
CDDO	Community Developmental Disability Organization
CSW	Community Support Waiver
CDT	Code on Dental Procedures and Nomenclature
CEO	Chief Executive Officer
CFO	Chief Financial Officer
CFR	Code of Federal Regulations
CHIP	Children's Health Insurance Program
CHR	Community Health Representative
CHW	Community Health Worker
CLIA	Clinical Laboratory Improvement Amendments
CM	Case Management
CMHC	Community Mental Health Center
CMD	Chief Medical Director
CMO	Chief Medical Officer
CMP	Foster Care Case Management Provider
CMS	Centers for Medicare & Medicaid Services
COB	Coordination of Benefits
COBRA	Consolidated Omnibus Budget Reconciliation Act

Acronym	Definition
COI	Conflict of Interest
COO	Chief Operating Officer
CPC	Clinical Policy Committee
CPS	Child Protective Services
CPST	Community Psychiatric Support and Treatment
CPT	Current Procedural Terminology
CRD	Chronic Renal Disease
CRNA	Certified Registered Nurse Anesthetist
CRO	Consumer Run Organization
CSHCN	Children with Special Health Care Needs
CT	Computed Tomography
CYSHCN	Children and Youth Special Health Care Needs
DCF	Department of Children and Families
DD	Developmental Disabilities
DEERS	Defense Enrollment Eligibility Reporting System
DHCF	Division of Health Care Finance
DHHS	Department of Health and Human Services
DME	Durable Medical Equipment
DMEPOS	Durable Medical Equipment, Prosthetics, Orthotics and Supplies
DMF	Death Master File
DOB	Date of Birth
DOH	Department of Health
DOI	Department of Insurance
DOS	Dates of Service
DRG	Diagnosis Related Group
DSH	Disproportionate Share Hospital
D-SNP	Dual Eligible Special Needs Plan
DUR	Drug Utilization Review or Report
DX	Diagnosis Code
EBP	Evidence-Based Practices
ECT	Electroconvulsive Therapy
ED	Emergency Department
EDI	Electronic Data Interchange
EDW	Enterprise Data Warehouse
EFT	Electronic Funds Transfer
EHR	Electronic Health Record
EITPR	External Independent Third-Party Review
EMC	Electronic Media Claims

Acronym	Definition
EOB	Explanation of Benefits
EOP	Explanation of Payment
EPO	Exclusive Provider Organizations
EPSDT	Early and Periodic Screening, Diagnosis and Treatment
EQR	External Quality Review
EQRO	External Quality Review Organization
ERA	Electronic Remittance Advice
ER	Emergency Room
ESRD	End Stage Renal Dialysis
EVV	Electronic Visit Verification (like AuthentiCare)
FDA	United States Food and Drug Administration
FE	Frail Elderly Waiver
FEB	Front End Billing
FFP	Federal Financial Participation
FFS	Fee For Service
FMS	Financial Management Services
FQHC	Federally Qualified Health Center
FTP	File Transfer Protocol
FWA	Fraud, Waste and Abuse
GAR	Grievance and Appeals Report
GROW	GED, Rides, Opportunities, Work (Sunflower program)
GTG	Good to Go Report (WORK)
HCBS	Home and Community Based Services
HCFA	Health Care Financing Administration
HCPCS	Healthcare Common Procedural Coding System
HEDIS	Healthcare Effectiveness Data and Information Set
HHS	Department of Health & Human Services
HIE	Health Information Exchange
HIO	Health Information Organization
HIPAA	Health Insurance Portability and Accountability Act
HIT	Health Information Technology
HITECH	Health Information Technology for Economic Clinical Health Act
HIV	Human Immunodeficiency Virus
HMO	Health Maintenance Organization

Acronym	Definition
HOS	Health Outcomes Survey (Medicare only)
HRA	Health Risk Assessment
HRS	Health Risk Survey
HUD	United States Housing and Urban Development
I/DD	Individuals with Intellectual and/or Developmental Disabilities
ICD	International Classification of Diseases
ICF/IDD	Intermediate Care Facility for Individuals with Intellectual and Developmental Disabilities
ICN	Internal Control Number
ICT	Integration Care Team
IDEA	Individuals with Disabilities Education Act
ID	Identification
IEP	Individual Education Plan
IFSP	Independent Family Services Plan
IHCPs	Indian Health Care Providers
ILC	Independent Living Counselor (WORK Program)
IMD	Institution for Mental Diseases
IPS	Individual Placements and Supports
KAPA	Kansas Administrative Procedures Act
K.A.R.	Kansas Administrative Regulations
KBH	KAN Be Healthy
KCPC	Kansas Client Placement Criteria
KDADS	Kansas Department of Aging and Disability Services
KDHE	Kansas Department of Health and Environment
KDHE-DHCF	Kansas Department of Health and Environment, Division of Health Care Finance
KHIN	Kansas Health Information Network
KID	Kansas Insurance Department
KMAP	Kansas Medical Assistance Program
KMMS	Kansas Modular Medicaid System
KSA	Kansas Statutes Annotated
K-TRACS	Kansas Tracking and Reporting of Controlled Substances
HIS	Indian Health Services
LACIE	Lewis and Clark Health Information Exchange
LEAs	Local Education Agencies
LEP	Limited English Proficient

Acronym	Definition
LOC	Level Of Care
LPN	Licensed Practical Nurse
LTC	Long Term Care
LTSS	Long Term Support Services
MAT	Medication Assisted Treatment
MCO	Managed Care Organization
MDL	Maintenance Drug List
MDS	Minimum Data Set
MFCU	Medicaid Fraud Control Unit
MH	Mental Health
MHPAEA	Mental Health Parity and Addiction Equity Act
MLR	Medical Loss Ratio
MRI	Magnetic Resonance Imaging
MRR	Medical Record Review
MTM	Medication Therapy Management
NA	Not Applicable
NAIC	National Association of Insurance Commissioners
NCPDP	National Council for Prescription Drug Programs
NCQA	National Committee for Quality Assurance
NDC	National Drug Code
NEMT	Non-Emergency Medical Transportation
NF	Nursing Facility
NFMH	Nursing Facility for Mental Health
NICU	Neonatal Intensive Care Unit
NOA	Notice of Action
NOMS	National Outcomes Measurement System
NPDB	National Practitioner Data Bank
NPI	National Provider Identifier
NUCC	National Uniform Claim Committee
OB/GYN	Obstetrics and Gynecology
OCK	OneCare Kansas – program ended Dec. 31, 2024
OIG	Office of Inspector General
OTR	Outpatient Treatment Request
P4Q	Pay for Quality
PA	Prior Authorization
PACE	Program for All-Inclusive Care for the Elderly
PAD	Physician-Administered Drug
PARIS	Public Assistance Reporting Information System

Acronym	Definition
PBM	Pharmacy Benefit Management
PBS	Positive Behavior Support
PCP	Primary Care Provider
PCS	Personal Care Services
PCSP	Person-Centered Service Plan
PD	Physical Disability Waiver
PDL	Preferred Drug List
PHI	Protected Health Information
PII	Personally Identifiable Information
PII	Personal Interest Inventory
PIP	Performance Improvement Project
PMPM	Per Member Per Month
PNC	Procurement Negotiating Committee
POC	Plan of Care
POS	Place of Service
PPACA	Patient Protection and Affordable Care Act
PPO	Preferred Provider Organization
PPS	Prospective Payment System
ProDUR	Prospective Drug Utilization Review
PRTF	Psychiatric Residential Treatment Facility
QAPI	Quality Assessment and Performance Improvement
QI	Quality Improvement
QM	Quality Management
QMB	Qualified Medicare Beneficiary
QMS	KanCare Quality Management Strategy
RA	Remittance Advices
RADAC	Regional Alcohol and Drug Assessment Center
RARC	Remittance Advice Remark Codes
RFP	Request for Proposal
RHC	Rural Health Clinic
RN	Registered Nurse
SAMHSA	Substance Abuse and Mental Health Services Administration
SBIRT	Screening Brief Intervention and Referral to Treatment
SDOH	Social Determinants of Health
SDP	State-Directed Payment
SED	Severe Emotional Disturbance

Acronym	Definition
SFH	State Fair Hearing
SFTP	Secured File Transfer Protocol
SIA	State Institution Alternative
SIU	Special Investigation Unit
SMHP	State Medicaid HIT Plan
SNF	Skilled Nursing Facility
SOBRA	Sixth Omnibus Budget Reconciliation Act
SPMI	Severe and Persistent Mental Illness
SSA	Social Security Administration
SSI	Supplemental Security Income
SSN	Social Security Number
ST	Speech Therapy
STC	Specific Therapeutic Class
STD	Sexually Transmitted Diseases
STEPS	Supports and Training for Employing People Successfully
STRS	Specialty Therapy and Rehabilitation Services
SUD	Substance Use Disorder
TA	Technology Assisted Waiver
TANF	Temporary Aid to Needy Families
TAT	Turnaround Time
TB	Tuberculosis
TBI	Traumatic Brain Injury
TCM	Targeted Case Management
TDD	Telecommunication Device for the Deaf
TIN	Tax Identification Number
Title XIX	Of the Social Security Act – Federal Funds Source for Medicaid
Title XXI	Of the Social Security Act – Federal funds source for health insurance for low-income children (CHIP)
TMS	Transportation Management System
TPL	Third-Party Liability
TTY	Teletype, Telecommunications Device
TPA	Third Party Administration
UM	Utilization Management
UPIN	Universal Physician Identification Number
UR	Utilization Review
URL	Universal/Uniform Resource Locator

Acronym	Definition
U.S.	United States
USDA	United States Department of Agriculture
VBP	Value-Based Purchasing

Acronym	Definition
WIC	Special Supplemental Food Program for Women, Infants, and Children
WORK	Work Opportunities Reward Kansans

Appendix XIII: Participating Provider Agreement, MedicaidProduct Attachment

Attachment A: Medicaid

PRODUCT ATTACHMENT
KANSAS MEDICAID AND CHIP PRODUCT
(Including Regulatory Requirements)

THIS MEDICAID PRODUCT ATTACHMENT (this "ProductAttachment") is made and entered between Celtic Insurance Company ("Celtic") and _____ ("Provider").

WHEREAS, Celtic and Provider entered into that certain Participating Provider Agreement, as the same may have been amended and supplemented from time to time (the "Agreement"), pursuant to which Provider and its Contracted Providers participate in certain Products offered by or available from or through Celtic;

WHEREAS, Contracted Providers will be designated and participate as Participating Providers in the Product described in this Product Attachment; and

WHEREAS, the Agreement is modified or supplemented as hereafter provided.

NOW THEREFORE, in consideration of the recitals, the mutual promises herein stated, the parties hereby agree to the provisions set forth below.

1. Defined Terms. All capitalized terms not specifically defined in this Product Attachment will have the meanings given to such terms in the Agreement.

2. Product Participation.

2.1 Kansas Medicaid and CHIP Product. This Product Attachment addresses the participation of Provider and the applicable Contracted Providers in the Kansas Medicaid and CHIP Product (the "Medicaid Product"). The ultimate purpose of this Product Attachment is to support the KanCare, Kansas Medicaid, and Children's Health Insurance ("CHIP") programs. The Medicaid Product includes those programs and health benefit arrangements offered by Sunflower State Health Plan, Inc. ("SSHP") or other affiliate of Celtic pursuant to a contract (the "State Contract") with the Kansas Department of Health and Environment ("KDHE"), or any successor thereto, to provide specified services and goods to covered beneficiaries under the KanCare, Kansas Medicaid, and/or CHIP programs, and to meet certain performance standards while doing so. This Product Attachment does not apply to any Coverage Agreements that are specifically covered by another Product Attachment to the Agreement. This Product Attachment applies only to the provision of health care services, supplies or accommodations (including Covered Services) to Covered Persons enrolled in the Medicaid Product.

2.2 Participation. Unless otherwise specified in this Product Attachment, all Contracted Providers under the Agreement will participate in the Medicaid Product as "Participating Providers," and will provide to Covered Persons enrolled in the Medicaid Product, upon the same terms and conditions contained in the Agreement, as supplemented or modified by this Product Attachment, those Covered Services that are provided by Contracted Providers pursuant to the Agreement. In providing such services, Provider shall, and shall cause Contracted Providers to, comply with and abide by the provisions of this Product Attachment and the Agreement (including the Provider Manual).

SAMPLE

2.3 Attachment. This Attachment constitutes the Product Attachment for the Medicaid Product.

2.4 Construction. Except as expressly provided herein, the terms and conditions of the Agreement will remain unchanged and in full force and effect. In the event of a conflict between the provisions of the Agreement and the provisions of this Product Attachment, this Product Attachment will govern with respect to health care services, supplies or accommodations (including Covered Services) rendered to Covered Persons enrolled in the Medicaid Product. To the extent Provider or any Contracted Provider is unclear about its, his or her respective duties and obligations, Provider or the applicable Contracted Provider shall request clarification from Celtic. To the extent any provision of the Agreement (including any exhibit, attachment, or other document referenced herein) is inconsistent with or contrary to any provision of the State Contract or Regulatory Requirements, the relevant provision of the State Contract or Regulatory Requirements shall have priority and control over the matter.

3. Term. This Product Attachment will be coterminous with the Agreement unless a party or a Contracted Provider terminates the participation of the Contracted Provider in the Medicaid Product in accordance with the applicable provisions of the Agreement or this Product Attachment.

4. Governmental Contract Regulatory Requirements. Schedule A to this Product Attachment, which is incorporated herein by this reference, sets forth the special provisions that are applicable to the Medicaid Product under a Governmental Contract.

5. State Mandated Regulatory Requirements. Schedule B to this Product Attachment, which is incorporated herein by this reference, sets forth the provisions that are required by State law to be included in the Agreement with respect to the Medicaid Product. To the extent that a Coverage Agreement is subject to the law cited in the parenthetical at the end of a provision on Schedule B, such provision will apply to the rendering of Covered Services to a Covered Person with such Coverage Agreement.

6. Other Terms and Conditions. Except as modified or supplemented by this Product Attachment, the compensation hereunder for the provision of Covered Services by Contracted Providers to Covered Persons enrolled in the Medicaid Product is subject to all of the other provisions in the Agreement (including the Provider Manual) that affect or relate to compensation for Covered Services provided to Covered Persons.

SAMPLE

Attachment A: Medicaid

SCHEDULE A
GOVERNMENTAL CONTRACT REGULATORY REQUIREMENTS

This schedule sets forth the special provisions that are specific to the Kansas Medicaid and CHIP Product under a Governmental Contract.

1. Definitions. For purposes of this schedule, the following terms have the meanings set forth below. Terms used in this schedule and not defined below will have the same meaning set forth in the Agreement, or, if not defined there, in the State Contract.

1.1 ***"Clean Claim"*** means the definition set forth in 42 C.F.R. 447.45, as amended. It is a claim that can be processed without obtaining additional information from the provider of service or from a third party. 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.

1.2 ***"Covered Person"*** or ***"Member"*** means a Title XIX or Title XXI beneficiary who has been certified by the State as eligible to enroll in the Kansas Medicaid or CHIP Program and whose name appears on Celtic enrollment information that will be transmitted monthly by the State to Celtic in accordance with an established notification schedule.

1.3 ***"Emergency Services"*** means those Covered Services that are inpatient and outpatient services furnished by a Participating Provider that is qualified to furnish the services and are needed to evaluate an emergency medical condition. An emergency medical condition is a medical condition that manifests itself by acute symptoms of sufficient severity, including severe pain that a prudent layperson who possesses an average knowledge of health and medicine, could reasonably expect that the absence of immediate medical attention could result in any of 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.

1.4 "Celtic" includes "Celtic" and "Company", as appropriate in the context.

1.5 ***"Medical Necessity"*** or ***"Medically Necessary"*** means the definition set forth in K.A.R. 30-5-58 (ooo)(1), as amended. As of the Effective Date, such definition is a health intervention that is an otherwise covered category of service, is not specifically excluded from coverage and is medically necessary, according to all of the following criteria: (i) Authority – the health intervention is recommended by the treating physician and is determined to be necessary by the Secretary of the Kansas Department for Children and Families or such individual's designee; (ii) Purpose – the health intervention has the purpose of treating a medical condition; (iii) Scope – the health intervention provides the most appropriate supply or level of service, considering potential benefits and harms to the patient; (iv) Evidence – the health intervention is known to be effective in improving health outcomes and (v) Value – the health intervention is cost-effective for this condition compared to alternative interventions, including no intervention. For new interventions, effectiveness shall be determined by scientific evidence as provided in paragraph (ooo)(3) of K.A.R. 30-5-58 (ooo)(3). For existing interventions, effectiveness shall be determined as provided in K.A.R. 30-5-58 (ooo)(4). In addition, Celtic is responsible for covering services related to the following: (1) the prevention, diagnosis and treatment of health impairments; (2) the ability to achieve age-appropriate growth and development; and (3) the ability to attain, maintain or regain functional capacity.

1.6 ***"Plan of Service"*** means a written document that describes and records the Covered Person's goals and service needs. The Plan of Service records the strategies to meet goals and interventions selection by the Covered Person and team to support them in improving the Covered Person's health and wellbeing and addressing Social Determinants of Health.

1.7 ***"Provider"*** means, for purposes of this Schedule A, the "Provider" as first indicated above and each Contracted Provider.

1.8 ***"State"*** means the State of Kansas, including, but not limited to, any entity or agency of the State.

1.9 ***"State Contract"*** means the then effective contract with the Kansas Department of Health and Environment (or any successor thereto) for Managed Care for Medicaid Program, CHIP Program or both.

1.10 ***"Title XIX"*** means the provisions of Title 42 United States Code Annotated Section 1396 et. seq. (the Social Security Act), including any amendments thereto. Title XIX provides medical assistance for certain individuals and families with low incomes and resources.

SAMPLE

1.11 ***"Title XXI"*** means the provisions of the Social Security Act as amended in August 1997 to add Title XXI, known at the federal level as the Children's Health Insurance Program (CHIP), which provides health insurance coverage to uninsured children from low-income families, who are not Title XIX eligible.

2. Compliance; Amendments. Provider shall comply with all provisions of the State Contract, federal, State and local laws and regulations, and all amendments thereto. Provider understands and agrees that the Product Attachment and/or the Agreement shall be deemed automatically amended as necessary to comply with any applicable State or federal law, regulation, policy or Medicaid manual, or any applicable provision of the State Contract.

3. Delivery of Services. Provider shall (i) deliver Covered Services in a culturally competent manner to all Covered Persons and be responsive to Covered Persons' health literacy needs, including those with limited English proficiency and diverse cultural and ethnic backgrounds, disabilities and regardless of gender, sexual orientation or gender identity; and (ii) provide physical access, reasonable accommodations and accessible equipment for Covered Persons with physical or mental disabilities. If Celtic identifies a problem involving discrimination or accommodations for individuals with disabilities by a Provider, Celtic shall intervene and require a corrective action plan from Provider and Provider shall comply with Celtic's request. Provider shall incorporate in their policies, administration and service practice the values of (i) honoring Covered Person's beliefs; (ii) sensitivity to cultural diversity; and (iii) fostering in staff and Providers' attitudes and interpersonal communication styles which respect Covered Person's cultural backgrounds. (Sections 2.5.3 and 2.5.5; 42 CFR 438.206(c)(2), (3) and 42 CFR 438.206(b)(1)).

4. Plans of Service. Provider shall cooperate with Celtic to ensure that (a) all Covered Persons receiving service coordination are able to participate in a Plan of Service planning process to create a Plan of Service that is compliant with the State's Plan of Service policy and the State Contract; (b) the Plan of Service is signed by the individuals specified in, and approved in the timeframes required under, the State Contract (e.g., within 30 days of the interdisciplinary team meeting); and (c) the Plan of Service is reviewed at every contact with the Covered Person and updated with new signatures obtained as prescribed at least annually or more often based on the changes on the Covered Person's needs. (Section 2.4.4.1)

5. Hours of Operation. Provider shall offer hours of operation for Title XIX Covered Persons that are no less than the hours of operation offered to commercial patients, or comparable to those whose Title XIX services are reimbursed on a fee-for-service basis if Provider serves only Medicaid enrollees. (Section 2.5.6)

6. Availability of Care. Provider shall provide, or arrange for the provision of, Covered Services, including Emergency Services, on a 24-hour-a-day, 7 day-a-week basis, as Medically Necessary. For the avoidance of doubt, all emergency care will be provided immediately at the nearest facility available, regardless of whether the Emergency Room (ER) is a Participating Provider. (Sections 2.3.1.B and 2.5.6.4; 42 CFR § 438.206(c)(1)(iii))

7. Access Standards. In accordance with 42 CFR 438.206(c) and State standards for timely access to care and services, Provider shall provide necessary and appropriate services to Covered Persons within a timely period, taking into account the urgency of need for services and applicable appointment wait times in accordance with the State Contract, as indicated below.

7.1 If Provider is a primary care provider, Provider will make available non-emergent after-hours physician services or primary care services. (Section 2.5.6.2)

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7.2 If Provider provides specialty services (e.g., specialty physician, hospice, home health care, substance use disorder ("SUD") treatment, rehabilitation services) or urgent care, appointment times shall not exceed 30 days from the date of a request for routine care, or 48 hours for urgent care, and waiting times for any such appointment will not exceed 45 minutes. (Section 2.5.6.3)

7.3 Provider will ensure that appointment times are in accordance with usual and customary standards, not exceed 3 weeks from the date of a request for regular appointments and 48 hours for urgent care. (Section 2.5.6.1)

7.4 Provider shall respond to referrals 24 hours per day, 7 days per week, and provide access to evening and weekend appointments. Provider shall respond to routine, urgent, and emergent needs within the established timeframes in conformance with State requirements. The waiting time for any appointment will not exceed forty-five (45) minutes. (Sections 5.5.5.1.A, 5.5.5.1.B and 5.5.5.1.D)

7.5 If Provider is a non-emergency medical transportation (NEMT) service ("NEMT Provider"), the standards in this Section apply. A Covered Person's transportation shall arrive at the pick-up location no later than 15 minutes after the scheduled pick-up time. Arrival later than 15 minutes after the scheduled time shall be considered a NEMT Provider no-show. The NEMT Provider shall wait at least 15 minutes after the scheduled pick-up time. A Covered Person's transportation for physical, behavioral health and long-term services and supports ("LTSS") services shall arrive at the Provider location (a) no sooner than one hour before the Covered Person's appointment, and (b) at least 15 minutes prior to the Covered Person's appointment time. The Covered Person shall not wait for more than one hour after the appointment for return transportation. The NEMT Provider shall communicate with the Covered Person regarding the approximate arrival time and shall promptly notify the Covered Person when the NEMT Provider will arrive later than the scheduled pick-up time. When returning the Covered Person to the point of origin, non-emergency medical transportation providers shall ensure return routes are efficient, do not result in unnecessary delays and do not include scheduled or unscheduled stops during the return trip. For urgent care, facility discharges and inter-facility transfers, the NEMT Provider shall arrange for pick-up within three hours of when the request is made. (Section 2.5.6.5)

8. State and Federal Monitoring. Provider shall comply with all requirements for State and federal monitoring found at 42 CFR 438.230 and as contained in the State Contract. Provider shall comply with Celtic's external quality review activities in accordance with the State Contract and State and federal law and regulations (42 CFR 438). Provider shall cooperate and participate in external quality review activities in accordance with protocols found in 42 CFR 438, Subpart E. (Section 2.9.2)

9. Program Integrity and Provider Disclosures. Provider shall comply with all federal and State laws and regulations related to program integrity and disclosure requirements. (Section 2.12.1.F)

9.1 Excluded Persons. Providers shall furnish at the time of enrollment, and promptly upon any change occurring thereafter, the identity of any person with an ownership or control interest in Provider as further described in 42 CFR § 1001.1001(a). Provider represents and warrants that there is no person who has ownership or control interest in Provider, or who is an agent or managing employee of Provider, that (i) has been convicted of a criminal offense as described in sections 1128(a) and 1128(b)(1), (2), or (3) of the Social Security Act; (ii) has had civil money penalties or assessments imposed under section 1128A of the Act; or (iii) has been excluded from participation in Medicare, Medicaid, CHIP or any federal or State health care program. (Section 2.12.1.R)

9.2 Disclosure of Ownership and Control Under 42 CFR § 438.608. Provider shall disclose the ownership and control information required pursuant to 42 CFR § 438.608 at the times specified therein,

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including upon execution of the Agreement, upon request of Celtic or within 35 days after any change in ownership occurs. (Section 2.12.1.P, 42 CFR § 438.608(c)(2)).

10. Clinical and Medical Records.

10.1 Provider shall maintain clinical and medical records in a manner that is current, detailed and organized, and which permits effective and confidential patient care and quality review, administrative, civil and criminal investigations and prosecutions. (Section 2.9.12.A)

10.2 Subcontractor shall maintain the confidentiality of clinical and medical records. All clinical and medical records of Covered Persons shall be confidential and shall only be released in compliance with HIPAA and other applicable record-protection laws. Subcontractors must maintain the confidentiality of clinical and medical record information and release the information only in the following manner: (a) all clinical and medical records of Covered Persons shall be confidential and shall only be released in compliance with HIPAA and other applicable record-protection laws; (b) written consent of the Covered Person is only required for the transmission of clinical and medical record information of a former enrolled Covered Person for "sensitive conditions" or as otherwise specified by HIPAA and other applicable record-protection laws. Authorization is not required when the Subcontractor is transitioning care to another KanCare managed care organization (MCO); (c) the extent of clinical or medical record information to be released in each instance shall be based upon tests of Medical Necessity and a "need to know" on the part of the provider requesting the information; (d) all releases of information for substance use disorder specific clinical or medical records must meet federal guidelines at 42 CFR Part 2. (Section 2.9.12)

11. Prohibited Relationships Under 42 CFR § 438.610. Provider warrants and represents that neither it nor any entity or individual with which it has an employment, consulting or other arrangement to provide items or services under the State Contract is (i) an individual who is debarred, suspended or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549; or (ii) an individual who is an affiliate, as defined in the Federal Acquisition Regulation, of a person described in subdivision (i) of this section. For purposes of prohibited affiliations, "relationship" is defined as (a) a director, officer or partner of Subcontractor; (b) a subcontractor of Subcontractor; (c) a person with beneficial ownership of 5% or more of Celtic's or Subcontractor's equity; and (d) a participating provider or person with an employment, consulting or other arrangement with Subcontractor for the provision of items and services that are significant and material to the Subcontractor's obligation under the State Contract or the Agreement. Subcontractor warrants and represents the Subcontractor does not have a relationship with an individual or entity that is excluded from participation in any federal health care program under Section 1128 or 1128A of the Social Security Act. Provider and Contracted Providers must provide written disclosures of any prohibited affiliation under 42 CFR § 438.610. (Section 2.12.1.S)

12. Licensure. Provider warrants and represents that it is licensed, registered, certified or accredited as required by applicable State laws, and shall submit a copy of its valid State license(s), registration(s), certification(s) or accreditation(s). If Provider is a laboratory or an entity providing laboratory services funded by Title XIX or Title XXI of the Social Security Act, Provider warrants and represents that it is CLIA-certified and that it will submit a copy of its valid CLIA certificate upon request by Celtic. If Provider is a nursing facility, Provider warrants and represents that it is certified under Medicaid, and will cooperate with Celtic to become Medicare certified. (Sections 2.5.10.C, 2.1.1.e, and Appendix A)

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13. Behavioral Health Standards.

13.1 Mental Health Services. If Provider provides mental health services, it shall ensure the following for Covered Persons presenting for mental health services: (a) for emergency needs, Covered Persons are referred to services immediately; (b) Covered Persons with urgent, non-emergency needs are assessed within 72 hours of a request for services and; (c) Covered Persons with routine, non-urgent needs are assessed within 10 business days of the date the services are requested. (Sections 2.5.9.E 2.5.9)

13.2 Behavioral Crisis Response. If Provider provides behavioral health crisis response services, it shall cooperate with Celtic to ensure, as appropriate, the following: (a) crisis responsiveness which includes 24 hours a day, 7 days a week, 365 days a year emergency treatment and first response, including, when appropriate, staff going to the Covered Person for personal intervention and for any Covered Person that staff become aware of experiencing a crisis or other emergency; (b) the provision of or referral to psychiatric and other community services, when appropriate; (c) assessment of any Covered Person experiencing a behavioral health crisis to determine the need for inpatient, treatment, crisis services, or other community treatment services; (d) emergency consultation and education when requested by law enforcement officers, other professionals or agencies, or the public for the purposes of facilitating emergency services; and (e) follow up with any Covered Person seen for or provided with any Emergency Services and not admitted for inpatient care and treatment to determine the need for any further services or referral to any services within 72 hours of crisis resolution. In cases of discharge from inpatient care, Provider will collaborate with Celtic on discharge planning upon admission and monitor contact with Covered Person following inpatient discharge with goals of offering and encouraging Covered Person's attendance at follow-up appointments. From the date of the Covered Person's discharge, Provider will ensure 85% of all contact attempts occur between 24 to 72 hours of discharge; 90% of contact attempts occur within one to seven calendar days; and 95% of contact attempts occur within one to seven calendar days. (Section 2.5.9.E.d)

13.3 Substance Use Disorders. If Provider provides SUD services, it shall ensure the following for Covered Persons presenting for SUD services: (a) for emergency needs, Covered Persons are referred to services immediately; (b) Covered Persons with urgent, non-emergency needs are assessed within 24 hours of a request for services, and services are delivered within 24 hours of the date and time of the assessment; (c) Covered Persons with routine, non-urgent needs are assessed within 10 business days of the date the services are requested; (d) pregnant women who are intravenous drug users and all other pregnant substance users, regardless of Title XIX status, receive treatment within 24 hours of assessment, or, when it is not possible to admit the Covered Person within this timeframe, interim services are made available within 48 hours of initial contact to include prenatal care; and (e) persons who inject drugs must receive an assessment and shall be admitted to treatment no later than 10 business days after making the request for assessment. If no program has the capacity to admit the Covered Person within the required timeframe, interim services shall be made available to the Covered Person no later than 48 hours after such request. Admission to treatment must not exceed 120 calendar days of the request for assessment. (Section 2.5.9.D)

13.4 Home and Community Based Services. If Provider provides home and community based services ("HCBS"), it will comply with, during the term of this Product Attachment, the HCBS Rule set forth at 42 CFR § 441.301, and comply with the requirements identified by the State for HCBS providers, including ensuring the Section 1915(c) provider qualifications are met. (Sections 2.5.2.c and 2.5.2.g)

14. Post-Stabilization Services. Provider shall not charge Covered Persons for post-stabilization care services an amount greater than what Celtic would charge Covered Person if Celtic were to provide such services. (Section 2.8.3.2.I)

SAMPLE

15. Hold Harmless. Provider agrees that Covered Persons shall not be liable for Covered Services for which the State does not pay Celtic or for which the State or Celtic does not pay the Provider under a contractual, referral or other arrangement. Provider agrees that Covered Persons shall not be liable for Celtic's debts in the event of Celtic's insolvency. Provider shall not charge Covered Persons for all or any part (i.e., balance of bill) of Covered Services provided pursuant to the Agreement. Provider agrees that Covered Persons are not liable for payments to Provider when the State does not pay Celtic for any reason. (Sections 2.10.12.C and 2.13.1.F)

16. Non-Discrimination; Corrective Action Plans. Provider will take Covered Person rights under federal and state laws rights into account when furnishing services to Covered Persons. Provider shall comply with all federal and state laws and regulations, including the provisions and applicable conditions of Title VI of the Civil Rights Act of 1964, as amended; Title IX of the Education Amendments of 1972 (regarding education programs and activities); the Age Discrimination Act of 1975, as amended; the Equal Pay Act of 1963; the Rehabilitation Act of 1973, as amended; the Americans with Disabilities Act; section 1557 of the Patient Protection and Affordable Care Act; the Civil Rights Act of 1991, and, if applicable, all provisions of Executive Order No. 11246 including amendments, as well as rules, regulations and relevant orders of the Secretary of Labor. Provider will provide Covered Services to Covered Persons without regard to race, color, national origin, sex, sexual orientation, gender identity, age or disability and will not use any policy or practice that has the effect of discriminating on the basis of race, color, national origin, sex, sexual orientation, gender identity, age or disability. Provider further agrees (a) to comply with the Kansas Act Against Discrimination (K.S.A. 44 1001, et seq.), the Kansas Age Discrimination in Employment Act (K.S.A. 44-1111, et seq.), the applicable provisions of the Americans With Disabilities Act (42 U.S.C. 12101, et seq.) (ADA) and Kansas Executive Order No. 19-02, and to not discriminate against any person because of race, color, gender, sexual orientation, gender identity or expression, religion, national origin, ancestry, age, military or veteran status, disability status, marital or family status, genetic information or political affiliation that is unrelated to the person's ability to reasonably perform the duties of a particular job or position; (b) to include in all solicitations or advertisements for employees, the phrase "equal opportunity employer"; (c) to comply with the reporting requirements set out at K.S.A. 44-1031 and K.S.A. 44-1116. If Celtic identifies a problem involving discrimination or accommodation for individuals with disabilities by Provider, Provider will cooperate with the Corrective Action Plan identified by Celtic. (Sections 2.5.5.j, 2.1.1.f, 2.10.12.A.h, 2.10.12.B and State Contract Anti-Discrimination Clause)

17. Termination or Inactivation of Medicaid Provider Agreement. Provider represents and warrants that Provider has not been terminated from participation in the Kansas Medicaid program. This Product Attachment will terminate by Celtic providing written notice to Provider in the event that the Agreement is terminated or inactivated by the State. Such termination will be effective on the date specified in the notice of termination or inactivation from the State. Provider is prohibited from employing or contracting with persons or entities that the State has terminated from participation in the Kansas Medicaid program. (Sections 2.12.1.J and 2.12.1.K)

18. Federal Deficit Reduction Act. If Provider receives or makes $5 million in annual Kansas Medicaid payments, Provider must comply with Section 6032 of the Deficit Reduction Act of 2005 (DRA), Section 1902(a)(68) of the Social Security Act and 42 CFR § 438.608(a)(6), as a condition of receiving payment under Kansas Medicaid. The $5 million amount, for Kansas Medicaid purposes, is based on paid claims, net of any adjustments to those claims. It is the responsibility of the Provider and/or Contracted Providers to make the determination as to whether they meet the $5 million threshold. (Section 2.12.1.S.e)

19. Person-Centered Planning Services. Provider shall cooperate with Celtic to ensure, for all Covered Persons enrolled in HCBS waiver services, children in foster care and Covered Persons with behavioral health needs, that (a) such Covered Persons are able to participate in a Person Centered Service Planning ("PCSP")

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process that is compliant with federal and state law, including 42 CFR § 441.301(c) and K.A.R. 30-63-1 Article 63, the State's PCSP policy and the State Contract; (b) the PCSP is signed by the individuals specified in, and approved in the timeframes required under, the State Contract; and (c) the PCSP is reviewed during every contact with the Covered Person and updated at least annually or more often based on the changes on the Covered Person's needs. (Section 2.4.4.2)

20. Overpayments. Provider shall report overpayments to Celtic and specify the reason for the overpayment in writing. Provider shall return the overpayment to the Celtic within 60 calendar days after the date on which the payment was identified. Provider agrees that, when directed by KDHE, Celtic may recover established overpayments made to a Provider by the State for performance or non-performance of activities not governed by the State Contract. Provider acknowledges and agrees that Celtic shall, when directed by the State, recover established overpayments made by the State for performance or non-performance of activities not governed by the State Contract. (Sections 2.12.1.M, 2.12.1.K and 2.19.5; 42 CFR § 438.608)

21. Provider Preventable Conditions. Provider will comply with the reporting requirements set forth at 42 CFR § 447.26(a)(12) and 447.26 applicable to provider preventable conditions as a condition of payment. Provider acknowledges and agrees that no payment will be made by Celtic for provider preventable conditions, as identified in the State Contract. (Section 2.15.17.K; 42 CFR §§ 434.6(a)(12) and 447.26)

22. Advance Directives. Provider must comply with the requirements of State law (whether statutory or recognized by the courts of the State) regarding advance directives. Provider will document in a prominent part of the Covered Person's current medical record whether or not the Covered Person has executed an Advance Directive. Provider will not condition the provision of care or otherwise discriminate against a Covered Person based on whether or not the Covered Person has executed an Advance Directive. (Section 2.10.2 D-F)

23. Conflict of Interest. Provider acknowledges that Celtic and its subcontractors are prohibited under the State Contract from undertaking any work that represents a potential conflict of interest, or which is not in the best interest of KDHE or the State, without written approval by KDHE; in addition, any such work that involves LTSS or behavioral health providers requires written approval from the Kansas Department for Aging and Disability Services (KDADS). Specific situations that may be indicative of a conflict of interest include, but are not limited to, the following: (i) a change of the distribution of referrals or reimbursement among providers within a level of care; (ii) referral by Celtic to only those providers with whom Celtic shares an organizational relationship; (iii) preferential financial arrangements by Celtic with those providers with whom Celtic shares an organizational relationship; (iv) different requirements for credentialing, privileging, profiling or other network management strategies for those providers with whom Celtic shares an organizational relationship; and (v) substantiated complaints by Covered Persons of limitations on their access to Participating Providers of their choice within an appropriate level of care. Provider acknowledges that Celtic shall fully and completely disclose (i) any situation that may present as a conflict of interest; and (ii) any proposal to provide services to Provider or any entity owning or controlling Provider. Provider acknowledges that, in the event that the State determines at any time during the term of the State Contract that a conflict of interest and/or preferential treatment exists involving Provider, the State reserves the right to sanction Celtic or to take other actions, up to and including recouping Company's payments, and terminating Provider from participation in Celtic's network. (Section 5.5.12)

24. Claims Processing Standards. Generally, Celtic will pay or deny 100% of all Clean Claims within 30 calendar days of receipt. Celtic will pay or deny 99% of all non-Clean Claims within 60 calendar days of receipt. Celtic will pay or deny 100% of all claims within 90 calendar days of receipt. For nursing facilities, Celtic will pay 90% of nursing facility Clean Claims within 14 calendar days and 99.5% of Clean Claims within 21 calendar days. (Section 2.14.D and 2.14.H)

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25. Post-Pay Recovery and Third Party Liability ("TPL"). TPL refers to any individual, entity or program that may be liable for all or part of a Covered Person's health coverage. Under Section 1902(a)(25) of the Social Security Act, the State is required to take all reasonable measures to identify legally liable third parties and treat verified TPL as a resource of the Covered Person. Celtic shall follow all federal regulations and all State statutes and regulations for TPL and medical subrogation. Celtic shall have procedures in place to collect TPL funds when primary coverage is identified after payment has been made. (Section 2.14.2.A)

26. Timely Filing. A Provider's claims (first-time) must be received by Celtic within 180 calendar days from the date of service (discharge date for inpatient or observation claims). All corrected claims must be received within 365 calendar days from the date of notification of payment. Additional timely filing requirements may be found in the Provider Manual. (Section 2.14.1.J)

28. Enrollment in Medicaid and Credentialing. Provider acknowledges that it is enrolled with KDHE as a Medicaid Provider consistent with applicable disclosures, screening and enrollment requirements under 42 CFR Part 455, Subparts B and E as incorporated in 42 CFR 438.608(b). Provider and Contracted Providers further acknowledge and agree that participation under this Product Attachment may be terminated immediately upon Celtic's notification by the State that Provider cannot be enrolled in the State Medicaid Program or the expiration of one 120-day period without Provider being enrolled by the State as a Medicaid Provider. Provider agrees to comply with the requirements of Celtic's credentialing and re-credentialing policies and procedures. (Sections 2.12.1.C, 2.5.1.B, 2.5.2)

29. Continuing Obligations. Termination of the Agreement or expiration of the State Contract shall not discharge Provider's obligations with respect to services or items furnished prior to termination or expiration, including retention of records and verification of overpayments or underpayments. Termination or expiration shall not discharge Celtic's payment obligations with respect to Covered Services furnished prior to termination or expiration. (Sections 2.19.5.B)

30. Audits. Provider acknowledges and agrees that Celtic, the State or any agent, including the State's Fiscal Agent or other contractor, has the right to review, audit and recover from Provider. Provider shall cooperate with reviews and audits and must respond to State requests. (Section 2.12.1.G.)

31. Suspension of Payments Due to Allegations of Fraud. Provider acknowledges and agrees that Celtic shall comply with 42 CFR §455.23 by suspending all payments after the State determines that there is a credible allegation of Fraud for which an investigation is pending under the Medicaid program against an individual or entity unless the State has identified in writing a good cause reason for not suspending payments or to suspend payments only in part. Provider shall report all suspected fraud, waste, or abuse to KDHE and Company upon discovery regardless of funding source, in accordance with the State Contract and applicable federal and State law. (Sections 2.12.1.O, 2.5.16.A. and 42 CFR §455.23)

32. Member Fraud and Abuse. Provider shall notify Celtic of Covered Persons suspected of participating in fraudulent or abusive activities. Notifications must be in writing with supporting documentation attached. (Section 2.12.2).

33. Adverse Incident Reporting. If Provider or a member of their staff has reason to believe a Covered Person has been abused, mistreated, neglected or financially exploited, or has knowledge of the occurrence of other Adverse Incidents, Provider shall report such incidents to Celtic so that Celtic may report such incidents to the State. (§2.9.9)

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34. Compliance with 41 USC § 4712. Provider shall inform all employees working on any federal award they are subject to the whistleblower rights and remedies of the pilot program, including whistleblower protection. (§2.12.1.S)

Attachment A: Medicaid

SCHEDULE B
STATE MANDATED REGULATORY REQUIREMENTS

This Schedule sets forth provisions that are required by State law to be included in the Agreement with respect to the Kansas Medicaid and CHIP Product. To the extent that a Coverage Agreement, or a Covered Person, is subject to the law cited in the parenthetical at the end of a provision on this schedule, such provision will apply to the rendering of Covered Services to a Covered Person with such Coverage Agreement, or to such Covered Person, as applicable.

KS-1 Hold Harmless. Provider agrees that a Covered Person is not liable to Provider or any Contracted Provider for any amounts owed by Celtic for Covered Services under the Covered Person's Coverage Agreement that are not paid by Celtic. Any action by Provider or Contracted Provider to collect or attempt to collect from a Covered Person any sum owed by the Celtic to Provider is deemed to be an unconscionable act within the meaning of KAN. STAT. ANN. § 50-627, and any amendments thereto. (KAN. STAT. ANN. § 40-3209(b))

KS-2 Examination by Insurance Commissioner. Provider shall provide access to their respective affairs, books and records to the State insurance commissioner including any delegate or duly authorized agent thereof for examination in accordance with State law. (KAN. STAT. ANN. § 40-3211)

KS-3 Emergency Services. To the extent that a Coverage Agreement requires prior authorization before receiving payment for treatment of an emergency medical condition, Provider shall not hold a Covered Person under such Coverage Agreement financially responsible for payment for such services if such prior authorization is not sought or received. (KAN. STAT. ANN. § 40-3229(c))

KS-4 Treatment Decisions. The parties acknowledge and agree that nothing in the Agreement or this Product Attachment prohibits or restricts Provider from discussing or disclosing to any Covered Person any medically appropriate health care information that such Provider deems appropriate regarding the nature of treatment options, the risks or alternatives thereto, the process used or the decision made by Celtic to approve or deny health care services, the availability of alternate therapies, consultations or tests, or from advocating on behalf of the Covered Person within any utilization review or grievance processes established by Celtic. (KAN. STAT. ANN. § 40-4604)

KS-5 Financial Incentives. The parties acknowledge and agree that nothing in the Agreement or this Product Attachment, including but not limited to the Compensation Schedule(s), serves as a direct or indirect inducement to reduce or limit the delivery of medically necessary services to a Covered Person. (KAN. STAT. ANN. § 40-4605)

KS-6 Use of Name. Provider hereby authorizes Celtic to use their respective names, telephone numbers, addresses, availability and a description of services in listings of Participating Providers. (KAN. STAT. ANN. §§ 40-3214, 40-4606(c))

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KS-7 Payor of Last Resort. If there is valid Medicaid coverage providing benefits for a loss or condition, the Medicaid coverage will be the source of last resort of any payment to Provider. (KAN. STAT. ANN. § 40-3208(b))

KS-8 Amendment to Provider Agreement with Vision Care Providers. Any modification to the terms, discounts or rates of a provider agreement for vision care services requires prior written approval by Provider. (KAN. STAT. ANN. § 40-5903(a))

KS-9 Grievance Procedures. Provider shall participate in the grievance procedures established under or in connection with the applicable Coverage Agreement. (KAN. STAT. ANN. § 40-3229(d))

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Appendix XIV: Provider Manual Updates

REVISION DATE	PROVIDER MANUAL SECTION	REVISION DESCRIPTIONS
April 14, 2015	New Provider Manual	Sunflower's Provider Manual was redesigned, updated and republished as the 2015 Edition. Information from all 2014 provider bulletins and announcements were incorporated. An announcement was made to Sunflower's provider network
October 2015	Appendix VIII: HCBS Programs Billing Information	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.
October 2015	Provider Appeal Process Timeline	Step 4 was updated from 5 business days to 10 business days to acknowledge receipt
October 2015	Appendix I: Common Causes of Up-front Rejections	Attending provider box 48 was updated to box 76 on the paper UB claim form
October 2015	Sunflower Health Plan Benefits Grid: Enteral and Parenteral	Oral Supplements Nutrition was changed to Oral Supplemental Nutrition
October 2015	Health Homes Program	"Chronic conditions" was replaced with "serious mental illness" 2nd paragraph includes creation of a Health Action Plan 11th bullet "problems" was replaced with "conditions"
October 2015	Provider Types That May Serve As PCPs	The definition of PCP was updated to reflect the definition found on the KMAP site
October 2015	Coding of Claims/Billing Codes	ICD-10 diagnosis code-related rejection or denial reasons added
October 2015	Appendix II: Common Causes of Claim Procession Delays and Denials	First bullet point was updated to include ICD-10 diagnosis code-related delays or denials
October 2015	Appendix III: Common EOP Denial Codes and Descriptions	ICD-10 diagnosis denial codes and descriptions added for d1, d2, d3, d4. Codes 3D and 4D were updated to reflect dates of service prior to 10/1/2015
October 2015	Appendix X: Billing Tips and Reminders	ICD-10 was added to the last bullet on the POA Indicator definition
October 2015	Benefit Explanation and Limitations	Benefit limitation for Oxygen and Respiratory Services entry was updated to: some limitations, exclusions and quantity limits may apply
October 2015	Appendix III Common EOP Denial Codes and Descriptions	Code ym 30 DAY READMISSION. SUBMIT ALL MEDICAL RECORDS FOR 30 DAY PERIOD, was added.
October 2015	Appendix X: Billing Tips and Reminders	Readmissions section added
January 2016	Provider Rights and Responsibilities	Sixth bullet point updated to "To file a grievance or appeal with Sunflower"

REVISION DATE	PROVIDER MANUAL SECTION	REVISION DESCRIPTIONS
October 2016	Contracting and Network Development	Renamed, reorganized and updated
October 2016	Welcome & Provider Rights and Responsibilities	Reorganized and updated throughout
October 2016	Population Health	Lock-In, other changes
October 2016	Billing and Claims Submission; Billing-Related Appendices (III, VII, X)	Numerous updates
October 2016	Health Homes	Section removed
December 2016	Various	Updated Timely Filing deadlines
December 2016	Various	Clarified discharge coordination language
December 2016	Performance Improvement Process	Added contract language
December 2016	Member Rights	Updated to match Member Handbook
December 2016	Miscellaneous	Additional minor corrections and updates throughout manual
June 2017	Population Health	Prior authorization updates
June 2017	Value Added Services	Updated for 2017 changes
June 2017	Provider & Member Rights and Responsibilities	Various updates
June 2017	Provider Appeals	Changes throughout manual
June 2017	Appendix XI	Addition of 837 Companion Guide
June 2017	Benefit Explanation and Limitations	Various updates
December 2017	Provider Network Development	Specialty companies & facilities types
December 2017	Population Health	Second Opinions updated
December 2017	Grievance and Appeal Process	Grievance Basics, Member Appeal Basics & Member Standard Appeal Process Timeline, various updates
December 2017	Appendix X: Billing Tips and Reminders	Obstetrical and Gynecological Billing Guidelines
December 2017	Provider Rights and Responsibilities	Travel Distances and Access Standards
December 2017	Provider Rights and Responsibilities	Appointment Availability and Wait Times
March 2018	Provider Rights and Responsibilities	Appointment Availability and Wait Times
March 2018	Grievances and Appeals	Updates throughout
March 2018	Appendix X: Billing Tips and Reminders	Multiple updates from state policies
January 2019	All Sections	Integrated behavioral health and other changes.
May 2019	Grievance and Appeal Process	Updated grievances section
January 2020	Grievance and Appeal Process	Added EITPR process
January 2020	Various	Updated Brain Injury Waiver info
January 2020	Contracting & Network Development	Added KMAP Enrollment info
January 2020	Quality Improvement	Updated QAPI goals & HEDIS recommendations
January 2020	Appendices	Various updates to match state and procedural accuracy
January 2020	Provider Rights & Responsibilities	Updated Travel Distance & Access Standards, Appointment Availability & Wait Times

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REVISION DATE	PROVIDER MANUAL SECTION	REVISION DESCRIPTIONS
May 2020	Grievance and Appeal Process	Updated EITPR verbiage to match bulletins
June 2020	Population Health	Updating information for NIA and PT/OT/ST
June 2020	Billing and Claims	Updated extrapolated methodology language
August 2020	Medical Records	Updated retention requirements
August 2020	Grievances and Appeals	Updated KDHE EITPR denial reasons
October 2020	Provider Rights & Responsibilities	Added Dismissing a Member from Your Practice
June 2021	Population Health	Various changes related to secondary/tertiary auths/claims
June 2021	Population Health	New Home Health Services section
June 2021	Population Health	Updated Retrospective Review section to match bulletins
September 2022	Appendix VII	Box 17 Instructions Change
September 2022	All Sections	Numerous minor updates throughout to match state and health plan policy and procedural accuracy
March 2023	Value-Added Services	Updated extra services to 2023 specifications.
March 2023	Billing and Claims	Clarified procedures for correcting claims via secure portal.
March 2023	Various	Removal of 5 p.m. deadline related to admissions/notifications.
February 2024	All Sections	Annual Review
May 2024	Key Contact and Important Numbers	Replacing previous musculoskeletal surgery prior authorization vendor with Evolent
May 2024	Benefit Explanation and Limitations	Addition of doula services
May 2024	Various	Changes to occupational and speech therapy prior authorization
May 2024	Population Health	Interventional Pain Management – new subsection
May 2024	Population Health	Musculoskeletal Care Management – new subsection
February 2025	Contracting and Network Development	Provider Right to be Informed of Application Status
February 2025	Provider Rights and Responsibilities	Beneficiary and Attorney Requests and Subpoenas Appointment Availability and Wait Times
February 2025	Member Rights and Responsibilities	Member Interpreter Services Advance Directives
February 2025	Benefit Explanation and Limitations	Dental Services; Dentures or Partials; Home Births; Vision and Eye Exams; Early and Periodic Screening, Diagnosis and Treatment (KAN Be Healthy); The Scope of EPSDT Treatment Services; Home Monitoring for High-Risk Pregnancies
February 2025	Value-Added Services for Members	2025 Value-Added Services
February 2025	Population Health	Inpatient Authorization; Authorization Determination Timelines; Utilization Review Criteria
February 2025	Medical Records	Medical Records Management and Records Retention
February 2025	Paper Claims Submission	SafeRide
February 2025	Grievance and Appreal Process	Grievance Process; Grievance Timeline; Member/Pre-Service Appeals; Provider Appeal Basics; Provider Appeal Process Steps and Timelines; Provider Appeal; State Fair Hearing; Where to Send Provider Claim Appeals

REVISION DATE	PROVIDER MANUAL SECTION	REVISION DESCRIPTIONS
February 2025	Quality Improvement Program	QAPI Program Structure; Quality Assessment and Performance Improvement Program Scope and Goals
February 2025	Appendix X: Billing Tips & Reminders	DME/Supplies/Prosthetics and Orthotics
February 2025	Appendix XII: Common Acronyms	Acronyms & Definitions
February 2025	Appendix XIII: Participating Provider Agreement Sample	New: Participating Provider Agreement Sample
June 2025	Appointment Availability & Wait Times	Various updates
June 2025	Value-Added Services	Removed Mobile Clinics benefit
June 2025	24-Hour Access to Providers	Additional guidance about after-hours messaging
June 2025	Identification Codes and Numbers	Referring provider guidance update
February 2026	All Sections	Annual Review
February 2026	Grievances and Appeals	Updates to appeals and EITPR specifications
November 2026	All Sections	Annual Review



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