2019 Provider Workshop

Presented by Provider Engagement

KDHE-Approved 2/19/2019

Today's Agenda

- Connecting with Members
- Online Provider Tools
- Prior Authorizations & Claims on the Portal
- Claims Overview
- Corrected Claims
- Medicare Crossover Claims
- Provider Demographics
- Quality Improvement
- Reconsiderations & Appeals
- Coding Accuracy & Closing Care Gaps
- Pharmacy
- Upcoming Events
- Contact Us!
- Helpful Links

Connecting with Members

Providing Culturally Competent Care

Sunflower is committed to providing quality health care services regardless of age, gender, ethnicity, socioeconomic status, disability, or sexual orientation. Sunflower requires annual Cultural Competency and sensitivity training for internal staff.

Sunflower provides educational information, resources, and quarterly webinars to participating providers on Cultural Competency to support providers as they endeavor to foster equitable treatment and to prevent discrimination.

For additional information and resources on Sunflower's Cultural Competency program, please go to www.sunflowerhealthplan.com.

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Social Determinants of Health

The *social determinants of health* are the conditions in which people are born, grow, live, work and age. These circumstances are shaped by the distribution of money, power and resources at global, national and local levels.

2019 Initiatives

- Employment
  - Sunflower Transition to Employment, GED preparation, transportation etc.
  - Employment Support Facilitator
- Housing
  - Housing Support Facilitator
- Food Insecurity
  - Farmers Market Vouchers

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Care Management

We provide Care Management services for everyone in our population by using a multidisciplinary team that includes physicians, nurses, social workers, behavioral health professionals, chronic disease specialists and pharmacists. Focusing on the whole person means partnering with our trusted providers to ensure members receive the right services, in the right place, at the right time.

These services are implemented through:

- Care Coordination
- Complex / Intensive Case Management

Members can self refer for care management services by calling Sunflower Health Plan's Customer Service Center at 1-877-644-4623.

Members who have been newly determined eligible for support through a Home and Community Based Services (HCBS) waiver will be automatically assigned to a care coordinator for outreach.

New members who already receive HCBS services will be automatically assigned to a care coordinator for outreach.

Sunflower makes coordination of care easy by listing the member's primary care physician and phone number on the main member page in the Secure Provider Portal

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Building Strong Relationships with Members

- Discuss Medications:
  - Member preferences
  - Options and substitutes
  - Benefits and Risks
- Labs & Testing Follow Up:
  - Document and acknowledge results in the member's chart
  - Inform the member of the results when they become available
  - Address abnormal results in a timely manor
- Communication
  - Stay A.L.E.R.T. during visits with the member / guardian: **A**lways **L**isten to the member carefully, **E**xplain in an understandable way, **R**espect what the member has to say, and **T**ime management perception (avoid having the member feel rushed).

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Advance Directives

- An **advance directive** is a legal document in which a person specifies what actions should be taken for their health if they are no longer able to make decisions for themselves because of illness or incapacity.
- A **living will** allows individuals to document their wishes concerning medical treatments at the end of life.
- A **medical power of attorney** (or healthcare proxy) allows an individual to appoint a person they trust as a healthcare agent (or surrogate decision maker), who is authorized to make medical decisions on their behalf. Before a medical power of attorney goes into effect a person's physician must conclude that they are unable to make their own medical decisions.
  - Sunflower Health Plan (SHP) provides information to members and providers regarding advance directives and how SHP facilitates member rights to utilize advance directives. Members receive a member handbook containing information regarding advance directives. Providers receive a provider manual that includes SHP policy on advance directives.

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Access Standards

Primary Care Providers

- **Regular Appointments** – not to exceed 3 weeks from the date of member request
- **Urgent Care** – Members seen within 48 hours

Mental Health

- **Post-Stabilization Services** – Referral made within 1 hour. Assessment and / or treatment within 1 hour from referral for post-stabilization services (both IP and OP) in an emergency room
- **Emergent** – Referral immediately. Assessment and / or treatment within 3 hours for an OP Mental Health service and within 1 hour from referral for an emergent concurrent utilization review screen
- **Urgent-** Referral within 24 hours. Assessment and / or treatment within 48 hours from referral for OP Mental Health services, and within 24 hours from referral for an urgent concurrent utilization review screen.
- **Planned inpatient psychiatric** – Referral within 48 hours. Assessment and / or treatment within 5 working days from referral.

Substance Use Disorder (SUD) Providers

- **Emergent** – On demand service, No prior authorization is required and members go directly to an emergency room. Members are seen immediately.
- **Urgent** – Assessment conducted within 24 hours of the initial contact and services delivered within 48 hours from initial contact.
- **IV Drug Users** – Within 14 days of initial contact
- **Routine Care** – Members assessed within 14 days of initial contact and treatment services are delivered within 14 days of assessment

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Provider Responsibilities

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

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Provider Rights

- To contact Customer Service with any questions, comments, or problems
- To not be excluded, penalized, or terminated from participating with Sunflower for having developed or accumulated a substantial number of members in the Sunflower plan with high-cost medical conditions or long-term support needs
- To be treated by their patients who are Sunflower members and other healthcare workers with dignity and respect
- To expect other network providers to act as partners
- To have access to information about Sunflower quality improvement programs, including program goals, processes, and outcomes that relate to member care and services
- To file a grievance or appeal with Sunflower
- To file a grievance on behalf of a member, with the member's consent

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Online Provider Tools

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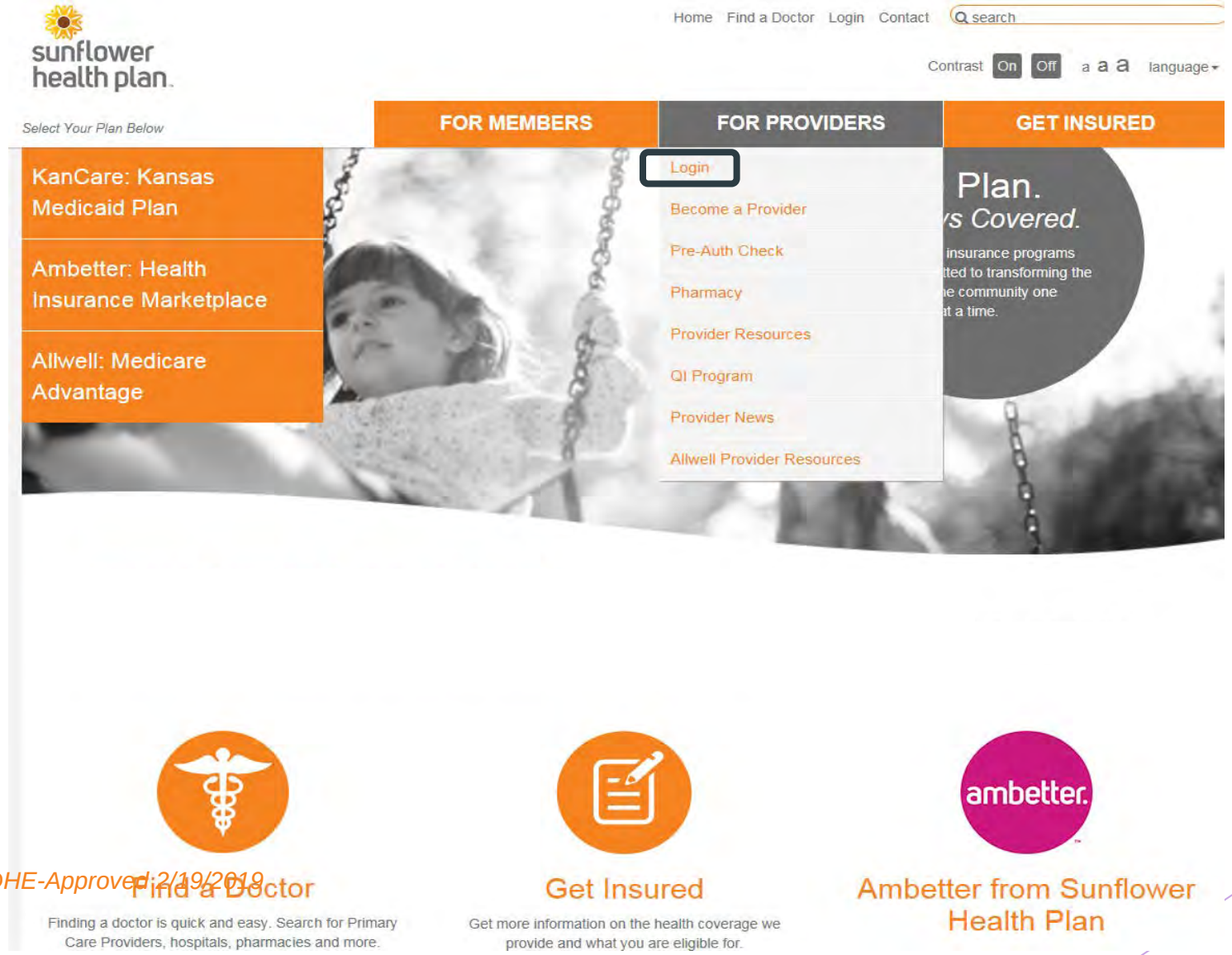
SunflowerHealthPlan.com



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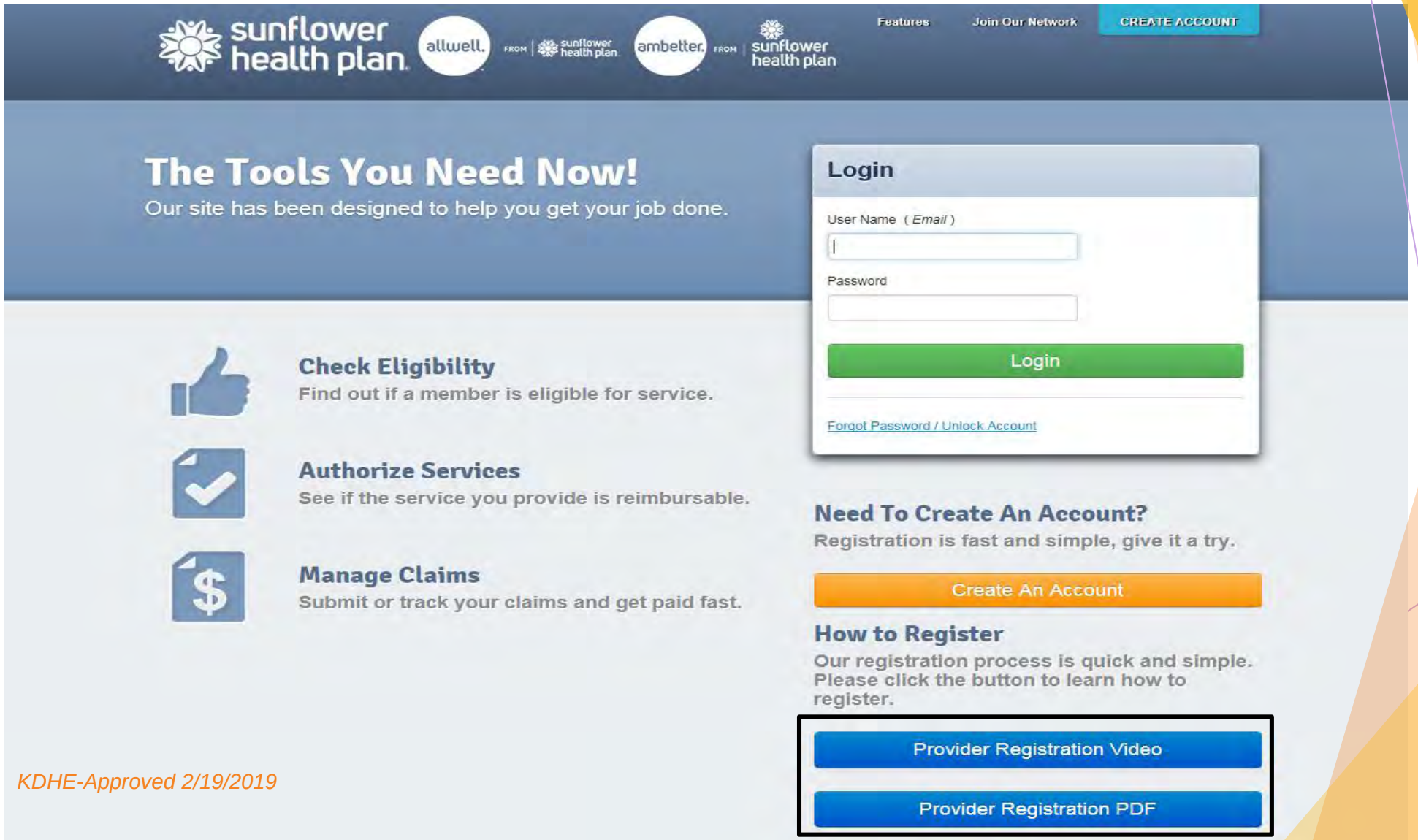
Secure Provider Portal



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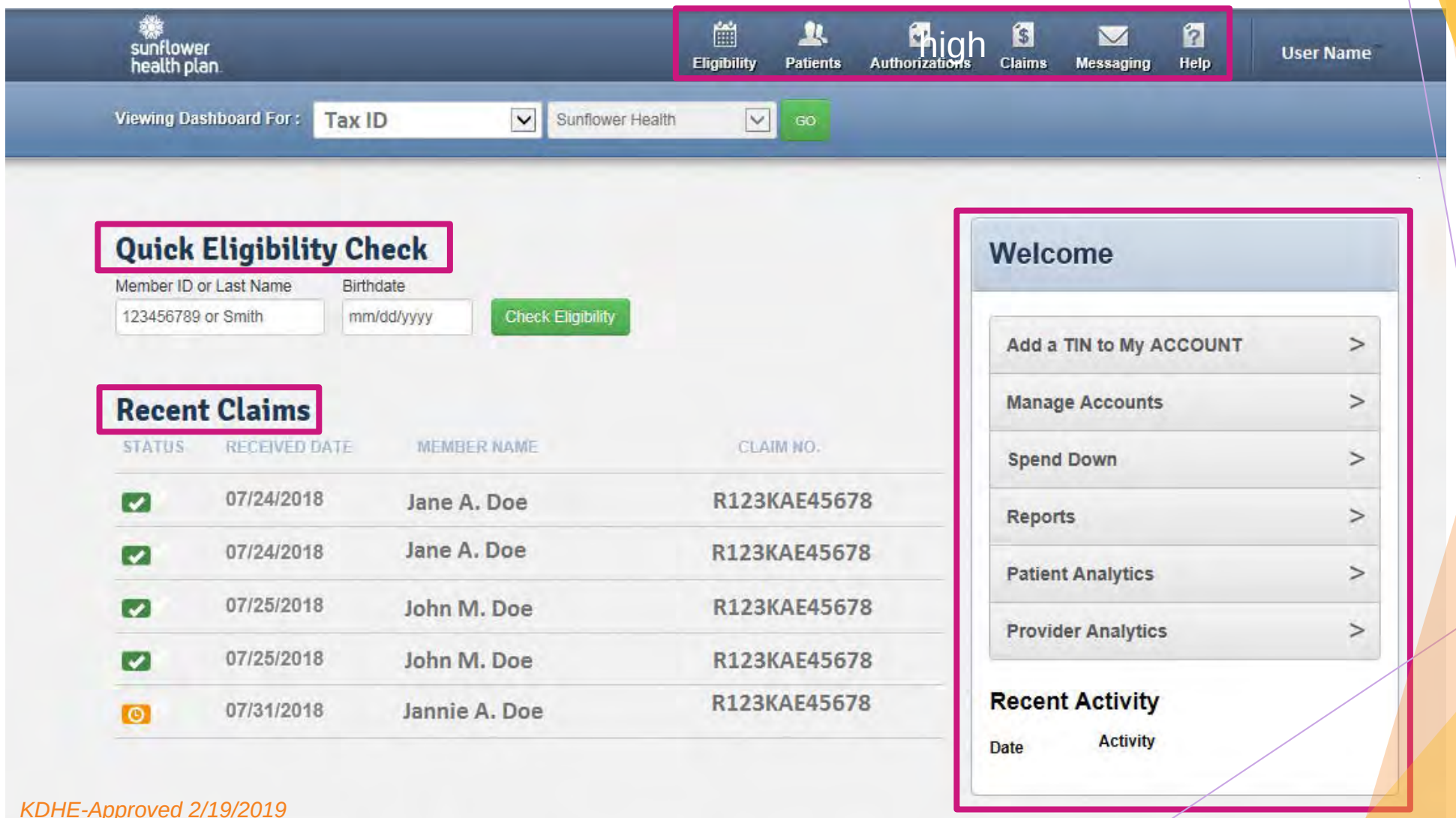
Portal Dashboard



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Account Management – Provider Portal

- **Role:** Account managers serve as the primary point of contact between the provider's office and the health plan.
- **Responsibility**: The Account Manager(s) at a practice is responsible for the day-to-day support of all the other user accounts registered for the same Tax Identification Number (TIN).
  - Verify new users for their TIN
  - Enable or disable access to the portal for existing users
  - Change the permissions of all users under their TIN
- **Access**: Account Managers can use all features within the portal: Health Record, Claims, Manage Account, Eligibility, Assessments, and Authorizations and will tightly manage the request for access from new users within their practice. Account managers are obligated to verify these requests and enable or disable their users' access as necessary, consistent with the user's role and responsibilities.
- **User Management:** Once a user is recognized as an Account Manager by the health plan, "User Management" in the drop-down box under their name is enabled.

Perk of the Portal: You control who has access to the Secure Portal at anytime, with no delay.

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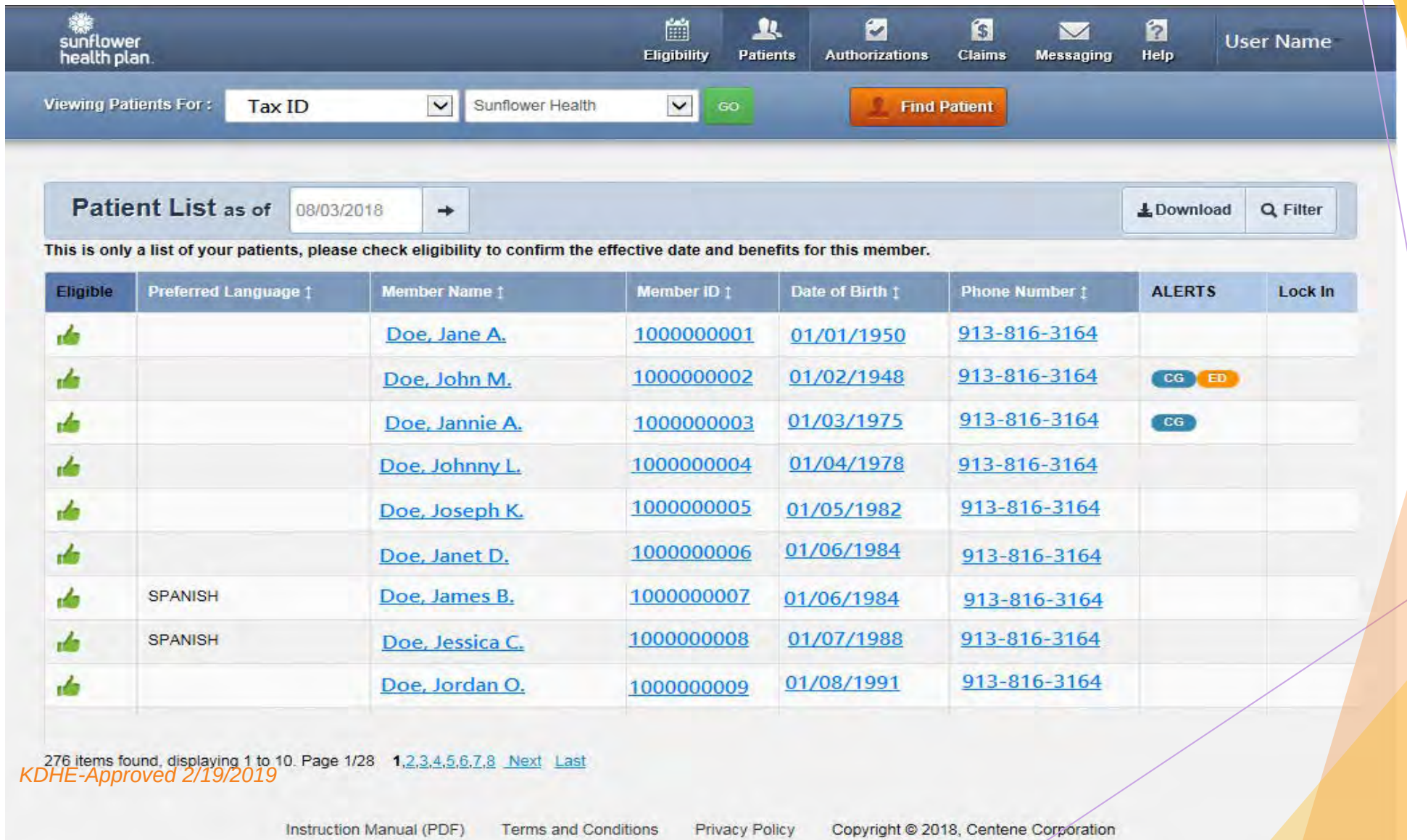
Eligibility and Patient Lists



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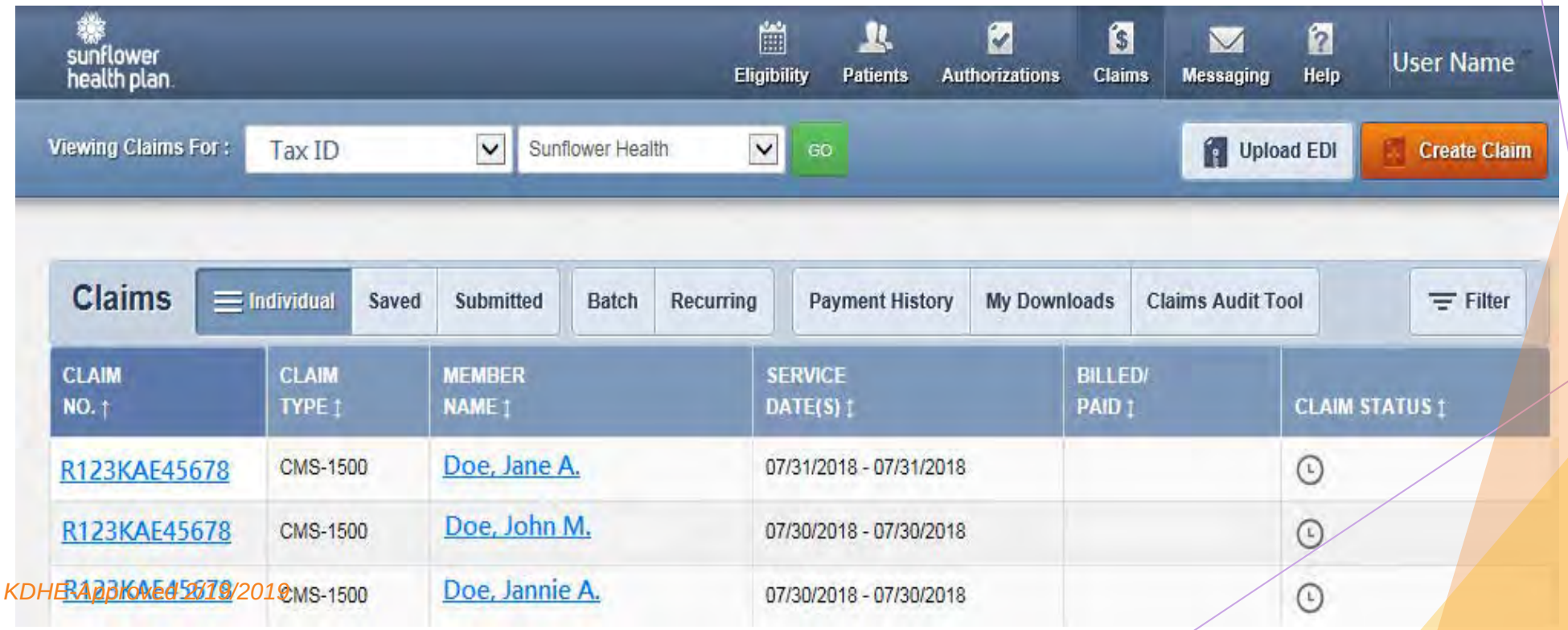
Claim Submissions

Saved: Claims that have been **entered and not yet submitted** will be stored in the “Saved” tab for you to review and submit when you are ready.

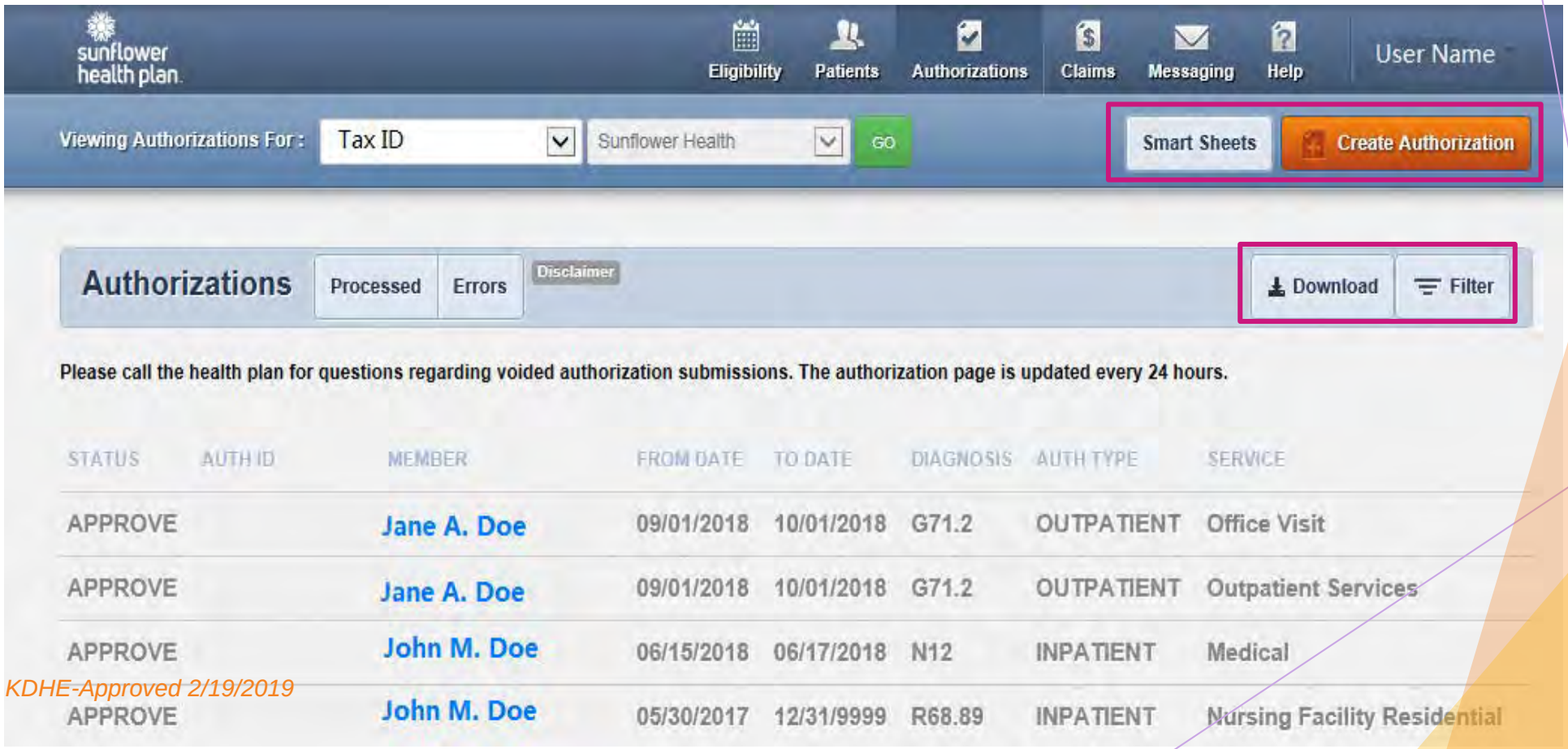
Recurring: Multiple LTC Claim Submission claim wizard feature developed to allow Sunflower Health Plan *LTC providers* to submit **multiple recurring claims easily**. The wizard saves time and reduces errors.

COMING SOON – APPEAL CLAIMS IN THE PORTAL!



Creating Authorizations

After using the "Prior Auth Needed?" tool on the www.sunflowerhealthplan.com website, providers are able to request prior authorizations for upcoming member visits.



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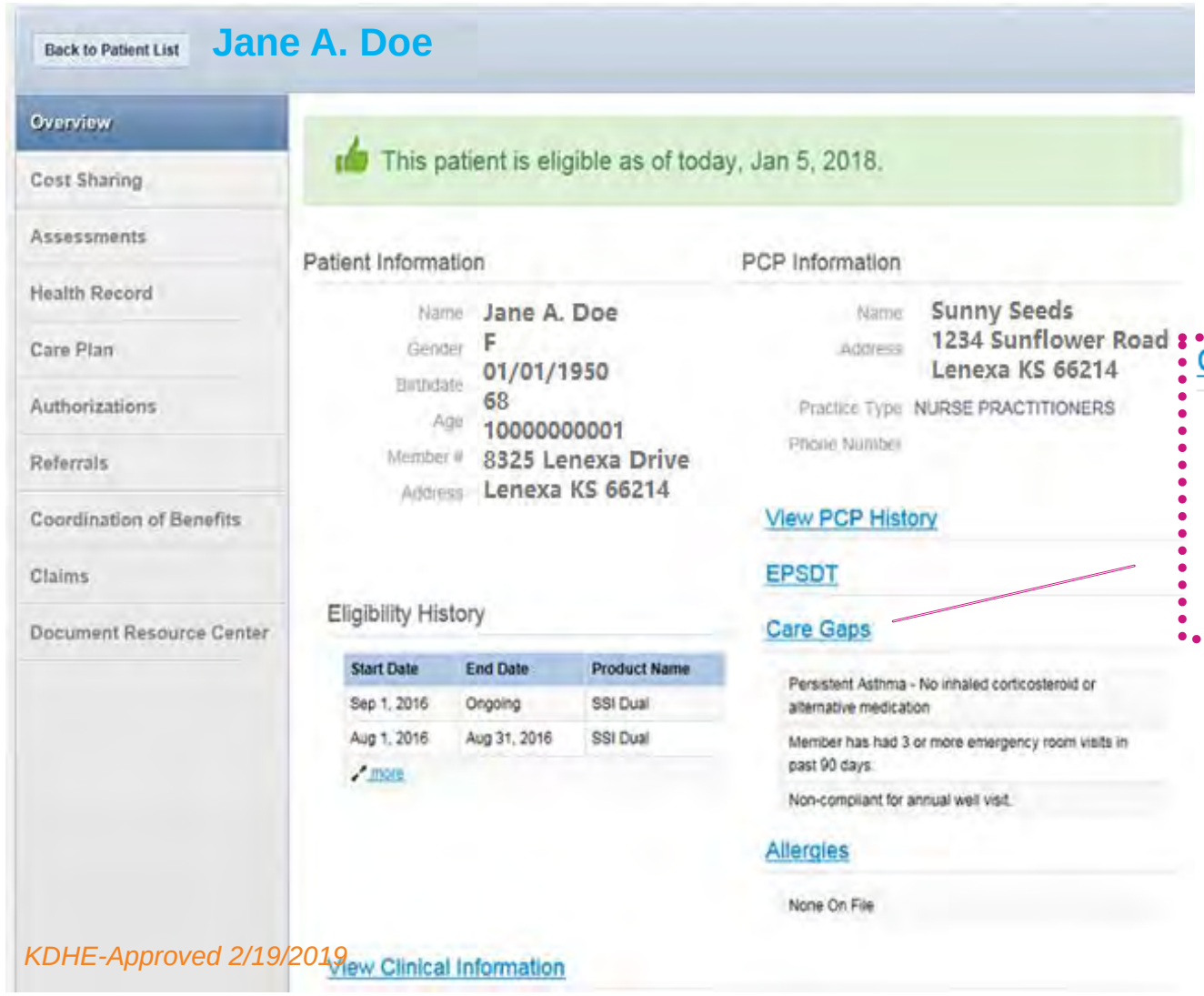
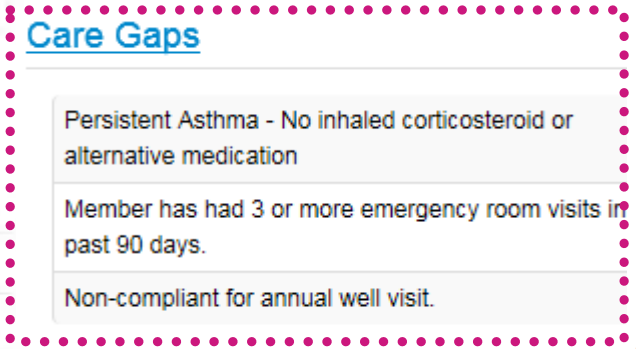
Care Gaps





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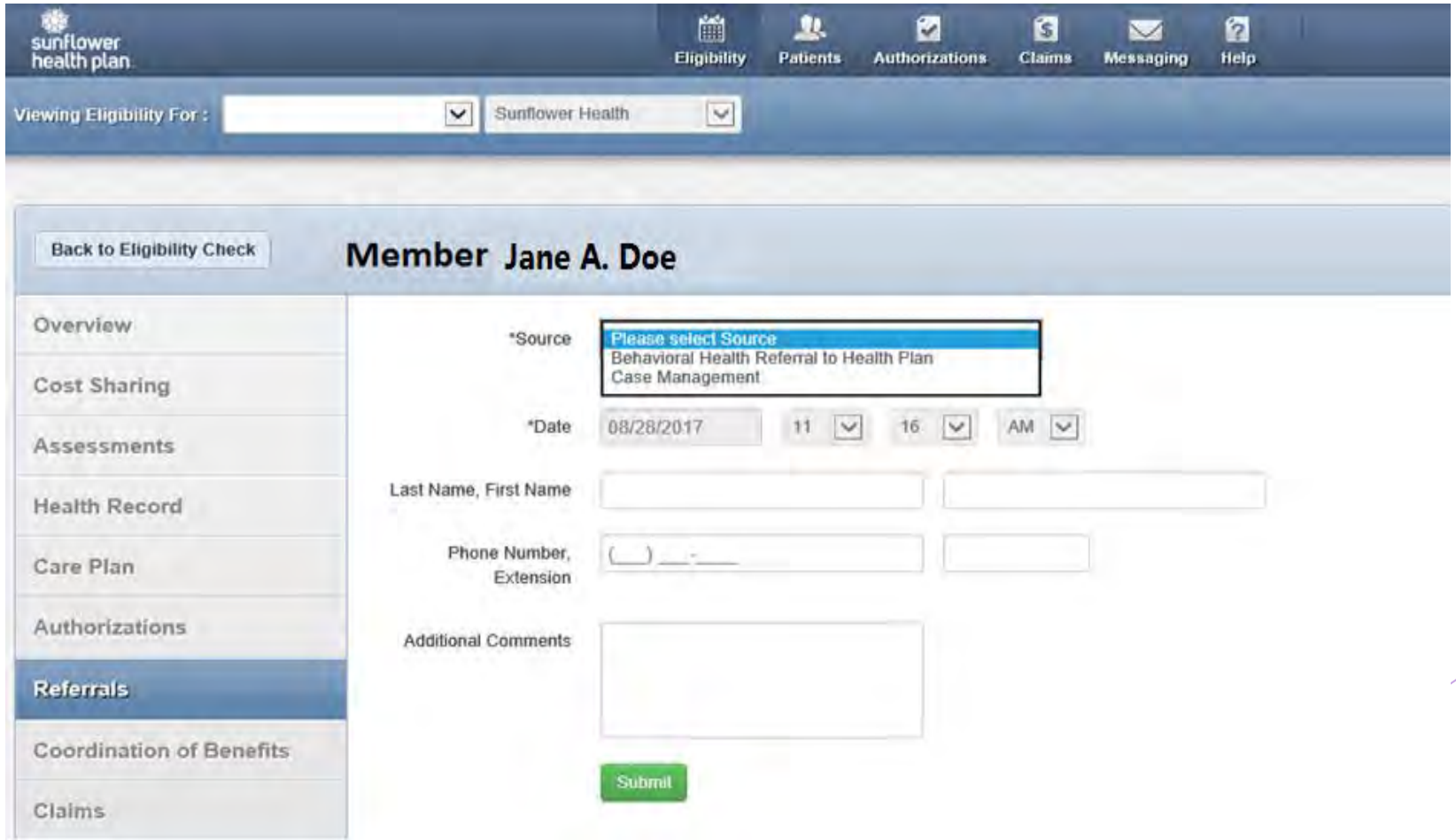
Case Management Referrals – Provider Portal

- Transportation needs? Create a referral!
- Assistance with housing or food? Create a referral!
- Assistance with chronic conditions? Create a referral!
- Looking for Mental Health services? Create a referral!



Why Did We Receive a Request for Medical Records?

You may receive a request from Sunflower's Medical Management, Quality, Auditing, etc. department. We would like to remind you that Medical Records are required by contract for:

- All covered members (including those dual eligible where Sunflower was not payer of service provided)
- Contractual reasons for record requests
- To conduct utilization or quality review of member care
- Regulatory audits, monitoring, or reviews by the state, federal government or MCO
- To meet document requests required by accrediting organizations
- Public official requests

Medical Record Requests and Review

Provider Responsibilities:

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

**Requests for clinical information due to an authorization request have different time frames to be adhered to*

Medical Record Release

- Participating providers and subcontractors are required to maintain clinical and medical records in a manner that is current, detailed and organized.
- Providers must maintain the confidentiality of clinical and medical record information and release the information in the following manner:
  - All clinical and medical records of Members shall be confidential and shall only be released in compliance with HIPAA and other applicable record-protection laws.
  - Written consent of the Member is only required for the transmission of the clinical and medical record information of a former enrolled Member for “sensitive conditions” or as otherwise specified by HIPAA and other applicable protection laws.
  - Authorization is not required when the provider is transitioning care to another KanCare provider.
  - The extent of clinical or medical record information to be released in each instance shall be based upon tests of medical necessity and a “need to know” on the part of the Practitioner or a facility requesting the information.
  - All releases of information for SUD specific clinical or medical records must meet Federal guidelines at 42 CFR Part 2.

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Record Retention Requirements

- Providers shall retain, preserve and make available upon request all clinical and medical forms and claim forms, for a period of no less than 10 years from the date the contract is terminated.
- Records involving matters which are the subject of litigation shall be retained for a period of no less than 10 years following the termination of such litigation, if the litigation is not terminated within the normal retention period.
- Upon expiration of the 10 year retention period, unless the subject of the records is under litigation, the subject records may be destroyed or otherwise disposed of without the prior written consent of the State.

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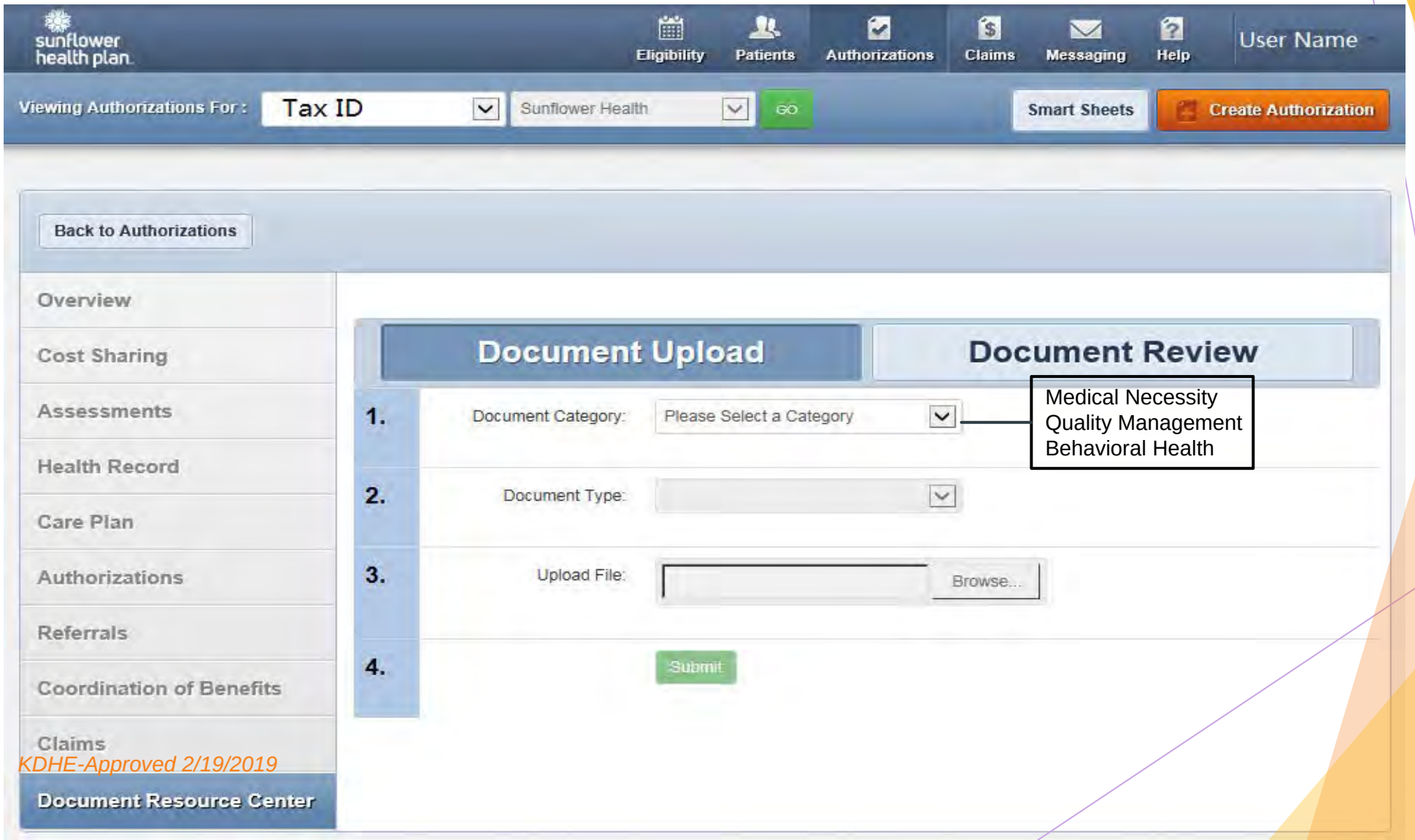
Save Time - Upload Medical Records on the Provider Portal!



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Prior Authorization and Claims Via the Secure Portal

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Why Should We Submit Prior Authorization Through the Portal?

- Member eligibility is validated prior to submission
- If generic codes are denied for claims, a message alerts the provider when they are submitting the prior authorization request. This prevents the claim from being denied
- Providers can view the status of prior authorization requests as well as the individual service lines – this prevents phone calls and waiting on hold
- Clinical documentation must be attached when submitting the request
- Interqual criteria/smart sheets can be accessed to determine the necessary criteria for approval
- Confirmation number is received immediately after submission

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Recurring Claim Submission – HCBS & LTC Providers

- The Secure Provider Website has a Multiple Claim Submission claim wizard feature developed to allow Sunflower Health Plan LTC providers to submit multiple recurring claims easily. The wizard saves time and reduces errors.
- After creating a secure provider portal account, LTC providers can create member rosters based on the service location. Claims for Home Health Waivers, Adult Day Care, Personal Care Workers, Assisted Living Facilities, Bed Holds, Hospice, Nursing Facility Residential and SNF-Skilled Nursing Facilities can be repeated daily, weekly or monthly with only minimal coding required.
- For a live demo or more information please contact your Sunflower Provider Representative!

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Prior Authorizations: Behavioral Health

- Behavioral health services follow Sunflower's standard notification requirements and timeframes noted in the Provider Manual. Not obtaining authorization or notifying timely will result in a denial for late notification. Backdated requests will be denied (with appeal rights) for untimely notification.
- For standard treatment requests, the health plan will make a determination within fourteen (14) calendar days of receiving the necessary information for routine services.
- For requests **MEETING** criteria, the provider will be notified of approval and authorization.
- For requests **NOT** meeting criteria, the provider has an opportunity to request a peer to peer (timeframes apply – please see provider manual for details) or an appeal.
- If a service requires prior authorization and an authorization is not obtained, if submitted a claim will deny and the provider will have to follow the appeal process.
  - This will cause the claim to deny for NO Auth.

Behavioral Health Outpatient Treatment Request (OTR)

- **Web-Based Authorization Requests**
  - OTR submissions will occur in “real-time” via the secure provider portal
  - Provider will be able to submit and view status of all OTR submissions
  - Electronic Signature is acceptable on the OTR request
- **FaxCom System**
  - IF electronic submission of completed OTRs is NOT possible, OTRs should be faxed to **(844) 824-7705**. The provider may use the appropriate inpatient or outpatient request form found on the Sunflower website under Provider Resources
  - System accepts attachments to OTR (e.g., progress notes, treatment plan updates)
  - Make sure OTR is signed by the clinician and completely filled out
- **KCPC System Disruption Workaround**
  - The KCPC system is currently down. To avoid delays in providing service to our members, please use the following workaround until KCPC returns to operation.
  - For requests that would normally be sent through the KCPC system, please submit your request using the Outpatient Treatment Request for Behavioral Health (PDF) form located on our website and fill in the appropriate sections. Include the ASAM criteria, services requested, dates and any details of the case needed to process the request in the section titled “services being requested” and the under the section “plan.” Please fax the form to **(844) 824-7705**.

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Claims Overview

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Claim Assistance

We have self service tools on our Secure Portal, Customer Service Call Center, and Provider Relations staff available to assist you with any question(s) regarding how a claim was processed. When reaching out for assistance please make sure you have the following information:

- The Sunflower claim number
- The member's Medicaid ID #
- The date of service on the claim
- Total billed charges
- The Tax ID # or NPI for the provider
- Provider contact information

If working with one of our Customer Service call centers or Provider Relations staff, please make sure you note in your file the name of the person you spoke with and the date and time of the call.

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Behavioral Health Claims

Secure Provider Portal

The behavioral health provider portal is available at: provider.sunflowerhealthplan.com

- Portal currently only accepts primary payer information

EDI

- Sunflower's behavioral health network providers may choose to submit their claims through a clearinghouse. Sunflower accepts EDI transactions through Emdeon (866-369-8805); Gateway (800-969-3666) or Availity (800-282-4548). The Behavioral Health Payor ID Number is **68068**.

Paper Claim Submission

- Submit clean claims on a CMS-1500 Form or a UB-04 Form to the following address for processing and reimbursement:
  - Sunflower Behavioral Health
    P. O. Box 6400
    Farmington, MO 63640-3807

For further information regarding electronic submission, contact the **Sunflower EDI Department at 800-225-2573, ext. 25525** or email at **ediba@centene.com**

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Corrected Claims

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What is a Corrected Claim?

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

What is a Corrected Claim?

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

How to Submit a Corrected Claim

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

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

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

Providers may mail in a corrected paper claim to the following address:
Sunflower Health Plan, PO BOX 4070 Farmington MO 63640

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How to Submit a Corrected Claim

Correction of Paper Claims

- All paper claims submissions should be free of handwritten verbiage and submitted on a standard red-and-white UB-04 or CMS1500 claim form. Any UB-04 or CMS1500 forms received that do not meet the Centers for Medicare and Medicaid Services (CMS) printing requirements will be rejected and sent back to the provider or facility upon receipt.
- In addition to submitting corrected claims on a standard red-and-white form, the previous claim number should be referenced as outlined in the National Uniform Claim Committee (NUCC) guidelines, http://www.nucc.org/.
- Paper Corrected Claims can be mailed to:

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

Behavioral Health
Sunflower Health Plan
Attn: Corrected Claims
P.O. Box 6400
Farmington MO 63640

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Top Denied Claim Reasons
&
How to Prevent Them

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Advance Beneficiary Notice for Fee-For-Service Medicaid Program

The KMAP beneficiary can be held responsible for payment of common services and situations. Beneficiaries can be billed only when program requirements have been met and the provider has informed the beneficiary in advance and in writing. The provider must notify the beneficiaries in advance if a service will not be covered. To ensure the beneficiary is aware of his or her responsibility, the provider has the option of obtaining a signed Advanced Beneficiary Notice (ABN) from the beneficiary prior to providing services. A verbal notice is not acceptable. Posting the ABN in the office is not acceptable.

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Non-Covered Service

- MCO Denial Code: 46; Deny this service is not covered
- Claim Adjustment Group Code: CO
- Claim Adjustment Reason Code: 96; Non-covered charge(s)
- Remittance Advice Remark Code: N216; We do not offer coverage for this type of service or the patient is not enrolled in this portion of our benefit package
- Primary causes for this type of claim denial:
  - Check coverage for the denied procedure code using the provider's preferred method
  - Review provider contract for information specific to services covered under the provider contract
  - If research supports the service provided is non-covered, the line item would be a provider write-off if a member advance beneficiary notice is not on file
  - If a provider believes the claims/line item was denied in error submit a claim reconsideration or a formal appeal

Duplicate Claim

- MCO Denial Code:18; Deny: Duplicate claim service
- Claim Adjustment Group Code: CO
- Claim Adjustment Reason Code: 18; Exact duplicate claim/service
- Remittance Advice Remark Code: N522; Duplicate of a claim processed, or to be processed, as a crossover claim
- Primary causes for this type of claim denial:
  - Check the status of the original claim with Sunflower before submitting additional claims
  - Check past Provider Remittance Advice documents or contact Provider Services to obtain information on the previously processed claims
  - Corrected claims will deny as duplicate if the original claim number is not documented on the claim submitted and the correct frequency code is not reported. If the corrected claim submitted by the provider did not include the original claim number and the required frequency code, submit a corrected claim with the required information:

    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)
  - If a corrected claim does not result in a different outcome from the original claim, the corrected claim will be denied

Member Has Other Insurance

- MCO Denial Code: L6; Deny: Bill primary insurance 1st resubmit with EOB
- Claim Adjustment Group Code: CO
- Claim Adjustment Reason Code: 252; An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).
- Remittance Advice Remark Code: N479; Missing Explanation of Benefits (Coordination of Benefits or Medicare Secondary Payer)
- Primary causes for this type of claim denial:
  - Original claim was submitted without primary/secondary payer information
  - If a provider has the primary/secondary payer information but it was not submitted, submit a corrected claim with the required information
  - If a provider does not have other insurance on file for the member, check the Provider Portal for member's other insurance information. The provider is required to submit a claim to the primary and/or secondary payer for consideration
  - If a provider believes they submitted the required primary/secondary payer information with the original claim and it was not considered, submit a claims reconsideration or formal appeal

Timely Filing Limits

- MCO Denial Code: 29; Deny: The time limit for filing a claim has expired
- Claim Adjustment Group Code: CO
- Claim Adjustment Reason Code: 29; The time limit for filing has expired
  Remittance Advice Remark Code: N30; Patient ineligible for this service
- Primary causes for this type of claim denial:
  - Provider needs to check the MCO provider contract to verify timely filing limits
  - If it is determined the claim was submitted outside timely filing limits, the claim needs to be posted as a contractual write-off
  - If a provider believes a claim was denied in error for timely filing, submit a reconsideration or a formal appeal
- Claims impacted by retro-eligibility
  - Timely filing requirements begin on the date the member was deemed eligible by the state. A provider has 180 days from the date the member was determined eligible by the state to file their initial claim

Retroactive Eligibility

Retrospective Review Due to Members Awarded Retroactive Eligibility

If prior authorization was not obtained due to a member being awarded retroactive eligibility with Sunflower Health Plan and a claim for services has been submitted, providers can submit a request for an optional reconsideration or appeal, including documentation indicating the member was retroactively enrolled to:

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

All requests for optional reconsideration or appeal due to retroactive eligibility will be verified.

If a claim has not been filed for the service, a request may be submitted to the Utilization Management department, indicating that retroactive eligibility was awarded and an authorization is being requested. Once verified that eligibility was granted retroactively and timely fling has occurred, an authorization will be created. The provider will be notified of the existence of the authorization so that they may proceed with billing for the service provided.

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Missing Authorization

- MCO Denial Code: A1; Deny: No authorization on file that matches service(s) billed
- Claim Adjustment Group Code: CO
- Claim Adjustment Reason Code: 197; Precertification/authorization/notification absent
- Remittance Advice Remark Code: None
- Primary causes for this type of claim denial:
  - An authorization is not on file for the facility, provider, member, services and/or date(s) of service.
  - An authorization was not obtained because the member was not eligible at the time of service.

State Guidelines

- MCO Denial Code: d4; Deny: Per State guidelines – procedure not separately reimbursable
- Claim Adjustment Group Code: CO
- Claim Adjustment Reason Code: B15; This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present
- Remittance Advice Remark Code: M5; Missing/incomplete/invalid procedure code(s)
- Primary causes for this type of claim denial:
  - The service has been identified as Not Separately Reimbursable per Kansas policy
  - The service is considered content of service to other services reimbursed

Medication Claims

- MCO Denial Code: N5; Deny: Name of drug, NDC number, and quantity is required to process claim
- Claim Adjustment Group Code: CO
- Claim Adjustment Reason Code: A1; Claim/Service denied
- Remittance Advice Remark Code: M119; Missing/incomplete/invalid/ deactivated/withdrawn National Drug Code (NDC)
- Primary causes for this type of claim denial:
  - Use appropriate NDC Code, Name of Drug and Quantity for billing. Revenue codes are not required for any outpatient service
  - If billing a service with a NDC, include all of the required information in this field. The N4 qualifier must be present before the NDC number, followed by the unit/basis of measurement and number of units.
  - Example: N412345678901UN1234.567

Corrected Claims

- MCO Denial Code: *1; Health Plan guidelines for submitting a corrected claim were not followed
- Claim Adjustment Group Code: CO
- Claim Adjustment Reason Code: 272; Coverage/program guidelines were not met
- Remittance Advice Remark Code: N584; Not covered based on the insured's noncompliance with policy or statutory conditions
- Primary causes for this type of claim denial:
  - A claim was billed as a first time claim, but was suspected as a duplicate to another similar claim in the member's history (e.g., same member, date of service and provider; charges were added or different).
  - A UB-04 claim was billed with a Type of Bill XX7 and the original claim number was missing or invalid.
  - A CMS 1500 claim was billed with an Resubmission Code of 7 and the original claim number was missing or invalid.

Missing Information

- MCO Denial Code: IV; Deny: CPT or HCPCS missing or invalid
- Claim Adjustment Group Code: CO
- Claim Adjustment Reason Code: A1; Claim/Service denied.
- Remittance Advice Remark Code: M51; Missing/incomplete/invalid procedure code(s)
- Primary causes for this type of claim denial:
  - Use appropriate CPT and/or HCPCS codes for billing. Revenue codes are not required for any outpatient service.
  - CPT and/or HCPCS codes are required for reimbursement of Hospital Outpatient services.

Modifiers

- MCO Denial Code: Mo; Deny: Resubmit with correct modifier
- Claim Adjustment Group Code: CO
- Claim Adjustment Reason Code: 4; The procedure code is inconsistent with the modifier used or a required modifier is missing
- Remittance Advice Remark Code: N517; Resubmit a new claim with the requested information
- Primary causes for this type of claim denial:
  - E&M procedure codes applicable to emergency department services include: 99281, 99282, 99283, 99284, 99285, 99291, and 99292. These codes must be billed with modifier ET prior to 03/01/2018.
  - Bilateral Procedures require a modifier 50.
  - Midwives, physician assistants & nurse practitioners are not eligible bill for services using modifier -80 and per KMAP, should use modifier AS for assistant at surgery services
  - KMAP uses the Medicare DME, Prosthetics/Orthotics & Supplies Fee Schedule to determine which procedures are appropriately billed with modifier NU.

Medicare Crossover Claims

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Medicare Billing Requirements

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

Medicare Billing Requirements

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

Claims Not Considered Crossover Claims

Services non-covered by Medicare are not considered crossover and should not be billed to Medicare but instead should be billed directly to Sunflower Health Plan or the other primary payer.

Inpatient Part B Only Claims

- Web Submission Process (Medicare): Providers must use an insurance type other than Medicare in the Insurance Type drop-down box, e.g., “CI-Commercial Insurance”
- EDI Submission Process (Medicare): Providers should submit with something other than MB or MA, for example: “CI- Commercial Insurance” in the SBR09 segment

If a provider wants to pursue third parties after the Medicare payment but before filing with Sunflower Health Plan

- Notify KMAP that you do not want any Medicare claims to cross over
- Providers should pursue payment from Medicare and any other insurer prior to seeking reimbursement from Sunflower. In these instances, claims should not crossover to the other insurance and Sunflower simultaneously
- When Sunflower is the Tertiary payer, claims with the attached primary and secondary EOBs must be billed on a paper claim and mailed to Sunflower

Claims Considered Crossover Claims

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

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

Provider Demographics

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KMAP Provider Enrollment Wizard

- The Kansas Modular Medicaid System (KMMS) Provider Enrollment Wizard became available for use starting Monday, December 31, 2018
- Providers must enroll directly with Sunflower Health Plan via the KMMS portal for Medicaid
- Providers may upload and submit the attachments required for enrolling with Sunflower Health Plan directly through KMMS
- Providers should direct any changes to their provider record to KMAP. KMAP is the central repository for these updates. Once the updates are received, KMAP will forward the requested updates to the MCOs. The MCOs will then update their records accordingly.
- portal.kmap-state-ks.us/ProviderEnrollment/EnrollmentCreate

For more information please view the KMAP GENERAL BULLETIN 18261: www.kmap-state-ks.us/Documents/Content/Bulletins/18261%20-%20General%20-%20PE_Upgrade_Complete.pdf

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Practitioner Terms and Member Reassignment

- In order to maintain a current provider profile, prevent billing delays and allow member access to the most accurate listing of practitioners, Group/Facility/Hospital Providers must give written notice to Sunflower Health Plan of **Roster Updates and Changes.**
- Providers are required to notify Sunflower of any practitioner additions, terminations or changes with **30** day advance notice.
  Visit the Sunflower website to review the Preferred Sunflower Roster Form, Provider Change Form, and the CAQH Provider Data Form submission requirements. These forms may be found at www.sunflowerhealthplan.com
- **Once the change form is received and processed, Sunflower will alert impacted members via letter that their PCP has been changed and a new ID card will be mailed out** – members are also provided the choice to call into Sunflower Member Services to choose a different provider.
- **If a Specialist is terming from the entire Sunflower network impacted Members will receive a letter advising their specialty provider is no longer in the network.** If the Member requests to continue seeing the Specialist after they have left the network, Sunflower will assist the Member with continued care under the Specialist.

Quality Improvement

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HEDIS and Provider Satisfaction

- **What is HEDIS? Healthcare Effectiveness Data and Information Set.** HEDIS is a set of standardized performance measures developed by the National Committee for Quality Assurance (NCQA) that allows comparison across health plans. It gives purchasers and consumers the ability to distinguish between health plans based on comparative quality instead of simply cost differences.
- **HEDIS Scores** – Physician-specific scores are also used to measure your practice's preventive care efforts. Your practice's HEDIS score determines your rates for physician incentive programs that pay you an increased premium—for example Pay For Performance or Quality Bonus Funds.
- **CAHPS** – Member satisfaction/experience survey, completed annually and scored by NCQA to demonstrate provider, specialist and health plan performance as perceived by members. Focuses on following domains: Getting Care Quickly, How Well Doctors Communicate, Care Coordination, Getting Needed Care, Customer Service, Shared Decision Making, Overall Rating of Personal Doctor, Specialist, Healthcare and Health plan.
- **Provider Satisfaction Surveys** – Sunflower conducts an annual provider satisfaction survey, which includes questions to evaluate provider satisfaction with our services such as claims, communications, utilization management, and customer service. Behavioral health providers receive a provider survey specific to the provision of behavioral health services in the Sunflower network.

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

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Immunization and Care Gaps

It is important that Sunflower and its participating providers work together to ensure our members are seen regularly for well child visits, diabetic care and prenatal care. Your Role Matters! Ask these questions when the member is:

- **Under 6 Years** – When was their last well child visit? Are they up to date on immunizations? Please assist in providing and educating on these services and their importance related to proper development and to prevent disease.
- **Pre-Teen –** Has the [11,12, or 13] year old had a check-up in the past 12 months? There are immunizations to keep them healthy and in school. Encourage their parent or guardian to schedule an office visit.
- **Diabetic** – When was the member's last doctor's appointment to assess their diabetes? How about their last retinal eye exam? A1C testing? Diabetic foot exam? Nephropathy testing? Blood pressure check? Please help ensure these members are getting all the necessary exams and labs to assess their diabetes and progression of disease and ensure effectiveness of treatment.

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Immunization and Care Gaps

It is important that Sunflower and its participating providers work together to ensure our members are seen regularly for well child visits, diabetic care and prenatal care. Your Role Matters! Ask these questions when the member is:

- **Women between 21-64 Years of Age –** Have they had an appointment in the last year? Women in this age group should have regular exams for Cervical Cancer Screening with frequency based on their individual risk factors and history. Please assist in educating and scheduling these appointments.
- **Pregnant** – What an exciting time! We want to ensure our pregnant members get the proper prenatal care, high-risk services and any additional care they may need. Please help us identify Sunflower members who have these needs so we may communicate all available benefits to them.

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EPSDT: What Is It?

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

Treatment: Control, correct, or reduce health problems found

EPSDT Page on Medicaid.gov

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Provider Interventions

- HEDIS Quick Reference Guide
- Provider Relations face-to-face meetings
- EPA tool on provider portal
- EPSDT Provider Reference Kit on Website
- Provider Bulletins
- Provider P4P
  - Financial incentive in collaboration with Sunflower to close **Care Gaps**
  - Child and Adolescent HEDIS Targets of 75th and 90th percentiles for:
    - Well-Child Visits 3-6
    - Immunizations for Adolescents Combo 2
    - Childhood Immunization Status Combo 10

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Lead Screening in Children

Record your efforts

- Blood lead test is required by CMS at 12 months & 24 months

Make sure that your medical record documentation reflects all of the following:

- Date the blood test was performed
- Results of findings
- Completing a lead risk assessment questionnaire does not count as lead screening
- Blood lead test should be done on children 3-6 years old **if never done before, regardless of the risk factors.**

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Bright Futures

AAP reports, “State Medicaid agencies have been especially influential in the implementation of Bright Future.” In June 2014, the CMS published *EPSDT – A Guide for States: Coverage in Medicaid Benefit for Children and Adolescents,* which refers to Bright Futures throughout. This guide helps states, healthcare providers and others understand the scope of services that are covered under EPSDT so that they may realize EPSDT’s goals and provide the best possible child and adolescent health benefit through their Medicaid programs.

Focusing on Coding Accuracy & Closing Care Gaps

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Closing Care Gaps & Coding Accuracy

Sunflower's goal through the coding accuracy and care gap closure programs is to gain the full perspective of a member's health status.

- The provider's role is crucial to these programs through the complete documentation of all patient medical conditions, including the reason for the visit and any known chronic health conditions at least once annually.
- The most overlooked conditions are those remaining stable but under current treatment by the PCP or are referred to a specialist
  - These stable conditions that remain under treatment should be documented and assessed at least annually
  - The continual review of these conditions benefits the member by ensuring they are compliant with all recommended care that may pertain to their specific chronic condition, regardless of the prescribing provider

Closing Care Gaps & Coding Accuracy

Ways to improve medical record documentation and coding accuracy:

- Member name and dates of service must be recorded within the documentation
- Verify signature and credentials of the servicing Physician, Nurse Practitioner or Physician Assistant are present
- Clearly document a face-to-face encounter occurred
- Ensure All diagnoses documented are either monitored, evaluated, addressed, or treated during the visit
- Verify all diagnoses documented in the medical record are coded in the claim submission
- Avoid the use of unspecified codes

Programs & Vendors

No “one solution” to improving Care Gap Closure & Coding Accuracy

TELEPHONIC PROGRAM:

Appointment Scheduling Assistance supported by our vendor Change Health

- Smart Appointment Scheduling (SMAS)
  - Goal is to get the member into their PCP to close risk gaps
  - Initial telephonic outreach PCP will be sent an appointment confirmation fax with member open gaps (both risk and HEDIS)
  - Appointment confirmation is performed post visit with the member vs. with PCP
  - Ability to offer transportation scheduling assistance if it is identified as an issue
- What members qualify for outreach:
  - Members who saw their PCP in the previous experience period, OR
  - Members who have an assigned PCP but have not been seen in current experience period

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Programs & Vendors

No “one solution” to improving Care Gap Closure & Coding Accuracy

IN-HOME ASSESSMENT PROGRAM:

In-Home Assessments (IHAs) – USMM is the vendor who supports this program

- Close risk and care gaps in the members home:
  - For members who did not see their PCP in the previous experience period, OR
  - For members who saw their PCP in the current experience period, but provider did not close all the risk gaps
- Program Benefits
  - No cost to the member to have the in-home assessment
  - Following the in-home visit, a member assessment is available to the provider on record
  - USMM will also facilitate PCP appointments and case management referrals

What takes place at the member visit?

- The provider, typically a Nurse Practitioner, will complete one hour assessment that includes the following:
  - Medical History Review
  - Limited Physical Exam (e.g., weight, height, blood pressure, BMI calculation)
  - Medication Review
  - Member Care Plan & Wellness Education
  - PCP appointment & Case Management Referrals
- There are also additional point-of-care services that the provider can perform at the time of the visit:
  - Blood and Urine Testing (HbA1C and Microalbumin)
  - Colon Cancer Screening (FOBT)

**if the member prefers not to have the testing done at the visit, the provider can leave behind individualized kits for the member to send back to USMM for resulting*

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Care Gap Closure Program Benefits

Benefits include:

- Identifies members who may need disease management intervention
- Identifies gaps in clinical documentation
- Accurate and timely documentation allows for more meaningful data exchanges between health insurance plans and providers, which helps members by:
  - Identifying new problems early
  - Reinforcing self-care and prevention strategies
  - Coordinating care collaboratively
  - Avoiding potential drug/disease interaction
- Coded data translates into:
  - Quality Reporting
  - Physician Report Cards
  - Better provider reimbursement opportunities
  - Public health data

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Provider Appeals Process

Provider Appeals Timeline

The provider appeal process can only be initiated by the provider or provider designee. Providers must exhaust the Sunflower provider appeal process prior to accessing the State Fair Hearing process.

- Provider Appeal Timeline:
  - Step 1: Provider files completed Provider Appeal Request form with any supporting documents to the address provided on the EOP or notice of action within 63 calendar days
  - Step 2: Sunflower sends a letter within 10 calendar days to acknowledge receipt
  - Step 3: Sunflower sends provider a notice of decision within 30 calendar days of receipt of the appeal
  - Step 4: If not satisfied with the Sunflower appeal decision, provider can request a State Fair Hearing

View the entire *Provider* Appeals process outlined here → **Provider Appeal Process**

Provider Reconsideration

Step 1 *OPTIONAL*

- Providers may request by calling Customer Service, notifying health plan staff, mailing to Sunflower/Specialty Partner as noted on EOP
- Should clearly indicate that they are requesting a reconsideration and send claim number/authorization information, reason for request, supporting documentation and other items as requested
- Providers must submit their request within 123 calendar days from the date of the original EOP
- Plan will resolve within 30 calendar days from the date received
- Provider will be sent a revised/unrevised EOP for same claim number within 5 business days of resolution
- Providers can request an appeal after the receipt of the reconsideration resolution notice or discontinue a reconsideration and proceed to appeal within 63 calendar days from date of the notice of action

Provider Appeals

Step 2 *REQUIRED*

- Provider appeals must be submitted to the health plan in writing using the Provider Appeal Request form or clearly indicate that they are requesting an appeal, along with the claim number/authorization, reason for request and supporting documentation
- Provider Appeal Request forms are submitted to address provided on notice of action or EOP
- Providers have 63 calendar days from the date of the notice of action or EOP to request their appeal
- Sunflower will acknowledge appeal request in writing within 10 calendar days of receipt
- Sunflower will resolve appeal request in writing within 30 calendar days of receipt
- Providers must complete appeal process before proceeding to State Fair Hearing

Provider State Fair Hearing

Step 3 *REQUIRED*

- Providers may request to have a Sunflower appeal decision reviewed by a judge from OAH
- Providers must exhaust the plan's internal appeal process step before proceeding to SFH
- Providers must submit SFH request to either OAH or Sunflower within 123 calendar days of the date of the Provider Appeal Resolution notice
- Providers must submit their request for SFH in writing to OAH or Sunflower/contracted vendor
- Written requests for SFH received by Sunflower or vendor, must be submitted to OAH within 1 business day of receipt
- Providers **must ensure** their request for SFH is received by OAH within 123 calendar days

Provider Expectations

- 60 Days – Providers have to refund overpayments or establish a payment plan
- 180 Days – Providers have to submit claims from the date of service (DOS) or from the date of eligibility determination
- 180 Days – Providers have to submit claims when the member has other insurance, from the date on the primary payer's EOP
- 365 Days – Providers have to submit corrected claims*

Sunflower Turnaround Times

- 30 Days – Sunflower has to pay or deny clean claims
- 30 Days – Sunflower has to pay or deny claims before Interest begins to apply
- 30 Days – Sunflower has to pay or deny corrected claims
- 90 Days – Sunflower has to pay or deny non-clean claims

Pharmacy

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Introducing CoverMyMeds

- Sunflower Health Plan is excited to offer providers a streamlined process for requesting electronic prescription drug prior authorizations through CoverMyMeds! CoverMyMeds provides a fast and efficient way to complete PA requests online.
- Benefits of using CoverMyMeds include:
  - Elimination of telephone calls and faxes, saving up to 15 minutes per PA request.
  - Renew previously submitted PA requests.
  - Complete pharmacy-initiated requests electronically.
  - Secure and Health Insurance Portability and Accountability Act (HIPAA) compliant.

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How to Use CoverMyMeds

1. **Log in:** Go to covermymeds.com and register for a free account, or log in to your existing CoverMyMeds account.
2. **Start a new request**: Click New Request, enter the drug name and the BIN, PCN and Rx Group from the patient's insurance card for the best results. If unavailable, enter the patient's plan or pharmacy benefit manager (PBM). Select the appropriate form and click Start Request.
3. **Complete the request:** Enter all demographic fields marked with a "Required" flag and click Send to Plan. Complete the returned list of patient-specific, clinical questions and click Send to Plan again to complete the request.
4. **Confirmation:** Once the request has been reviewed, the determination will appear in your CoverMyMeds account.

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CoverMyMeds Training

Our partners at CoverMyMeds host webinars (3) times per week for providers to learn how easy it is to use CoverMyMeds and to ask questions.

To sign up for a training, please go to:

register.gotowebinar.com/rt/6087409114949257218

Pharmacy Resources

- Have a question for our Pharmacy Team? Contact them directly at: pharmacy@sunflowerhealthplan.com
- Pharmacy Quick Links:
  - Sunflower Pharmacy Webpage https://www.sunflowerhealthplan.com/providers/pharmacy.html
  - KDHE Pharmacy Webpage – Forms, PDL Drug Listing*, Criteria: PDL and Clinical http://www.kdheks.gov/hcf/pharmacy/default.htm
- *Sunflower Health Plan follows KDHE's policies on the Preferred Drug Listing (PDL) and Drug Utilization Review (DUR).
- *Did you know?* Sunflower encourages PCPs to have the ability to electronically send prescriptions directly to a member's pharmacy. This is a way Sunflower can ensure the transfer of clinical information to improve efficiencies and quality of care.

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Contact Us!

For more information, visit our website:
www.SunflowerHealthPlan.com

Or call Customer Service:
1-877-644-4623
TTY 711

Provider Relations Email
providerrelations@sunflowerhealthplan.com

Or contact your designated Provider Network Specialist

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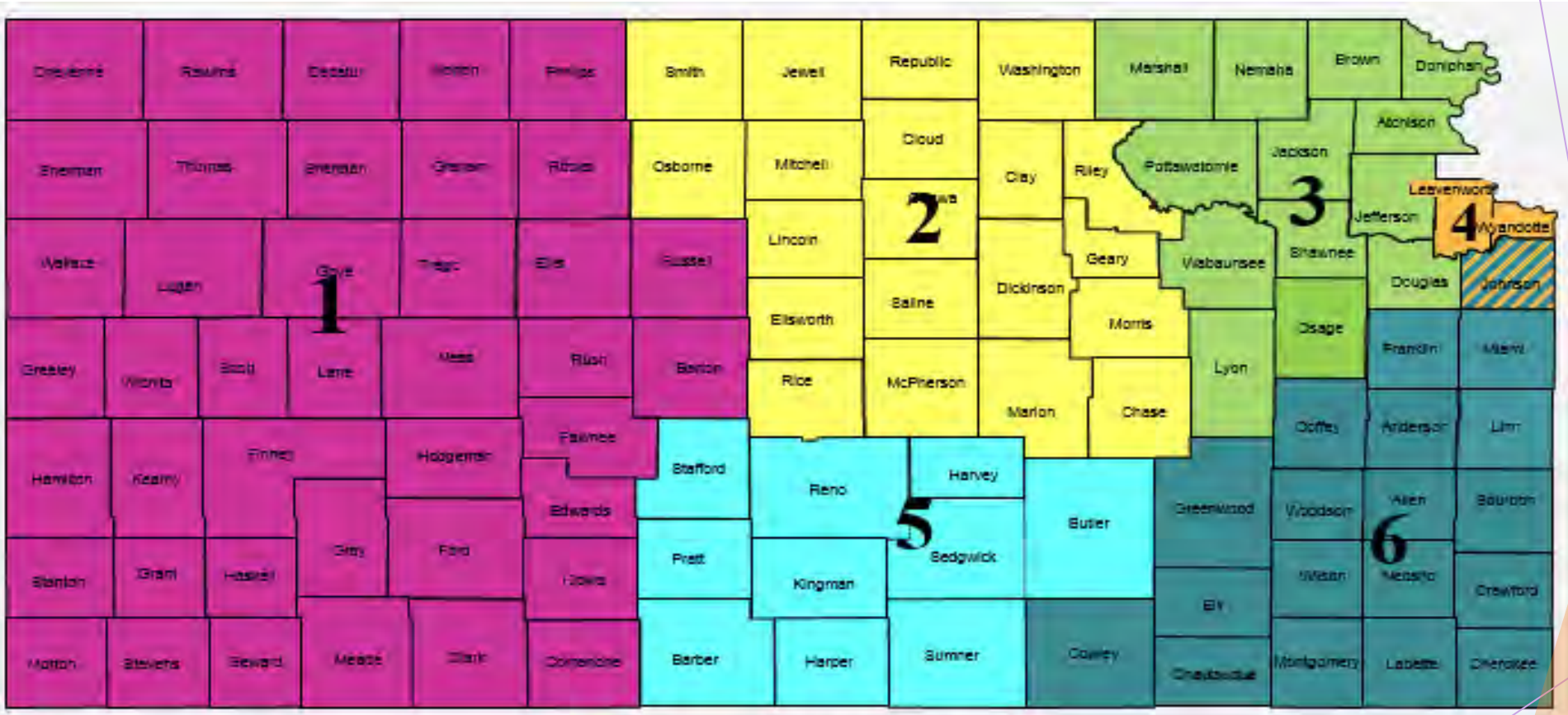
Sunflower Provider Relations Territory Map



1 DAVE VOSS 785-250-5532
davoss@sunflowerhealthplan.com

2 DERRICK RICHARDSON 913-403-6854
dsrichardson@sunflowerhealthplan.com

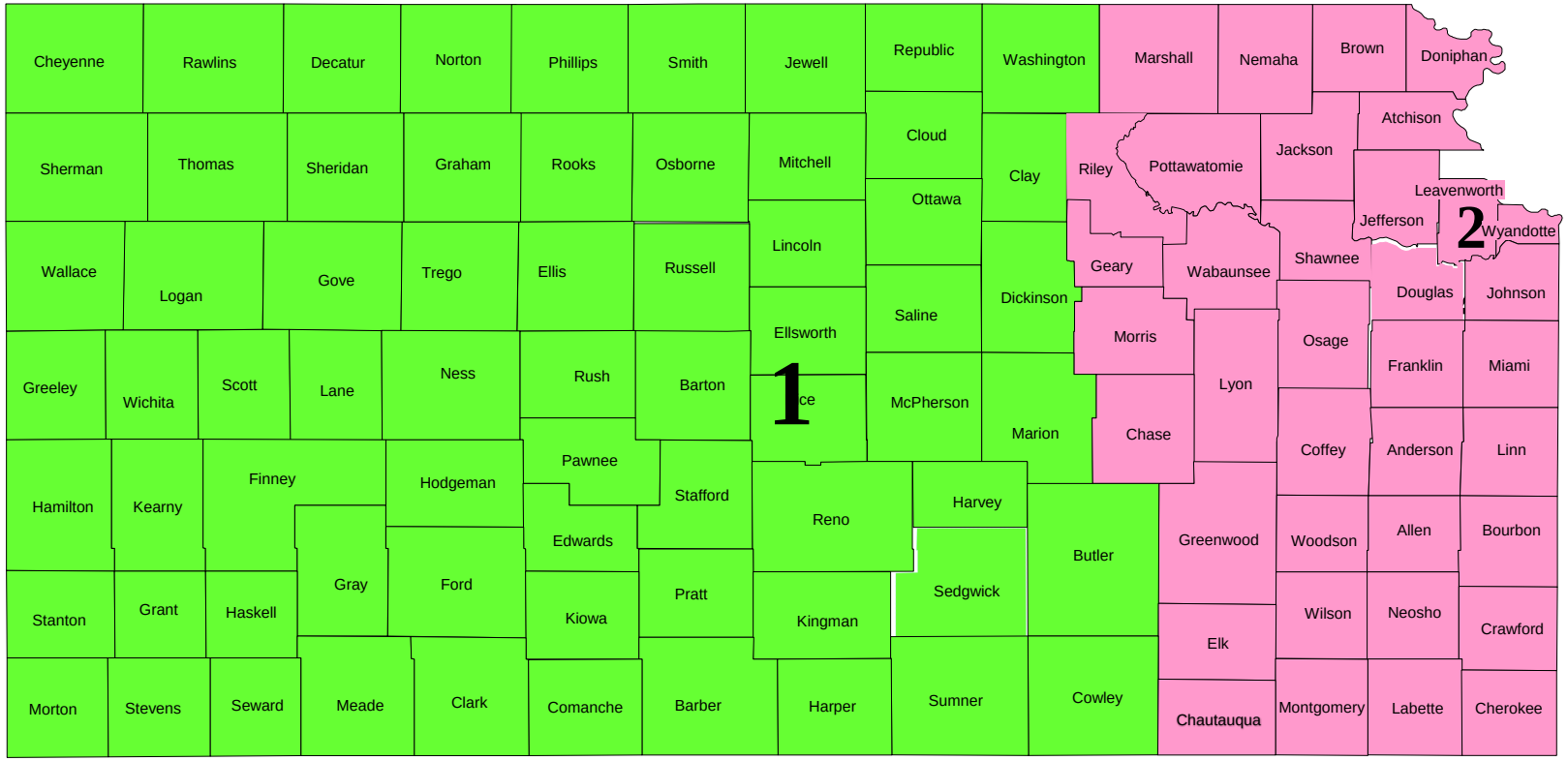
3 TAMMY ADAMS 785-207-4926
tamadams@sunflowerhealthplan.com

4 MICHELLE SWAIN 913-305-7654
mswain@sunflowerhealthplan.com

5 MARC MADDEN 316-680-8968
mmadden@sunflowerhealthplan.com

6 LAURA BLACK-JOHNSON 620-212-8802
lbjohnson@sunflowerhealthplan.com

Provider Relations LTSS/HCBS Territory Map



1 EMILY GAGNEBIN 316-218-2019
egagnebin@sunflowerhealthplan.com

2 ALANA DOTSON 316-249-2172
adotson@sunflowerhealthplan.com

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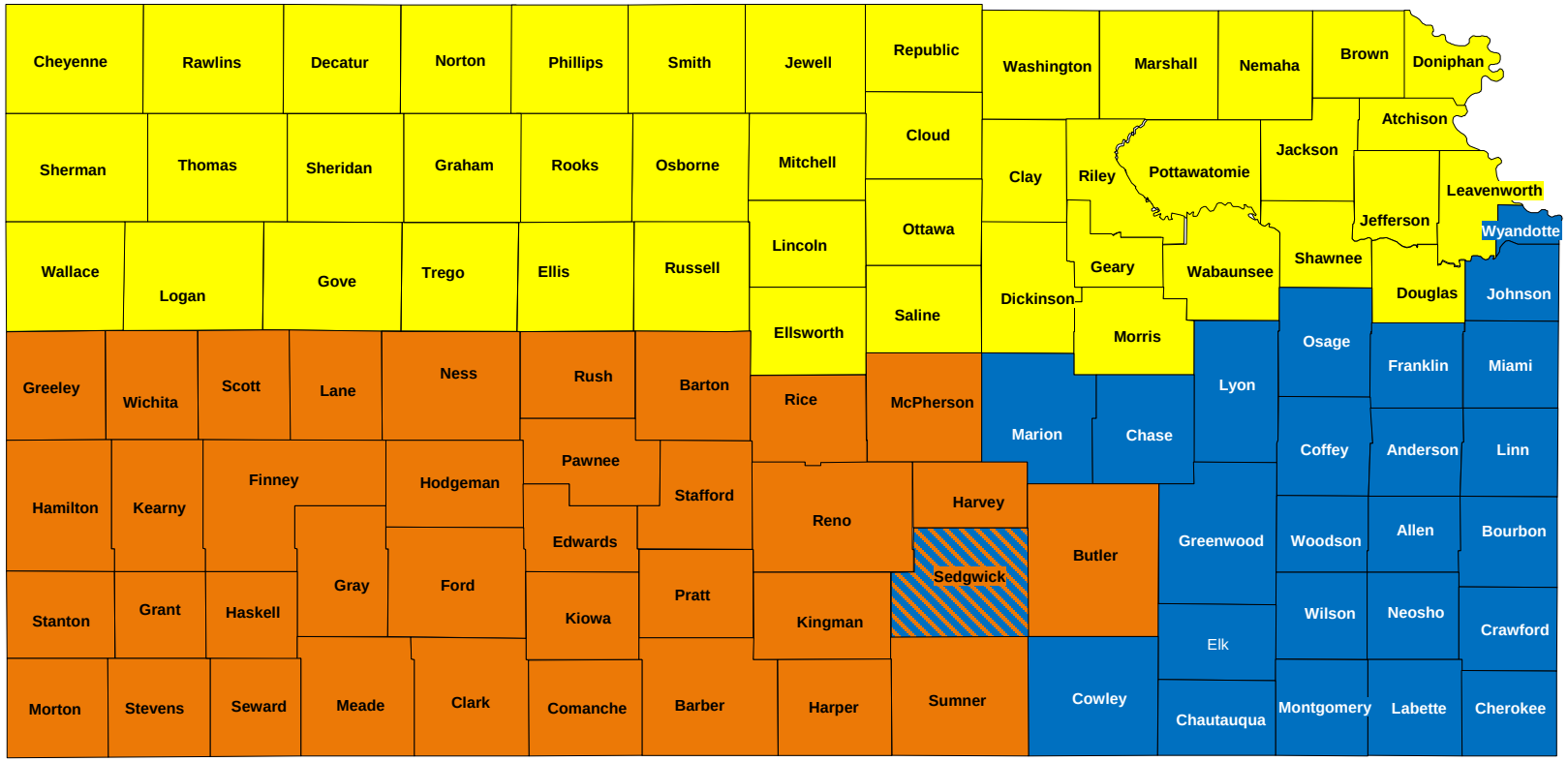
Behavioral Health Provider Relations Territory Map



Leon Frankiewicz - 913-401-4210
Leon.R.Frankiewicz@sunflowerhealthplan.com

Erin Pettera - 316-295-0887
Erin.Pettera@sunflowerhealthplan.com

Ryan Bernasek - 913-333-4560
Ryan.D.Bernasek@sunflowerhealthplan.com

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Helpful Tips and Links

- Provider Resources – *www.sunflowerhealthplan.com/providers/resources.html*
- Provider Quick Reference Guide - *www.sunflowerhealthplan.com/content/dam/centene/sunflower/pdfs/Provider%20Quick%20Reference%20Guide%20QRG%20508.pdf*
- Corrected Claims – Quick Reference Guide – *www.sunflowerhealthplan.com/providers/resources/forms-resources/corrected-claims-qrg.html*
- Provider Post-Service or Claim Appeal Process REFERENCE GUIDE - *www.sunflowerhealthplan.com/providers/resources/dispute-appeal-process.html*
- Sunflower Provider Office Manual - *www.sunflowerhealthplan.com/providers/resources/forms-resources.html*
- HEDIS FAQs - *www.sunflowerhealthplan.com/providers/resources/forms-resources.html*
- Advance Directives – "Five Wishes" www.agingwithdignity.org/five-wishes/about-five-wishes

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Questions?

Thank you for your attendance