Sunflower State Issues Log
Stakeholder Q&A

Issue #	Date Identified	Affected Groups	Issue Description (Q&A)	Est. Date of Resolution	Status	Resolution Date
	1/3	Physicians	Q: How does Sunflower credential and contract with locums? A: Locum tenen providers are temporary, so most Health Plans do not credential these practitioners. Because of this, these providers are not listed in the network or in a directory. The arrangement a locum tenen provider has is generally with the physician's practice where they are temporarily assigned. The services provided by the locum tenen provider are billed under the authorizing provider's name and Tax ID number. Since they are "temporary", Sunflower State Health Plan does not make them available to be primary care physicians with membership assigned.	Complete		1/4
	1/3	Department of Health	Q: Can Departments of Health be PCPs? i.e. Does Sunflower have any members assigned to JOCO Health as a PCP? A: No members have been assigned to JOCO Health. Research to verify DOH with acute providers to assure accurate set-up for all DOH providers		JOCO DOH issue resolved Additional research in process	1/4
	1/3	CMHC	Q: Is CMCHS supposed to do continued stay reviews? If Medicare benefits are primary but member goes over their limits for mental health therapy, do they need to prior authorize with us for coverage of additional services that are covered by Medicaid? A: CMHCs should contact	Complete	Assure communication with all CMHCS	1/4

			Centpatico for continued stay reviews. If Medicare benefits are exhausted and prior auth is required for services, CMCHS should contact Centpatico at that time.			
	1/3	Members	Q: How can an RN be reached after hours? A: Members will call the main Sunflower number 1-877-644-4623 24/7 to reach a nurse after hours.		Complete	1/3
	1/3	Urgent Care Centers	Q: Do Urgent Care Centers have members assigned to them? A: Urgent Care Centers should not have members assigned to them. Review of urgent care center provider set-up and reassignment of any members impacted. Reassignment for KU Urgent Care to Jayhawk Physicians	1/14		
	1/4	CMHC	Q: There are some CMHC services that are same day same service. How to bill so services are not denied as duplicate. There are 2 potential modifiers to bill this one (KHS and State required different modifiers) A: Cenpatico will use modifier 76. If a CMHC runs into a duplication denial when this modifier is billed, it may be possible that our system was in process of being adjusted to match the State rules in this manner, and therefore we may inadvertently deny a claim as a duplicate. If this occurs, CMHCs may contact our Claims Customer Service department at 866-324-3632 for resolution.		Outreach to individual CMCH who asked question; Incorporate in FAQ to all CMHCs	1/5
	1/4	Providers	Q: What do we do if there are specific changes that are needed to my existing plan of care? A: Assure members and providers to continue services to members. Contact Sunflower medical management and work with assigned case manager.		Complete / Ongoing	1/7
	1/4	Pharmacy	Q: Does Sunflower State Health Plan cover general prescription drugs even if they are not specific to a member? A: Sunflower follows the Medicaid pharmacy benefits. Prescriptions must be specific to a member to be filled.		Complete	1/4

	1/7	OB / Hospital	Q: How is notification of pregnancy handled by the MCO? A: Providers are asked to submit a Notification of Pregnancy form. This helps us identify members who are pregnant and provide them additional support. Specific question from hospital is if we will deny a claim if Notification of Pregnancy not received. We will not deny the claim but do ask the hospital to call us as soon as possible so we can assist with discharge planning for the member		Complete	1/7
	1/3	Pharmacy	Q: Does Sunflower allow auto refills on prescriptions? A: No, we do not allow auto-refills. Sunflower reviews prescription request and will only refill when prescription should be needed based on dosage..		Complete	1/3
	1/8	Pharmacy	Q: A member called and stated she is unable to get her daughter's scripts filled and not able to resolve with USScripts. A: Outreach to member and pharmacy and scripts completed. Research indicates this is member specific and not a general issue		Complete	1/8
	1/7	FQHC	Q: Members not assigned to clinics; FQHCs added as PCPs with membership reassignment.		In Process	
	1/9	Nursing Facility	Q: Nursing facility claim with diagnosis of depressive psychosis; How to bill so claim goes to Sunflower versus to Cenpatico for payment? A: Claims triage to medical or behavioral health system was not successful. Manual review until system issue resolved. Provider should not change diagnosis on claims – reeducation of staff occurred.		In Process	
	1/9	CMHC	Will Sunflower accept letters stating services not covered for TPL Claims; what is the denial code that should be indicated – 184? A:		In Process	
	1/9	FMS	How are FMS providers notified of changes in plans of care: what is the method and timeframes: A: We are outreaching to FMS providers with any changes in plan of		In Process	

			care. We are determining the best long-term method of providing that information			
	1/4		Q – Is the provider required to submit the Lock In Referring Provider KMAP ID as they are required to do today? A – The Lock In Referring Provider NPI is required in the same fields the billing provider is required to use today. Physician claims the referring provider information is located in box 17A. Hospital claims the referring/ordering provider information is located in FL (form locator) 76. The provider should submit the referring provider's NPI in these fields, NOT the provider's KMAP ID.			1/10
	1/10		Third Party Liability/Coordination of Benefits: For members that have dual coverage, claims for services must be submitted to the primary payor before a submission to Cenpatico. There are instances where certain KanCare covered services are not covered under Medicare or other commercial insurances. Cenpatico will not require an EOP from the primary carrier for those services identified in state documentation by insurance carrier as Medicaid covered services but not as Medicare/commercial covered services. Additionally, where documentation of the policy is available, Cenpatico will not require an EOP from the primary carrier when the rendering practitioner is eligible to provide select services for Medicaid but is ineligible to provide the same services for the primary carrier. When the primary carrier is Medicare, Cenpatico will automatically identify services performed by LPCs and LMFTs as ineligible for submission to Medicare and therefore no EOP will be necessary. For other carriers, the provider may need to submit a letter from the carrier documenting their policy regarding ineligible provider types. **Update:** The State is currently compiling all carrier letters from CMHCs and will distribute to the MCOs.			Updated 1/10

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<tr><td></td><td></td><td></td><td>Update: We are currently researching and investigating denial code 184 and will provide an update when we have more information.</td><td></td><td></td><td></td></tr>
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<tr><td></td><td>1/15/2013</td><td></td><td>Issue: Several behavioral health / Cenpatico fees were configured incorrectly and will be corrected. Below is a table of the current and correct fees by code.
Resolution: We are re-programming our system to be aligned with the correct fee schedule. To minimize impact on our providers we have developed a manual pricing process for the claims team to pay claims at the correct rates while we reprogram the system. Once programing is complete we will review all claims paid prior to the change to determine if they were paid at the correct rate. If not, those claims will automatically be reprocessed. The providers will not have to resubmit their claims.
<table>
<tr><th>Code</th><th>Current CHB Fee Schedule</th><th>Corrected Fee Schedule*</th></tr>
<tr><td>90791</td><td>$120.00</td><td>$120.00</td></tr>
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				90785	$2.16	$2.95			
				90832	$34.00	$34.00			
				90833	$18.70	$25.45			
				90834	$60.00	$68.00			
				90836	$30.60	$41.64			
				90837	$90.00	$102.00			
				90838	$49.13	$66.86			
				90839	$110.00	$110.00			
				90840	$55.00	$55.00			
				90863	$49.00	$49.00			
				T1023	$350.00				
				H0032 HA	$400.00				
				99366	$20.00	$20.00			
				99367	$20.00	$20.00			
				99368	$20.00	$20.00			
				H0001	$130.00				
				H0002	$400.00	$400.00			

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<tr><td>H0004</td><td>$20.00</td><td>$22.00</td></tr>
<tr><td>H0005</td><td>$7.50</td><td>$8.50</td></tr>
<tr><td>H0006</td><td>$8.75</td><td>$12.50</td></tr>
<tr><td>H0007</td><td>$32.50</td><td>$32.50</td></tr>
<tr><td>H0011</td><td>$250.00</td><td>$250.00</td></tr>
<tr><td>H0015</td><td>$120.00</td><td>$132.00</td></tr>
<tr><td>H0015 HA</td><td>$120.00</td><td>$132.00</td></tr>
<tr><td>H0018</td><td>$180.00</td><td>$198.00</td></tr>
<tr><td>H0019</td><td>$114.28</td><td>$126.00</td></tr>
<tr><td>Q3014</td><td>$20.00</td><td>$36.00</td></tr>
<tr><td>T2038</td><td>$40.00</td><td>$40.00</td></tr>
<tr><td>T2038 U1</td><td>$3,000.00</td><td>$5/unit up to 3,000</td></tr>
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<td>1/15/2013</td>
<td>Providers – Network and Contracting</td>
<td>Providers who may have questions regarding their contracting and credentialing status for Sunflower State Health Plan may call 1-877-644-4623. The caller will be asked if they are a member or provider; please respond, “Provider.” The caller will then be asked to identify the reason for their call and one of the choices is Network Contracting; the caller will say, “Network Contracting.” The caller will be connected to a provider call group that is trained to investigate provider contracting and</td>
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<td>1/17/2013</td>
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			credentialing status for Sunflower State Health Plan. Paul and Kim, if the provider does not state Network Contracting and selects another option, they will NOT get directed to the provider call group.			

Claims Issues

Claims under/overpayments can be identified many ways, including internal review and inquiries received from providers. As those issues are identified and verified, they will be tracked below until completion. Closed issues will be tracked on a separate worksheet. As the issue is resolved, all effected claims for all providers will be reprocessed within 20 days of the issue resolution date. Any provider who feels their effected claims were not appropriately adjusted within said 20-day timeframe, please contact the claims call center at 877-644-4623.

Note: HCBS Providers whose claims are submitted through EVV (Kansas AuthentiCare) rarely see claims in a pended status/critical exception status. Typically once a service is reported, it is matched to a prior authorization record in real time. Providers then see that AuthentiCare forwards claims for payment processing the morning after they have been confirmed. Over the next 24-48 hours, providers may see some claims in a critical exception status in AuthentiCare, related to missing authorization. This event is a one-time occurrence as part of the transition being resolved by Authenticare, the State, and the MCOs. Providers do not need to take additional action on these pended claims. During the next 24-48 hours providers should see that any pended claims have been automatically submitted for processing. MCOs are committed to promptly paying claims for services submitted through EVV. At this time, there is no indication affected providers will experience any delays in payment due to the temporary pending of EVV related claims.

Date Issue Verified	Modified Date	Item Reference Number	Issue Title	Issue Description	Affected Provider Types	Issue Status	Issue Resolution Date	Date Effected Claims are to be Reprocessed	Date Item Closed
1/6/2013				Sunflower will follow the current KS State Modifier	All				

				requirements as published in provider manuals. If you do not submit with the state required modifiers, your claim will be denied with EX Code IM "Missing or Invalid Modifier" and you should submit a corrected claim with the appropriate modifiers.					
1/6/2013				RHC and FQHC providers are required to bill the appropriate location code of 50 or 72 on their claims. If another location is billed by a rendering provider billing as part of the clinic, the claim will be denied with EX Code 4B "Invalid Location Code Submitted" and your claim should be corrected and resubmitted.					
1/9/2013				IMPORTANT: Paper claims for					1/10/2013

				HealthWave XXI services must be mailed to the State, not Cenpatico's PO Box in Farmington, Missouri. Paper claims must be sent to the State (KMAP), who then routes claims to the MCOs, and applicable vendors, like Cenpatico. This includes the submission of HealthWave XXI paper claims. The mailing address for paper claims is as follows: KanCare Office of the Fiscal Agent P.O. Box 3571 Topeka, KS 66601-3571 Electronic claims can be sent in one of three ways; 1- as an EDI transaction through a clearinghouse, 2- directly to					

				Cenpatico via our secure web portal, or 3- using the State's electronic system (KMAP)					
1/05/2013	1/11/2013	734	SNF Claims Incorrectly Routed to CBH (Cenpatico)	SNF claims are incorrectly being routed to Cenpatico Behavioral Health via the Front-End Billing Process. CBH and the state continue to work to correct this programming. You may receive confirmation reports indicating the claims were re-routed to CBH. Sunflower is manually voiding those claims and re-keying them into the medical account. There is nothing the provider needs to do. Until the systemic issue is corrected, you may see a 2-4 day delay in your claims appearing on the Sunflower State Health Secure Provider portal. If	SNF	Testing Needed		1/25/2013	open

				after 4 days, your claim doesn't appear, please contact Teresa Dodd at 314/452-4403.					
1/9/2013	1/11/2013 22:52	769		SNF and LTC providers experiencing a delay in payment or seeing B2 pends on their claims via the web or when calling for status should verify the admit date on submitted claims and change admit date on the header of the claim to 1/1/2013 or after to allow payment in Sunflower State Health Plan's System. Please look for fax blast submitted on the subject. Claims received as of 1/08/2013 should be paid on 1/15/2013.	SNF/LTC Claims Admit	Update needed			FYI Only

1/10/2013	1/11/2013 22:33	768	EX 4B - Invalid Place of Service for FQHC/RHC	Per state provided material, FQHC's and RHC's are required to bill POS 50/72 and should not bill POS 11, 23 or any others. Individual practitioners not billing for the clinic can bill alternate places of service. No adjustments will be made at this time. Please contact Lisa Markham at 636-399-0928.	FQHC/RHC	CR/User Story Needed		1/10/2013	CR/User Story Needed
1/14/2013	1/15/2013 10:17	775	T2040 U2 Modifier Not Covered by MCO's for MR/DD Waivers	T2040 U2 Modifier is being denied for FMS providers when the member is in the MR/DD waiver population as the MCO's are not administering this population until 2014. Please submit your claims to the state for these members."	HCBS	Training Needed			Open

1/15/2013	1/15/2013 14:40	810	EX 46 (Non-Covered) Denials for Waiver Members	"Several claims for waiver services are denying as non-covered because the member is not identified in our system (or by the state's eligibility system) as a waiver member. This could be because the case worker has not updated the member's record with the state. If you feel this may be the issue please contact the member's case worker to have the member's eligibility updated. At that time, we will reprocess all claims affected."	HCBS;#Home Health;#SNF	CR/User Story Submitted		1/31/2013	Open
1/14/2013	1/15/2013 22:45	814	Fee Schedule: HCBS Fee Schedule - New Version	1/15 TD: We appreciate feedback received from some of our HCBS providers who helped us identify a few issues with our HCBS fee schedules. We have re-worked the entire	HCBS	CR/User Story Submitted		2/8/2013	open

				fee schedule to ensure all issues are resolved, have submitted the configuration request to have the schedule updated and expect to have these changes into production before 1/18/2013 EOD. All claims should be reprocessed before 2/8/2013. If your claims are not reprocessed by 2/8/2013 please contact your provider relations representative.					
1/10/2013	1/16/2013 9:29	817	ICF Type of Bill (TOB) 61X Invalid as of 1/1/2013	1/16/2013 TD: ICF facitlities were allowed to bill TOB 61X to KMAP which is not a valid TOB. The state has issued the following bulletin to providers asking them to rebill with TOB 65X or 66X as appropriate. The bulliten information	Other	Training Needed (Provider)	1/16/2013		open

				is below. Please follow instruction in the Sunflower Billing Manual to submit a corrected claim or use KMAP's system to correct and resubmit. If you have questions please contact your provider relations representative. *KMAP will begin utilizing TOB 65X and 66X series to replace 61X for Intermediate Care effective 1/1/13. Providers should rebill any claims for dates of service 1/1/2013 and after. Refer to the National Uniform Billing Committee (NUBC) manual for appropriate billing guidelines.*					

1/18/2013	1/19/2013 9:08	860	EX A1 (No Auth) Denials to Providers in Error	We have identified several claims that were denied to HCBS, SNF and other providers in error on recent check runs. We will do a claims project to identify any others and will have the claims adjusted without the provider having to do anything. Our system has been corrected to eliminate this problem going forward. If your claim is not adjusted before February 8th check run, please contact the claims call center at 1-877-644-4623.	HCBS;#Home Health; #Hospice;#SNF;#Other	Claims Project Needed	1/19/2013	2/8/2013	open
1/16/2013	1/18/2013 15:08	825	SNF 2013 Rate Updates	1/16/2013 TD: The state had issued updated 2013 Nursing Facility rates which are now in production in our system. This may have lead to claims	SNF	Claims Project Needed	1/16/2013	2/08/2013	open

				paying with a small variance in the expected 2013 amount. All effected claims will be reprocessed without the provider having to do anything.					