SUNFLOWER STATE HEALTH PLAN

KanCare

Billing Guidelines for Providers of I/DD Waiver Services

Claim Submission Options

Providers may submit claims through a variety of channels:

- Electronically through an established claim clearinghouse – our electronic payer ID is 68069
- Through the KanCare Front End Billing option
- Through our web portal (please provide details)
- On paper – the paper claim address is:
    - KMAP, P.O. Box 3571, Topeka, KS 66601-3571
- Some HCBS service require Electronic Visit Verification (EVV) and are billed via AuthentiCare

NPI Billing Requirements

Providers need to obtain a NPI number to be contracted with Sunflower State. The National Provider Identifier (NPI) is a Health Insurance Portability and Accountability Act (HIPAA) Administrative Simplification Standard. The NPI is a unique identification number for covered health care providers. Covered health care providers and all health plans and health care clearinghouses must use the NPIs in the administrative and financial transactions adopted under HIPAA. The NPI is a 10-position, intelligence-free numeric identifier (10-digit number). This means that the numbers do not carry other information about healthcare providers, such as the state in which they live or their medical specialty.

The NPI must be used in lieu of legacy provider identifiers in the HIPAA standards transactions. Typically, one NPI number for services is sufficient for all HCBS-I/DD program services. However, separate NPI numbers are needed for ICF/MR, other HCBS program services, and WORK ILC services.

How can a health care provider apply for and obtain a National Provider Identifier (NPI)?

A health care provider may apply for an NPI in one of three ways:

1. Apply through a web-based application process. The web address to the National Plan and Provider Enumeration System (NPPES) is https://nppes.cms.hhs.gov.

2. If requested, give permission to have an Electronic File Interchange Organization (EFIO) submit the application data on behalf of the health care provider (i.e., through a bulk enumeration process). If a health care provider agrees to permit an EFIO to apply for the NPI, the EFIO will provide instructions regarding the information that is required to complete the process.

3. Fill out and mail a paper application form to the NPI Enumerator. Health care providers may wish to obtain a copy of the paper NPI Application/Update Form (CMS-10114) and mail the completed, signed application to the NPI Enumerator located in Fargo, ND, whereby staff at the NPI Enumerator will enter the application data into NPPES. This form is now available for download from the CMS website (http://www.cms.gov/cmsforms/downloads/CMS10114.pdf) or by request from the NPI Enumerator. Health care providers who wish to obtain a copy of this form from the NPI Enumerator may do so in any of these ways:

SUNFLOWER STATE HEALTH PLAN

KanCare

Phone: 1-800-465-3203 or TTY 1-800-692-2326
E-mail: customerservice@npienumerator.com
Mail:

NPI Enumerator
P.O. Box 6059
Fargo, ND 58108-6059

Electronic Funds Transfer- EFT

Sunflower State partners with PaySpan to provide Electronic Funds Transfer (EFT) and Electronic Remittance Advice (ERA) to its participating providers. EFT and ERA services help providers reduce costs, speed secondary billings, improve cash flow by enabling online access of remittance information, and provides straight forward reconciliation of payments. As a Provider, you can gain the following benefits from using EFT and ERA:

- Reduce accounting expenses – Electronic remittance advices can be imported directly into practice management or patient accounting systems, eliminating the need for manual re-keying
- Improve cash flow – Electronic payments mean faster payments, leading to improvements in cash flow
- Maintain control over bank accounts – You keep TOTAL control over the destination of claim payment funds and multiple practices and accounts are supported
- Match payments to advices quickly – You can associate electronic payments with electronic remittance advices quickly and easily
- For more information on our EFT and ERA services, please visit our website at www.sunflowerstatehealth.com, contact Provider Services at 1-877-644-4623 or directly contact PaySpan at 1-877-331-7154.

Billing Codes and Limitations

HCBS – Intellectual/Developmental Disabilities

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

Benefit Description	HCPCS	Diagnosis	Limits
Residential Regular Tier 1-5	T2016	n/a	1 unit = 1 Day, Max of 31 per month. (Can not be billed with S5125, H0045 & T2025/deny)
Residential Super Tier 1-5	T2016	n/a	1 unit = 1 Day, Max of 31 per month. (Can not be billed with S5125, H0045, T1000 and T1000TD & T2025/deny)
Day Service Regular Tier 1-5	T2021	n/a	1 unit = 15 minutes. , Max of 23 days (460 units a month.

Day Service Super Tier 1-5	T2021	n/a	1 unit = 15 minutes. , Max of 23 days (460 units a month.
Supportive Home Care-Agency Directed	S5125	n/a	1 unit = 15 minutes, Max of 12 hours or 48 units/day or 1488 units per month.
Personal Assistant Services-Self Directed	T1019	n/a	1 unit = 15 minutes, Max of 12 hours or 48 units/day or 1488 units per month.
Respite Overnight	H0045	n/a	1 unit = 1 Day, 60 days per calendar year. Not allowable with T2016 in same day
Supported Employment	H2023	n/a	1 unit = 15 minutes
Sleep Cycle Support	T2025	n/a	1 unit = 1 Day, Max of 31 per month.
Specialized Medical Care (RN)	T1000TD	n/a	1 unit = 15 minutes, limited to 12 hours/day (48 units) and 1824 units per month (372 hours).
Specialized Medical Care (LPN)	T1000	n/a	1 unit = 15 minutes, limited to 12 hours/day (48 units) and 372 hours (1488 units)/month.
Medical Alert Rental	S5161	n/a	1 unit = 1 month, max of 12 per year
Financial Managemeent Services	T2040U2	780.99	1 unit = 1 month, max of 12 per year
Wellness Monitoring	S5190	n/a	1 unit equals 1 visit. Max 1 per 60 days
Assistive Services	S5165	n/a	Lifetime max $7,500
PBS Environmental Assessment	H2027	n/a	1 unit = 15 minutes max of 120 units/year (Max of $1,200/yr)
PBS Treatment	H2027U3	n/a	1 unit = 15 minutes, max of 240 units/year (Max of $6,000/yr)
PBS Person-Centered Planning	9088222	n/a	1 unit = 15 minutes, max of 240 units/year (Max of $1,600/yr)
Targeted Case Management	T1017	n/a	1 unit = 15 minutes. Max of240 units per year ***Billing must be in whole units and cannot be billed as a partial unit***

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

Date Span Billing

- Span Billing will be allowed effective January 1, 2014.
- Span Billing is allowed during pilot and on January 1, 2014 – We encourage you to bill date span and correct number of units that match (You can bill daily, weekly or monthly). You must bill within the same month, cannot overlap any given month i.e., 01/15/14 thru 02/10/14 – this would be two claims one for January and one for February.
- During the Pilot Project, date range and number of units ***must*** match.
- Day Supports (T2020/T2021) and Residential Services (T2016) must be billed as separate claims. Effective January 1, 2014 Day Support - T2020 changes to T2021 and the 1 unit = 15 minutes, with a Max of 460 units per calendar month. Residential Supports T2016 – allows 23 day maximum per calendar month.
- Day and Residential Services ***must*** be billed as separate claims.
- Services provided on days within separate months ***must*** be billed as separate claims.
- Overview of Day Service Billing: Per KMAP policy, effective with dates of service October 1, 2013, providers participating in the DD pilot may ***not*** submit fractional units for procedure code T2020 (Day Services). During the pilot 1 unit = 1 day.
- Effective with dates of service beginning January 1, 2014 and thereafter, the current HCBS I/DD Day Supports procedure code and unit of service T2020 (1 unit = 1 day) will be replaced with T2021 (1 unit = 15 minutes). Maximum limits for T2021 are as follows: 100 units per week (a week is defined as 7 days), 460 units per month (a month is defined the 1st to 31st of any calendar month). The State currently only allows for a 23 day maximum for day services. The State is determining whether to allow up to 20 units (5 hours) or 32 units (8 hours) per day.

Client Obligation

Client Obligation will be applied to the highest cost provider of services to a Sunflower State Health Plan member. Client Obligation is to be taken from the following services, in this order:

T2016
T2021
S5125
T1019

Providers are notified of the Client Obligation on the Plan of Care. Providers can review their authorizations on our website and see which services will have Client Obligation applied. Providers will also see the Client Obligation on their Explanation of Payment (EOP) with their payment.

Third Party Liability

COORDINATION OF BENEFITS/THIRD PARTY LIABILITY
Sunflower State Health Plan will exclude IDD waiver HCPCS from the Coordination of Benefits process and pay the claims as the primary carrier.

Below is our standard Third Party Liability guidelines for your information.

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 maybe liable to pay all or part of a member's healthcare expenses. Coordination of Benefits refers to Sunflower State Health Plan determining the remainder to pay.

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

- Children and Youth with Special Health Care Needs (CYSHCN) program
- Department of Children and Family
- Indian Health Services (IHS)
- Crime Victim's Compensation

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

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

Kancare
P.O. Box 3571
Topeka, KS 66601-3571

Providers can submit the first EOB denial for a service that is non-covered by the primary carrier for a total of 365 days from that denial date, regardless of the date of service on the claim, as proof that the primary carrier does not cover the service.

CMS-1500

- Complete one of the following to indicate other insurance is involved: o Fields 9 and 9A-D (Other Insured's Name)
  - o Field 11 and 11A-D (Insured's Policy Group or FECA Number)

- Field 29 (Amount Paid) – Make sure it is completed with any amount paid by insurance or other third-party sources known at the time the claim is submitted. If the amount shown in this field is the result of other insurance, documentation of the payment must be attached. **Do not enter copayment or spenddown payment amounts. They are deducted automatically.**

- Providers submitting claims electronically must include TPL/COB information for each detail line level, where applicable.

UB 04

- Field 50 (Payer Name) – Indicate all third-party resources (TPR). If TPR exists, it must be billed first. Lines B and C should indicate secondary and tertiary coverage. Medicaid will be either the secondary or tertiary coverage and the last payer. When B and C are completed, the remainder of this line must be completed as well as Fields 58-62.
- Field 54 (Prior Payments Payer) – Required if other insurance is involved. Enter amount paid by other insurance. Documentation of the payment must be attached. **Do not enter copayment or spenddown payment amounts. They are deducted automatically.**
- Field 58 (Insured's Name) – Required.
- Field 59 (Patient's Relationship to Insured)

  - o Line A – Required.
  - o Line B and C – Situational.
- • Field 60 (Insured's Unique ID) – Required. Enter the 11-digit beneficiary number from the State of Kansas Medical Card on Line C. If billing for newborn services, use the mother's beneficiary number. The mother's number should only be used if the newborn's ID number is unknown.
- • Field 61 (Insured's Group Name) – Required, if group name is available. Enter the primary insurance information on Line A and Medicare on Line C.
- • Field 62 (Insured's Group Number) – Required, when insured's ID card shows a group number.

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

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

When Sunflower's allowed amount is **equal** to or **less** than other insurance allowed amount 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 State Health Plan will not coordinate benefits when the primary insurer denies for the following administrative reasons:

- o No Authorization
- o Untimely Filing
- o Duplicate Denial

If the primary insurer denies for non-administrative reasons, the provider would be required to obtain an authorization for any service Sunflower State 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:

- o Non-covered Service
- o Benefits exhausted

Claim Correction – Electronic

Submit corrected claims electronically via your Clearinghouse using the values specified for the fields below:

HCFA 1500 / Professional Claims:

- Field CLM05-3 = 6
- 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

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

HCFA 1500 / Professional Claims:

- Box 22 = Must contain the original claim number from the Explanation of Payment (EOP)

UB / Institutional Claims:

- Box 4 = Must contain a Bill Type that indicates a correction e.g., 0XX7

Correction of Provider Portal Claims

Submit corrected claim via the secure Provider Portal at www.sunflowerstatehealth.com

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.

Please contact your Provider Relations Specialist if you are interested in training to use our secure Provider Portal. Contact information may be viewed here:
http://www.sunflowerstatehealth.com/for-providers/provider-resources/
If you have further questions, please review the Sunflower State Health Plan Provider Manual located on our website or contact our provider services team at 877-644-4623.

Claim Appeals

Provider Grievances and Appeals

Grievance. A Grievance is a verbal or written expression by a provider regarding dissatisfaction or dispute with any of the following: policies, procedures or any aspect of Sunflower State's administrative functions; handling of Notice of Proposed Actions or Explanation of Payments; claim adjudication, to include the amount reimbursed or a denial of payment for a particular service.

Sunflower State's Provider Grievances Coordinator (PGC) serves as the primary contact and coordinates on a daily basis with Provider Service Representatives, Appeals Coordinator, Claims Department staff, the Medical Director, QI Director and other key clinical staff to ensure prompt communication with providers during the investigation of the grievance. The PGC sends an acknowledgement notice to the provider within 5 business days of receipt of the grievance. Depending on the nature of the grievance, the PGC will coordinate with multiple departments at Sunflower State and Centene to thoroughly investigate each grievance leveraging statutory, regulatory and state contractual provisions, Sunflower State' Provider Manual, policies and procedures, and other key claims payment rules. Upon final resolution, the PGC will summarize the findings and send a notice of resolution to the provider within 30 calendar days of receipt of the grievance.

In the event Sunflower State receives a provider grievance from a State agency, Sunflower State's VP of Compliance will coordinate with the PGC to investigate the grievance and identify a resolution. Sunflower State's VP of Compliance will send a written response to the State agency within the timeframes outlined in the original communication from the State agency. If the original communication does not specify a timeframe, Sunflower State will respond within 10 business days.

Appeals. An appeal is a verbal or written request by a provider to reconsider the disposition of a claim payment, contracting issue or termination from Sunflower State's network.

Acknowledgement. The PGC will document written or oral appeal requests within one business day of receipt. The content of the appeal, including all clinical aspects involved and any actions taken will be documented. The PGC will send the provider an acknowledgement letter within 5 business days of receiving the request that will include the subject of the appeal, explanation of the appeal process, including the right to submit comments, documents, or other evidence relevant to the appeal

Resolution. The PGC will coordinate with appropriate departments (claims, credentialing, network management, medical management and/or QI) to review the provider's appeal and reach a decision. Sunflower State will resolve a provider appeal within 30 calendar days of receipt and provide written notice of the appeal resolution to the provider. Appeal resolution notices will include, but are not limited to, the appeal decision and reasons for the decision and reference to the protocol or criterion on which the decision was based.

Final Medical Review. In the event a provider does not agree with a claims appeal, the provider can request, orally or in writing, a final medical claims dispute review. Sunflower State's PGC will document the request in CRM and send an acknowledgement to the provider within 5 business days. The PGC will gather all documentation on the case and send the dispute to a physician for further review. The physician will have appropriate clinical expertise to review provider appeal requests involving claim disputes related to a denial on the basis of medical necessity decisions. The individual will be a clinical peer of the same or similar specialty, who is not a Sunflower State network provider and who was not involved in the initial determination or any prior decision-making. Once the physician has reviewed the case, the PGC will summarize the resolution and send notice to the provider within 30 calendar days of receipt. If the provider is not satisfied with the final medical claims dispute review, the provider may utilize the Dispute Resolution process as defined in the Participating Provider Agreement or request a fair hearing appeal through the Office of Administrative Hearings.

SUNFLOWER STATE
HEALTH PLAN

KanCare

Website Resources

Through the **secure provider website,** participating providers can:

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

The secure provider website 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 State. Registration is quick and easy. There is also a reference manual on the site to answer any questions you may have. On the home page, select the Login link on the top right to start the registration process. We are continually updating our website with the latest news and information, so save this site to your Internet "Favorites" list and check our site often.

EMAIL ALERTS ARE NOW AVAILABLE! Visit our website at www.sunflowerstatehealth.com to sign up for Sunflower's email alerts.