WELCOME

Welcome to Sunflower State Health Plan (Sunflower State). We thank you for joining our network of Financial Management Service (FMS) providers as well as participating long-term care providers, physicians, hospitals, and other healthcare professionals. Our number one priority is the promotion of healthy, independent lifestyles through the provision of preventive healthcare and options for independent, integrated long-term services for persons who are enrolled in Sunflower State. By partnering with FMS providers like you, we can reach this goal together.

About Sunflower State Health Plan

Sunflower State is a Medicaid Managed Care Organization (MCO) contracted with the Kansas Department of Health and Environment (KDHE) – Division of Health Care Finance (DHCF) and the Kansas Department for Aging and Disability Services (KDADS) to serve Medicaid eligible members through the KanCare program. Sunflower State’s management company, Centene Corporation (Centene), has been managing the provision of healthcare services for individuals receiving benefits under Medicaid and other government-sponsored healthcare programs since 1984. Centene operates Sunflower State locally and offers a wide range of health insurance solutions for individuals and families. Sunflower State is a physician-driven organization committed to building collaborative partnerships with providers throughout Kansas. We were selected by KDHE and KDADS due to our unique expertise and dedication to serving persons enrolled in Medicaid programs to improve their health status and quality of life. Sunflower State will serve our members in a manner consistent with our core philosophy that quality healthcare is best delivered locally.

Our Mission

Sunflower State strives to provide improved health status, successful outcomes, and member and provider satisfaction in an environment focused on coordination of care. As an agent of KDHE and KDADS and partner with local healthcare providers, Sunflower State seeks to achieve the following goals for our client, KDHE, KDADS, and members:

- Ensure access to primary, preventive, and long-term care services in accordance with the Kansas Department of Health and Environment-DHCF and KDAD standards;
- Ensure care is delivered in the best setting to achieve optimal outcomes;
- Improve access to necessary specialty services;
- Encourage quality, continuity, and appropriateness of medical and long-term care;
- Provide medical and long-term care coverage in a cost-effective manner.

All of our programs, policies and procedures are designed with these goals in mind. We trust that you, our valued network provider, share our commitment to serving KanCare members and will assist Sunflower State in reaching these goals. We look forward to your active involvement in improving access to care for the State of Kansas’ most vulnerable citizens.
HOW TO USE THIS FINANCIAL MANAGEMENT SERVICES (FMS) PROVIDER MANUAL

Sunflower State is committed to serving with our Kansas provider community and by supporting their efforts to deliver high quality health and long-term care to our members. We are committed to disseminating comprehensive and timely information to providers through this FMS Provider Manual as it relates to Sunflower State operations, benefits, policies and procedures. Updates to this manual will be posted on the Sunflower State website. Additionally, FMS providers will be notified via bulletins and notices posted on our website. For hard copies or CD copies of this Financial Management Services Provider Manual please contact the Provider Services department at 1-877-644-4623 or if you need further explanation on any topics discussed in this manual.

PROVIDER RELATIONS

The Sunflower State Provider Relations department is dedicated to making each participating provider’s experience with Sunflower State a positive one. The Provider Relations department is responsible for oversight, coordination or initiation of the services listed below for all providers:

- Credentialing and Contracting
- Re-credentialing
- Physician and office staff initial and ongoing education, training
- FMS initial and ongoing education and training
- HCBS waiver provider initial and ongoing training
- Hospital, facility and ancillary provider initial and ongoing education, training
- Distribution of Provider Manuals and similar provider reference materials
- Assistance with claims inquiries and other administrative services
- Assistance with installation, access, and training regarding available web-based tools and functions
- Distribution of notices, bulletins, newsletters and similar information regarding program, process or policy updates or changes
- On-site quality reviews
- Regularly scheduled in-service meetings

The Provider Relations department can be reached toll free at 1-877-644-4623. Our Provider Relations Specialists work in unison with our team of phone staff (Provider Services representatives) to assist FMS providers. As a participating FMS provider, you will have a dedicated Provider Relations Specialist who will be a key contact for you and will provide education and training regarding Sunflower State’s administrative processes. He/she will visit you or your designee on a routine basis. Regularly scheduled in-service meetings are intended to be a proactive way for us to build a positive relationship with you and your staff; to identify issues, trends or concerns quickly; to answer questions; share new information regarding the program; and to identify any changes within your organization (ex. change in office staff, new location) or scope of service. The primary objective for each Provider Relations Specialist is to ensure you and your staff receives stellar service support from Sunflower State. FMS Providers
are encouraged to call or e-mail their dedicated Provider Relations Specialist for assistance at any time. For example, always contact your Provider Relations Specialist to:

1. Discuss any claims or billing questions  
2. Ask questions regarding reimbursement  
3. Schedule an in-service training  
4. Conduct ongoing education  
5. Obtain clarification of state and health plan policies and procedures and contract language regarding FMS services  
6. Find out about special programs available for members and/or FMS providers  
7. Get assistance with claims or encounter submissions, or  
8. Learn how to use electronic solutions on web authorizations, claims submissions, and check eligibility.

Your dedicated Provider Relations Specialist will keep you apprised of any network changes, new additions or needs.

FINANCIAL MANAGEMENT SERVICES (FMS)
In accordance with the state of Kansas law (K.S.A. 39-7.100) and the self-direct model and within the scope of the “Agency with Choice” model, Sunflower Health Plan members who are aging or disabled, have the option to self-direct some or all of their services. The self-direct model allows the Sunflower Health Plan member to make a decision about, direct the provisions of and control the attendant care services received by the member, including but not limited to selecting, training, managing, paying and dismissing of a direct support worker. A Sunflower Health Plan member or the members’ representative has authority over selected services and can accept direct responsibility for these services with the assistance of a FMS provider.

RIGHTS AND RESPONSIBILITIES
When a Sunflower State member or the member’s representative chooses an FMS provider, he or she must be fully informed by the FMS provider of his or her rights and responsibilities to:

- Choose and direct support services  
- Choose and direct the workers who provide the services  
- Perform the roles and responsibilities as employer  
- Understand the roles and responsibilities of the FMS provider  
- Receive initial and ongoing skills training as requested

Once fully informed, the Sunflower State member or the member’s representative must negotiate, review, and sign a FMS Service Agreement made available by Sunflower State Health Plan. Below are the responsibilities of the Sunflower State member or the member’s representative as well as the FMS provider responsibilities.

The Sunflower State member or the member’s representative has the responsibility to:
• Act as the employer for the direct support workers or designate a representative to manage or help manage the direct support workers
• Negotiate a FMS Service Agreement with the chosen FMS provider that clearly identifies the roles and responsibilities of the member and the FMS provider
• Select the direct support worker(s)
• Refer the direct support workers to the FMS provider for completion of required human resources and payroll documentation Note: In cooperation with the FMS provider, all employment verification and payroll forms must be completed.
• Negotiate an Employment Service Agreement with the direct support worker that clearly identifies the responsibilities of all parties
• Provide or arrange for appropriate orientation and training of the direct support worker(s)
• Determine the schedules of the direct support worker(s)
• Determine the tasks to be performed by the direct support worker(s) and where and when they are to be performed in accordance with approved and authorized Plan of Care/person-centered support plan (PCSP)/Attendant Care Worksheet (ACW)/Customer Service Worksheet (CSW) and/or others as identified and applicable to each specific waiver.
• Manage and supervise the day-to-day Home and Community Based Service activities of the direct support worker(s)
• Verify the time worked by the direct support worker(s) was delivered according to the approved Plan Of Care (POC)
• Ensure submission of required direct support worker documents to the FMS provider for processing and payment in accordance with the established FMS, state, and federal requirements Note: The documentation must reflect actual hours worked in accordance with an approved POC.
• Report work-related injuries incurred by the direct support worker(s) to the FMS provider agency staff
• Develop an emergency worker backup plan in case a substitute direct support worker is ever needed on short notice or as a backup (short-term replacement worker)
• Ensure all appropriate service documentation is recorded as required by the State of Kansas HCBS waiver program policies, procedures, or by the Sunflower State Provider Agreement
• Inform the FMS provider of any changes in the status of direct support worker(s) such as a change of address or telephone number, in a timely fashion
• Inform the FMS provider and care manager of the dismissal of a direct support worker within three working days
• Inform the FMS provider and Sunflower State Care Manager of any changes in the status of the member or member’s representative, such as member’s address, telephone number, or hospitalizations, within three working days
• Participate in required quality assurance visits with Sunflower State Care Managers or Quality Assurance staff or other authorized reviewers/auditors

The FMS provider has the rights and responsibilities to:

• Comply with the provisions of KSA 39-7,100 [Home and community based services program] and KSA 65-6201 [Individuals in need of in-home care; definitions]
• Execute a Sunflower Health Plan Provider Agreement
• Comply with state regulations, comply with Sunflower Health Plan provider agreement requirements to provide services to eligible Sunflower Health Plan members
• Develop and implement procedures, internal controls, and other safeguards that reflect Kansas state law (the guiding principles of self-direction) to ensure the Sunflower Health Plan member or the members’ representative, rather than the FMS provider, have the right to choose, direct, and control the services and direct support worker(s) who provide them without excessive restrictions or barriers. Note: The procedures, internal controls, and other safeguards must be written and must include, at a minimum:
  ➢ A mechanism to process the direct support worker’s human resource documentation and payroll in a manner that is efficient and supports the member’s or member’s representative’s authority to select, recruit, hire, manage, dismiss, and train direct support workers
  ➢ Information for the direct support worker that outlines the completion of time keeping process, wages, benefits, pay days, work hours, and the member’s self-direct preferences
  ➢ An assurance that Sunflower Health Plan member or the members’ representative, not the FMS provider, determines the terms and conditions of work (when and how the services are provided, such as establishing work schedules, determining work conditions [for example, smoking restrictions in the home, conditions for dismissal] and tasks to be performed)
  ➢ Internal controls to ensure the Sunflower Health Plan member or the members’ representative is afforded choice and control over workers without excessive restrictions or barriers
  ➢ A process to respond, within a reasonable time frame, when a Sunflower Health Plan member or the members’ representative informs the FMS provider of the decision to dismiss a particular direct support worker
  ➢ A process for the self-directing Sunflower Health Plan member or the members representative to pay the direct support worker(s) or for the self-directing Sunflower Health Plan member or the members’ representative to delegate the direct support worker(s) payment by direct deposit, first class mailing, or other means through the FMS provider agency staff
  ➢ Unless otherwise stipulated in the agreement between the Sunflower member or the member’s representative, FMS provider shall pay the direct support worker within ten business days of receipt of the explanation of payment from Sunflower State
• Ensure the self-directing Sunflower Health Plan member or the members representative and the case manager have the name and contact information of the FMS provider agency staff who can address their issues
• Assume responsibilities in providing the following administrative services:
  ➢ Establish and maintain all required records and documentation, to include a file for each self-directing member per State of Kansas regulations, policies, and procedures and in accordance with Medicaid provider requirements
  **Note:** All files must be maintained in a confidential, HIPAA-compliant manner.
  ➢ Obtain authorizations to conduct criminal background checks, child abuse, and adult registry checks in accordance with applicable waiver requirements
  ➢ Verify citizenship and legal status of potential direct support workers
  ➢ Collect and process all required federal, state, and local human resource forms required for employment and the production of payroll
  ➢ Help the self-directing Sunflower Health Plan member or the members’ representative set the correct pay rate for each direct support worker as allowed under the procedures set by the Sunflower Health Plan
  ➢ Verify and process time worked by direct support worker(s)
  ➢ Compute, withhold, file, and deposit federal, state, and local employment taxes for the direct support worker(s).
  ➢ Compute and pay workers compensation as contractually and statutorily required
  ➢ Approve and pay wages to the direct support worker(s) in compliance with federal and state labor laws
  ➢ Perform all end-of-year federal, state, and local wage and tax filing requirements, as applicable (that is, IRS forms W-2 and W-3, state income tax forms and reporting)
  ➢ Have policies and procedures in place for reporting fraud and/or abuse, neglect, or exploitation by a direct support worker to the appropriate authority and informing the Sunflower Health Plan member or the members’ representative that if the direct support worker continues to work for the member, they will no longer be able to serve as the FMS provider agency
  ➢ Collection of patient obligation

• Ensure each self-directing Sunflower Health Plan member:
  ➢ Maintains control and oversight of his or her direct support worker
  ➢ Is aware of the benefits/services available to him or her
  ➢ Is aware of his or her requirements and responsibilities to the FMS provider agency including payment of patient obligation
  ➢ Is aware of his or her requirements and responsibilities to the direct support workers, including a signed Employment Service Agreement that specifies the responsibilities of the parties in a language/format that is understandable to the worker

• Ensure each direct support worker hired by the self-directing Sunflower Health Plan member:
  ➢ Is aware of the benefits/services available to him or her
  ➢ Is aware of the employment requirements and job responsibilities of the self-directing member and FMS provider

• Maintain a listing of direct support workers who are available and desire additional employment
• Develop, implement, and maintain an internal quality assurance program that monitors for:
  ➢ Self-directed Sunflower Health Plan members’ satisfaction
  ➢ Direct support worker’s satisfaction
• Correct submission of direct support worker’s time worked
• Correct payroll distribution

• Develop, implement, and test an adequate backup plan that ensures records are preserved and fiscal functions are replicated in case of a natural disaster or state of emergency
• Maintain evidence of certifications, agreements, and affiliations as required by waiver or policy (such as community developmental disability organization [CDDO] affiliation agreements for developmental disabilities services)

FMS PROVIDER REQUIREMENTS
To participate as a FMS Provider with Sunflower Health the following is required:

• Complete provider application
• Signed Sunflower Health Plan Provider Agreement
• Register with the Secretary of State office
  ➢ Be in good standing with all Kansas laws/business requirements.
  ➢ Owners/Principles/Administrators/Operators have no convictions of embezzlement, felony theft, or fraud.
  ➢ Businesses established to provide FMS to individuals that live in a separate household from the owner, primary operator or administrator of the FMS business.
  ➢ Business is established to provide FMS to more than one individual.

• Insurance defined as:
  ➢ Liability Insurance
  ➢ Workers Compensation Insurance
  ➢ Unemployment insurance

• Annual Independent Financial Audit
• Financial solvency with evidence that 30 days operation costs are met (estimate of cash requirements will be estimated utilizing the past quarter’s performance from the date of review; or if a new entity, provider must estimate the number of individuals that they reasonably expect to serve utilizing nominal costs). Evidence may include the following:
  ➢ Cash (last three bank statements)
  ➢ Open line of credit (statement(s) from bank/lending institution)
  ➢ Other

• Maintain required policies/procedures including but not limited to:
  ➢ Policies/procedures for billing Medicaid in accordance with approved rates, and for services as authorized by POC.
  ➢ Policies/procedures for billing AWC FMS administrative fees
  ➢ Policies/procedures to receive and disburse Medicaid funds, track disbursements and provide reports as requested
    * Report semi-annually to the individuals self-directing their care, billing/funds disbursed on their behalf
    * Report to Sunflower Health Plan as requested:
Policies/procedures that ensure proper/appropriate background checks are conducted on all individuals (FMS provider and DSW) in accordance with program requirements.

Policies/procedures that ensure that self-directing individuals follow the pay rate procedures as established by Sunflower Health Plan when setting direct support workers’ pay rates.

- Clear identification of how this will occur
- Prohibition of wage/benefit setting by AWC FMS provider
- Prohibition of “recruitment” of self-direct individuals (HCBS waiver consumers/customers and/or DSW staff) by enticements/promises of greater wages and/or benefits through the improper use of Medicaid funds.

Policies/procedures that ensure proper/appropriate process of timesheets, disbursement of pay checks, filing of taxes and other associated responsibilities

Policies/procedures regarding the provision of Information & Assistance services

Policies/procedures for Grievance. The grievance policy is designed to assure a method that Direct Support Workers can utilize to address hours paid that differ from hours worked, lack of timely pay checks, bounced pay checks, and other AWC FMS issues.

SUNFLOWER STATE WEBSITE

www.SunflowerStateHealth.com

The Sunflower State website was designed to reduce administrative burdens for providers and their staff while optimizing their ability to access information quickly in order to provide efficient service for members. Utilizing the website allows immediate access to current provider and member information 24 hours a day, seven days a week. Please contact your Provider Relations Specialist or our Provider Services department at 1-877-644-4623 with any questions or concerns regarding the website.

The Sunflower State website is located at www.SunflowerStateHealth.com. The public website contains useful information, data and learning tools for providers, such as:
FMS BILLING AND CLAIMS SUBMISSION

Sunflower State processes claims in accordance with applicable prompt pay and timely claims payment standards specified for Medicaid fee-for-service in Section 1902(a) (37) (A) of the Social Security Act, 42 CFR 447.46 and applicable State law and regulation. Sunflower State agrees to comply with these timely claims payment standards and will pay or deny, and shall require our subcontracted vendors that process claims to pay or deny clean claims as follows:

- 100% of all clean claims including adjustments will be processed and paid or processed and denied within 30 days of receipt
- 99% of all non-clean claims including adjustments will be processed and paid or processed and denied within 60 days of receipt
- 100% of all claims including adjustments must be processed and paid or processed and denied within 90 days of receipt
- For Nursing Facilities, 90 percent of clean claims must be paid within 14 days and 99.5 percent of clean claims within 21 days.

The date of receipt is the date Sunflower State receives the claim as indicated by its date stamp on the claim.

Clean Claim Definition

In order to eliminate confusion among providers and further ensure compliance, Sunflower State has adopted the State of Kansas definition of Clean Claim: A clean claim means the definition set forth in 42 C.F.R 447.45, as amended. As of the effective date of a contract, such definition is a claim that can be processed without obtaining additional information from the provider of services or from a third party. It includes a claim with errors originating the State’s claims system. It does not include a claim from a provider who is under investigation for fraud or abuse, or a claim under review for Medical Necessity.

Non-Clean Claim Definition

A non-clean claim is defined as a submitted claim that requires further investigation or development beyond the information contained in the claim. The errors or omissions in the claim may result in:

- A request for additional information from the provider or other external sources to resolve or correct data omitted from the claim;
- A need for review of additional medical records; or
- A need for other information necessary to resolve discrepancies.
In addition, non-clean claims may involve issues regarding medical necessity and include claims not submitted within the filing deadlines.

**Timely Filing**
Claims must be received within 180 days of the date of service. When Sunflower State is the secondary payer, claims must be received within 180 calendar days from the date of disposition (final determination) of the primary payer. Claims received outside of this timeframe will be denied for untimely submission.

All corrected claims, requests for reconsideration or claim disputes must be received within 180 days from the date of notification of payment or denial is issued.

**Who Can File Claims?**
All providers – whether in-network or out-of-network - who have rendered services to Sunflower State members can file claims. It is important that providers ensure Sunflower State has accurate billing information on file. Please confirm with the Provider Services department or your dedicated Provider Relations Specialist that the following information is current in our files:

- Provider Name (as noted on current W-9 form)
- National Provider Identifier (NPI)
- Tax Identification Number (TIN)
- Taxonomy Code
- Physical Location Address (as noted on current W-9 form)
- Billing Name and Address
- Current Valid License

We recommend that providers notify Sunflower State as soon as possible, but no later than 30 days in advance of changes to billing information. Please submit this information on a W-9 form. Changes to a Provider’s TIN and/or address are NOT acceptable when conveyed via a claim form.

**How to File a Claim**
Providers must file claims using the CMS 1500 form. Enter the provider’s NPI number in the “Rendering Provider ID#” section of the CMS 1500 form (see box 24J). **The NPI number entered on the claim form must be the same NPI number that was utilized when requesting an authorization (if the service required an NPI number.)** Providers must list their **taxonomy code in this section to avoid processing delays.** Claims missing the necessary requirements are not considered “clean claims” and will be returned to providers with a written notice describing the reason for return.

Sunflower State will accept claims from our providers in multiple, HIPAA compliant methods. Also, Sunflower State will accept claims for FMS Providers and Home and Community Based (HCBS) providers through the AuthentiCare system. We support all HIPAA EDI (Electronic Data Interchange) transaction formats, including HIPAA 837 Institutional and Professional transactions. Providers may submit EDI using over 60 claims clearinghouses, through the Kansas
Medical Assistance Program (KMAP) or submit HIPAA 837 claims to us directly via our secure web based Provider Portal. Providers may enter claims directly online in HIPAA Direct Data Entry (DDE) compliant fashion via our online claims entry feature – another secure component of our Provider Portal. Paper claims should be submitted to:

KanCare
Office of the Fiscal Agent
P.O. Box 3571
Topeka, KS  66601-3571

Claims eligible for payment must meet the requirements as stipulated in the Sunflower State Billing Manual which can be found at [www.SunflowerStateHealth.com](http://www.SunflowerStateHealth.com).

**Electronic Claims Submission**

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

Sunflower State
c/o Centene EDI Department
1-800-225-2573, extension 25525
or by e-mail at:
EDIBA@centene.com

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

KanCare will maintain a single, front-door billing interface where providers can submit claims. You can also submit claims to Sunflower State directly through our Secure Web Portal, or use an established commercial clearinghouse.

The Sunflower State Payer ID is 68069 and we work with the following clearinghouses:

- Emdeon
- SSI
- Gateway
- Availity
- Smart Data Solutions
Providers already enrolled in KMAP as of January 1, 2013 may continue to submit claims electronically through the state’s secure portal.

**Paper Claims Submission**

All newly filed paper claims and encounters or claims that have been corrected for resubmission, should be mailed or submitted to:

KanCare  
Office of the Fiscal Agent  
P.O. Box 3571  
Topeka, KS  66601-3571

**Claim Disputes**

If a provider has a question or is not satisfied with the information they have received related to a claim, there are five effective ways in which a provider can contact Sunflower State.

1. Review the claim in question on the secure Provider Portal. Participating providers who have registered for access to the secure provider portal can access claims to obtain claim status, submit claims or submit a corrected claim.
2. Contact a Sunflower State Provider Service Representative at 1-877-644-4623. Providers may inquire about claim status, payment amounts or denial reasons. A provider may also make a simple request for reconsideration by clearly explaining the reason the claim is not adjudicated correctly.
3. Submit an adjusted or corrected claim to Sunflower State:
   - Corrected claims must be received within 180 calendar days of the original explanation of payment
   - Corrected claims must clearly indicate they are corrected in one of the following ways:
     - Submit corrected claim via the secure Provider Portal
       - Follow the instructions on the portal for submitting a correction
     - Submit corrected claim electronically via Clearinghouse
     - Professional Claims (CMS): Field CLM05-3 = 6 and REF*F8 = Original claim number
   - Mail corrected claims to:
     KanCare  
     Office of the Fiscal Agent  
     P.O. Box 3571  
     Topeka, KS  66601-3571
4. Submit a “Request for Reconsideration” to Sunflower State:
   - Requests for Reconsideration should be mailed to Sunflower State at the address below:
     Sunflower State Health Plan  
     Attn: Reconsideration
P.O. Box 4070
Farmington, MO  63640-3833

- A request for reconsideration is a written communication (i.e. a letter) from the provider about a disagreement with the manner in which a claim was processed, but does not require a claim to be corrected and does not require medical records.
- The claim form should not be resubmitted; however, the claim number must be referenced in the documentation.
- The request must include sufficient identifying information which includes, at a minimum, the patient name and patient ID number, date of service, total charges, provider name and provider tax identification number.
- The documentation must also include a detailed description of the reason for the request.
- Unclear or non-descriptive requests could result in no change in the processing, a delay in the research or delay in the reprocessing of the claim.

5. Submit a “Claim Dispute Form” to Sunflower State:

- Claim Dispute Forms should be mailed to Sunflower State at the address below:
  Sunflower State Health Plan
  Attn: Claim Dispute
  P.O. Box 4070
  Farmington, MO  63640-3833
- A claim dispute should be used only when a provider has received an unsatisfactory response to a request for reconsideration.
- Providers wishing to dispute a claim must complete the Claim Dispute Form located at www.SunflowerStateHealth.com. To expedite processing of your dispute, please include the original request for reconsideration letter and the response.
- The claim form should not be submitted; however, the claim number must be referenced in the documentation.

If the corrected claim the request for reconsideration or the claim dispute results in an adjusted claim, the provider will receive a revised Explanation of Payment (EOP). If the original decision is upheld, the provider will receive a revised EOP or letter detailing the decision and steps for escalated reconsideration.

Sunflower State shall process, and finalize all corrected claims, requests for reconsideration and disputed claims to a paid or denied status within 30 calendar days of receipt of the corrected claim, request for reconsideration or claim dispute.

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.
Electronic Funds Transfers (EFT) and Electronic Remittance Advices (ERA)

Sunflower State provides an innovative web-based solution for Electronic Funds Transfers (EFTs) and Electronic Remittance Advices (ERAs). Through this service, providers can take advantage of EFTs and ERAs to settle claims electronically. As a participating provider, you can gain the following benefits from using 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, please visit our provider home page on our website at [www.SunflowerStateHealth.com](http://www.SunflowerStateHealth.com). If further assistance is needed, please contact our Provider Services department at 1-877-644-4623.

Third Party Liability

Third party liability refers to any other health insurance plan or carrier (e.g., individual, Medicare, group, employer-related, self-insured or self-funded, or commercial carrier, automobile insurance and worker's compensation) or program that is or may be liable to pay all or part of the healthcare expenses of the member.

As a Medicaid managed care plan, Sunflower State is always the payer of last resort. Sunflower State shall make reasonable efforts to determine the legal liability of third parties to pay for services furnished to Sunflower State members; however, since providers have direct contact with members, providers may have the most accurate and complete information regarding third party liability. Should a provider become aware of third party liability not known by Sunflower State, the provider shall notify Sunflower Provider Services at 1-877-644-4623.

When Sunflower State has established the probable existence of third party liability at the time the claim is filed, Sunflower State will reject the claim and return it to the provider with instructions to bill the primary insurance with the following exception: Sunflower State will pay the provider’s negotiated rate and then seek reimbursement from any liable third party if the claim is for labor and delivery and postpartum care.

If a provider becomes aware of a potential Third Party Liability after Sunflower State has paid the claim and the provider wants to pursue payment from the Third Party Liability carrier the provider can file a claim with the TPL carrier. If Sunflower State has made payment, the provider must submit an adjustment request within one month. If a third-party carrier makes payment to a provider while a claim is pending to Sunflower State, the provider should wait until the Sunflower State claim has processed and then adjust the Sunflower State claim within one month.
month. The provider must also notify Sunflower State of the TPL carrier and Sunflower State will notify KanCare.

Sunflower State also utilizes the services of a third party for post payment review of potential third party liability issues. The third party analyzes post payment claims data, investigates potential third party liability situations and pursues any potential recoveries. Any identified third party liability will be reported to KanCare.

**Electronic Visit Verification – “KS AuthentiCare”**

As mentioned previously, Sunflower State will utilize the KS AuthentiCare system to accept claims from FMS and Home and Community Based (HCBS) providers. If you are not currently registered for KS AuthentiCare, go to [https://www.authenticare.com/kansas/register.aspx](https://www.authenticare.com/kansas/register.aspx).

**Billing the Member**

Providers may not bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against members for covered services in the event, including but not limited to, non-payment by Sunflower State, health plan insolvency, or breach of the agreement between Sunflower State and the Provider.

Specifically, Members may not be held liable for the following situations:

- Payment for covered services that KDHE and KDADS does not reimburse Sunflower State
- Payment for covered services for which KDHE and KDADS or Sunflower State does that pay the individual or healthcare provider that furnishes the services under a contractual, referral, or other arrangement
- No member shall be held liable for Sunflower State’s debts in the event of Sunflower State’s insolvency.

**KANSAS MEDICAID PROGRAM SUMMARY**

The Kansas Department of Health and Environment-DHCF has oversight authority and manages the provision of health care services for all Medicaid beneficiaries. Effective January 1, 2013, the Kansas Department of Health and Environment contracted with Sunflower State and several other health plans to manage access to Covered Services and provider networks for those who qualify for the state’s KanCare program. Almost all Medicaid members and 100% of CHIP members are required to enroll in a managed care plan.

Below is a summary of Categories of Eligibility that will be included in the KanCare program.

- Adults and children eligible under the Temporary Assistance to Families (TAF) program
- Certain pregnant women and children through the month of their first birthday
- Certain children over the age of one year and through the month of their sixth birthday
- Certain children over the age of six and through the month of their 21 birthday
• Children under the age of 19 years who are not eligible for Medicaid, but are living in families with incomes less that 200 percent of the federal poverty level
• Aged and disabled individuals receiving Supplemental Security Income (SSI)
• Medically needy aged and disabled individuals (spendown populations)
• People eligible for Medicaid Buy-In (Working Healthy)
• Children in foster care
• Children whose families receive adoption support
• Beneficiaries in the Health Insurance Premium Payment System (HIPPS)
• Beneficiaries in the State’s FFS lock-in program
• Beneficiaries residing in a Nursing Facility (NF)
• Beneficiaries residing in a swing bed NF
• Beneficiaries residing in a private Immediate Care Facilities for individuals with Intellectual Disabilities.
• Beneficiaries residing in a head injury rehabilitation facility
• Beneficiaries served through one of the Home and Community Based Services HCBS (1915 c) waivers
• Children with special health care needs (CSHCN)
• Beneficiaries of Native American descent
• Youth residing in an institution (PRTF, State Hospital alternative, or acute inpatient) for more than 30 days
• Beneficiaries who are eligible for Medicaid while residing in a State Mental Hospital

MEDICAL MANAGEMENT

All HCBS services require prior authorization. The assigned Sunflower State Care Manager will do an assessment and approves/authorizes the services. The authorization information will then be communicated to the FMS provider.

GRIEVANCES AND APPEALS PROCESS

Member Grievances

A Member grievance is any expression of dissatisfaction about any matter. Grievances may include, but are not limited to: denial of service, partial denial of service, not given clear and accurate information from staff, lack of action being taken on a case, the quality of care or services provided to a Member, any aspects of interpersonal business relationships such as the rudeness of a Sunflower State employee or provider, or failure to respect the Member’s rights. Members may access the Office of Administrative Hearings (OAH) State Fair Hearing process at any time except when an expedited appeal is requested. Members must exhaust Sunflower’s expedited appeal process prior to accessing the expedited State Fair Hearing process.

Receipt and Documentation. Members, authorized representatives acting on a Member's behalf, and providers, with the Members’ written consent, may file a grievance, within 180 days, orally by using our toll-free or TTY/TDD number, in person, in writing, via email or via the Secure Member Portal.
Grievances may be submitted to:

Sunflower State
Complaint and Grievance Coordinator
8325 Lenexa Drive
Lenexa, KS 66214
Phone: 1-877-644-4623
Fax: 1-866-491-1824

Acknowledgement. Staff receiving grievances orally will acknowledge the grievance and attempt to resolve it immediately. Staff will document the substance of the grievance. For informal grievances, defined as those received orally and resolved immediately to the satisfaction of the Member, representative or provider, the staff will document the resolution details. All oral or written grievances will be forwarded to the Complaint and Grievance Coordinator for tracking, written acknowledgment, and resolution. If resolved upon intake, the acknowledgement letter will include appropriate language advising of the resolution agreed upon. If not resolved at the time of intake, the Complaint and Grievance Coordinator will send a written acknowledgment letter within 10 business days of receipt. The Complaint and Grievance Coordinator will include a description of the grievance procedure including timeframe for resolution.

Investigation. The Complaint and Grievance Coordinator will conduct an initial review, which may include contacting the Member for additional information or clarification of the issue and gathering applicable documentation from other Sunflower State departments. Clinical issues, including grievances filed as a result of a service denial, partial service denial or a decision to deny a request for an expedited appeal resolution, are forwarded to the Medical Management Department for investigation or review by a physician or other appropriate clinician. If the grievance involves a quality of care issue, it is escalated to the Director, Quality Improvement for review, resolution and inclusion in the quality of care investigation process. Matters involving privacy concerns or potential fraud and abuse are forwarded to the Sunflower State Compliance Officer for resolution. The Compliance Officer will also determine whether the issue should be forwarded to KDHE, KDADS, and Kansas’ Medicaid Fraud Control Unit (MFCU), and will report credible cases of Member fraud, waste, and abuse within 24 hours. If the Member has requested disenrollment, Sunflower State’s Complaint and Grievance Coordinator will provide the Member with information on the disenrollment process and direct the Member to the appropriate State contact. Sunflower State’s Complaint and Grievance Coordinator will also inform the Member how to access a State Fair Hearing if the Member is dissatisfied with denial of a Member’s request to transfer or disenroll from the plan. If the request for disenrollment includes a grievance, the grievance will be handled separately via the grievance process described herein.

Notice of Resolution.

The Complaint and Grievance Coordinator will resolve the grievance as expeditiously as possible, not to exceed twenty (20) days from receipt of the grievance, and send a written notice of the resolution to the Member. Our internal goal is to resolve grievances within 10 business days. Regardless of the outcome, Sunflower State will not discriminate or retaliate against a Member, a Member’s representative or a provider, for filing a grievance or appeal or requesting an OAH State fair hearing.
Member Appeal Process

An appeal is defined as a request for the review of an Action taken by a health plan. The definition of an Action includes: the denial or limited authorization of a requested service, including the type or level of service; reduction, suspension or termination of a previously authorized service; denial, in whole or in part, of payment for a service; failure to provide services in a timely manner including failure of Sunflower State to act within the required timeframes; or a request for reconsideration of a previously resolved grievance. Members will have 30 calendar days from the date of the receipt of the Notice of Action to request an appeal. Members, the legal representative of a deceased Member’s estate, or a Member’s authorized representative with written consent from the Member acting on behalf of the Member, may file an appeal orally or in writing. Appeals may be directed to:

Sunflower State
Appeals Coordinator
8325 Lenexa Drive
Lenexa, KS 66214
Phone: 1-877-644-4623  Fax: 1-866-491-1824

Providers filing an appeal on behalf of a Member will require the Member’s written consent, other than in the case of an expedited appeal request. Oral or written requests to review an Action will be treated as an appeal. An oral appeal request must be followed by a written, signed appeal; however, if the appeal request is received orally, the oral receipt date will be considered the initial receipt date of the appeal. Expedited requests do not require written follow up, but Sunflower State’s Appeals Coordinator will inform the Member of the limited time available to present evidence, either in person or in writing. When received, any additional documentation related to the appeal is date-stamped and included in the file for review.

Continuation of Benefits. Sunflower State will continue a Member’s benefits through the appeal resolution process if the appeal was filed within 10 calendar days of the Notice of Action or the intended effective date of a proposed action and the appeal involves the termination, suspension, or reduction of a previously authorized course of treatment; the services were ordered by an authorized provider; the original period covered by the original authorization has not expired and the Member requested an extension of benefits. If these conditions are met, benefits will be continued until at least one of the following occurs: the Member withdraws the appeal or the appeal decision is rendered and the Member does not request a continuance within the designated timeframe. If the Member, or their authorized representative, requests an extension of the services, but the authorized units of service have already been exhausted, Sunflower State may not extend the benefits pending the outcome of the appeal.

If a Member requests an extension of benefits pending an OAH fair hearing, Sunflower State will continue or reinstate the benefits until one of the following occurs: the Member withdraws the request for hearing; it is determined the Member did not request a fair hearing within 10 days from the adverse decision; a State Fair Hearing officer issues a decision adverse to the Member; or the authorization or service limits are met.

Acknowledgement. The Appeals Coordinator 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 Appeals Coordinator will send the
Member or authorized representative an acknowledgement letter within 3 business days of receiving the request that will include the subject of the appeal, explanation of the appeal process, and the Member’s rights. The Member’s right will include the right to submit comments, documents, or other evidence relevant to the appeal in person or in writing and the right to access the OAH state fair hearing process at any time during the appeal process.

**Medical Reviewer.** A physician with appropriate clinical expertise will review appeal requests involving clinical issues or any medical necessity decisions. The individual will be a clinical peer of the same or similar specialty, who is not a subordinate of the individual who made the initial adverse determination, and who was not involved in the initial determination or any prior decision-making. In addition, the individual will not be a Sunflower State network provider.

**Resolution.** Sunflower State will resolve standard appeals and provide notice within 14 calendar days of receipt, or sooner, if the Member’s health condition requires. The resolution timeframe may be extended up to 14 calendar days if the Member requests the extension. If Sunflower State requires an extension to obtain additional information that would be in the best interest of the Member, Sunflower State will obtain permission from KDHE, KDADS and the Member. We will provide the Member with written notification of the reason for the delay for extensions not requested by the Member. Appeal resolution notice will include, but is not limited to, the appeal decision and reasons for the decision in easily understood language, reference to the protocol or criterion on which the decision was based, notification of the Member’s rights, including the right to receive a copy of the actual protocol or criterion on which the decision was based, a list of titles and qualifications of individuals participating in the appeal review.

For any adverse decision, the notice will also include the following information: the Member’s right to request an OAH State fair hearing within 30 days; instructions on how to request an OAH fair hearing; how to request a continuance of previously authorized benefits pending a hearing, including the 10 day timeframe for requesting the continuation; information regarding the Member’s liability for the cost of any continued benefits if Sunflower State’s decision is upheld; the Member’s right to represent him/herself or use legal counsel, a relative, friend or a spokesperson; the specific regulation, Federal or State law that supports the action; and the Member’s rights to request and evidentiary hearing if one is available.

**Expedited Appeal Process.** During the appeal process, a Member or provider may request, orally or in writing, an expedited appeal of an Action, if it could seriously jeopardize the Member’s life or health or ability to attain, maintain or regain maximum function. An oral expedited appeal request does not need to be followed by a written request for the expedited appeal. The Appeals Coordinator will contact the Member and notify him/her of the limited time available to submit any supporting information or evidence and how to submit the information for consideration. In addition, the Member will be notified that they must exhaust Sunflower State’s expedited appeal process prior to filing a State Fair Hearing with OAH. The Appeals Coordinator will immediately gather all supporting documentation for expedited appeal requests and forward the information to a Medical Director (MD) with the same or similar specialty, who was not involved in any previous level of review. Prior to issuing a final determination, the MD will also contact the requesting provider to obtain any additional information the provider, or Member, would like the MD to consider.

Requests related to an ongoing emergency, continued hospitalization, or other health care services for a Member who has received emergency services but has not been discharged will be
processed within 24 hours. For all other expedited appeal requests, the MD will render a decision within 72 hours of receiving the request, or as expeditiously as the Member’s condition warrants. The MD or Appeals Coordinator will provide prompt verbal notice of all decisions to the provider and Member within the 72 hour timeframe that will include the decision outcome. The Appeals Coordinator will send written notification within 48 hours of the expedited decision. In the event of an adverse Action, the verbal and written notices will include information on how the Member can access an expedited fair hearing from OAH.

If a request for an expedited appeal resolution is denied, Sunflower State will transfer the appeal to the standard resolution process and the Member will be notified with prompt oral notice of the denial of the expedited request. Written notice will be sent to the Member within two calendar days. The notice will not be considered an Action and a Member can file a grievance in response to the decision.

Access to OAH Fair Hearings

Sunflower State’s Appeals Coordinator will notify a Member during the appeal process of their right to access the OAH fair hearing process at any time during the appeal or following a final adverse appeal notice. As outlined previously, a Member will not have a right to an expedited OAH fair hearing unless the Member has exhausted Sunflower State’s expedited appeal process. If a Member requests an OAH fair hearing, Sunflower State will submit the electronic form to the appropriate OAH office within five calendar days of the Member’s request. Once Sunflower State receives notice of the fair hearing date, in accordance with OAH’s fair hearing requirements, the Appeals Coordinator will prepare an evidence package and send a copy to both OAH and the Member within five calendar days of the receipt of the notice. If OAH reverses the decision from Sunflower State, Sunflower State will promptly authorize and coordinate services with the Member and the provider to ensure services are rendered. If Sunflower State’s decision is reversed and services were already rendered, Sunflower State will ensure payment of those services.

To request a hearing from the Department of Social and Health Services contact:
Office of Administrative Hearings
1020 Kansas Avenue
Topeka, KS 66612
Phone: 1-785-296-2433

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.
CULTURAL COMPETENCY

Sunflower State views Cultural Competency as the measure of a person or organization’s willingness and ability to learn about, understand and provide excellent customer service across all segments of the population. It is the active implementation of a system wide philosophy that values differences among individuals and is responsive to diversity at all levels in the community and within an organization and at all service levels the organization engages in outside of the organization. A sincere and successful Cultural Competency program is evolutionary and ever-changing to address the continual changes occurring within communities and families. In the context of health care delivery, Cultural Competency is the promotion of sensitivity to the needs of patients who are members of various racial, religious, age, gender and/or ethnic groups and accommodating the patient’s culturally-based attitudes, beliefs and needs within the framework of access to health care services and the development of diagnostic and treatment plans and communication methods in order to fully support the delivery of competent care to the patient. It is also the development and continued promotion of skills and practices important in clinical practice, cross-cultural interactions and systems practices among providers and staff to ensure that services are delivered in a culturally competent manner.

Sunflower State is committed to the development, strengthening and sustaining of healthy provider/member relationships. Members are entitled to dignified, appropriate, and quality care. When healthcare services are delivered without regard for cultural differences, members are at risk for sub-optimal care. Members may be unable or unwilling to communicate their healthcare needs in an insensitive environment, reducing effectiveness of the entire healthcare process.

Sunflower State has incorporated an evaluation of each provider’s cultural competency level within its credentialing program. By virtue of their participation status, all in-network providers have been evaluated regarding their cultural competence level and have been approved for participation in the Sunflower State network. Nevertheless, we offer all in-network providers access to reference materials, training programs and tool kits to assist each provider to further develop culturally competent staff and culturally proficient practices.

As part of Sunflower State’s Cultural Competency Program, we require our employees and in-network providers to ensure that:

- Members understand that they have access to medical interpreters, signers, and TDD/TTY services to facilitate communication without cost to them.
- Medical care is provided with consideration of the members’ primary language, race and/or ethnicity as it relates to the members’ health or illness.
- Office staff routinely interacting with members has been given to opportunity to participate in, and have participated in, cultural competency training and development offered by Sunflower State.
- Office staff responsible for data collection makes reasonable attempts to collect race and language specific information for each member. Staff will also explain race categories to a member in order assist the member in accurately identifying their race or ethnicity.
- Treatment plans are developed with consideration of the member’s race, country of origin, native language, social class, religion, mental or physical abilities, heritage, acculturation,
age, gender, sexual orientation, and other characteristics that may influence the member’s perspective on healthcare.

- Office sites have posted and printed materials in English and Spanish, and if required by KanCare, any other required non-English language.
- Providers establish an appropriate mechanism to fulfill obligations under the Americans with Disabilities Act including that all facilities providing services to members must be accessible to persons with disabilities. Additionally, no member with a disability may be excluded from participation in or be denied the benefits of services, programs or activities of a public facility, or be subjected to discrimination by any such facility.

Disabilities Awareness

Sunflower provider contracts require compliance with KDHE, KDADS, and Sunflower non-discrimination and cultural competency requirements, such as timely use of professional interpreter services and meeting access requirements under the Americans with Disabilities Act to accommodate members with disabilities. Sunflower will also offer focused training to Providers to better equip staff to meet the needs of our Members. Training sessions will focus on sensitivity help creating an awareness of the societal and personal barriers people with disabilities face, and offer solutions to help accommodate their needs. For example, Providers will be encouraged to be flexible with appointment times or help coordinate home visits where possible and recognizing people with disabilities may require additional time to explain health care concerns, ask questions or prepare for examinations. Sunflower will also draw on the expertise of advocacy groups, such as those mentioned above to assist with this training. When Sunflower identifies a Provider who excels at providing care that is accessible for people with disabilities, we will ask this Provider to serve as a mentor to other Providers who are interested in improving their accessibility to these Members.

QUALITY IMPROVEMENT PROGRAM

Overview

Sunflower State culture, systems and processes are structured around its mission to improve the health of all enrolled members. The Quality Assessment and Performance Improvement (QAPI) Program utilizes a systematic approach to quality improvement initiatives using reliable and valid methods of monitoring, analysis, evaluation and improvement in the delivery of healthcare provided to all members, including those with special needs.

Sunflower State recognizes its legal and ethical obligation to provide members with a level of care and access to services that meets recognized professional standards and is delivered in the safest, most appropriate settings. To that end, Sunflower State will provide for the delivery of quality care with the primary goal of improving the health status of its members. This will include the identification of members at risk of developing conditions, the implementation of appropriate interventions and designation of adequate resources to support the interventions.
Medical Records Audits
Sunflower State will conduct random medical record audits as part of its QAPI Program to monitor compliance with processes and documentation standards stated in this manual. The coordination of care and services provided to members, including over/under utilization of services, as well as the outcome of such services, is also subject to review and assessment during a medical record audit. Sunflower State will provide written notice prior to conducting a medical record review.

FRAUD, WASTE AND ABUSE
Sunflower State takes the detection, investigation, and prosecution of fraud and abuse very seriously, and has a fraud, waste, and abuse (FWA) program that complies with the State of Kansas and federal laws. Sunflower State, in conjunction with its parent company, Centene, operates a fraud, waste, and abuse unit. Sunflower State routinely conducts audits to ensure compliance with billing regulations. Our sophisticated code editing software performs systematic audits during the claims payment process. To better understand this system; please review the Billing and Claims section of this provider manual. The Centene Special Investigation Unit (SIU) performs retrospective audits which, in some cases, may result in taking actions against providers who commit waste, abuse, and/or fraud. These actions include but are not limited to:

- Remedial education and training to prevent the billing irregularity
- More stringent utilization review
- Recoupment of previously paid monies
- Termination of provider agreement or other contractual arrangement
- Civil and/or criminal prosecution
- Any other remedies available to rectify

Some of the most common FWA practices include:

- Unbundling of codes
- Up-coding services
- Add-on codes billed without primary CPT
- Diagnosis and/or procedure code not consistent with the member’s age/gender
- Use of exclusion codes
- Excessive use of units
- Misuse of Benefits
- Claims for services not rendered

If you suspect or witness a provider inappropriately billing or a member receiving inappropriate services, please call our anonymous and confidential FWA hotline at 1-866-685-8664. Sunflower State and Centene take all reports of potential waste, abuse or fraud very seriously and investigate all reported issues.
FWA Program Compliance Authority and Responsibility
The Sunflower State Vice President of Compliance and Regulatory Affairs has overall responsibility and authority for carrying out the provisions of the compliance program. Sunflower State is committed to identifying, investigating, sanctioning and prosecuting suspected fraud and abuse. If you wish to report any type of compliance concern, please call 800-345-1642.

No table of contents entries found.
The Sunflower State provider network will cooperate fully in making personnel and/or subcontractor personnel available in person for interviews, consultation, grand jury proceedings, pre-trial conferences, hearings, trials and in any other process, including investigations.

False Claims Act

The False Claims Act establishes liability when any person or entity improperly receives from or avoids payment to the Federal government (tax fraud is suspected). The Act prohibits:

1. Knowingly presenting, or causing to be presented a false claim for payment or approval;
2. Knowingly making, using, or causing to be made or used, a false record or statement material to a false or fraudulent claim;
3. Conspiring to commit any violation of the False Claims Act;
4. Falsely certifying the type or amount of property to be used by the Government;
5. Certifying receipt of property on a document without completely knowing that the information is true;
6. Knowingly buying Government property from an unauthorized officer of the Government, and;
7. Knowingly making, using, or causing to be made or used a false record to avoid, or decrease an obligation to pay or transmit property to the Government.

For more information regarding the False Claims act, please visit www.cms.hhs.gov.