ambetter.

FROM sunflower health plan

PROVIDER RESOURCE GUIDE

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GENERAL INFORMATION

Provider Services Contact

1-844-518-9505 or TTY 1-844-546-9713

Find us on the web

Ambetter.SunflowerHealthPlan.com

There are many services that can be accessed through our website and our secure provider portal including eligibility verification, benefits, cost shares, prior authorization submissions, claim submissions, claim status and many other functions.

Medical Management Contact

1-844-518-9505 or TTY 1-844-546-9713

Claim Submission

Mailing Address
Ambetter from Sunflower Health Plan | ATTN: Claims
P.O. Box 5010 | Farmington, MO 63640-5010

Timely Filing is 180 days from date of service or primary payment (when Ambetter is secondary) for participating providers.

EDI Payor ID 68069

EDI Help Desk
For issues submitting electronic claims call **1-800-225-2573, Ext. 6075525**

PaySpan

For Electronic Payment and Remittance Services (EFT/ERA) call **1-877-331-7154** or visit **www.payspanhealth.com**

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Medical Admissions

Notification of Medical Admission & Clinical Information Fax:
1-844-474-7115

Prior Authorization Guide

How to Submit Prior Authorizations

Secure Web Portal: Ambetter.SunflowerHealthPlan.com
Fax (Medical): 1-844-474-7115 **(Behavioral Health):** 1-844-824-7705
Call: 1-844-518-9505

To quickly validate whether a particular CPT code requires authorization, **visit:** Ambetter.SunflowerHealthPlan.com/provider-resources/manuals-and-forms/pre-auth.html *Answer all questions. You will then be prompted to enter CPT code to validate authorization needs.*

THE FOLLOWING REQUIRE PRIOR AUTHORIZATION

THE FOLLOWING LIST IS NOT ALL-INCLUSIVE. Visit our website at Ambetter.SunflowerHealthPlan.com and use our procedure specific "Pre-Auth Needed?" tool to determine if a service requires prior authorization, or call our Authorization Department with questions at 1-844-518-9505. **Failure to obtain the required approval or pre-certification may result in claim denial. All out-of-network services and providers require prior authorization, excluding emergency services.**

Procedures | Services

- Potentially cosmetic
- Certain lab procedures
- High tech imaging administered by NIA (CT, MRI, PET)
- Implants
- Infertility
- Pain management

THE FOLLOWING REQUIRE PRIOR AUTHORIZATION

Inpatient Authorization

All elective/scheduled admission notifications requested at least 5 business days prior to the schedule date of admit including but not limited to:

- Medical admissions
- Surgical admissions
- Hospice care
- Rehabilitation facilities
- Behavioral health/substance use disorder
- Transplants, including evaluation
- Newborn deliveries must include birth outcomes
- Observation conversion to inpatient admission require authorization as well as notification to the health plan
- Urgent/emergent admissions: within 1 business day following the date of admission
- Behavior health admissions: all behavioral health admissions require authorization within 24 hours of admission via phone call to the Utilization Management Department.
- Partial inpatient, PRTF and/or intensive outpatient programs

Ancillary Services

- Air ambulance transport (non-emergent fixed wing airplane)
- All home services, excluding home sleep studies
- Hospice
- Furnished medical supplies & durable medical equipment (DME)
- Orthotics/prosthetics
- Hearing aid devices, including cochlear implants
- Genetic testing
- Definitive urine drug screen
- Certain specialty drugs and injectables

Prior authorization determination appeals must be made within 180 days of the date of the denial letter.

WEBSITE & SECURE PROVIDER PORTAL

There are great provider resources available on our public website as well as within the Secure Provider Portal.

Public Website

The following items are available on our public site at **Ambetter.SunflowerHealthPlan.com**

- Prior auth needed tool
- Provider webinars
- Provider newsletters
- Forms
- Billing and provider manual
- Clinical and payment policies

Secure Web Portal

Sign up for your own secure web portal account to gain access to helpful information and interactive tools.

Get Started!

Visit: Provider.SunflowerHealthPlan.com **Click:** LOGIN

Benefits of using the Provider Portal

- Check member eligibility
- Prior auth requests
- Benefit guides
- Care gaps
- Adjust/submit claims
- View
  - → Patient lists
  - → Claims
  - → Payment history
  - → Pay for performance payment summaries
- Patient and provider analytics

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HELPFUL TIPS

How to Submit Claims

Secure Web Portal — Provider.SunflowerHealthPlan.com

Clearinghouses — EDI Payor ID 68069

Paper Claims — Mail to: Ambetter from Sunflower Health Plan
ATTN: Claims
P.O. Box 5010
Farmington, MO 63640-5010

- Certain services must include appropriate modifiers (i.e. anesthesia, therapy, DME)
- Demographic changes for the member must be submitted directly to the entity to which the member applied for healthcare. Demographic changes **cannot** be submitted to Ambetter from Sunflower Health Plan.

Common Causes for Claim Rejection | Denial

- APC contracts not following CMS billing guidelines
- Black and white claim forms
- Use of incorrect form
- Handwritten claims
- ID numbers that do not match member data
- Misaligned data on paper claims
- Mismatched member ID/date of birth combination
- Missing NPI
- Missing appropriate modifiers for certain services (i.e. anesthesia, therapy, DME)
- Missing CLIA number if the claim contains CLIA certified or CLIA waived service
- Missing or invalid data
- Missing or incorrect POA indicator on inpatient claims
- Missing taxonomy code

Timely Filing Guidelines

Initial Claims — Timely filing is 180 days from date of service or primary payment (when Ambetter is secondary) for participating providers.

Corrections/Reconsiderations/Disputes — Corrected claims, requests for reconsideration and claim disputes must be submitted **180 days from the date of explanation of payment** or denial is issued.

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HELPFUL TIPS (continued)

Rejected Claim

A *rejected* claim is a front end rejection, which means it is not in our system. If submitted electronically, the *rejection* will show on the rejection report from the clearinghouse. Claims submitted on paper receive a response via letter. If a claim is rejected, the problem must be corrected and the **claim must be resubmitted as a first time claim.**

Corrected Claims

All corrected claims require the appropriate resubmission code and reference of the original claim number. Please see billing manual for specific instructions on filing corrected claims.

Resubmissions | Corrections | Reconsiderations

Claim resubmissions, corrected claims and requests for reconsideration must be submitted to:

Ambetter from Sunflower Health Plan
ATTN: Claims
P.O. Box 5010
Farmington, MO 63640-5000

Disputes

In order to dispute a claim a **Claim Dispute Form** must be completed and submitted. The Claim Dispute Form can be found at **Ambetter.SunflowerHealthPlan.com** under Provider Resources.

Completed Claim Disputes must be mailed to:

Ambetter from Sunflower Health Plan
P.O. Box 5000
Farmington, MO 63640-5000

Refund of Payment

Refund checks should be mailed to **Ambetter Health Plan:**

For medical health:
P.O. Box 955889
St. Louis, MO 63195-5889

For behavioral health:
Attn: Claims Recovery Team
P.O. Box 3656
Carol Stream IL 60132-3809

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Checking Eligibility Status

To verify member benefits, eligibility, and cost share information, the preferred method is the Ambetter secure provider portal found at **Provider.SunflowerHealthPlan.com**. Using the portal, any registered provider can quickly check member eligibility, benefits and cost share information. Eligibility and cost share information loaded onto this website is obtained from and reflective of all changes made within the last 24 hours. The eligibility search can be performed using the date of service, member name and date of birth or the member ID number and date of birth.

When searching for eligibility on the secure provider portal, you will see one of the following statuses:

ELIGIBLE	DATE OF SERVICE	PATIENT NAME	DATE CHECKED
	07/21/2016	JOHN DOE	07/21/2016

*Member is **eligible** for services performed on this date of service.*

ELIGIBLE	DATE OF SERVICE	PATIENT NAME	DATE CHECKED
 Delinquent	07/21/2017	JOHN DOE	07/21/2017

*Members premium payment is in delinquent status. **Claims will be processed.***

ELIGIBLE	DATE OF SERVICE	PATIENT NAME	DATE CHECKED
 Suspended	07/21/2016	JOHN DOE	07/21/2016

*Members premium payment is past due status. **Claims may be denied.***

ELIGIBLE	DATE OF SERVICE	PATIENT NAME	DATE CHECKED
 Ineligible	07/21/2016	JOHN DOE	07/21/2016

*Member is **not eligible** for services performed on this date of service.*

Other Methods to Verify Benefits, Eligibility and Cost Shares

24/7 Toll Fee Interactive Voice Response Line (IVR) at 1-844-518-9505

The automated system will prompt you to enter the member ID number and the month of service to check eligibility.

Provider Services at 1-844-518-9505

If you cannot confirm a member's eligibility using the secure portal or the 24/7 IVR line, call Provider Services. Follow the menu prompts to speak to a Provider Services Representative to verify eligibility before rendering services. Provider Services will require the member name or member ID number and date of birth to verify eligibility.

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Behavioral Health

Ambetter.SunflowerHealthPlan.com
1-844-518-9505
Payor ID 68069

Services

- Behavioral health
- Health and wellbeing care
- Mental health/substance abuse related authorizations, admissions, concurrent review
- Nurse advice line

Envolve Benefit Options

1-844-518-9505

Services

- Dental Services — dental.envolvehealth.com
- Vision Services — visionbenefits.envolvehealth.com

Envolve Pharmacy Solutions

pharmacy.envolvehealth.com
1-844-518-9505

Services

- Pharmacy Services

High Tech Radiology Imaging Services – NIA

www.RadMD.com
1-844-518-9505

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PROVIDER INCENTIVE PROGRAMS

Pay for Performance (P4P) Overview

The objective of the Pay for Performance (P4P) program is to enhance quality of care through a primary care physician driven program which focuses on preventative and screening services.

Targeted Services

Engaging Members in Care

- Member Engagement Ratio
- Cervical Cancer Screening
- Colorectal Cancer Screening
- Breast Cancer Screening
- Controlling Blood Pressure

Diabetes Care

- Eye exam
- HbA1c Control
- Monitoring for Nephropathy

Medication Measures

- Medication Management Asthma
- Antidepressant Medication - Acute Phase
- Antidepressant Medication - Continuation Phase
- Proportion of Days Covered (Statins)
- Proportion of Days Covered (ACE/ARB)
- Proportion of Days Covered (Diabetes)

Performance Incentive

Each measure in the program is designed to pay out the specified amount once the provider's compliance rate achieves a designated target.

For additional information on **P4P Program** please contact your Provider Engagement Representative.

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QUESTIONS

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1-844-518-9505

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