Welcome, Introductions & Agenda

• Welcome
• Introductions
  – United Healthcare
  – Amerigroup
  – Sunflower Health Plan
  – Kansas Department of Health and Environment
  – Kansas Department for Aging and Disability Services

• Agenda for the day
  – Morning Session – 8:00 a.m. to 11:45 a.m.
  – Afternoon Session – 1:00 p.m. to 4:45 p.m.
  – Break out rooms for each MCO – All day
Who is Assigned to a MCO?

- The majority of Medicaid beneficiaries will be assigned to one of the 3 KanCare Managed Care Organizations (MCO).
- Examples of populations excluded:
  - Qualified Medicare Beneficiary (QMB) only members
  - Low Income Beneficiary (LMB) only members
  - SOBRA members
  - Tuberculosis (TB) Only members
  - MediKan members

Claims for members in these categories will be submitted to Kansas Medical Assistance Program (KMAP) for processing.

**Note:** If a member has retro-eligibility which exceeds 90 days, there may be months where the member does not have an MCO assignment. Claims for those months would be billed to KMAP.
Member Eligibility and MCO Assignment?

- Options
  - KMAP Website
  - MCO Websites
  - EDI transactions (270/271 transactions)
  - KMAP Automated Voice Response System (AVRS)
  - KMAP Provider Services Call Center
  - MCO Provider Services Call Center

- Important items to look for:
  - Which MCO is the member assigned to?
  - Is the member in the lock-in program?
  - Does the member have other insurance?
    - It is important providers check the MCO specific website for member Third Party Liability (TPL)/Coordination of Benefit (COB) information
  - Does the member have a spenddown amount, client obligation or patient liability?
Amerigroup

- Log into the provider portal, Availity at [www.availity.com](http://www.availity.com)

- Select the Payer

- The Service Type description box lists the benefit details included for the selected benefit/service

- Add to Batch allows a provider to inquire about multiple patients from multiple payers in one batch submission.
Sunflower

• Log into Sunflower Secure Web portal and click on the Eligibility tab
• Enter Medicaid Member ID and Date of Birth
• Click the Green box “Check Eligibility”
• On the left click the Coordination of Benefits tab for COB details
• Provider’s other option is to contact Sunflower Providers Services Call Center
Member Third Party Liability Information

UHC

Providers may obtain the following member TPL/COB information online using LINK eligibility function via UnitedHealthCareOnline.com

- Member’s policy start and stop date, COB Primary payer information and other payer details are available

Provider’s other options is to contact our Provider Services Call Center to obtain TPL/COB information for a member.
MCOs provide the same benefits required under KMAP. There are several ways to determine if a service is a covered benefit:

- KMAP Website
  - Procedure code look up tool
  - Fee schedules
  - KMAP Provider Manuals
- MCO Provider Manuals, Administration Guides, or Quick Reference guides
- MCO Provider Services Call Center
Each MCO determines which services and supplies require a prior authorization (PA) for their members. Each MCO will have a unique list of services requiring a PA. A provider can validate whether services require a PA by using the following:

- MCO Website
- MCO Provider Services Call Center
- MCO Provider Manuals or Admin guides

Retro-Eligibility and Prior Authorization

- Each MCO has a process in place for providers to follow when the member was not eligible at the time of the service, preventing a provider from obtaining a PA.
How Do I Request a PA?

Amerigroup

Providers may make verbal requests by calling 1-800-454-3730

Providers may fax requests to 1-800-964-3627

If a provider has an urgent issue, “Urgent” may be written on the top of the fax, or indicate this when calling, and Amerigroup will expedite the request.

For HCBS Providers, if claims deny for pre-authorizations or exceeding units, contact LTSS, our Long Term Services and Support Team, to have the authorization reviewed.

LTSS may be reached by phone at 1-800-454-3730, ext. 50103 or by email at kscasespec@amerigroup.com
How do I request a PA?

Sunflower

- Authorization requests may be submitted by secure web portal, phone or fax and should include all necessary clinical information.
- Using the fax forms located in the Provider Resources section of the Sunflower website, providers may fax requests to:
  - Inpatient Fax Form: 1-888-453-4316
  - Outpatient Medical Services: 1-888-453-4316
  - Concurrent Review – Clinicals: 1-877-213-7732
  - Admissions/Face Sheet/Census: 1-866-965-5433
  - PT/ST/OT Outpatient and Home Services: 1-866-254-1798
  - HCBS Authorizations: 1-877-644-4623 ext. 44329
  - Behavioral Health Services: 1-866-264-4452
  - High Tech Imaging Services (CT, MRI) are authorized by National Imaging Associates at [www.radmd.com](http://www.radmd.com)
How do I request a PA?

UHC

Providers have 3 options for requesting a PA with UHC:

Online:
• UnitedHealthCareOnline.com. Then select Notifications/Prior Authorizations, then select submissions. Use of this option allows a provider to submit and track a PA request through every step of the process.

Phone:
• Providers can contact the UHC PA department at 1-866-604-3267 to initiate a Prior Auth

Fax:
• Providers would complete the standard form and fax it to UHC. The form and instructions can be found at the following link: http://www.uhccommunityplan.com/content/dam/communityplan/healthcareprofessionals/ProviderForms/KS-Forms/KS_Prior_Authorization_Form.pdf
Claims Timely Filing

Each MCO is allowed to set timely filing requirements as part of each individual contract with providers. Review individual provider contracts for timely filing requirements.

- **New day claims**
  - Generally, the timely filing requirement for new day claims is 180 days* from the date of service

- **Corrected claims**
  - Generally, the timely filing requirement is 365 days* from the paid date

- **Claims impacted by Retro-eligibility**
  - Timely filing requirements begin on the date the member was deemed eligible by the state. A provider has 180 days* from the date the member was determined eligible by the State to file an their initial claim

*Providers must check their individual contract for each MCO for provider specific timely filing requirements.
Eligibility Related Denials

Claim is denied for member not eligible

PI 31: Patient cannot be identified as our insured

The MCO cannot identify the member based on the patient ID# submitted on the claim

- Check the Member Medicaid ID# submitted on the claim and ensure it is accurate
- If the Medicaid ID# was not correct on the claim submitted, submit a corrected claim
- If the Medicaid ID# was correct on the claim submitted, submit a claims reconsideration or formal appeal
Eligibility Related Denials

Claim is denied for member not eligible

PR 26: Services provided prior to effective date
PR 27: Expenses incurred after coverage terminated
PR 177: Patient has not met the required eligibility requirements
The date of service on the claim is either before the member’s effective date or is after the member’s termination date in the MCO system

• Check member eligibility for the date of service on the claim and ensure they were active
• Check member MCO assignment and ensure claim was submitted to the correct MCO
• If the claim was submitted with incorrect information, submit a corrected claim
• If a provider feels a claim was submitted accurately to the MCO, submit a claims reconsideration or formal appeal
• If member was retro-actively approved for the date of service, providers will be required to submit a reconsideration. MCOs do not automatically reprocess those claims
Non-Covered Service Denial

Claim or claim line is denied for non-covered

CO 96: Non-covered charge

CO 256: Service not payable per Managed Care Contract

The service being billed on this claim and/or line item is not a covered service for this specific provider, service is non-covered for the member, or service is a non-covered service per the state of Kansas for all members and providers

• Check coverage for the denied procedure code using the provider’s preferred method

• Review MCO contract for information specific to services covered under the provider contract

• If research supports the service provided is non-covered, the line item would be a provider write-off if a member advance beneficiary notice is not on file

• If a provider believes the claims/line item was denied in error submit a claim reconsideration or a formal appeal
Duplicate Services

Claim or claim line is denied as a duplicate service

OA/CO 18: Exact duplicate claim/service
The claim or claim line in question has already been submitted and processed within the MCO system.

- Check the status of the original claim with the MCO before submitting additional claims
- Check past Provider Remittance Advice documents or contact Provider Services to obtain information on the previously processed claims
- Corrected claims will deny as duplicate if the original claim number is not documented on the claim submitted and the correct frequency code is not reported. If the corrected claim submitted by the provider did not include the original claim number and the required frequency code, submit a corrected claim with the required information
- If a corrected claim does not result in a different outcome from the original claim, the corrected claim will be denied
Member Has Other Insurance

Claim or claim line denied because member has other insurance (Medicare or other commercial plan) responsible for payment prior to Medicaid consideration of payment

PI 252: An attachment/other documentation is required to adjudicate this claim/service

CO 252: An attachment/other documentation is required to adjudicate this claim/service

Original claim was submitted without primary/secondary payer information
Member Has Other Insurance

Original claim was submitted without primary/secondary payer information

• If a provider has the primary/secondary payer information but it was not submitted, submit a corrected claim with the required information.

• If a provider does not have other insurance on file for the member, check the appropriate MCO Website for member’s other insurance information. The provider is required to submit a claim to the primary and/or secondary payer for consideration.

• If a provider feels the primary/secondary payer information on file for the member is outdated or invalid, contact the MCO Provider Services Call Center to request a COB/TPL validation.

• If a provider believes they submitted the required primary/secondary payer information with the original claim and it was not considered, submit a claims reconsideration or formal appeal.
Claim or claim line denied or zero paid because the service being billed is considered included in the payment of another service provided on the same date of service

CO 97: The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated

- Check KMAP Policy and National Correct Coding Initiative (NCCI) rules for the code or codes impacted to ensure the initial claim was submitted correctly
  - KMAP General bulletin 16065 posted in July 2016 provides a list of codes always considered content of service per KMAP policy
  - IVs, medications, supplies, and injections provided on the same day as an ambulatory/outpatient surgery procedure are considered content of service of the surgery and cannot be billed separately
  - Medical supplies and injections (99070 and J7030-J7130) are considered content of service of ER room visits and Observation stays
Content of Service

• If the original claim line was filed without a required modifier, submit a corrected claim with appropriate modifiers

• If a provider believes the original claim was processed in error by the MCO, submit a claim reconsideration or file a formal appeal

Note: This denial reason code may return on O/P hospital claims billed with no procedure code
Timely Filing Limits

Claim or claim line denied because the claim was received after the providers contractual timely filing limit

CO- 29: The time limit for filing has expired

• Provider needs to check the MCO provider contract to verify timely filing limits

• If it is determined the claim was submitted outside timely filing limits, the claim needs to be posted as a contractual write-off

• If a provider believes a claim was denied in error for timely filing, submit a reconsideration or a formal appeal

• Claims impacted by Retro-eligibility
  – Timely filing requirements begin on the date the member was deemed eligible by the state. A provider has 180 days from the date the member was determined eligible by the state to file their initial claim
Prior Authorization

Claim or claim line denied because the a prior authorization was required and not obtained or the prior authorization was requested and denied.

CO 197: Precertification/authorization/notification absent
A PA is required for the service billed and one was not requested

CO 39: Services denied at the time authorization/pre-certification was requested
A PA has been requested and processed but was denied by our clinical staff

- If a PA was obtained and a provider believes the PA denial is being applied in error, submit a claims reconsideration or formal appeal
- If a PA was required and none was obtained, the services denied for no PA are a provider contractual write-off
- Each MCO has a specific process in place to address members who are retroactively deemed eligible
Missing Required Documentation

Claim or claim line denied for missing required documentation

CO 16: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication

CO 252: An attachment/other documentation is required to adjudicate this claim/service

Required information for processing the claim was not submitted on the claim or as an attachment. Common examples of missing items or attachments: NDC codes, Sterilization Consent Form, Present On Admission (POA) indicator required

• Providers needing assistance to determine what documentation is required can contact the MCO Provider Services call team
• Identify the required information missing from the claim, make the necessary corrections to the claim, and submit a corrected claim to the appropriate MCO
• If a provider feels the required documentation was provided with the initial claim and the claim was denied incorrectly by an MCO, submit a claims reconsideration or a formal appeal

Note: This denial reason code may return on O/P hospital claims billed with no procedure code
Member Level of Care

Member Level of Care does not support the claim billed

CO150 – Payer deems the information submitted does not support this level of service

CO186 – Level of Care change adjustment

The level of care on file with KDHE does not support payment of a Nursing Facility claim

• Per State of Kansas Policy, an MCO must ensure a member has the correct level of care (LOC) on file prior to paying a Nursing Facility, Swing bed, PRTF, or ICF/IDD provider claim.

• If the LOC does not match the type of claim being billed, the claim will deny and cannot be reprocessed for payment until the member LOC has been updated by the KanCare Eligibility clearinghouse.

• It is critical for providers to check the member LOC anytime the member has left and returned to the facility to ensure it remains correct for the type of claim being billed.
Where Do I Send My MS-2126 Forms

The following facilities are required to submit an MS-2126 form anytime a member is admitted or discharged from their facilities:

- Nursing Facilities
- Swingbed Facilities
- Psychiatric Residential Treatments Facilities
- Intermediate Care Facilities for members with Intellectual/Developmentally Disability

Send required forms to:

- FAX for Elderly and Disabled 1-844-264-6285
- Mailing address:
  KanCare Clearinghouse
  P. O. Box 3599
  Topeka KS 66601

It is critical that these forms be completed and submitted as soon as the admission or discharge date is known to ensure correct claims payment.
How to bill Medical Services for members in PRTF

• Effective January 1, 2013, when the primary diagnosis on a claim submitted for medical services is considered “planned” and the member has a level of care (LOC) indicating PRTF, this claim should be submitted for reimbursement to the KanCare MCO.

• Claims submitted with the primary diagnosis considered as “unplanned” are not part of the KanCare program and are reimbursed through KMAP. Claims for unplanned services will need to be submitted to KMAP for processing and payment
  – Medical claims billed to the MCO in error for unplanned services will deny with a CO 109 - Claim/service not covered by this payer/contractor. The provider must send the claim/service to the correct payer/contractor
Remittance Advice Remark Codes (RARC)
The following RARC codes are tied to the Top 10 denials all MCOs see on a regular basis and provide more specific detail in regards to why a claim denied

- N479 – Missing Explanation of Benefits (Coordination of Benefits or Medicare Secondary Payer)
- N448 – This drug/service/supply/is not included in the fee schedule or contract/legislated fee arrangement
- N216 – We do not offer coverage for this type of service or the patient is not enrolled in this portion of our benefit package
- MA63 – Missing/incomplete/invalid principal diagnosis
- M119 – Missing/Incomplete/invalid/deactivated/withdrawn National Drug Code (NDC)
- N30 – Patient ineligible for this service
- N15 – Services for a newborn must be billed separately
- N434 – Missing/Incomplete/Invalid Present on Admission indicator
- M51 – Missing/incomplete/invalid procedure code(s)
- N95 – This provider type/provider specialty may not bill this service
- M86 – Service denied because payment already made for same/similar procedure within set time frame
- N584 – Not covered based on insured’s noncompliance with policy or statutory conditions
- M79 – Missing/incomplete/invalid charge
- N381 – Consult our contractual agreement for restrictions/billing/payment information related to these charges
General Tips for Filing Claims

• If submitting a paper claim a provider must use a red and white claim form. Hand written claims and photo copied claims are not allowed.

• Claim must be submitted with the member’s Medicaid ID # which can be found on their ID card.

• The name submitted on the claim must match the name on their ID card.

• Always include the appropriate NDC code when submitting a drug related procedure code. If the NDC is not submitted, the line will deny.

• MCOs have 30 days to process and provide a response on a claim. Submitting the same claim multiple times will only result in duplicate claim denials. If a provider is unsure of a claim status, utilize the MCO self service tools or call Provider Services prior to submitting additional claims.
Tips and Reminders for Billing on a UB-04 Claim Form

• Use the correct Bill Type/Type of Bill for the service provided. If submitting a corrected claim, the 3rd digit must be a 7
• All Outpatient (O/P) claims must include both a revenue code and a procedure code. Line items billed without a procedure code will be denied. Submitting O/P claims without a procedure code is the top denial reason code for this claim type
• For Inpatient Claims, make sure all diagnosis codes submitted have an accurate 5010 POA code
• When billing for the Emergency Room facility fee, the ET modifier is required. If a hospital provider bills without an ET modifier the line item will deny
Tips and Reminders for Billing on a CMS 1500 Claim Form

- Referring provider NPI is required in field 17b for Home Health, DME, Therapy, Lab, and Diagnostic X-Ray provider.
- When billing a vaccine, the vaccine and vaccine administration code must be billed on the same claim form.
- Vaccines, covered under the Vaccine for Children (VFC) program, may only be provided by VFC providers. Providers who do not participate in the VFC program will not be paid for vaccines covered under VFC.
- Ensure the address noted in box 33a matches the address on file with the state, if applicable, and with the MCO.
- Ensure claims are submitted with the appropriate modifier on initial submission to avoid unnecessary claim corrections.
Medicare Cross-Over Claims

• When a member has Medicare Primary, a secondary payer or Medicare supplemental plan and KanCare
  – Medicare will send the cross-over claims to both the secondary payer and the KanCare MCO at the same time
  – If the secondary payer is not listed on the member file on the KMAP eligibility site and/or the MCO system, it is likely the claim will not process as expected resulting in an overpayment. If this occurs, submit a corrected claim with the secondary EOB attached

• There are times where the state requires a modifier on a service and Medicare will not accept those modifiers.
  – When this occurs, the cross-over claim will deny. Submit a corrected claim with the required modifier for KanCare

• There are providers who are required to bill on a UB-04 form for Medicare and a CMS 1500 form for Medicaid. Electronic cross-over claims will never be successful in those situations. The provider will need to submit those secondary claims to the KanCare MCO directly, with the EOB attached, on the required claim form.
All 3 KanCare MCOs are required to follow the same pricing logic when pricing and paying claims as the secondary payor.

Medicare
- Look at Medicare allowed amount in comparison to Medicaid allowed amount and the lessor of the two amounts becomes the allowed amount for the claim.
- Once allowed amount is determined, Medicare payment is deducted and the MCO will pay any difference between the allowed amount and the Medicare paid amount up to the patient responsibility.

Medicare when Part A is exhausted and Medicare Part B is paying
- This would only apply to inpatient claims.
- The allowed amount is calculated (no comparison with Medicare allowed amount) and then the Medicare B payment is deducted from the allowed amount and the MCO would pay the remaining balance.
All 3 KanCare MCOs are required to follow the same pricing logic when pricing and paying claims as the secondary payer. (cont.)

- **Commercial payers**
  - The MCO reviews Commercial payors EOB, determines the allowed amount for the claim and then compare to the Medicaid allowed amount. The lessor of the two amounts becomes the allowed amount for the claim.
  - Once the allowed amount is determined, Commercial payment is deducted and the MCO will pay any difference between the allowed amount and the Commercial paid amount up to the patient responsibility.

- **RHCs/FQHCs/Indian Health Centers**
  - These providers are always paid up to the state determined encounter rate so that amount is always the allowed amount for the claim.
  - MCOs are required to deduct the primary carrier payment from the state set encounter rate and then pay the remaining balance.
How Do I Submit a Corrected Claim?

A corrected claim would be needed if the provider determines there was an error on the original claim either by their internal review or based on how the MCO processed their claim. The following items must be included on the corrected claim or it will be denied as a duplicate claim:

- Indicate 7 as the 3rd digit of the Type of bill on a UB-04 or as the frequency code on a CMS 1500
- Include the original MCO claim number in the appropriate field on the claim.
- Submit the corrected claim within 365 days of the original paid date, although it is recommended these be submitted as quickly as possible.
How Do I Submit a Claim Reconsideration?

Claim reconsiderations can be submitted by a provider when they believe a claim was processed incorrectly by one of the MCOs. This is the most efficient way to have claims reviewed, and possibly reprocessed, by an MCO. Although each MCO process may vary slightly the general guidance is the same.

Effective with claims processing date 5/1/17 and after, reconsiderations must be submitted within 120 calendar days of the claim adjudication date on the Providers Remittance Advice (PRA) or Explanation of Payment (EOP).

- Submit the reconsideration to the MCO making note of the specific error made on the claim
- Explain what the correct outcome should be on the claim
- Provide any documentation or additional supporting information for the desired outcome for the claim
- Provide all data elements required on the MCO form or electronic reconsideration request

— KanCare
How Do I Submit a Claim Reconsideration?

— Submit reconsideration requests timely, within 120 days from the adjudication date. Providers are strongly encouraged to submit a reconsideration as soon as they determine the claim needs to be reviewed by the MCO.

— Allow 30 days for the MCO to review the reconsideration and provide a response.

— Providers will receive a notice of reconsideration determination either through a provider remittance advice or a notification letter.

— Providers may submit a request for an appeal based on the reconsideration determination notice.

Note: Providers are not required to file a reconsideration prior to an appeal. A provider can withdraw a reconsideration and initiate an appeal during the 60 calendar days following the adjudication date. If it is beyond 60 calendar days, a provider must wait for the reconsideration determination to file an appeal.
How Do I Submit a Claim Reconsideration?

Amerigroup

Verbal submissions may be submitted by calling Provider Services at 1-800-454-3730.

Amerigroup can receive reconsiderations via the Availity Payment Appeal Tool at www.availity.com

Providers may mail their written Reconsideration Requests to:

Payment Appeal Unit
Amerigroup Kansas, Inc.
P.O. Box 61599
Virginia Beach, VA 23466-1599

Note: Corrected Claims are not considered a reconsideration.
How Do I Submit a Claim Reconsideration?

Sunflower

Reconsiderations may be submitted via:

• Phone – 1-877-644-4623
• Email:
  – Log into the secure web portal and click “Create Message”,
  – In the subject line drop down box choose “Reconsideration”.
  – In the note section describe the reasoning for the Reconsideration request and the appropriate claim number.
  – Then click send.
• Mail
  Sunflower Health Plan P.O. Box 4070 Farmington, MO 63640-3833
How Do I Submit a Claim Reconsideration?

**UHC**

Providers have 3 options for submitting a reconsideration:

- **Online** – Providers can submit online reconsiderations online using Link reconsideration function via UnitedHealthCareOnline.com
- **Phone** – Providers can call our Provider Services Call Center at 1-877-542-9235
- **Mail** – Providers can submit a UHC Reconsideration form and submit via mail. Reconsideration forms are located at UnitedHealthCareOnline.com under the claims payment section. Mail reconsiderations to:

  UnitedHealthcare  
P.O. Box 5270  
Kingston NY 12401
How Do I Submit an Appeal?

If a provider disagrees with an MCO action or a reconsideration determination the next step would be to initiate the formal appeal process

- Providers must submit an appeal within 60 calendar days, plus 3 calendar days for mailing, from the date of the negative action
- All provider appeals must be submitted in writing
- The written request must specifically indicate an appeal is being requested
- Providers will receive a written acknowledgment of the appeal within 10 calendar days of the appeal receipt, unless the appeal is resolved prior to this timeframe
- The MCO must resolve 98% of all appeals within 30 calendar days and 100% of all appeals within 60 calendar days
- The provider will receive a written notice from the MCO indicating the outcome of the appeal
How Do I Submit an Appeal?

Amerigroup

All appeals must be filed in writing. Providers may mail appeals to the below address:

Payment Appeal Unit
Amerigroup Kansas, Inc.
P.O. Box 61599
Virginia Beach, VA 23466-1599

Or providers may submit appeals via the Availity Payment Appeal Tool at www.availity.com:

• If the provider files online with the expectation that Amerigroup process the first level as an appeal, the provider must specifically note, “I would like to bypass the reconsideration.”

• When inquiring on the status of a claim, a dispute selection box will display. Once this box is clicked, a Web form will display for the provider to complete and submit. The provider will receive immediate acknowledgement of the submission once the form is fully completed. Supporting documentation can be uploaded by the use of the attachment feature on the Web dispute form and will attach to the form when submitted.
How Do I Submit an Appeal?

Sunflower

Providers may only file an appeal in writing and must include the Provider Reconsideration & Appeal Form and send it to:

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

If the request does not specifically indicate an appeal is being requested, it will process as a reconsideration.
How Do I Submit an Appeal?

UHC

All appeals must be submitted in writing and mailed to UHC at the following address:

UnitedHealthcare
Attention: Formal Grievances and Claim Appeals
PO Box 31364
Salt Lake City, UT 84131-0364

If the request does not specifically indicate an appeal is being requested, it will process as a reconsideration.
How Do I File for a State Fair Hearing?

All providers have the right to request an administrative fair hearing, also known as a state fair hearing, following receipt of the negative outcome of their claims appeal or clinical appeal.

- To request a state fair hearing, the provider must send a written request to:
  Office of Administrative Hearings
  1020 South Kansas Avenue
  Topeka, KS 66612-1327

- The request must specifically request a fair hearing. The request should describe the decision appealed and the specific reasons for the appeal.

- The request must be received by that office within 30 calendar days of the date of the negative action. Providers are given 3 additional calendar days to allow for mailing the state fair hearing request.

Provider must complete the MCO appeals process prior to filing for a state fair hearing.
Recoupments

Recoupments are generated when an overpayment is identified for a provider and the MCO is working to recover the amount owed. Overpayments can be identified in a number of ways:

Corrected or adjusted claims identified by a provider
Post pay claim reviews conducted by the MCO.

Common reasons for post pay review:
- Coordination of Benefits/Third Party Liability
- Patient Liability
- Client Obligation
- Duplicate claim payment
- Overlapping Dates of Service
- Retro-active rate changes
How Do I Refund an MCO Overpayment

Amerigroup

Below are the two options for providers to notify Amerigroup of an overpayment of claims. Both of these forms are found under the “Forms” section of our website at providers.amerigroup.com/ks and both should be mailed to the applicable addresses:

**Refund Notification Form** is used when the provider wants to issue a refund check immediately. This form should be filled out and mailed to the below address, along with the refund check.

Amerigroup
P.O. Box 933657
Atlanta, GA 31193-3657

**Recoupment Notification Form** is used when the provider wants to alert us to an overpayment, and initiate the recovery process. This form should be filled out and mailed or faxed to the below address:

Attn: Cost Containment – Disputes
Amerigroup
P.O. Box 933657
Atlanta, GA 31193-3657
How Do I Refund an MCO Overpayment

Sunflower

Providers can report “unsolicited” overpayments or improper payments to Sunflower Health Plan.

• Providers have 60 days from the date of notification to refund “unsolicited” overpayments or to establish a payment plan (when available) before claims are reprocessed.

• Providers have the option of requesting future off-sets to payments or may mail refunds and overpayments, along with supporting documentation (copy of the remittance advice along with affected claims identified), to the following address:
  – Sunflower Health Plan
    P.O. Box 955889
    St. Louis, MO 63195-5889
How Do I Refund an MCO Overpayment

Sunflower

Providers can submit a letter authorizing recoupment or application of an enclosed check with a the following supporting documentation. The downloadable spreadsheet is posted on our website.

- Claim number
- Service line number
- Member Name
- Medicaid ID
- Patient Control Number (provider’s unique identifier)
- Date of Service
- Procedure
- Billed Amount
- Paid Amount
- Paid Date
- Amount to recoup* required
- Reason for recoupment* required

- Sunflower cannot recoup claims or coordinate benefits if all other payer’s EOBs are not attached.
- Providers may utilize the Secure Provider Portal and within the Claims tab may select to Void/Recoup a Claim.
How Do I Refund an MCO Overpayment

UHC

Unsolicited Refund process

Providers can use this process when wanting to return an overpayment. Providers can find information on the process on UHCCommunityplan.com, Kansas, forms section or use the following link:


Do not use this process if UHC has already identified the overpayment and sent and overpayment notification letter.
KMAP Provider Enrollment and MCO Credentialing

Upcoming Changes

**May 2017** - Updated Kansas Organizational Credentialing and Recredentialing Application will be available as a fillable PDF form on KMAP and MCO Websites

**October 2017** - The new KMAP provider portal will go live on 10/16/2017 and will contain new functionalities

**January 2018** - Effective 1/1/2018 all new provider enrollments and re-credentialed providers must enroll with KMAP in order to be enrolled/credentialed with an MCO

**July 2018** – All providers in one of the MCO networks must have an active KMAP Provider ID # in order to remain in the MCO network

If a provider is in an MCO Network and does not have an active KMAP Provider #, it is strongly recommend that providers submit an enrollment application to KMAP as quickly as possible to ensure compliance well before the due date
## Value Added Services – Amerigroup

<table>
<thead>
<tr>
<th>2017 VAS Type</th>
<th>2017 VAS Description (See Member Handbook for Additional Detail)</th>
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</table>
| Adult Dental Care                      | Preventive dental coverage including:  
  • Two (2) cleanings annually  
  • Scaling and polishing procedures                                                                                                                                                                                                                                  |
| Member Transportation to Community Locations | Transportation for members to non-provider, community locations for various health and wellness activities.                                                                                                                                                      |
| Caregiver Transportation to Provider Appointments | Transportation for member caregivers to Medicaid covered appointments.                                                                                                                                                                                                                   |
| Respite Care for FE Waiver Population  | Caregivers of FE Waiver members can receive up to 56 hours of respite services.                                                                                                                                                                                                     |
| Additional Respite Care for DD Waiver Population | Caregivers of DD waiver members can receive an additional 15 days of overnight respite care per year.                                                                                                                                                                           |
| Additional Respite Care for Autism Waiver Population | Caregivers of Autism waiver members are eligible to receive an additional 24 hours of respite care per year.                                                                                                                                                                     |
| Mail Order OTC                         | $10 member monthly allowance towards the purchase of OTC products via a secure website.  
  Costs reflect member benefit plus shipping plus administration charges.                                                                                                                                                                                                  |
| Smoking Cessation Program              | Holistic stop-smoking program for members 18 and older that includes:  
  − Support and coaching services  
  − Unlimited calls to a health coach for tips and advice  
  − Help understanding the nicotine replacement therapy (NRT) products available through KanCare                                                                                                                                               |
| Pest Control                           | Eligible members can receive up to four treatments of free in-home pest control.                                                                                                                                                                           |
# Value Added Services – Amerigroup

<table>
<thead>
<tr>
<th>2017 VAS Type</th>
<th>2017 VAS Description (See Member Handbook for Additional Detail)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safelink Phone Service</td>
<td>SafeLink provides cell phones and monthly cell phone minutes to eligible individuals through the Federal Lifeline program. The Lifeline program provides 350 minutes per month at no cost, Amerigroup members also receive: 200 bonus minutes // unlimited nationwide text messages // Free outbound calls to Member Services</td>
</tr>
<tr>
<td>Healthy Family Programs</td>
<td>Telephonic whole-family education program for families with a child between the ages of 7–13 who are overweight, obese, or at risk of becoming overweight or obese.</td>
</tr>
<tr>
<td>Additional Personal Care Services for IDD Waiver Population</td>
<td>Extra Personal Care Services (PCS) for Intellectual or Developmental Disability waiver members</td>
</tr>
<tr>
<td>Girls and Boys Club Membership</td>
<td>Free yearly membership at participating locations, for members ages 5-18</td>
</tr>
<tr>
<td>Air purifier with permanent filter</td>
<td>Free air purifier with a permanent filter to help reduce allergens in your home. To get this benefit, you must be diagnosed with allergies and get an order from your doctor.</td>
</tr>
<tr>
<td>Member Incentive Program</td>
<td>The Healthy Rewards program provides members incentives of $10, $15, or $25 for completing screenings and checkups. These incentives are issued on a debit card that can only be used at a closed loop network of retailers. Cards can only be used in stores to purchase from an approved list of items.</td>
</tr>
<tr>
<td>Weight Watchers Vouchers</td>
<td>Members can receive one Weight Watchers voucher good for initiation fee and 4 weeks of classes. Units equals the number of vouchers.</td>
</tr>
</tbody>
</table>
# Value Added Benefits - Sunflower

<table>
<thead>
<tr>
<th>2017 Value Added Benefits</th>
<th>2017 Value Added Benefit Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dental</td>
<td>One dental visit for adults 21 and older every six months. Children receive regular benefits on most dental services. We provide practice visits to dentists for members with developmental disabilities and children on the autism waiver to help them become more comfortable with dental preventive care visits.</td>
</tr>
<tr>
<td>Healthy Rewards Program</td>
<td>Healthy Rewards Program: Members can earn between $5 - $50 in healthy rewards or a combination of rewards on a CentAccount card for receiving healthy checkups. These rewards can be used to buy from hundreds of items like groceries, baby formula, and over the counter cough/cold medicine from participating retail stores.</td>
</tr>
<tr>
<td>Connections Plus</td>
<td>Free cell phone through our Connections Plus program or through SafeLink®, which provides up to 250 free minutes of service per month. This includes unlimited texting and free calls to and from Sunflower Health Plan. Members will be able to have telephone access to their KanCare providers.</td>
</tr>
</tbody>
</table>
| Smart Start for Your Baby | Support, education and gifts for moms, babies, and families. The program includes the services below. There is no cost to member.  
  • In-home help with healthcare and social service benefits  
  • Baby showers for pregnant members. At these events, members are given diapers, the Baby Fuel book and other gifts and health material  
  • Birthday programs for children |
## Value Added Benefits - Sunflower

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<tr>
<td><strong>Choose Health</strong></td>
<td>Choose Health program serves members with chronic health conditions. The program helps members determine how emotions can impact their condition (i.e. stress, poor sleep, and change in appetite). As a part of the program, participants are assigned a Choose Health Coach who works with the entire health care team to ensure members have everything they need to feel their best.</td>
</tr>
<tr>
<td><strong>Smoking Cessation</strong></td>
<td>Members can participate in a smoking cessation program offered through Healthy Solutions for Life. (Nicotine replacement therapy is a regular benefit when prescribed by your doctor.)</td>
</tr>
<tr>
<td><strong>Weight Management Program</strong></td>
<td>Weight management program through Healthy Solutions for Life.</td>
</tr>
<tr>
<td><strong>Member Connections</strong></td>
<td>The Member Connections Program has community-based staff to provide in-home member visits to assist with scheduling healthcare appointments and transportation as well as paperwork for benefits and local services.</td>
</tr>
<tr>
<td><strong>MyStrength</strong></td>
<td>My Strength online program offers eLearning to help members overcome depression and anxiety. This online program includes simple tools, weekly exercises, mood trackers and daily inspirational quotes and videos. The program can be used on its own or with other care.</td>
</tr>
</tbody>
</table>
## Value Added Benefits - Sunflower

### Sunflower

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<th>Benefits Category</th>
<th>Description</th>
</tr>
</thead>
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<tr>
<td><strong>Disease Management</strong></td>
<td>Disease management for members with asthma, COPD, diabetes of heart disease or high blood pressure through Healthy Solutions for Life Program. Members can enroll in any of these programs.</td>
</tr>
<tr>
<td><strong>Tele-Health</strong></td>
<td>In-home tele-health available for adults. This service helps members stay at home when they need help to manage their chronic conditions.</td>
</tr>
<tr>
<td><strong>Frail &amp; Elderly</strong></td>
<td>Eligible members on the Frail &amp; Elderly waiver receive adult incontinence supplies up to $100 per year.</td>
</tr>
<tr>
<td><strong>Kids Community</strong></td>
<td>Community Programs for Children: Free services and events to promote healthy lifestyles for kids, such as membership fees to Boys &amp; Girls Clubs and the Adopt-a-school Program.</td>
</tr>
<tr>
<td><strong>Hospital Companion</strong></td>
<td>Up to 16 hours of hospital companionship for persons on the Intellectual/Developmental Disability (I/DD) and Frail &amp; Elderly waivers.</td>
</tr>
<tr>
<td><strong>IDD Care Attendant</strong></td>
<td>We provide members on the I/DD waiting list with a care attendant for medical appointments if needed. Mental Health First Aid training to teach how to help identify and understand signs of mental illness or substance abuse.</td>
</tr>
<tr>
<td><strong>Pharmacy</strong></td>
<td>A Comprehensive Medication Review with a local pharmacist is available to eligible members. The review includes a 30 minute Face to Face consultation with a local pharmacist.</td>
</tr>
<tr>
<td><strong>Respite</strong></td>
<td>Up to 16 hours of respite care for persons on the I/DD waiting list, person on the Frail &amp; Elderly waiver and children adopted from Foster Care.</td>
</tr>
<tr>
<td><strong>Farmers Markets</strong></td>
<td>Members can receive produce vouchers worth $10 at special events with participating Farmers Markets.</td>
</tr>
</tbody>
</table>

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**KanCare**
# UHC Value Added Benefits

## UnitedHealthcare

### All Members
- **Community Rewards Program** that offers points redeemable for merchandise for healthy activities.
- **MyUHC.com** Online Tool
- **Health4Me** Mobile Application

### Child Members
- **A is for Asthma** Newsletter
- **Sesame Street Food for Thought** program about eating healthy on a budget
- One $50 valued **Youth Organization Activity**

### I/DD Waiver Members
- Up to 40 Hours of **Respite Care**
- Transportation to **Job Related Activity** (3 round-trip or 6 one-way trips)
- Annual $30 purchase from **Home Helper Catalog**

### FE / PD Waiver Members
- FE & PD can get up to 2 boxes of 80 count **Adult Briefs**
- FE & PD can get $30 in items from **Home Helper Catalog**
- FE & PD can get one $50 valued **Adult Parks and Rec Activity**
- FE members are mailed an **Annual Wellness Calendar**
- FE members can get one full set of **Dentures** every 5 years

### FE / PD Waiver Members
- Annual **Dental Exam**, Cleaning and X-ray
- Free 3 month membership to **Weight Watchers**
- **Free Cell Phone Program** with 350 minutes, unlimited text and 500 MB data, and **MyHealthLine** text for wellness program
- Two **Podiatry** Visits annually
- Additional **Vision** benefits that includes higher quality lenses

### HCBS Waiver Members
- All HCBS members who own their own home can get **Pest Control** treatment
- **Community Baby Showers** held across the State.
- Off Brand **Pest Repellant** to ward of mosquitos

### Behavioral Health Members
- **Mental Health First Aid** training to teach how to help identify and understand signs of mental illness or substance abuse
- **Peer Coaches Program** to connect people in recovery to peers who can assist them
- **$25 Wellness Prepaid Card** for getting a follow-up with a BH practitioner within 7 days of hospitalization release

### Pregnant Members
- **Baby Blocks** online rewards program
- Infant Care Book – **Baby Basics**
- **Community Baby Showers** held across the State.
- Off Brand **Pest Repellant** to ward of mosquitos

### All Adult Members
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Questions?