MERCY MANAGED CARE BULLETIN
Affiliate Providers

*****Due to large number of providers participating in the Mercy Network LLC, please carefully review the plan updates specific to your group's participation agreement with Mercy Network LLC. This will help ensure you are aligned with the most accurate and relevant information for your providers*****

IMPORTANT CONTACTS

SPRGMMC@Mercy.Net
contact to join Mercy Network LLC.

MercyMCenrollment@Mercy.Net
contact for provider Managed Care enrollment, provider health plan effective dates, and provider load questions.

Mercy_MC_Network_Operations@Mercy.Net
contact for prior auth/denials, health plan contract/rate related inquiries, network management support, acquisitions, contract updates, and panel/ member attribution.

Mercy_MC_Contract_Operations@Mercy.Net
contact for contract questions, claims escalation, and health plan query requests.

IMPORTANT SITES

MANAGED CARE CONTRACT NEWS
Review health plan updates including administrative, reimbursement, clinical, pharmacy and/or authorization policy changes, and provider newsletters.

FRIENDLY REMINDERS

SWMO, East, Kansas:

Humana Retro Authorization Change Effective May 1st:

As a reminder, certain services require prior authorization before the services are fully furnished. Contract providers must timely submit an authorization request when required. Please see Humana's Prior Authorization and Notification List (PAL) and Provider Manual for details. Based on recent CMS guidance, requests submitted after services are fully furnished must be processed as payment requests. Accordingly, providers should submit a claim after the services have been fully furnished – not a request for authorization (retro authorizations).

Please see Humana's Prior Authorization and Notification List (PAL) and the Provider Manual for details on the services that require prior authorization. Please see attached FAQs on pages 9-11 and/or contact Humana at 800-457-4708.

Devoted Health Payment Platform Change This Fall:

Devoted will move electronic payments to a Devoted-sponsored ePayment Center in partnership with Zelis in September 2026. For more information, see the FAQs linked here: Getting Started with Devoted ePayment Center | Devoted Health

What's changing:
✓Payments and remittance will be delivered through Devoted ePayment Center instead of Payspan

What stays the same:
✓There is no cost to receive electronic payments
✓Your claim submission process does not change

What you need to do:
✓To continue receiving payments and remittance advice electronically, enroll in the Devoted ePayment Center at devoted.epayment.center/registration or call 855-774-4392
✓Historical payment data will remain available on payspanhealth.com

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✓You will hear from the Zelis team directly. Follow the instructions if you receive communication from them.

SWMO, East, Southeast:

HealthSpring Prior Authorization Changes Effective July 1, 2026:

Prior authorization requirements that may apply to some HealthSpring Medicare Advantage members are changing. Changes are based on updates from utilization management prior authorization assessment, Current Procedural Terminology (CPT) code changes released by the American Medical Association or Healthcare Common Procedure Coding System code changes from the Centers for Medicare & Medicaid Services.

For some services and members, prior authorization may be required through HealthSpring utilization management, and related services for Medicare Advantage members will be reviewed by HealthSpring and EviCore healthcare.

These changes begin July 1, 2026:

- Implementation of Part B Step Therapy Program
- Addition of orthotic codes to be reviewed by HealthSpring
- Addition of new Medicare Advantage Prescription Drug plan codes to be reviewed by HealthSpring

For more information, refer to the prior authorization requirements list on the clinical review page.

Cigna Healthcare: Claim Editing Update to Flag Errors in Electronically Submitted Claims-Coming Soon

If you submit claims through electronic data interchange (EDI) using the 837 transaction, you already benefit from a fast, efficient process that supports timely adjudication. Building on that foundation, Cigna Healthcare will soon release an enhancement that flags certain billing errors at the time of submission, allowing you to correct issues earlier in the claims process and helping to reduce post-adjudication denials.

Effective July 1, 2026, claims with dates of service on or after January 1, 2026, that include an unacceptable primary diagnosis may be returned at the point of submission for correction, rather than being processed through post-

adjudication review. *This allows you to correct and resubmit the claim before adjudication begins.*

What this update means to you

Identifying and correcting the claim at submission can help you:

- Reduce rework and rebilling associated with post-adjudication claim corrections.
- Support more streamlined administrative workflows.
- Support quicker issue identification and more predictable payment timelines.
- Reduce time spent on administrative follow-up, allowing greater focus on patient care.
- Experience a more transparent claims submission process.

Learn more

Read the Provider Newsroom article for additional details, including steps you can take to prepare for this update.

New Tool to Improve Transparency into Claim Offsets and Balances

Cigna is introducing a new enhancement to the Cigna for Healthcare Professionals portal (CignaforHCP.com) designed to give you clearer, more timely insights into claim offsets.

The negative balance report (NBR) offers affected providers increased visibility into overpaid claims that have been offset and their related balances, helping support reconciliation, reduce uncertainty, and make it easier to track when and how offsets occur.

How this enhancement helps you

The NBR brings key information into one place, so you can:

- Easily identify claims that have been offset against future payments
- Track remaining balances tied to overpaid claims
- Reconcile payments with fewer manual steps or follow-up inquiries

Cigna's commitment to you

They are committed to improving transparency, reducing administrative burden, and making your experience as seamless as possible. The NBR is one

of several enhancements designed to help you better understand claim activity and manage your accounts with greater confidence.

Additional information

To help you get started, review the Provider Newsroom article, which includes directions and training to access the NBR. It will also help you better understand claim offsets and what to expect if a claim is offset.

SWMO Region:

Essence: Referrals Are No Longer Required for PCP-Directed Urgent Specialists Evaluations

Effective June 15, 2026, referrals are no longer required for PCP-directed urgent specialist evaluations.

To support this change, claims processing has been configured to allow payment for these urgent services without a referral on file. Claims meeting these criteria will be adjudicated accordingly and will not be denied due to the absence of a referral.

This update is designed to:

- Enable timely access to urgent specialty care
- Reduce administrative burden for providers
- Ensure members receive clinically appropriate care without unnecessary delays

What qualifies as an urgent specialist evaluation: Services are considered *urgent* when a member presents with a condition that:

- Requires prompt evaluation to prevent clinical deterioration, complications, or escalation of symptoms
- Cannot reasonably be delayed until a routine or scheduled specialist visit
- Is identified by the PCP as needing expedited specialty assessment based on clinical judgment

Examples may include:

- Acute or worsening symptoms requiring rapid specialty input
- New findings with potential for serious underlying conditions
- Situations where delay could result in avoidable ER utilization or hospitalization

Standard referral requirements remain in place for:

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- Ongoing specialty care
- Non-urgent or routine specialist evaluations
- Elective or planned services

Kansas Region:

KanCare: Early Detection Works Fiscal Year End Letter

Please see the attached Early Detection Works (EDW) program year end letter on page 12. All EDW services must be entered by 08/01/26.

PAYOR COMMUNICATIONS

Healthy Blue:

- SWMO, Kansas, East, Southeast: Please see the Healthy Blue Provider News online linked below by month containing important information such as policy updates, new programs, and training opportunities:
  - April: April 2026 Provider Newsletter - Provider News
  - May: May 2026 Provider Newsletter - Provider News
  - June: June 2026 Provider Newsletter - Provider News

Medica:

- SWMO, Kansas, East: Please see the Medica Connections news bulletin regarding clinical, pharmacy, network, administrative news, and self-service helpful tips linked below by month:
  - April: view.email-medica.com/?vawpToken=ENMDUMCDJCQURFPUNWGNTRNL4A.10197
  - May: view.email-medica.com/?vawpToken=WQJJBNYM7ZVUTJ3E5ZSFZKAJV4.10191

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- June: view.email-medica.com/?vawpToken=7JLYWQQDDDEUHOSZ6V4RV2IBSA.10194

Sunflower:

- Kansas: Please see the attached Sunflower Health May-June Newsletter that includes Important Dates and Upcoming Dates, Behavioral Health Measures, Substance Use Disorder Measures, and Training on pages 13-25.

Cigna Healthcare:

- SWMO, East, Southeast:

Easy Access to Virtual Speech Therapy

As demand for speech-language pathology services increases, patients may experience barriers such as long wait times, limited local availability, and travel challenges. Virtual speech therapy helps bridge these gaps by offering convenient, at-home care with outcomes comparable to in-person therapy.

Great Speech virtual speech therapy
Great Speech, a Cigna Healthcare national provider, offers virtual speech therapy that connects eligible patients with licensed speech-language pathologists.

If you have patients who may benefit from speech therapy, consider Great Speech as one available option. Their services are considered in network for many Cigna Healthcare commercial plans. For additional in-network referral options, patients can log in to myCigna.com®.

Additional information

- Read the article in the Provider Newsroom.
- Download our flyer to support patient conversations.
- Visit GreatSpeech.com.

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Cigna Healthcare 2nd Quarter Precertification List

Please see the linked payor resources from our Baggot Street site under Cigna below regarding the 2nd Quarter Master Precertification List and a listing of codes that have been removed effective April 1, 2026.

- 2ND QUARTER 2026 MASTER PRECERTIFICATION - EFF 4.1.26
- 2nd Quarter 2026 Master Precertification - Removed Codes Eff 4.1.26

PAYOR CONTRACT UPDATES

Managed Care Contracts

One Call:

- SWMO: Contract for One Call/ Network Synergy/ Align Networks for their Work Comp PT program in the State of Missouri will term and process as out of network effective August 9, 2026.

Midwest Sterilization:

- All Regions: New DTE Contract, Midwest Sterilization, will go into effect July 1, 2026 and insurance cards are attached on pages 26-27. Midwest Sterilization has a side-by-side plan, please see Healthlink ID card attached on pages 28-29.

Tall Tree:

- All Regions: DTE Contract for Tall Tree added the following groups effective May 1, 2026. Tall Tree insurance cards are attached on pages 30-35.
  - Missouri Incutech Foundation
  - Allied Medical
- All Regions: DTE Contract for Tall Tree is termed the following groups effective March 31, 2026:
  - Show Me Luxe

- McClay Health & Rehab

Level Health:

- All Regions: DTE Contract for Level Health added the following groups effective June 1, 2026. Tall Tree insurance cards are attached on pages 36-39.
  - Rock Solid Creations – Group #LHP45
  - Wasabi Management Company – Group #LHP46

Trailiner Corporation:

- All Regions: DTE Contract for Trailiner Corporation is terming effective July 31, 2026.

COFMC:

- All Regions: DTE Contract for COFMC, termed their Mercy Direct Custom Network plan effective 12/31/24 and moved to a BCBS OK plan.

Retro Authorization
Internal Talking Points

December 2025

Talking Points for Use with Provider Audience

Timely Submission of Authorization Requests

What Providers Need to Know
Per longstanding requirements, certain services require prior authorization **before** the services are fully furnished. Contract providers must timely submit an authorization request when required.

Based on recent CMS guidance, requests submitted after services are fully furnished must be processed as payment requests. Accordingly, providers should submit a claim after the services have been fully furnished – not a request for authorization (retro authorizations).

Why This Matters
This impacts providers who request authorizations after fully furnishing a service. If an item or service requires prior authorization, a request for authorization is required **before** the services are fully furnished.

Who to Contact
If providers have questions, they can contact Humana at 800-457-4708.

Frequently Asked Questions

What is a "retro authorization"?
A "retro authorization" is a request for "authorization" submitted **after** the services have been **fully** furnished.

Retro authorizations do **not** include authorization requests submitted while the service is ongoing (e.g., concurrent reviews).

Internal-Only Note: This information should not be shared with providers, but some providers have negotiated non-standard contract language that may require provider-specific

adjustments. Humana is in the process of identifying these exceptions and will provide Market leadership information in advance of operationalizing process changes.

When is this effective?
We recommend providers take action now to improve their processes in accordance with existing authorization requirements and CMS guidance.

Internal-Only Note: We do not have a specific date at this time but are targeting an implementation toward the end of Q1 2026 for updates in Availity to no longer support the acceptance of retro "authorization" requests.

When am I required to obtain a prior authorization?
Prior authorization is important because it builds checks and balances into the healthcare system by verifying that treatments or prescriptions are in the best interest of patient safety and quality of care. Please see Humana's Prior Authorization and Notification List (PAL) and Provider Manual for details on the services that require prior authorization.

Why is Humana raising this now?
As a reminder, certain services have long required prior authorization ***in advance*** of services rendered. Contracted providers must timely submit an authorization request when required. Humana is working to make adjustments to ensure its processes comply with recent CMS guidance and reflect expectations for providers.

When is a prior authorization not required?
Prior authorization is not required in certain circumstances, such as urgent or emergent services, natural disasters, and provider-specific catastrophic events (i.e., cyber events). If providers feel a claim was denied inappropriately, they may dispute the denial. Providers can provide additional information about why a prior authorization was not obtained as part of the dispute process.

Can providers still dispute a denied claim (exceptions)?
Yes. Providers can submit a dispute in alignment with the terms of their contract. Please see the Provider Manual for more information. Providers can provide additional information about why a prior authorization was not obtained as part of the dispute process.

Is Humana making any other updates to the prior authorization process?
Separate from this process update, in July 2025 Humana announced efforts to eliminate some prior authorization requirements and make the process faster and more seamless. You can learn more about those changes here.

Contact Information

- Regulatory Compliance- Mary Rafel- MRafel@humana.com
- Legal- Isabella Wood- IWood1@humana.com

- Claims- Gina Centner- GCentner@humana.com
- Resolutions Team- Amy Grimes- adiers@humana.com

Division of Public Health
Curtis State Office Building
1000 SW Jackson St., Suite 230
Topeka, KS 66612-1368

Kansas
Department of Health and Environment

Phone: 785-296-1207
Fax: 785-559-4235
www.kdheks.gov

Janet Stanek, Secretary

Laura Kelly, Governor

April 28, 2026

Dear Early Detection Works Partners,

Thank you for your continued partnership with the Kansas Department of Health and Environment (KDHE) Early Detection Works (EDW) program. Through our collaborative efforts to serve the citizens of Kansas, 77,555 Kansans have received free breast or cervical cancer screening services through EDW since the program was established in 1996. This incredible achievement is due, in large part, to your diligence in identifying and serving eligible Kansans.

The EDW program will begin a new State Fiscal Year on **July 1, 2026** (SFY26). To ensure future federal funding for breast and cervical services is available, the EDW program will liquidate the current grant year without extension. Below are the scheduled deadlines for the EDW fiscal year-end items:

- **May 15, 2026** – EDW services must be entered by this date to **avoid a delay in payment processing**. Services and payment requests entered after this date will not be processed until after July 1, 2026.

- **Aug. 1, 2026** – EDW services provided July 1, 2025, through June 29, 2026, **must be entered into the Catalsyt120 data system by the close of business Aug. 1, 2026.**

All payment requests submitted <u>after Aug. 1, 2026</u>, for services provided prior to June 29, 2025, will be denied per the EDW contract, *5.12 "Submit all payment requests to the KDHE EDW program within 30 days of services being provided."*

Should you have any questions, please contact the EDW regional nurse in your area:

Northeast Region
Crystal Stuart, LPN
785-250-3505
crystal.stuart@ks.gov

Southeast Region
Shelly Tridle, RN, BSN
620-235-7136
stridle@crawfordcountykansas.org

Central Region
Ana Means, LPN
316-217-1979
antriana.mean@ks.gov

Northwest Region
Beth Komarek, RN, CCHP-RN
785-471-0066
beth.komarek@ks.gov

Southwest Region
Susan Woolwine, LPN
785-230-0493
susan.woolwine@ks.gov

EDW program staff and patients appreciate your continued support in providing Kansans with access to quality care.

Thank you,

Suzanne L. Proctor

Suzanne Proctor, RN, BSN
KDHE Early Detection Works Nurse Manager
Telephone: 785-338-2682
Email: suzanne.proctor@ks.gov

sunflower health plan

Quality Cares

Did You Know?

HEDIS® emphasizes access, continuity, follow-up and outcomes for behavioral health. Social Determinants of Health (SDoH) directly influence performance across multiple measures. The measures in this quality cares email focus on behavioral health, and we offer information and tips for best practice to close gaps in care and positive member outcomes. Our website includes resources designed to support both providers and members as they navigate care and services

Sunflower Help connects Sunflower Health Plan members, caregivers and communities to free or low-cost social services in their local area. The resource supports access to nonmedical services that address social needs and promote overall health and wellbeing.

What's Inside:

Important Dates & Upcoming Dates Behavioral Health Measures

Substance Use Disorder Measures Trainings

Important & Upcoming Dates

May is Mental Health Awareness Month. According to the National Alliance on Mental Illness (NAMI):

- 1 in 5 Americans have a diagnosable mental illness.
- 1 in 20 adults experience serious mental illness each year.
- 1 in 7 youth ages 6-17 experience a mental health disorder each year.
- 50% of all lifetime mental illness begins by age 14 and 75% by age 24.

Caregiver Support Resources provides a centralized collection of tools and support for caregivers of Medicaid members. It focuses on helping caregivers access trusted health information, emotional and peer support, crisis assistance, and self-care resources to support both the member and the caregiver's own well-being.

Sunflower Health Plan provides Opioid & Substance Use Resources for Medicaid members and families affected by opioid use and substance use disorders. The page focuses on helping individuals find treatment, access educational materials, support loved ones and respond to overdose situations.

Mental health awareness prompts us to recognize the impact these disorders can have on our physical health. Stress, anxiety and depression can impact your cardiovascular health as well. Managing mental conditions is a key component of hypertension management and stroke prevention. Members ages 18-85 years meet the Controlling High Blood Pressure (CBP) measure if their most recent blood pressure reading is <140/90. Tips on managing blood pressure include:

- Ask directly about adherence and barriers
- Engage pharmacists or care managers as needed
- Educate staff on the importance of techniques when taking a blood pressure including:

- Use validated, calibrated equipment
- Seat the patient quietly for ≥5 minutes
- Use the correct cuff size
- Repeat elevated readings and document the lowest valid reading.

Behavioral Health Measures

Behavioral health plays a critical role in overall member well-being and HEDIS performance. These measures emphasize timely access to care, continuity, follow-up, and meaningful outcomes that support whole-person care. The information below highlights key measure reminders and practical best practices providers can apply during routine and follow-up visits to help close gaps in care and improve outcomes for the members you serve.

Follow-up After Hospitalization for Mental Illness (FUH) Medicaid (MCD), Medicare (MCR) and Marketplace (MKT)

- Time frame for measure: January 1-December 1, Measurement Year
- The percentage of discharges for members 6 years of age and older who were hospitalized for a principal diagnosis of mental illness, or any diagnosis of intentional self-harm and had a mental health follow-up service. Two rates are reported:
  - The percentage of discharges for which the member received follow-up within 30 days after discharge.
  - The percentage of discharges for which the member received follow-up within 7 days after discharge.

➢ **Tips:**

- Schedule members for 7-day or 30-day follow-ups prior to the member being discharged from the hospital.

- Maintain appointment availability in your office for patients with recent hospital discharges
- Offer in person, virtual, or e-visits when possible.

Follow up Care for Children Prescribed ADHD medication (ADD-E) *(MCD)*

- Time frame for measure: January 1-December 1, Measurement Year
- Measure evaluates the percentage of children newly prescribed attention deficit hyperactivity disorder (ADHD) medication who had at least three follow-up care visits within a 300-day (10-month) period, one of which was within 30 days of when the first ADHD medication was dispensed. Two rates are reported:
    - Initiation Phase: percentage of people 6 to 12 years of age with a prescription dispensed for ADHD medication, who had one follow-up visit with a practitioner with prescribing authority during the 30-day Initiation Phase.
    - Continuation and Maintenance (C&M) Phase: percentage of persons 6 to 12 years of age with a prescription dispensed for ADHD medication, who remained on the medication for at least 210 days and who, in addition to the visit in the Initiation Phase, had at least two follow-up visits with a practitioner within 270 days (nine months) after the Initiation Phase ended.

➢ **Tips:**

- Limit the first prescription of ADHD medication to a 28- to 30-day supply and schedule follow-up before the family leaves the office.
- Re-evaluate medication effectiveness no more than 30 days after initiation via telehealth when available and regularly monitor medication effects thereafter.
- Reschedule any canceled appointments right away.
- Schedule telehealth visits if office visits are not acceptable.

Use of First Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP) *(MCD)*

- Measure evaluates the percentage of children and adolescents 1 to 17 years of age who had a new prescription for an antipsychotic medication and had documentation of psychosocial care as first-line treatment. Identify people eligible for antipsychotic medications and provide psychosocial care from 90 days prior to 30 days after beginning a medication.

➢ **Tips:**

- Before prescribing antipsychotic medication, complete or refer for a trial of first-line psychosocial care.
- Antipsychotic medications should be part of a comprehensive, multi-modal plan for coordinated treatment that includes psychosocial care.
- The need for continued therapy with antipsychotic medications should be reviewed periodically.

Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA) *(MCD and MCR)*

- Time frame for measure: January 1-December 1, Measurement Year. The index prescription start date (IPSD) is the earliest prescription dispensing data for any antipsychotic medication during the measurement period. The treatment period is defined as the time beginning on the IPSD through the last day of the measurement period.
- This measure evaluates the percentage of people 18 years of age and older during the measurement period with schizophrenia or schizoaffective disorder who were dispensed and remained on antipsychotic medication for at least 80% of their treatment period.

If an oral medication and a long-acting injection are dispensed on the same day, calculate number of days covered by an antipsychotic medication using the prescription with the longest days' supply.

- **Tips:**
    - Consider the use of long-acting injectable antipsychotic medications to increase adherence.
    - Provide education on how to take the medication, expected side effects, and the importance of talking to the prescriber before stopping the medication.

Diabetes Screening for People with Schizophrenia or Bipolar Disorder who are using Antipsychotic Medications (SSD) *(MCD)*

- Time frame for measure: January 1-December 1, Measurement Year
- The measure evaluates the percentage of persons 18 to 64 years of age with schizophrenia, schizoaffective disorder, or bipolar disorder who were dispensed an antipsychotic medication and had a diabetes screening test during the measurement period.

- **Tips:**
    - Provide persons/caregivers with lab orders for HbA1c or glucose lab test to be completed yearly.
    - Consider using standing orders to get lab tests.
    - Educate people and their caregivers on the importance of completing annual visits and blood work.

Follow-up after Emergency Department visit for Mental Illness (FUM) *(MCD and MCR)*

- Time frame for measure: January 1-December 1, Measurement Year
- The measure evaluates the percentage of ED visits for persons six years of age and older with a principal diagnosis of mental illness, or any diagnosis

of intentional self-harm, and had a mental health follow-up service during the measurement period.

- **Tips:**
    - Offer virtual, telehealth, and phone visits.
    - Maintain appointment availability in your practice for people and schedule follow-up appointments before the person leaves the office.
    - Discuss the benefits of seeing a primary or specialty provider and appropriate ED utilization.

Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM-E) *(MCD)*

- Time frame for measure: January 1-December 1, Measurement Year
- This measure evaluates the percentage of children and adolescents 1 to 17 years of age who had two or more antipsychotic prescriptions and had metabolic testing during the measurement period. Three rates reported:
    - Percentage of children and adolescents on antipsychotics who received blood glucose testing.
    - Percentage of children and adolescents on antipsychotics who received cholesterol testing.
    - Percentage of children and adolescents on antipsychotics who received blood glucose and cholesterol testing.

- **Tips:**
    - Provide persons/caregivers with lab orders for HbA1c or glucose and cholesterol or LDL-C to be completed yearly.
    - Coordinate care between behavioral and physical health providers.

- Educate the person and caregiver about the risks associated with taking antipsychotic medications and the importance of regular follow-up care.

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Substance Use Disorder Measures

Substance use disorder (SUD) measures are designed to support some of the most vulnerable moments in a person's care journey, when timely follow-up and continuity can significantly influence safety, stability, and recovery. Consistent provider engagement during and after acute events helps reinforce trust, reduce the risk of relapse or repeat emergency visits and promote sustained treatment participation. The information below highlights key measure reminders and practical best practices providers can integrate into routine and follow-up care to support better outcomes for the members you serve.

Initiation and Engagement of SUD Treatment (IET) *(MCD, MKT, MCR)*

- Time frame for measure: (to capture episodes) Nov. 15 of the year prior to the measurement year through Nov. 14 of the measurement year.
- This measure evaluates the percentage of adolescent and adult members with a new episode of substance use disorder (SUD) episodes during the measurement year that result in treatment initiation and engagement. Two rates are reported:
    - Initiation of SUD Treatment: percentage of new SUD episodes that result in treatment initiation through an inpatient SUD admission, outpatient visit, intensive outpatient encounter, or partial hospitalization, tele-health, or medication treatment within 14 days.
    - Engagement of SUD Treatment: percentage of new SUD episodes that have evidence of treatment engagement within 34 days of initiation.

- **Tips**:
    - Complete a comprehensive exam before diagnosing; co-existing disorders are not uncommon and can undermine effectiveness and adherence to treatment.
    - Develop working alliances with specialists in substance use disorders for patients who would benefit from specialty care.
    - Explain the importance of a follow-up to your patients.
    - Schedule an initial follow-up appointment within 14 days.
    - Reschedule patients as soon as possible who do not keep initial appointments.
    - Use telehealth where appropriate.
    - Offer mutual help options like case management, peer recovery support, harm reduction, 12-step fellowships, e.g., Alcoholics Anonymous (AA), Narcotics Anonymous (NA), etc., or other community support groups.

Follow-Up After High-Intensity Care for SUD - (FUI) (*MCD, MCR)*

- This measure evaluates the percentage of acute inpatient hospitalizations, residential treatment or withdrawal management visits for a diagnosis of substance use disorder among members 13 years of age and older that result in a follow-up visit or service for substance use disorder during the measurement period. Two rates are reported:
    - The percentage of visits or discharges for which the person received follow up for substance use disorder within the 30 days after the visit or discharge.
    - The percentage of visits of discharges for which the person received follow up for substance use disorder within the seven days after the visit or discharge.

- **Tips**:
    - Offer virtual, telehealth and phone visits.

- Maintain appointment availability in your practice for patients and schedule follow-up appointments before the patient leaves the office.
- Offer mutual help options like case management, peer recovery support, harm reduction, 12-step fellowships, e.g., Alcoholics Anonymous (AA) or Narcotics Anonymous (NA), etc., or other community support groups.
- Reach out proactively within 24 hours if the patient does not keep scheduled appointment to schedule another.

The Claim should include a principal diagnosis of substance use disorder (e.g. applicable code F10.10-F19.29)

Follow up after Emergency Department Visit with SUD (FUA) *(MCD, MCR)*

- Measure evaluates the percentage of emergency department (ED) visits among members age 13 years and older with a principal diagnosis of substance use disorder (SUD), or any diagnosis of drug overdose for which there was a follow up. The measure is based on ED visits; members may appear in a measure sample more than once. Each ED visit requires separate follow-up. Two rates are reported:
    - Discharges for which the member received follow-up within 30 days of discharge. A follow-up visit or a pharmacotherapy dispensing event within 30 days after the ED visit (31 total days). Include visits and pharmacotherapy events that occur on the date of the ED visit.
    - Discharges for which the member received follow-up within seven days of discharge. A follow-up visit or a pharmacotherapy dispensing event within seven days after the ED visit (eight total days). Include visits and pharmacotherapy events that occur on the date of the ED visit.

➢ **Tips:**

- Offer virtual, telehealth, and phone visits.
- Maintain appointment availability in your practice for patients and schedule follow-up appointments before the patient leaves the office.
- Discuss the benefits of seeing a primary or specialty provider.

- Offer mutual help options like case management, peer recovery support, harm reduction, 12-step fellowships, e.g., Alcoholics Anonymous (AA), Narcotics Anonymous (NA), etc., or other community support groups.
- Reach out proactively within 24 hours if the patient does not keep scheduled appointment to schedule another.

Unhealthy Alcohol Use Screening and Follow-Up (ASF-E) *(MCD, MCR)*

- This measure evaluates the percentage of persons 18 years of age and older who were screened for unhealthy alcohol use using a standardized instrument between Jan. 1 and Nov. 1 of the measurement period and, if screened positive, received appropriate follow-up care. Two rates are reported:
    - Unhealthy Alcohol Use Screening. The percentage of persons who had a systemic screening for unhealthy alcohol use.
    - Follow-Up Care on Positive Screen. The percentage of persons receiving brief counseling or other follow-up care within 60 days (two months) of screening positive for unhealthy alcohol use.
    - *Note: A LOINC code submission via flat file is required to be adherent for the screening numerator.*

- **Tips:**
    - Train staff on the importance of screenings and recognizing the risk factors for unhealthy alcohol use.
    - Develop a workflow that includes using a standardized instrument for unhealthy alcohol screening at least annually.
    - Ask your provider relations representative about ways to submit data to the health plan directly from your HER/EMR.
    - Document follow-up on positive screens on or up to 60 days after the first positive screen.

Provider Trainings

Sunflower Health Plan values the commitment and care you provide to our members.

Here are some upcoming Provider Trainings:

All Providers:

- Office Hours – (registration not required, save this link to your calendar) UPDATED DAY & TIME Wednesdays 12:30 PM to 1 PM
    - May 13, 2026
    - May 27, 2026
    - June 10, 2026
    - June 24, 2026
- *NEW!* Utilization Management (aka Prior Authorization) Provider Training – Thursday, May 14, 2026, 2 PM to 3PM CT

Ambetter Providers:

- Ambetter New Provider Orientation – Wednesday, June 17, 2026, 9 AM to 10 AM CT

Medicaid Providers:

- Medicaid Behavioral Health Provider Review – Tuesday, June 16, 2026, 1:30 PM to 2:30 PM CT
- Medicaid New Provider Orientation – Thursday, June 18, 2026, 9 AM to 10:30 AM CT

Wellcare Providers:

- Wellcare Provider Orientation – Tuesday, May 19, 2026, 9 AM to 10 AM CT

Return to Top

Rachel Honey, LPN

Quality Practice Advisor

sunflower health plan

Lenexa, Ks. – Remote

Preferred Contact – Teams or 913-558-7538

Rachel.honey@sunflowerhealthplan.com| **sunflowerhealthplan.com**

Auxiant
Independent Solutions › Real Results

MIDWEST
STERILIZATION CORPORATION

Member

Group #: M1240
Member ID: SMPL0001
Coverage:
Employee: JOHN SAMPLE
Dependent: JOHN SAMPLE

Plan Benefits

	Single/Family
In-Network Deductible	$500/$1,000
Non-Network Deductible	$1,000/$2,000
In-Network Out of Pocket	$3,000/$6,000
Non-Network Out of Pocket	$6,000/$12,000

Out of Pocket includes covered Medical & Prescription member responsibility

HealthJoy
For Help Using Any Service
GET IT ON Google Play
Available on the App Store

Benefit Verification & Eligibility

Call Auxiant at 800-279-6772 or Visit www.auxiant.com for Coverage (Eligibility), Benefits (Co-Pay, Deductible & Out of Pocket), Medical Necessity Reviews & Claims status.

Medical Plan

Mercy
www.mercyoptions.net

Pharmacy Plan

RxBIN: 024368
RxGRP: M1240
RxPCN: 3207

SmithRx

member.mysmithrx.com
Members Call: 844-454-5201
Pharmacy Help Desk: 844-512-3030

Benefits are not insured by Cigna Healthcare or affiliates. **This card does not guarantee coverage and/or benefits.**

1271-P3 3363 M1240-M1240-16--M1240-- M(*)D()V()
20260612T9A Sh: 0 Bin 1
J024 Env [1] CSets 2 of 2

Pre-Certification

MPORTANT: ADMISSION NOTIFICATION IS REQUIRED
FOR PRE-CERTIFICATION CALL: 866-726-6584
You are REQUIRED to call or have your doctor call at least 48 hours prior to a scheduled hospital admission or within 48 hours for an emergency admission.

For Chemotherapy, Radiation Therapy and other services needing Medical Necessity Reviews call Auxiant at 800-279-6772.

FAILURE TO CALL WILL RESULT IN REDUCED BENEFITS

Out of Area

First Health Network

To locate providers outside of the primary service area or when traveling out of state call First Health at 800-226-5116 or visit www.myfirsthealth.com

Claims Submission

Submit Mercy and Affiliate Medical Claims To:
Mercy Benefit Administrators
P.O. Box 211197
Eagan, MN 55121
Payor ID: 43185

Submit All Other Medical Claims To:
Auxiant
P.O. Box 909991
Milwaukee, WI 53209-9991
Payor ID: 76079 or AUX01

Auxiant
Independent Solutions › Real Results

MIDWEST
STERILIZATION CORPORATION

Member

Group #: M1240
Member ID: SMPL0001
Coverage:
Employee: JOHN SAMPLE
Dependent: JOHN SAMPLE

Plan Benefits

	Single/Family
In-Network Deductible	$1,500/ $3,000
Non-Network Deductible	$3,000/$6,000
In-Network Out of Pocket	$3,850/ $7,700
Non-Network Out of Pocket	$8,000/$16,000

Out of Pocket includes covered Medical & Prescription member responsibility

HealthJoy
For Help Using Any Service
GET IT ON Google Play
Available on the App Store

Benefit Verification & Eligibility

Call Auxiant at 800-279-6772 or Visit www.auxiant.com for Coverage (Eligibility), Benefits (Co-Pay, Deductible & Out of Pocket), Medical Necessity Reviews & Claims status.

Medical Plan

HealthLink OAIII | UniCare Affiliate
www.healthlink.com 800-624-2356

Pharmacy Plan

RxBIN: 024368
RxGRP: M1240
RxPCN: 3207

SmithRx
member.mysmithrx.com
Members Call: 844-454-5201
Pharmacy Help Desk: 844-512-3030

This card does not guarantee coverage and/or benefits

1271-P3 3363 M1240-M1240-05--M1240-- M(*)D()V()
20250513T09 Sh: 0 Bin 1
J129 Env [1] CSets 2 of 2

20250513T09 Sh: 0 Bin 1
J129 Env [1] CSets 2 of 2
1271-P3 28AF M1240-M1240-05--M1240-- M(*)D(V()

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Claims Submission

Mail all Medical Claims to:
HealthLink Claims
P.O. Box 659986
San Antonio, TX 78265
HealthLink EDI: #90001

MISSOURI INCUTECH FOUNDATION

TALL TREE ADMINISTRATORS

PatientPAL

PHCS

Group ID#: WCMIF

Name: JOHN SMITH

ID#: **A3476BCF1**

Mercy

www.mercyoptions.net

PCP Copay:	$10 / $25
Specialist Copay:	$20 / $45
Urgent Care Copay:	$20 / $45
ER Benefit:	Ded then 20%
RX Benefit:	$0 / $35 / $75 / $200
Ded Tier 1/Tier 2/Tier 3:	$0/$250/$500
OOP Tier 1/Tier 2/Tier 3:	$625/$1,250/ 3,750

TELEMEDICINE:

Lyric Health
https://portal.getlyric.com
866-223-8831

lyric

MEDICAL CLAIMS:

Tall Tree Administrators
Emdeon payor ID#: 88067
P.O. Box 1807
Draper, UT 84020

MERCY CLAIMS:

Mercy Benefit Administrator
P.O. Box 211197
Eagan, MN 55121
Payor ID#: 43185

PHARMACY PLAN:

RxBIN: 023385
RxPCN: CPT
RxGRP: CPRX
Customer Service: 945-260-2281
www.cerpassrx.com

MEMBER BENEFIT:

Eligibility Benefits- Call 844-525-2387
Provider Network: To find a PHCS provider call 800-922-4362 or visit www.multiplan.com/TTAPHCS

PRE CERTIFICATION:

Call Integrated Health Management at 866-587-2700.

All services requiring a Pre-Auth will be denied if not obtained.

TALL TREE ADMINISTRATORS

ALLIED MEDICAL LLC

PatientPAL PHCS

Group ID#: WCAME

Name: JOHN SMITH

ID#: **A3476BCF1**

Mercy
www.mercyoptions.net

PCP Copay:	$10 / $20
Specialist Copay:	$20 / $40
Urgent Care Copay:	$25 / $50
ER Benefit:	$300
Ntwk. Ded./Non-Ntwk. Ded.:	$4,000 / $9,000
Ntwk. OOP/Non-Ntwk OOP:	$6,250 / $14,000

TELEMEDICINE:

Lyric Health
https://portal.getlyric.com
866-223-8831

lyric

MEDICAL CLAIMS:

Tall Tree Administrators
Emdeon payor ID#: 88067
P.O. Box 1807
Draper, UT 84020

IIS Benefit Administrators

MERCY CLAIMS:

Mercy Benefit Administrator
P.O. Box 211197
Eagan, MN 55121
Payor ID#: 43185

PHARMACY PLAN:

RxBIN: 005285
RxPCN: ACB
RxGRP: 50003684-01
Customer Service: Member: 800-311-3446
Pharmacy: 800-699-3542. www.ehimrx.com

ProCare Rx

MEMBER BENEFIT:

Eligibility Benefits- Call 844-525-2387
Provider Network: To find a PHCS provider call 800-922-4362 or visit www.multiplan.com/TTAPHCS

PRE CERTIFICATION:

Call Integrated Health Management at 877-587-2700.

All services requiring a Pre-Auth will be denied if not obtained.

TALL TREE ADMINISTRATORS

ALLIED MEDICAL LLC

PatientPAL PHCS

Group ID#: WCAME

Name: JOHN SMITH

ID#: **A3476BCF1**

Mercy
www.mercyoptions.net

PCP Copay:	$10 / $20
Specialist Copay:	$20 / $40
Urgent Care Copay:	$25 / $50
ER Benefit:	$150
Ntwk. Ded./Non-Ntwk. Ded.:	$500 / $9,000
Ntwk. OOP/Non-Ntwk OOP:	$500 / $14,000

TELEMEDICINE:

Lyric Health
https://portal.getlyric.com
866-223-8831

lyric

MEDICAL CLAIMS:

Tall Tree Administrators
Emdeon payor ID#: 88067
P.O. Box 1807
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All services requiring a Pre-Auth will be denied if not obtained.

level health

Mercy HealthLink REZILIENT Quest Select™ QuestSelect.com 800-646-7788

Member: {{firstName}} {{lastName}}

Member ID: {{base}} {{code}}

Group: LHP45

No-Cost Primary Care
Rezilient Health 314-900-1615
Mercy (www.mercyoptions.net)

No-Cost Mental Health Care
ViCare 314-282-2055

No-Cost Rx & Surgeries
Level (877) 426-2162

Copays:

OV $0 | SOV $25
ER $300

Deductible/Out of Pocket Maximum

$0 Care Ded: $0/$0
$0 Care MOOP: $0/$0
Tier 1 Ded: $0/$0
Tier 1 MOOP: $5,000/$10,000
INN Ded: $5,000/$10,000
INN MOOP: $9,450/$18,900
OON Ded: $10,000/$20,000
OON MOOP: $18,900/$37,800

level health

Pharmacy

Rx Bin: 012528

Rx Group: VRX0412

Rx PCN: VENTEG

Providers

Payer Name: Level Health

Portal: my.levelhealthplans.com/providers

Call: 203-208-9898

Pharmacies: +1(877) 867-0943

Prior Authorizations: 800-432-8421

Mail Claims: Payer ID: IHS15
Yuzu Health
3723 Greenville Ave #92165
Dallas, TX 75206

QUESTIONS ? Contact us.

Members Call (877) 426-2162

my.levelhealthplans.com/signin

This card does not guarantee eligibility or payment.
FAILURE TO OBTAIN PRIOR AUTHORIZATION WILL RESULT IN BENEFIT PAYMENT REDUCTION.

level health

Mercy HealthLink REZILIENT Quest Select™ QuestSelect.com 800-646-7788

Member: {{firstName}} {{lastName}}

Member ID: {{base}} {{code}}

Group: LHP46

No-Cost Primary Care
Rezilient Health 314-900-1615
Mercy (www.mercyoptions.net)

No-Cost Mental Health Care
ViCare 314-282-2055

No-Cost Rx & Surgeries
Level (877) 426-2162

Copays:

OV $0 | SOV $25
ER $300

Deductible/Out of Pocket Maximum

$0 Care Ded: $0/$0
$0 Care MOOP: $0/$0
Tier 1 Ded: $0/$0
Tier 1 MOOP: $5,000/$10,000
INN Ded: $5,000/$10,000
INN MOOP: $9,450/$18,900
OON Ded: $10,000/$20,000
OON MOOP: $18,900/$37,800

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Mail Claims: Payer ID: IHS15
Yuzu Health
3723 Greenville Ave #92165
Dallas, TX 75206

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