Children's Medical Services Health Plan
OPERATED BY SUNSHINE HEALTH

PROVIDER MANUAL

Children's Medical Services Health Plan

1-844-477-8313
Provider Services

SunshineHealth.com/CMS
CMS_7580

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Chapter 1: Welcome to Children's Medical Services (CMS) Health Plan

CMS Health Plan appreciates your partnership as we work to improve the lives of our members, your patients. We are here to support you and have many tools available to help.

SunshineHealth.com contains a wealth of tools, and the information in this manual. You can find forms and information on billing policies, telemedicine, vendors and more.

Please consider using SunshineHealth.com as your first stop for information. It's easy to navigate, and it's updated frequently.

For important updates, please check For Providers and Provider News.

Key Contacts and Important Phone Numbers

CMS Health Plan provides a 24-hour help line to respond to requests for prior authorization. In addition, CMS Health Plan staff is available from 8 a.m. to 8 p.m. Eastern Monday through Friday to answer provider questions and respond to provider complaints, emergencies and notifications.

After regular business hours, the provider services line is answered by an automated system. The line has the capability to provide callers with information about operating hours and instructions about how to verify enrollment for a member with an emergency or urgent medical condition. The requirement that CMS Health Plan provides information to providers about how to verify enrollment shall not be construed to mean that the provider must obtain verification before providing emergency services and care.

Sunshine Health Website: SunshineHealth.com

The following are key services for which you may have a question and the phone number for that service:

Service	Phone Number
Provider Services	1-844-477-8313
Medical or behavioral health authorizations	1-844-477-8313
Formulary or prior authorization questions	1-833-705-1351
AcariaHealth Specialty Pharmacy	1-855-535-1815
Advanced imaging	1-877-807-2363
Arranging covered transportation for CMS members	1-877-583-1554

About Sunshine Health

Sunshine Health, a wholly-owned subsidiary of Centene Corporation, is a managed care organization (MCO) contracted with AHCA to provide Medicaid managed care – including behavioral health and long-term care services to members in all counties of Florida. For more than 30 years, Centene has provided comprehensive managed care services to Medicaid populations and currently operates health plans throughout the United States.

Sunshine Health features an integrated model of care that incorporates both physical health and behavioral health along with long term care services. Sunshine Health's mission is to improve the health of the community, one person at a time.

Overview

Children's Medical Services (CMS) Health Plan is operated by Sunshine Health, in partnership

with the Florida Department of Health (DOH). Sunshine Health is a wholly-owned subsidiary of Centene Corporation, a leading multi-line healthcare enterprise offering both core Medicaid and specialty services. Sunshine Health provides managed care services targeted exclusively to government-sponsored healthcare programs. It focuses on Medicare, Medicaid and Children's Health Insurance Programs, including prescription drug plans and health plans for families, and the aged, blind and disabled. Sunshine Health's corporate office is located in Fort Lauderdale.

Purpose of this Provider Manual

This Provider Manual is intended for Sunshine Health-contracted (participating) CMS Health Plan Providers who offer healthcare service(s) to Members enrolled in the Children's Medical Services Health Plan. This manual serves as a guide to the policies and procedures governing the administration of the CMS Health Plan and is an extension of and supplements the Provider Participation Agreement (the Agreement) between Sunshine Health and healthcare providers, who include, without limitation: Primary Care Providers, Hospitals and Ancillary Providers (collectively, Providers).

A paper copy may be obtained, at no charge, upon request by contacting Provider Services or a Provider Relations representative.

In accordance with the policies and procedures clause of the Agreement, participating Sunshine Health providers must abide by all applicable provisions contained in this manual. Revisions to this manual reflect changes made to Sunshine Health's policies and procedures. Revisions shall become binding 30 days after notice is provided by mail or electronic means, or such other period of time as necessary for Sunshine Health to comply with any statutory, regulatory, contractual and/or accreditation requirements. As policies and procedures change, updates will be issued by Sunshine Health in the form of Provider Bulletins and will be incorporated into subsequent versions of this manual. Provider Bulletins that are state-specific may override the policies and procedures in this Manual.

The CMS Health Plan, operated by Sunshine Health in partnership with DOH, is a specialty plan for children and youth with special healthcare needs. The CMS Health Plan serves children up to age 21 who qualify for Medicaid and have a qualifying clinical diagnosis or up to age 19 who have a qualifying clinical diagnosis through the state's Children's Health Insurance Program (CHIP).

Description of the Florida Medicaid program, CHIP and the SMMC Program

Medicaid is the medical assistance program that provides access to healthcare for low- income families and individuals. Medicaid also assists the elderly and people with disabilities with the costs of nursing facility care and other medical and long-term care expenses. In 2014, the Florida Medicaid program implemented a new system through which Medicaid enrollees receive services. It is referred to as the Statewide Medicaid Managed Care (SMMC) program. Most

Medicaid recipients must enroll in a health plan that was selected through a competitive procurement to participate in the SMMC program.

Medicaid is managed by the Florida Agency for Health Care Administration (Agency), otherwise known as AHCA. Sunshine Health is contracted with the Agency to provide managed care services to Medicaid recipients enrolled with Sunshine Health. Sunshine Health is also contracted with DOH to operate their SMMC specialty plan for children and youth with special healthcare needs, otherwise known as the Children's Medical Services Health Plan.

Covered Services

The following core benefits and services, expanded benefits and special programs are provided to Medicaid CMS Health Plan Members.

The following core benefits and services, expanded benefits and special programs are provided to KidCare CMS Health Plan Members (CHIP Title XXI recipients only).

In addition, some covered services require prior authorization. To see a list of services requiring prior authorization, check the Health Plan prior authorization page.

Excluded Services

The following services are not covered by the CMS Plan but are available to eligible Medicaid members through Medicaid FFS:

- Behavioral Analysis (BA) services
- CHD Certified Match Program services
- Developmental Disabilities Individual Budgeting (iBudget) home and community- based services (HCBS) Waiver services
- Familial Dysautonomia HCBS Waiver services
- Hemophilia Factor-related Drugs Distributed through the Comprehensive Hemophilia Disease Management Program services
- ICF/IID services
- Model HCBS Waiver services
- Newborn hearing services
- Prescribed Pediatric Extended Care services (PPEC)
- School-based services provided through the Medicaid Certified School Match Program
- PACE services
- Substance Abuse County Match Program services

The following services are not covered by the CMS Plan for Title XXI members:

- Home and Community Based Services
- Behavioral health services for BNet enrolled members

CMS Health Plan Eligibility

The specialty population eligible to enroll in the CMS Health Plan will consist of only those recipients who meet the following criteria:

- Identified pursuant to a rule(s) promulgated by DOH; and
- Children ages 0-21 years with a qualifying condition and who are eligible for Medicaid or CHIP.

Guiding Principles

Sunshine Health's top priority is the promotion of high quality care and outcomes through preventive healthcare and evidence-based care of chronic conditions. Sunshine Health works to accomplish this goal by partnering with primary care providers (PCPs), who oversee the healthcare of Sunshine Health members and work toward Sunshine Health's mission to transform the health of the community, one person at a time.

Using an integrated model of care, Sunshine Health partners with behavioral health providers, specialists and ancillary providers as part of a whole-person philosophy to healthcare.

Sunshine Health is committed to the philosophy of providing appropriate treatment at the least restrictive level of care that meets the member's needs. Individualized consideration and evaluation of each member's treatment needs are required for optimal medical necessity determination.

To attain those goals, Sunshine Health follows these guiding principles:

- Embrace a culture of diversity
- Forge local partnerships to enable meaningful, accessible healthcare
- Foster open, consistent and two-way communication
- Foster teamwork
- Innovate and encourage challenges to the status quo
- Operate at the highest ethical standards
- Remove barriers to accessing care
- Treat people with kindness, respect and dignity
- Treat the whole person

Sunshine Health believes quality healthcare is best delivered locally, and successful managed care is the delivery of appropriate, medically necessary services rendered in the appropriate setting – not in the elimination of such services. As such, it is committed to providing access to high-quality, culturally sensitive healthcare services by building a collaborative partnership with PCPs, specialists, behavioral health providers, ancillary providers and facilities.

Sunshine Health's programs, policies and procedures are designed to:

- Encourage quality, continuity and appropriateness of medical and behavioral health care
- Ensure access to primary and preventive care services
- Ensure access to services for the management of chronic conditions and other needed care
- Ensure care is delivered in the best and least-restrictive setting to achieve

optimal outcomes
- Ensure member and provider satisfaction
- Provide coverage of benefits in a cost-effective manner

Sunshine Health allows open provider and member communication regarding appropriate treatment alternatives. Sunshine Health does not penalize providers for discussing medically necessary, appropriate care or treatment options with members.

All Sunshine Health's programs, policies and procedures are designed to minimize administrative responsibilities in the management of care, enabling providers to focus on the healthcare needs of their patients.

Sunshine Health conducts its business affairs in accordance with the standards and rules of ethical business conduct and abides by all applicable federal and state laws. Sunshine Health takes the privacy and confidentiality of members' health information seriously and has processes, policies and procedures to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and state privacy law requirements. For questions regarding these privacy practices, please contact the privacy officer at 1-866-796-0530.

Sunshine Health follows the Section 1557 nondiscrimination provision of the Affordable Care Act (ACA). Sex discrimination includes, but is not limited to, discrimination based on an individual's sex, including pregnancy, medical related conditions, termination of pregnancy, gender identity and sex stereotypes. The law prohibits discrimination based on race, color, national origin, sex, age or disability in certain health programs or activities.

Informational Tools for Providers

Sunshine Health uses the following tools to inform providers of new programs, requirements and policies:

- Communications sent by mail, email or fax
- New provider orientation
- Secure provider portal for member information
- Web-based materials, including provider directory, provider manual and other provider resources, including policies and procedures on SunshineHealth.com
- Web-based trainings
- Workshops led by certified trainers on a variety of specialized topics, including behavioral health

Website

By visiting SunshineHealth.com, providers may find information about Sunshine Health policies, processes, trainings and quality programs. In addition, providers may:

- Access claims auditing tools
- Access EDI companion guides
- Access frequently used forms
- Access provider webinar schedules
- Access the most recent provider and billing manual (PDF)

- Access provider directories
- Complete required trainings
- Access the link for Availity to see gaps in care; including HEDIS
- Register for the secure web portal at SunshineHealth.com/login
- Sign up for electronic funds transfers (EFT) via vendors
- Utilize the Find My Provider Relations Representative tool to identify the assigned Provider Relations Representative for your practice

Secure Provider Portal

Sunshine Health offers all providers and their office staff the opportunity to register for the secure provider portal via the Sunshine Health website. On the secure site, providers can use tools that make obtaining and sharing information seamless. Through the secure site, providers can:

- Contact Sunshine Health securely and confidentially
- Submit claims and check claim status
- Submit claim reconsiderations
- Resubmit claim adjustment and reconsideration for payments online
- Submit prior authorization requests
- Submit attachments for claims and resubmitted claims for payment reconsiderations and primary payer information for secondary payment
- Update certain provider demographics information such as phone number and address
- View and print enrollee eligibility
- View patient list
- Submit referrals to case management
- Complete the provider notification of pregnancy
- View disease management and case management indicators
- View eligibility history for all products
- View member's historical PCP assignment
- View provider analytics and pay-for-performance reports

Chapter 2: Member Eligibility

Eligibility Determination

The Florida Department of Health (DOH) administers a specialty plan, Children's Medical Services (CMS) Health Plan, for children with serious chronic conditions. Members must meet clinical eligibility through DOH and financial eligibility through Department of Children and Families (DCF) or the Social Security Administration (SSA) for Title XIX (19) or by Florida KidCare for Title XXI (21) members.

Until the actual date of the enrollment, Sunshine health is not financially responsible for services

the prospective member receives.

CMS Health Plan Eligibility

The specialty population eligible to enroll in the CMS Health Plan will consist of only those recipients who meet the following criteria:

- Identified pursuant to a rule(s) promulgated by DOH; and
- Children ages 0-21 years with a qualifying condition and who are eligible for Medicaid or CHIP.

Enrollment

CMS Health Plan must obey laws that protect from discrimination or unfair treatment. Sunshine Health does not discriminate based on a person's race, disability, religion, sex, health, ethnicity, creed, age or national origin.

Upon enrollment in CMS Health Plan, members are provided with the following:

- Terms and conditions of enrollment
- Description of Covered Services in network and out-of-network (if applicable)
- Information about PCPs, such as location, telephone number and office hours
- Information regarding out-of-network emergency services
- Grievance and disenrollment procedures
- Brochures describing certain benefits not traditionally covered by Medicaid and other value-added items or services, if applicable

Member ID Cards

NOTE: Presentation of a member ID card is not a guarantee of eligibility. Providers must always verify eligibility on the same day services are required.

Children's Medical Services Health Plan (Medicaid) Member ID Card

Children's Medical Services Health Plan (KidCare) Member ID Card

Member identification cards are intended to identify CMS Health Plan Members, the type of plan they have and to facilitate their interactions with healthcare providers.

Information found on the member identification card may include the member's name, identification number, plan type, PCP's name and telephone number, co-payment information, CMS Health Plan contact information and claims filing address.

Note: Members who have Medicare or other health insurance as their primary insurance are not required to choose a PCP with Sunshine Health and they will receive an ID card stating that a PCP is not required.

Member Engagement

CMS Health Plan utilizes a number of engagement strategies to establish a relationship with members. Engagement begins with notification of Member enrollment. Notice of enrollment triggers an attempt to reach the CMS Health Plan member or their guardian by phone to complete a comprehensive health assessment and to familiarize the member and guardian with the plan benefits. Three attempts are made to contact the member.

Assessments for Members

All CMS Health Plan Members are assigned a local care manager. Care managers are either licensed registered nurses or social workers. Care managers complete assessments with the member within the first 30 days of enrollment. Upon completion of the comprehensive assessment, a care plan is developed with input from the Member and his/her guardian, the provider, and the CMS Health Plan care manager. The care plan is available for providers to view via the Secure Provider Portal. Care managers collaborate with the provider to ensure the most successful care plan is developed and implemented to effect positive outcomes for the member.

Assignment of Primary Care Provider

Members enrolled in the CMS Health Plan must choose a PCP or they will be assigned to a PCP within our network. To ensure quality and continuity of care, the PCP is responsible for arranging all of the member's healthcare needs from providing primary care services to coordinating referrals to specialists and Providers of ancillary or hospital services.

Changing Primary Care Providers

Members may change their PCP selection at any time by calling Member Services. The requested change will be effective the first day of the following month of the request if the request is received after the tenth day of the current month.

Women's Health Specialists

PCPs may also provide routine and preventive healthcare services that are specific to female members. If a female Member selects a PCP who does not provide these services, she has the right to direct in-network access to a women's health specialist for Covered Services related to this type of routine and preventive care. CMS Health Plan members have the right to obtain family planning services from any participating provider without prior authorization.

Hearing-Impaired, Interpreter and Sign Language Services

Hearing-impaired, interpreter and sign language services are available to CMS Health Plan Members through our Member Services Department. PCPs should coordinate these services for CMS Health Plan members and contact Member Services if assistance is needed.

Verifying Member Eligibility

Sunshine Health recommends providers verify eligibility before rendering services for our CMS Health Plan members. Providers may use the Secure Provider Portal to verify member eligibility.

➢ See Methods to Verify Eligibility.

Providers must verify a member's eligibility each time a Sunshine Health member schedules an appointment and arrives for services. Because members may change PCPs and MMA plans, PCPs should also verify that a member is their assigned member.

Methods to Verify Eligibility

Preferred Method

Providers are asked to verify member eligibility by using the Sunshine Health secure provider portal on SunshineHealth.com. Using the portal, any registered provider is able to quickly check member eligibility by indicating the date of service, member name, and date of birth or the member ID number and date of birth.

Other Methods

Providers may call provider services at 1-844-477-8313 and follow the prompts to use the 24/7 toll-free interactive voice response (IVR) lines to verify member eligibility.

The automated system prompts providers to enter the member's identification number and the month of service.

If the secure portal or IVR lines are unavailable, providers may call the Provider Services number.

Providers are asked to supply the member's name and date of birth or the member's member identification number and date of birth.

Chapter 3: Credentialing and Recredentialing

Credentialing and Recredentialing Overview

Sunshine Health has established rigorous standards for the selection and evaluation of licensed independent practitioners and organizational providers to offer a high quality network with appropriate licenses and experience as well as facilities that are safe, clean and offer exceptional care. The application process for all product lines focuses on the review and verification of each practitioner's license, education, certification/accreditation, experience and quality-of-care attributes.

For consideration to participate in the Sunshine Health network, each practitioner or provider must meet the minimum qualifications outlined by the state of Florida Agency for Health Care Administration (AHCA), the Florida Department of Health, Sunshine Health and the National Committee for Quality Assurance (NCQA).

The CMS Health Plan Credentialing Department is responsible for verifying the information from all medical, long-term care and behavioral health practitioners and providers seeking a contract with Sunshine Health. The department performs credentialing for all lines of business.

Practitioners may include physicians, advanced registered nurse practitioners, physician assistants, podiatrists, chiropractors and therapists (occupational, physical and speech).

Providers may include the following: hospitals, free-standing surgical centers, urgent care centers, diagnostic radiology centers, adult living facilities, federal qualified health centers, community mental health centers, substance use treatment facilities, long-term rehabilitation centers, skilled nursing facilities, nurse registries and home health agencies, contractors for pest control, home modification and other services, durable medical equipment providers, home delivery meal providers, homemaker and companion services, hospice facilities, adult day care centers, adult family care homes and assisted living facilities.

Sunshine Health's partners and vendors are responsible for credentialing pharmacists, dentists and vision and hearing practitioners. Some practitioners and providers that are considered delegated entities follow Sunshine Health's policies and perform their own credentialing under the auspices of a Sunshine Health delegation contract with oversight by Sunshine Health.

No one source exists that can verify all the information on an application. Therefore, the credentialing staff must contact various sources to check the accuracy of the information – from verifying a practitioner's education and degree to determining the existence of any current or past sanctions against a provider or practitioner.

Once a practitioner or provider submits an application, the credentialing staff takes up to 60

calendar days to complete the credentialing process. It includes verification of the information on the application; verification of site visits of primary care physician (PCP) practices, obstetrics and gynecology (OB/GYN) practices, assisted living facilities and adult family care homes; final approval by a senior medical director; and review by the credentialing committee, if appropriate.

Practitioners and providers must be contracted and credentialed before accepting or treating members. PCPs are not permitted to accept member assignments until they are fully credentialed.

The process for practitioners involves several steps, including:

- Verification of the practitioner's license, DEA, education, training, board certifications and hospital privileges
- Determination of any malpractice history, sanctions or exclusions, legal actions and Medicare opt-out status, if applicable
- Verification of the practitioner's Social Security number, Level 2 background check and unsanctioned ownership of the practice
- Confirmation of work history
- Completion of a site visit of applicable practices by the Sunshine Health Contracting Department.

The process for credentialing providers includes:

- Verification of the facility's license and accreditation with appropriate governing bodies
- Determination that the facility is in good standing with state, federal and regulatory agencies
- Verification of unsanctioned ownership of the facility

The Credentialing Department also verifies that the Contracting Department conducted site visits at the appropriate practices and facilities.

Site visits are conducted in accordance with federal, state, and accreditation requirements. Focusing on quality, safety and accessibility, performance standards and thresholds were established for:

- Office-site criteria
- Physical accessibility
- Physical appearance
- Adequacy of waiting room and examination room space
- Medical/treatment record keeping criteria

Site visits are conducted for:

- Unaccredited facilities
- Primary Care Physicians
- Obstetrics/Gynecology
- At Initial & Re-credentialing
- When a complaint is received related to office site or quality of care concern

All participating practitioners and providers are required to go through the recredentialing process every 36 months. The recredentialing evaluation requires the verification of many of the same primary sources as required in the initial credentialing process as well as a summation of all practitioners' performance measured against current utilization and quality standards.

Credentialing Requirements for CMS Practitioners and Providers

The credentialing and recredentialing processes ensure participating practitioners and providers meet the criteria established by Sunshine Health as well as government regulations and standards of accrediting bodies. To maintain a current provider profile, practitioners and providers are required to promptly notify Sunshine Health of any relevant changes to their credentialing information.

Requirements for Practitioners

Practitioners must submit at a minimum the following information when applying for participation with Sunshine Health:

- Sunshine Health standardized application or online universal application, called a Council for Affordable Quality Healthcare (CAQH) Provider Data Collection form
- Signed and dated attestation of the correctness and completeness of the application, history of loss of license and/or clinical privileges, disciplinary actions, and/or felony convictions; lack of current illegal substance and/or alcohol abuse; mental and physical competence, and ability to perform the essential functions of the position, with or without accommodation (not older than 120 days)
- Signed and dated authorization and release of information form (not older than 120 days)
    - Copy of current malpractice insurance policy face sheet that includes expiration dates, amounts of coverage and provider's name, or evidence of compliance with Florida State regulations regarding malpractice coverage
    - Copy of updated W-9
    - Current copy of specialty/board certification certificate, if applicable
    - Curriculum vitae that lists, at a minimum, the most current five-year work history to include month and year
    - Disclosure of ownership form per practice location, listing any individuals or facilities having an ownership or control in the entity of 5 percent or greater as well as any general manager, business manager, administrator, director, or other individual who exercises operational or managerial control of the disclosing entity.
    - List of current hospital privileges at a Sunshine Health participating facility or covering physician agreement form if no hospital admitting privileges exist
    - Number of current Drug Enforcement Administration (DEA) registration certificates
    - Number of current unrestricted medical license to practice in the state of Florida
    - Total patient attestation load for all PCPs and OB/GYNs

In addition to the preceding list of items, behavioral health practitioners also must submit:

- Completed provider specialty profile

- Current copy of art therapy certification, if applicable

The CMS Health Plan verifies the following information submitted for credentialing and/or recredentialing purposes:

- State license through appropriate licensing agency
- DEA license through issuing agency
- Board certification or residency training and/or medical education
- National Practitioner Data Bank (NPDB)
- Hospital privileges in good standing at a participating Sunshine Health hospital
- Work history for the past five years
- Federal sanction activity, including Medicare/Medicaid services (Office of Inspector General System for Award Management)
- Completion of a site visit for all PCPs and OB/GYNs
- Fully or limited enrolled Medicaid ID
- State sanction activity, including Medicare/Medicaid final orders (AHCA)

Requirements for Providers

Providers are required to submit a credentialing application. Once the application is received, CMS Health Plan verifies the following information for credentialing and/or recredentialing purposes:

- Accreditations with the accepted agencies for each facility
- Certificates of license and AHCA inspection reports
- Federal Medicare and Medicaid sanctions
- Federal tax identification number (TIN)
- Liability claims against the provider in the past five years
- Medicaid eligibility
- National provider identifier (NPI) number
- Past or current disciplinary or legal action by the state of Florida against the provider

New Providers – A Provider is required to have a Florida Medicaid Provider number as well as a National Provider Identifier (NPI) to participate in Sunshine Health's network.

Special Provisions for CMS Health Plan Providers – Primary Care Providers who have recently completed a National Board for Certification of Training Administrators of Graduate Medical Education Programs-approved residency program in pediatrics or family practice and are eligible for board certification but have not yet achieved board certification may participate as Providers in the CMS Health Plan. If the non-board-certified Primary Care Provider does not achieve board certification within the first three years of initial credentialing, the Provider will be removed from the Plan panel and Members will be reassigned.

Credentialing Requirements for Behavioral Health Facilities

Behavioral health facilities/agencies must submit the following information when applying for participation:

- A complete signed and dated application
- List of current professional mental health/substance use disorder staff recommended for membership in the individual provider panel who are privileged to admit and/or treat members in the facility, to include license type, address, telephone numbers, social security numbers and Council for Affordable Quality Healthcare (CAQH) number
- Copy of accreditation letter with dates of accreditation in addition to a list of all practice locations covered under the applicable accreditation body from one of the following:
  - Joint Commission on Accreditation of Health Care Organizations (JCAHO)
  - Commission on the Accreditation of Rehabilitation Facilities (CARF)
  - Council on Accreditation (COA)
  - American Osteopathic Hospital Association (AOHA)
- Copy of the state or local license(s) and/or certificate(s) under which the facility operates
- Copy of Clinical Laboratory Improvement Amendments (CLIA), if applicable
- Copy of current malpractice insurance policy face sheet that includes expiration dates, amounts of coverage, the name of the liability carrier, and the insurance effective date and expiration date (month/day/year), and the provider's name
- List of satellite locations and services offered at each location (include copies of accreditation, license, insurance, CLIA and DEA certificate, if applicable)
- Copy of credentialing procedures
- Disclosure of ownership and controlling interest statement, if applicable
- For facilities contracted under a facility agreement that list a rendering NPI in box 24-J of the claim form that is different than the facility's billing NPI (box 33-A): Electronic (Excel) roster of clinicians rendering covered services with their credentialing materials

Facilities with targeted case management supervisors (TCM) and/or child behavioral health assessors (CBHA) must include a signed form as noted in the Florida TCM Medicaid manual as part of the credentialing and recredentialing process and submit the appendices with updated rosters.

Non-accredited facilities must include the following in addition to the items listed above:

- Copy of state or local fire/health certificate
- Copy of quality assurance plan
- Description of aftercare or follow-up program
- Organizational charts, including staff to patient ratio

Credentialing Committee

The credentialing committee has the responsibility to establish criteria for practitioner and provider participation, termination and direction of the credentialing procedures, including

provider participation, denial and termination. The committee bases decisions solely on business needs, completeness of the applicant's file, and review of any sanctions or malpractice history, as applicable, and not on race, ethnic/national identity, gender, age, or sexual orientation, or on type of procedure or plan type in which the provider specializes.

Committee meetings are held at least monthly and more often as deemed necessary.

Failure by the applicant to adequately respond to requests for additional information within 30 days of submission will result in discontinuance of the application process. Applicants wishing to be reconsidered for participation must resubmit all updated documentation.

Site visits are performed at applicable practitioner offices during the initial credentialing process, at recredentialing and upon a change in or additions to office locations. This review is conducted for all PCPs, pediatricians, OB/GYNs, high-volume behavioral health providers and non-accredited facilities. A satisfactory review of 80 percent or greater must be completed prior to finalization of the credentialing process. If the practitioner scores less than 80 percent, the practitioner may be subject to rejection and/or continued review until compliance is achieved. Site review evaluates appearance, accessibility, record- keeping practices and safety procedures.

In between credentialing cycles, Sunshine Health conducts provider performance monitoring activities on all network practitioners/providers. This monthly inquiry is designed to monitor any new adverse actions taken by regulatory bodies against practitioners/providers in between credentialing cycles. Additionally, Sunshine Health reviews monthly reports released by the Office of Inspector General to identify any network practitioners/providers who have been newly sanctioned or excluded from participation in Medicare or Medicaid.

Recredentialing

To comply with accreditation standards, Sunshine Health conducts the recredentialing process for practitioners and providers at least every three years from the date of the initial credentialing decision.

The process identifies any changes in the practitioner's licensure, sanctions, certification, competence or health status, which may affect the ability to perform services the practitioner is under contract to provide. It also includes a review of provider-specific performance data, including information from member complaints/grievances and other quality improvement activities.

Additionally, between credentialing cycles, a practitioner may be requested to supply current proof of any credentials such as state licensure, malpractice insurance, DEA registration or a copy of certificate of cultural competency training, which may have expiration dates before the next review process.

A provider's accreditation, licensure, Medicaid eligibility, AHCA inspection reports, and complaint, grievance or quality of care/services trends may be reviewed between credentialing cycles.

A practitioner or provider's agreement may be terminated at any time if Sunshine Health's

board of directors or the credentialing committee determines the practitioner or provider is no longer meeting credentialing requirements.

Right to Review and Correct Information

All providers and practitioners participating with Sunshine Health have the right to review information obtained by Sunshine Health to evaluate their credentialing and/or recredentialing application. This includes information obtained from any outside primary source such as the National Practitioner Data Bank, malpractice insurance carriers, and the Florida State Board of Medical Examiners and Florida State Board of Nursing for nurse practitioners. This does not allow a provider to review references, personal recommendations or other information that is peer- review protected.

Should a practitioner or provider believe any of the information used in the credentialing/recredentialing process to be erroneous, or should any information gathered as part of the primary source verification process differ from that submitted by a practitioner, he or she has the right to correct any erroneous information submitted by another party. To request release of such information, a written request must be submitted to the Sunshine Health Credentialing Department. Information is sent back to the practitioner or provider via restricted delivery certified mail within 14 days of the receipt of the request from the practitioner or provider. Upon receipt of this information, the practitioner or provider has 21 days to provide a written explanation detailing the error or the difference in information to Sunshine Health. Sunshine Health's credentialing committee then includes this information as part of the credentialing/ recredentialing process.

A practitioner or provider has the right to be informed of the application's status upon request to the Credentialing Department.

Right to Appeal Adverse Credentialing Determinations

Practitioner and provider applicants who are denied participation for reasons such as quality-of-care or liability claims have the right to request a reconsideration of the decision in writing within 30 days of formal notice of denial.

All written requests should include additional supporting documentation in favor of the applicant's reconsideration for participation in Sunshine Health.

The Credentialing Committee will review the reconsiderations at the next regularly scheduled meeting but in no case later than 60 days from the receipt of the additional documentation. If a hearing cannot be scheduled within six months due to the unavailability of the provider or practitioner or their representative, the request for the hearing is considered withdrawn. The committee will send the applicant a written response to his/her request within 60 days of the final decision.

Chapter 4: Utilization Management and Prior Authorization

Utilization Management Program Overview

The purpose of the utilization management program is to promote fair, impartial and consistent utilization decisions and coordination of care for health plan members. The Sunshine Health utilization management program serves to:

- Ensure confidentiality of personal health information
- Initiate process improvement activities to enhance utilization management practices
- Make evidence-based decisions that take into consideration medical necessity, appropriateness and availability of benefits
- Objectively and consistently monitor and evaluate the delivery of high quality and cost-effective services

Sunshine Health does not discriminate in the provision of services based on an individual's race, color, national origin, sex, age or disability, including to:

- Deny, cancel, limit or refuse to issue or renew a Sunshine Health insurance plan or other Sunshine health coverage
- Deny or limit coverage of a claim, or impose additional cost sharing or other limitations or restrictions on coverage
- Exclude or limit categories of services related to gender transition (for the Medicaid product, this follows the benefits established by AHCA)
- Use discriminatory marketing practices or benefit designs

All utilization management employees are required annually to sign an affirmative statement regarding compensation. Compensation or incentives are prohibited to Sunshine Health staff or any subcontractor or vendor performing utilization management on behalf of Sunshine Health based on the following circumstances:

- Amount or volume of adverse determinations
- Reductions or limitations on lengths of stay, benefits or services
- Frequency of telephone calls or other contacts with health care practitioners or patients

Utilization management policies and processes serve as an integral component to prevent, detect and respond to fraud, waste and abuse among practitioners and members. The utilization management department works closely with the compliance officer, risk manager and Centene Corporation's special investigation unit to resolve any potential issues that are identified.

➢ See Fraud, Waste and Abuse.

UM Contact Information

The utilization management department is staffed from 8 a.m. to 5 p.m. Monday through Friday. Providers should call Provider Services at 1-844-477-8313 and select the prompt for authorization.

After-hours requests for members in the following plans are received by the Sunshine Health 24-hour nurse advice line, which may be contacted by calling the number assigned to each product. The nurse advice line can contact a utilization management staff for reviews after hours.

Clinical Practice Guidelines

Sunshine Health adopts preventive and clinical practice guidelines from evidence-based sources for the provision of acute, chronic and behavioral health services relevant to member health needs or for identified opportunities for improvement. The criteria in the clinical guidelines are used to ensure consistency with all decisions relating to utilization management, member education and covered services.

Sunshine Health adopts practice guidelines that:

- Are based on valid and reliable clinical evidence or a consensus of health care professionals in a field
- Are adopted in consultation with providers
- Consider the needs of the members

Guidelines are presented to the quality improvement committee for appropriate physician review and adoption. They are updated at least every two years or upon significant new scientific evidence or changes in national standards.

Providers may view Sunshine Health's preventive and chronic condition management on our Practice Guidelines web page.

Emergency Services

CMS Health Plan covers emergency services by a qualified provider, including non-participating providers, until the member is stabilized. If CMS Health Plan determines a medical emergency does not exist, CMS Health Plan reimburses the provider for any screening, evaluations and examinations conducted to make the determination as defined by the requirements of the product in which the member is enrolled.

During an episode of emergency care, CMS Health Plan does not require prior authorization, regardless of whether the member obtains a service within or outside Sunshine Health's network.

If the provider determines an emergency medical or behavioral health condition exists, the facility to which the member was admitted must notify Sunshine Health within two (2) business days after the inpatient admission, or after a Baker Act (BA52) psychiatric admission.

If the facility is unable to notify CMS Health Plan, the facility must document its notification

attempts or the circumstances that precluded the facility's attempts to notify Sunshine Health. Sunshine Health does not deny payment for emergency services and care based on a facility's failure to comply with the notification requirements of this section.

CMS Health Plan covers any medically necessary duration of a stay in a non-participating facility resulting from a medical emergency until Sunshine Health can safely transport the member to a participating facility. The attending emergency physician or treating provider is responsible for determining when the member is sufficiently stabilized for transfer.

Services Requiring Prior Authorization

Prior authorization requires the provider to make a formal medical necessity determination request to the plan before the service may be rendered.

"Medical necessity" or "medically necessary" means any goods or services provided in accordance with generally accepted standards of medical practice that are necessary to palliate the effects of a terminal condition or to prevent, diagnose, correct, cure, alleviate or preclude deterioration of a condition that threatens life, causes pain or suffering, or results in illness or infirmity. For purposes of determining Medicaid reimbursement, the agency is the final arbiter of medical necessity. In making determinations of medical necessity, the agency must, to the maximum extent possible, use a physician in active practice, either employed by or under contract with the agency, of the same specialty or subspecialty as the physician under review. Such determination must be based upon the information available at the time the goods or services were provided.

Providers should refer to the Pre-Auth Check Tool to look up a service code to determine if prior authorization is needed. To view those codes, select the Pre-Auth Check Tool link followed by the product in which the Sunshine Health member is enrolled. Under the Provider Resources section of our website, providers can find our specific service requirements and medical necessity criteria. Providers may request authorizations though our secure portal. The specific service requirements are built into many of these forms.

Submitting Prior Authorization Requests

Medical practitioners and providers are to submit requests for inpatient or outpatient authorizations – except for home-health requests related to hospital discharges – through the secure, online portal at SunshineHealth.com unless otherwise previously approved by Sunshine Health. Behavioral health providers are to submit requests for inpatient psychiatric services by phoning 1-844-477-8313. All other medical or behavioral health authorization requests submitted via telephone or fax will not be processed unless the secure online portal is experiencing temporary technical difficulties or providers do not have Internet access. Most Behavioral Health Outpatient Services will not require prior authorization. Providers should refer to the Pre-Auth Check Tool to look up a service code to determine if prior authorization is needed. To view those codes, select the Pre-Auth Check Tool followed by the product in which the Sunshine Health member is enrolled.

Requests for residential treatment (behavioral health or substance abuse) and admission into a State Inpatient Psychiatric Program are available on our Behavioral Health web page, require prior authorization and should be submitted via fax to 1-844-244-9755.

DME and home-health requests related to hospital discharges are available on our Manuals, Forms and Resources web page and may be faxed to 1-844-801-8413. This process has been established to assist with prompt reviews of services related to an inpatient discharge.

Practitioners, providers and/or facilities must submit prior authorization requests for services in all lines of business within the following periods:

- Non-emergent/non-urgent pre-scheduled services requiring prior authorization: Within seven calendar days before the requested service date
- Urgent or emergent inpatient admission: Within two business days following a medical admission or 10 days following an admission to a behavioral health facility
- Emergent or urgent care services to stabilize a member: Prior authorization is not required
- Hospice authorization request for admissions that occur outside of business hours, including weekends and holidays: The following business day

Timeliness of Decision

The Utilization Management Department responds to requests for authorization within established timeframes as determined by NCQA guidelines and AHCA requirements for all Medicaid products.

Non-Urgent Pre-Service Determination

Determinations for non-urgent, pre-service medical and behavioral health prior authorization requests are made within seven calendar days of receipt of the request. If Sunshine Health is unable to issue a decision due to matters beyond its control, it may extend the decision timeframe once, for up to an additional four calendar days.

For approved requests the utilization management staff will provide written follow-up documentation with a non-participating provider within one (1) business day after determination.

Urgent or Expedited Pre-Service Determination

Determinations for urgent medical pre-service or expedited requests are made within 48 hours of receipt of the requests. If the utilization management staff requires additional information before issuing a determination, the staff may implement a one-time extension of one (1) additional calendar day.

If the request for authorization is approved, the utilization management staff will provide written follow-up documentation with a non-participating provider within one (1) business day after determination.

If the determination results in a denial, reduction or termination of coverage, Sunshine Health

notifies the requesting provider verbally within one business day. Written notification to the provider and member follows within 72 hours and includes information about the member appeal process and the rationale used to make the adverse determination.

Urgent Concurrent and Post-Stabilization Determination

An urgent concurrent and post-stabilization request is a request for services made while the member is in the process of receiving care. A determination is issued within 24 hours of receipt of the request for services.

If the request is approved, the utilization management staff provides verbal or faxed notification within 24 hours. For continued inpatient stay requests, the practitioner and the servicing facility may assume continued approval unless otherwise informed via a denial notification.

Medical Necessity Review

When a request for authorization for services has been received from a practitioner or provider, the utilization management nurse or licensed clinician reviews all relevant clinical information about the member's condition, including factors that may require special consideration such as co- morbidities, psychosocial issues, home environment and support structure.

The utilization management professional also considers the AHCA MMA definition of medical necessity, American Society of Addiction Medicine (ASAM) criteria for substance use admissions, InterQual criteria and other applicable guidelines, such as Florida's Medicaid coverage and limitations policy, or the Florida Department of Health.

If the information does not meet the applicable criteria, a medical director or appropriate health care practitioner reviews the request.

If the medical director or contracted vendor decides denies or limits a service, the requesting provider may request a peer-to-peer review by calling 1-844-477-8313.

Medical Necessity of Services Under CHCUP/EPSDT

The Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program provides comprehensive and preventive healthcare services for children under age 21 who are enrolled in Medicaid. EPSDT is key to ensuring that children and adolescents receive appropriate preventive, dental, mental health, developmental and specialty services. The Child Health Check-up Program (CHCUP) is Florida's name for EPSDT.

Services that fit within the scope of coverage under CHCUP/EPSDT must be provided to a child if medically necessary to correct or ameliorate the individual child's physical or mental condition.

➢ See Credentialing Requirements for MMA Practitioners and Providers.

The determination of whether a service is medically necessary for an individual child will be

made on a case-by-case basis, considering the needs of the child. If the provider has identified that the child may need a service that is not on the AHCA state benefit plan or that the child may need services which exceed the applicable benefit limit, the provider may contact our utilization management department at 1-844-477-8313. The provider will need to give the clinical rationale and evidence for the specific services.

The determination considers the child's long-term needs, not just what is required to address the immediate situation, and should consider all aspects of a child's needs, including nutritional, social development, and mental health and substance use disorders.

CHUP/EPSDT does not require coverage of treatments, services, or items that are experimental or investigational.

Other considerations regarding medical necessity for CHCUP/EPSDT include the following:

- CMS Health Plan may not deny medically necessary treatment to a child based on cost alone but may consider the relative cost effectiveness of alternatives as part of the prior authorization process
- CMS Health Plan may approve services in the most cost-effective mode if the less expensive service is equally effective and available
- CMS Health Plan must consider the child's quality of life
- The provision of services must be delivered in the most integrated setting appropriate to a child's needs

Post-Service Decisions/Retrospective Review

CMS Health Plan will complete a retrospective medical necessity review if the following services were delivered without prior authorization or timely notification:

- Inpatient admissions when the member is still hospitalized
- Outpatient services when the member is still receiving the outpatient services requiring authorization
- Planned transplant that has not yet occurred
- Hospice

For these reviews, the utilization management department follows the same process as outlined in the urgent pre-service decisions (expedited prior authorization) section.

➢ See Urgent or Expedited Pre-Service Determination.

CMS Health Plan requests notification – but will not deny claims payment based solely on lack of notification – for the following:

- Obstetrical admissions exceeding 48 hours for vaginal delivery and 96 hours for caesarean sections
- Obstetrical care with a non-participating provider
- Transplants

CMS Health Plan does not make retrospective review determinations for services that have already been rendered. Medical providers may submit the claim for processing, which will be denied as "services not authorized," and may initiate the provider dispute resolution process

after receiving the denied claim notice.

In situations in which a service does not meet medical necessity and the claim has been denied with an EXEB code, providers may submit a redetermination request to Sunshine Health for a review of the denial along with supporting documentation to prove medical necessity. Instructions for submitting the request are contained in the information that is sent with the rejected claim.

Since EXEB Denials require medical records for a redetermination review, if the provider fails to provide the medical records before the 60-day turn-around-time, the claim shall continue to be denied. A Sunshine Health Medical Director reviews the case and makes an approval or denial determination based on Medical Necessity.

➢ See Process for Claims Reconsiderations and Disputes.

Continuity of Care

Continuity of Care for New Members

Members in active treatment may continue care when such care is medically necessary, through the completion of treatment of a condition for which the Member was receiving at the time of the termination or until the Member selects another treating provider, for a minimum of sixty days, not to exceed six months from a not-for-cause terminated provider.

Sunshine Health will allow pregnant Members who have initiated a course of prenatal care, regardless of the trimester in which care was initiated, to continue care with a not-for-cause terminated treating provider until completion of postpartum care.

For continued care under this provision, Sunshine Health and the terminated provider shall continue to abide by the same terms and conditions as existed in the terminated contract.

Transition of Care

CMS Health Plan will honor any written documentation of prior authorization of ongoing covered services for a maximum of 90 days for all new enrollments, or until the enrollee's PCP or behavioral health service provider (as applicable to medical care or behavioral healthcare services, respectively) reviews the enrollee's plan of care, whichever comes first.

The following services may extend beyond the 90-day transition of care period, and Sunshine Health shall continue the entire course of treatment with the Member's current Provider as described below:

- Prenatal and postpartum care – Sunshine Health shall continue to pay for services provided by a pregnant Member's current Provider for the entire course of her pregnancy, including the completion of her postpartum care (six weeks after birth), regardless of whether the Provider is in Sunshine Health 's network
- Transplant services (through the first year post-transplant) – Sunshine Health shall continue

to pay for services provided by the current Provider for one year post-transplant, regardless of whether the Provider is in Sunshine Health 's network

- Oncology (radiation and/or chemotherapy services for the current round of treatment) – Sunshine Health shall continue to pay for services provided by the current Provider for the duration of the current round of treatment, regardless of whether the Provider is in Sunshine Health 's network
- Full-course therapy Hepatitis C treatment drugs

During the transition of care period, authorization is not required for certain Members with previously approved services by the state or another managed care plan. We will continue to be responsible for the costs of continuation of such Medically Necessary Covered Services, without any form of prior approval and without regard to whether such services are being provided within or outside Sunshine Health's network until such time as Sunshine Health can reasonably transfer the member to a service and/or network Provider without impeding service delivery that might be harmful to the Member's health. However, notification to Sunshine Health is necessary to properly document these services and determine any necessary follow-up care.

Sunshine Health will cooperate with the receiving health plan regarding the course of ongoing care with a specialist or other Provider when Members move to a new health plan for transition of care needs.

When we becomes aware that a covered member will be disenrolled from CMS Health Plan and will transition to a Medicaid Fee-For-Service (FFS) program or another managed care plan, the CMS Health Plan Case Manager who is familiar with that Member will provide a Transition of Care (TOC) report to the receiving plan, or appropriate contact person for the designated FFS program.

If a Provider receives an adverse claim determination which they believe was a transition of care issue, the Provider should fax the adverse claim determination to the Appeals department with documentation of approval from agency or previous managed care organization for reconsideration.

Care Management Program

CMS Health Plan offers comprehensive care management services to facilitate health status assessment, care planning, and advocacy to improve health and quality of life outcomes for its Members and their guardians. The CMS Health Plan Care Management Program is built around every Member's unique healthcare needs to assess their needs, facilitate their access to care, and help them when they need CMS Health Plan:

- Identify
- Reach
- Engage
- Assess
- Care
- Help

CMS Health Plan understands that care management must complement primary care, specialty care,

behavioral health services, ancillary services, outpatient and inpatient services. The plan's care management services are specifically designed to:

- Foster the relationship between a Member and his or her providers.
- Empower Members and their guardians to take control of their health by initiating and reinforcing healthy behaviors.
- Help Members and their guardians obtain timely, effective, quality and culturally-sensitive care and minimize gaps in care
- Assist Members and their guardians with understanding and accessing their benefits to improve Member outcomes

The plan's multidisciplinary care management team includes registered nurses (RNs) and licensed behavioral health clinicians who perform comprehensive assessments of the Members' health status, develop an individualized person and family-centered care plans with agreed- upon goals, monitor outcomes and update the care plans as necessary. Our CMS Health Plan care managers share the care plans and work collaboratively with Providers, schools and other relevant agencies to coordinate and facilitate access to care and services when needed. Care plans are available by mail or fax and can be accessed on the Provider Portal. CMS Health Plan requests that Providers participate as active members of the interdisciplinary care team for those Members that are engaged in case and disease management programs.

All children enrolled in the CMS Health Plan are enrolled in Care Management including children with:

- **Catastrophic Conditions** – Traumatic injuries, i.e., amputations, blunt trauma, spinal cord injuries, head injuries, burns and multiple traumas
- **Multiple Chronic Conditions** – Multiple comorbidities such as diabetes or multiple intricate barriers to quality healthcare, i.e., AIDS or a comorbid behavioral health and complex medication condition.
- **Transplantation** – Organ failure, donor matching, post-transplant follow-up
- **Complex Needs** – Children receiving skilled nursing facility services, Medical Foster Care Services, private duty nursing, and prescribed pediatric extended care.
- **Special Healthcare Needs** – Children who have serious medical or chronic conditions with severe chronic illnesses, physical, mental and developmental disabilities
- **At Risk Populations:** Children in the State Inpatient Psychiatric Program (SIPP) as well as those with involvement, or at risk for involvement, with the justice system, DJJ or DCF.

In addition to the covered services, CMS Health Plan offers and coordinates access to quality enhancements (QEs). It is our goal to promote positive health outcomes by offering the following quality enhancements/services.

- Domestic Violence: CMS Health Plan ensures that PCPs screen members for signs of domestic violence and shall offer referral services to applicable domestic violence prevention community agencies.
- Pregnancy Prevention: CMS Health Plan conducts regularly scheduled pregnancy prevention programs and makes a good faith effort to involve members in existing community pregnancy prevention programs, such as the Abstinence Education Program. The programs target teen members, but are open to all members, regardless of age,

gender, pregnancy status or parental consent.

- Prenatal/Postpartum Pregnancy Programs: CMS Health Plan provides regular home visits, conducted by a home health nurse or aide, and counseling and educational materials to pregnant members and postpartum Members who are not in compliance with the plan's prenatal and postpartum programs. CMS Health Plan coordinates our efforts with local Healthy Start Care Coordinator/ Case Managers to prevent duplication of services.
- Behavioral Health Programs: CMS Health Plan provides outreach to homeless and other populations of members at risk of justice system involvement, as well as those members currently involved in this system, to assure that services are accessible and provided when necessary.
- Other Programs and Services: CMS Health Plan actively collaborates with community agencies and organizations, including County Health Departments, local Early Intervention Programs and local school districts in offering services.

Disease Management Program

Disease management is a component of Care Management. Clinically trained care managers support Members with targeted chronic conditions. CMS Health Plan's primary role is to give its Members and their guardians the education and the tools that they need to take control of their health. To accomplish this, CMS Health Plan identifies Members with chronic conditions and provides education and health coaching to empower them to make behavior changes and self-manage their condition(s).

To support the Members' relationship with their physicians, we will provide the disease management plan of care through our Provider Portal. Our physician engagement strategies are designed to give Providers feedback and information about their patients' progress as well as any care gaps or risk management issues.

The Disease Management Program targets the following conditions:

- Asthma
- Diabetes
- Cancer
- Sickle cell anemia
- Phenylketonuria (PKU) and other metabolic conditions
- Developmental disabilities, including autism
- Rare congenital conditions including cleft lip/palate, spina bifida, congenital heart disease;
- Mental health including ADHD and severe emotional disturbance;
- Substance abuse;
- Hemophilia;
- HIV/AIDS; and
- Children with special healthcare needs.

CMS Health Plan disease management process will consist of:

- Identification: Identify and outreach to all Members to perform an initial screening to

determine who has chronic conditions and may benefit from disease management program(s)
- Assessment and Plan: Assessment completed and individualized disease management plan of care developed
- Education and Support: Develop a disease management focused care plan in collaboration with the Member and guide them through the disease management milestones
- Program Evaluation: Evaluate the effectiveness of the disease management program, both from a patient-centered and population management perspective

CMS Health Plan disease management offerings employ innovative biometric monitoring solutions for high-risk Members diagnosed with CHF, COPD, CAD and diabetes. Biometric measurement devices provide critical, actionable data to the Member's Care Manager as well as to their Provider regarding biometric values, such as weight, glucose levels or blood pressure readings, combined with Member-reported symptom data specific to their condition.

CMS Health Plan makes education available to Providers and Members regarding their health conditions on both the Member and Provider Portals which can be accessed through the Secure Provider Portal.

Continuity of Care Following Provider Termination

In addition to the Provider termination information included in the Agreement, Providers must adhere to the following terms:

- Any contracted Provider must give at least 90 days' prior written notice to Sunshine Health before terminating their relationship with CMS Health Plan "without cause," unless otherwise agreed to in writing. Requests can be emailed to the Provider Relations Department at Sunshine_Provider_Relations@sunshinehealth.com in addition to sending via mail and facsimile, as long as sufficient notice is provided as indicated above. This ensures that adequate notice may be given to CMS Health Plan Members regarding the Provider's participation status with CMS Health Plan. Please refer to the Agreement for the details regarding the specific required days for providing termination notice, as the Provider may be required by contract to give more notice than listed above.
- Unless otherwise provided in the termination notice, the effective date of a termination will be on the last day of the month.
- Members in active treatment may continue care when such care is Medically Necessary, through the completion of treatment of a condition for which the Member was receiving at the time of the termination or until the Member selects another treating Provider, for a minimum of 60 days, not to exceed six months after the Provider termination. For pregnant Members who have initiated a course of general care, regardless of the trimester in which care was initiated, continuation shall be provided until the completion of postpartum care.

Chapter 5: Provider Requirements for Pregnant Members and Newborns

Notice of Pregnancy

Practitioners must submit a notice of pregnancy (NOP) form to Sunshine Health within 10 days of the member's first prenatal visit and identify the estimated date of confinement and delivery facility. The form may be accessed and submitted electronically via the Secure Provider Portal at SunshineHealth.com/login. Once in the portal, click on the "Assessments" tab.

Providers can also download a paper version of the NOP form (PDF) from our website.

This information is used to identify members for the Start Smart for Your Baby® maternity case management program. The program's care managers educate pregnant members; address barriers – particularly those that contribute to poor birth outcomes; arrange appointments; and link members to community resources, such as Florida's Healthy Start and the Women, Infants and Children (WIC) programs.

- See Florida's Healthy Start Program.

Practitioners are encouraged to refer any pregnant members who may benefit from the Start Smart for Your Baby® program by calling 1-866-796-0530 and selecting the case management prompt.

Prenatal Vitamins Benefit

CMS Health Plan members receive an over-the-counter (OTC) medication benefit that includes prenatal vitamins. Additionally, the CMS Health Plan Preferred Drug List (PDL) covers some prenatal vitamins. A member must have a prescription for the over-the-counter prenatal vitamin, which they may take to a participating pharmacy to obtain.

Doula Expanded Benefit

A doula is a person who provides emotional and physical support to a member's pregnancy and childbirth. This benefit is available to all pregnant Children's Medical Services Health Plan members ages 13 and older. **Some services may require prior authorization.**

Florida's Healthy Start Program

Florida's Healthy Start program provides universal risk screening of all pregnant women and newborn infants to identify those at risk of poor birth, health and developmental outcomes. The voluntary program serves pregnant women until they reach their goals, or up to six weeks post-partum, and infants up to age 3 depending on resources and family consent.

Practitioners managing the care of pregnant Sunshine Health members must follow AHCA requirements for the Healthy Start program and agree to:

- Collaborate with the Healthy Start care coordinator within the member's county of residence to assure delivery of risk-appropriate care
- Complete the AHCA-approved Healthy Start (prenatal) risk screening instrument and submit it to the county health department in the county where the prenatal screen was completed
- Refer all infants, children up to age 5 and pregnant, breast-feeding and postpartum women to the local WIC office
- Refer infants born to members who are HBsAg-positive to Healthy Start regardless of their Healthy Start screening score
- Refer to case management those pregnant members or infants who have actual or potential factors associated with high risk, such as HIV, hepatitis B, substance abuse, domestic violence or any other risk condition

Florida hospitals must file the Healthy Start (prenatal) risk screening instrument certificate of live birth with the county health department in the county where the infant was born.

Sunshine Health agrees to educate providers in the following Healthy Start tasks and responsibilities:

- Use of the AHCA-approved Healthy Start (prenatal) risk screening instrument
- Submission of the Healthy Start (prenatal) risk screening instrument to the county health department in the county where the prenatal screen was completed within 10 business days of the screening
- Referrals of all infants, children up to age 5, and pregnant, breast-feeding and postpartum women to the local WIC office
- Referrals of infants born to members who are HbsAg-positive to Healthy Start
- Documentation of Healthy Start screenings, assessments, findings and referrals in the members' medical records

Medical Record Documentation Requirements for Pregnant Members

Obstetricians, gynecologists and PCPs are required to include the following documentation in the medical record for pregnant Sunshine Health members:

- Completed Healthy Start risk screening instrument along with notes that:
  - The member was given a copy of the completed Healthy Start risk screening

instrument
    - The completed Healthy Start risk screening instrument was sent to the local county health department
    - The member was referred to the Healthy Start program based on her risk score or because the member has HIV, hepatitis B, substance abuse or noted domestic violence history
- Completed WIC program referral form for the pregnant, breast-feeding or post-partum member along with notes indicating:
    - The member was given a copy of the completed form
    - The member was referred to the WIC program
    - The member required special medical or nutritional needs at the time of WIC referral
    - Infant's current height/length and weight recorded within 60 days of WIC appointment
    - Laboratory results for hemoglobin or hematocrit levels at the time of the member's WIC referral
- HIV-related documentation, including:
    - Notes that the member was given HIV counseling and offered HIV testing at the initial prenatal visit and again at 28 and 32 weeks
    - Documentation to support an attempt to obtain a signed objection if a pregnant member declines an HIV test
        - Documentation that a pregnant member with HIV was counseled about and offered the latest antiretroviral regimen recommended by the U.S. Department of Health & Human Services (Public Health Service Task Force Report entitled Recommendations for the Use of Antiretroviral Drugs in Pregnant HIV-1 Infected Women for Maternal Health and Interventions to Reduce Perinatal HIV-1 Transmission in the United States)
    - Hepatitis B-related documentation, including:
        - Laboratory test results showing the pregnant member was screened for the hepatitis B antigen HbsAg during the first prenatal visit
        - Laboratory tests for a second screening for HbsAg from 28 to 32 weeks of pregnancy for those who tested negative at the initial screening and who are considered high-risk for hepatitis B infection
        - Copy of the report that was sent to the local CHD perinatal hepatitis B prevention coordinator and to Healthy Start for members confirmed HbsAg-positive
        - Medical record documentation to support an infant born to an HbsAg-positive mother was referred to Healthy Start
        - A copy of the DH form 2136 for the member or medical record documentation indicating the form was filed electronically for members who test HbsAg- positive

Pregnancy-Related Care by Maternity Providers

Sunshine Health has adopted nationally recognized clinical practice guidelines from the American Academy of Family Physicians on prenatal care and related issues, including preconception care, folic acid, medication safety, nausea and vomiting, pregnancy complications

and prenatal screening. Additionally, Sunshine Health has adopted the American Congress of Obstetricians and Gynecologists guidelines for deliveries before 39 weeks.

Maternity providers are encouraged to follow these recommendations:

- Complete a pregnancy test and note results
- Complete a preterm delivery risk assessment by week 28
- Complete the notification of pregnancy form via the secure provider portal within 30
- days of the first prenatal visit for incentive reward
- Discuss arrangements for delivery (especially for high-risk members), family planning and contraception alternatives, as well as the importance of timely childhood checkups for infants
- Discuss nutritional concerns and/or make referrals for:
  - Breastfeeding and/or breast milk substitutes
  - Individualized nutritional counseling
  - Nutritional assessment
  - Nutritional care plan
- Document referrals and follow up appointments made during pregnancy
- Schedule return prenatal visits at least every four weeks until week 32, every two weeks until week 36, and every week thereafter until delivery, unless the member's condition requires more frequent visits, and document attempts to reschedule missed appointments
- Screen for tobacco use and offer counseling and treatment

Hospital Service and Documentation Requirements for Newborns

Hospitals are required to perform the following documentation for Sunshine Health newborns:

- Completed Healthy Start infant (postnatal) screening instrument and note indicating the newborn's mother was mailed a copy of the completed Healthy Start risk screening instrument within five business days with a copy of the completed screening attached to the member's medical record
- Labor- and delivery-related records indicating:
  - A cord blood sample was taken to determine Rh and value of Coombs test if the mother was Rh negative
  - A physical assessment of the infant's abnormalities and/or complications, if applicable, was completed
  - Newborn was given the standard dose of vitamin K
  - Newborn was given hepatitis B immune globulin (HBIG) and hepatitis B vaccine once stable
  - Newborn was given prophylactic eye medications into each eye
  - Newborn was screened for metabolic, heredity and congenital disorders and any hearing abnormalities
  - Referrals were made based on the newborn's status, including but not limited to referrals to any specialty physician or Healthy Start, including infants born to a HbsAg-positive mother

- Weight, length and APGAR score of the newborn

Infant Care Service and Documentation Requirements

PCPs are required to perform the following for Sunshine Health infants in their care:

- Completed Healthy Start infant (postnatal) risk screening instrument within five business days of birth along with a note indicating:
  - The infant's parent/guardian was given a copy of the completed Healthy Start Risk screening instrument
  - The completed Healthy Start risk screening instrument was sent to the local county health department
  - Referrals were made to the Healthy Start program based on the infant's risk score or due to risk factors associated with the mother such as HIV, hepatitis B, substance abuse or domestic violence history
- Completed WIC program referral form including the infant's current height and weight along with the following:
  - Laboratory results for hemoglobin or hematocrit levels at the time of the infant's WIC referral
  - Note identifying any special medical or nutritional needs of the infant at the time of the WIC referral
  - Note indicating that the parent/guardian was given a copy of the completed WIC program referral form
- Discussion with the infant's mother/parent/guardian of the important of timely childhood check-ups (CHCUP) along with dates of and notes for the CHCUP visits

➢ See EPSDT and CHCUP Programs.

- For infants born to an HbsAg-positive mother:
  - Laboratory test results for both HbsAg and hepatitis B surface antibodies (anti- HBs) at 6 months following the completion of the vaccine to monitor the success or failure of the therapy
  - Referral to Healthy Start and to the perinatal hepatitis B prevention coordinator
- For infants who tested HbsAg positive:
  - A copy of the Florida Department of Health form #2136 or documentation indicating the form was filed electronically
  - A copy of the report sent to the county health department indicating the positive HbsAg results for the infant before 24 months of age within 24 hours of receipt of positive test results
  - Report to the local county health department indicating member demographics, race, ethnicity, test results and immunization date

Chapter 6: Provider Requirements for Treating Children and Youth

EPSDT and CHCUP Programs

The Child Health Check-up Program (CHCUP) is Florida's name for the federal Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program, which promotes the early detection and treatment of health conditions that could lead to chronic illnesses and disabilities in children. The program is for children under age 21 enrolled in Medicaid and provides for coverage of all medically necessary services that are included within the categories of mandatory and optional services listed in the Social Security Act, regardless of whether such services are covered under the state plan and regardless of any restrictions or limits that the state may impose on coverage for adult services if those services could be covered under the state plan.

CHCUP/EPSDT covers a treatment or service that is necessary to "correct or ameliorate" defects and physical or mental illnesses or conditions. Services include the following:

- Home health services, including medical equipment, supplies and appliances
- Physical, speech/language and occupational therapies
- Physician, nurse practitioner and hospital services
- Treatment for mental health and substance use disorders
- Treatment for vision, hearing and dental diseases and disorders

A service does not need to cure a condition to be covered. EPSDT services are covered when they prevent a condition from worsening or prevent development of additional health problems.

Services that maintain or improve a child's current health condition are covered because they "ameliorate" or "make more tolerable" a condition.

PCPs and/or pediatricians are responsible for completing these child health check-ups according to the "Bright Futures" periodicity schedule to ensure children routinely have health screenings combined with appropriate diagnosis, treatment, referrals and follow up. This schedule is available on our Practice Guidelines web page under "Immunizations."

Screenings included as part of CHCUP are the following:

- Appropriate immunizations according to the recommended childhood immunization schedule for the United States
- Comprehensive health and developmental history, including assessments of past medical history, developmental history and behavioral health status

- Comprehensive unclothed physical examination, developmental assessment and nutritional assessment
- Dental screening, including a direct referral to a dentist beginning at age 2 or as early as indicated, i.e. first tooth
- Health education, including anticipatory guidance
- Hearing screening, including objective testing as required
- Laboratory testing, including blood lead testing
- Tuberculin skin testing as appropriate to age and risk
- Vision screening, including objective testing as required

Comprehensive periodic screenings must be performed according to the timeframes identified in the periodicity schedule. In addition, a child may receive a child health check-up whenever it is medically necessary or requested by the child, the child's parent or the child's caregiver. If a child is diagnosed as having a medical problem, the child should be referred to and treated by the appropriate provider, such as a specialist, dentist or physical therapist.

PCPs or pediatricians are required to:

- Provide immunizations in accordance with the "recommended childhood immunization schedule for the United States" or when medically necessary
- Provide for the simultaneous administration of all vaccines for which a member under the age of 21 is eligible at the time of each visit

PCPs or pediatricians may follow only true contraindications established by the Advisory Committee on Immunization Practices ("ACIP"), unless:

- In making a medical judgment in accordance with accepted medical practices, such compliance is deemed medically inappropriate; or
- The requirement is not in compliance with Florida law, including Florida law relating to religious or other exemptions

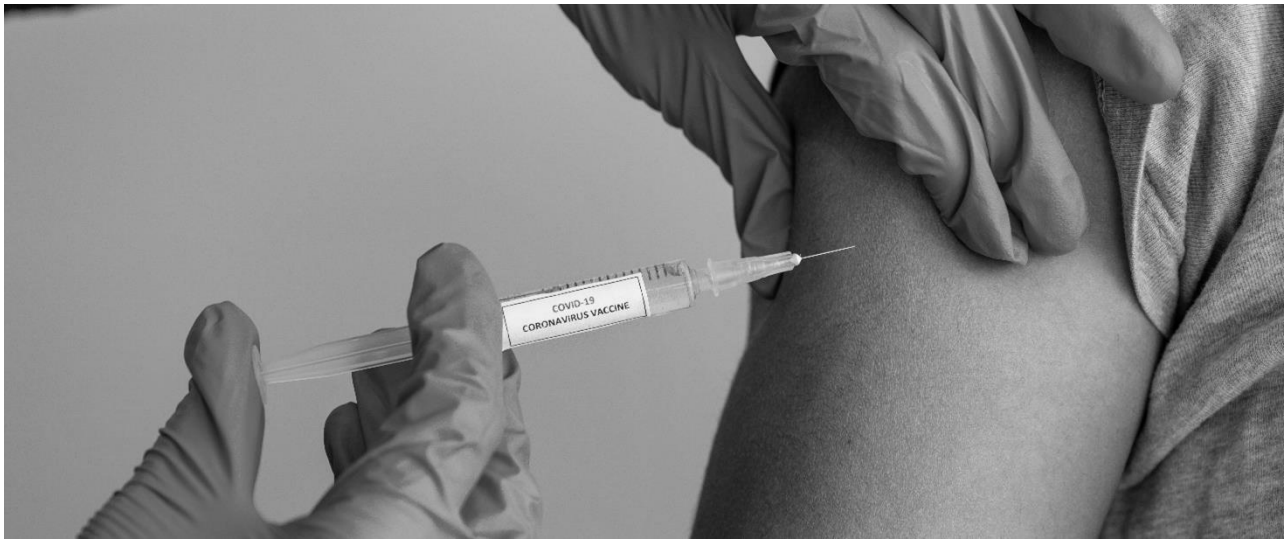
Vaccines for Children Program

Sunshine Health requires contracted practitioners who administer vaccines to children to participate in the "Vaccines for Children" (VFC) program. The Florida VFC program provides routine vaccines to children 0 through 18 years of age who meet program eligibility at no cost to the member or physicians and eliminates the physicians' need to refer children to county health departments. Sunshine Health does not reimburse for vaccines that are covered under this program but will pay the administrative fee.

(Note that Title XXI MediKids enrollees do not qualify for the VFC program. Managed by AHCA, MediKids is the Florida KidCare program, which provides low-cost health insurance for children ages one through four. Providers should bill Medicaid fee-for-service directly for vaccines administered to Title XXI MediKids participants.)

If a PCP does not routinely administer immunizations as part of his/her practice, the PCP may refer the child to the member's county health department but must maintain a current record of the child's immunization status.

As immunizations are a required component of CHCUP screening services, an assessment of a child's immunization status should be made at each screening, and immunizations should be administered as appropriate. If a child is due for an immunization, the immunization must be administered at the time of the screening. However, if illness precludes immunization, the reason for delay should be documented in the child's record, and an appointment should be scheduled for the child to return for immunization later.



Florida SHOTS™

PCPs are required to register with Florida's State Health Online Tracking System (SHOTS™), a free, statewide centralized online immunization registry that tracks vaccination records. Providers must report vaccine usage and inventories to the VFC program based on their designated reporting schedule and must submit the vaccine report form in Florida SHOTS during their ordering cycle.

In addition, providers are required to enter their twice daily temperature readings for each storage unit into Florida SHOTS. Providers may refer to the Florida Health website for more information about VFC.

Nursing Facility Notification Requirements

Nursing facilities are required to notify the Department of Children and Families of any MMA member under the age of 18 who is admitted to or discharged from their facility. The facility must submit a completed client referral/change form (DCF #2506A) to DCF within 10 business days of the admission and a completed client discharge/change notice (DCF #2506) to DCF within 10 business days of discharge.

Chapter 7: Member Complaints, Grievances and Appeals

Member Rights for Grievances and Appeals

Federal law requires Medicaid managed care organizations to have internal grievance procedures under which Medicaid members or providers acting as their authorized representatives may challenge a denial of coverage or payment for medical assistance. These procedures must include an opportunity to file a complaint, grievance and/or an appeal and the right to seek a Medicaid fair hearing or subscriber assistance hearing upon successful completion of the internal appeal process.

Providers may file a grievance or appeal on behalf of the member only with the member's written consent. Members may use a sample consent form, found on the member portal of the Sunshine Health website, in the member handbook or as an attachment in the notification letter members receive with denial notices. They also may craft their own letter appointing their provider as their representative in the grievance or appeal. Members also may appoint any other person to act as their representative in the grievance or appeal.

If the grievance or appeal requires additional medical records, providers are expected to respond within five business days of receiving the request to ensure member grievances or appeals are completed within the established grievance and appeal timeframes.

Definitions of Complaints, Grievances and Appeals

Complaint

A complaint is the lowest level of problem resolution and provides Sunshine Health an opportunity to resolve a problem without it becoming a formal grievance. If a complaint is not resolved by close of the following business day after it is received, it will be moved to a formal grievance.

Grievance

A grievance is an expression of dissatisfaction about any matter other than an "action." For example, a member may file a grievance regarding issues such as:

- Appointment waiting times
- Quality of care
- The behavior of a doctor or his/her staff

- Wait times to be seen while in a doctor's office

Sunshine Health must resolve grievances within 90 days of receipt of the grievance. Member may request to extend the resolution by up to fourteen (14) calendar days if there is a need for additional information and that the delay is in the member's best interest.

Appeal

An appeal is a request for a review of an action, which may include:

- Denial, reduction, suspension or termination of a service already authorized
- Denial of all or part of the payment for a service

Sunshine Health must resolve the standard appeal within 30 days and an expedited appeal within 48 hours. Member may request to extend the resolution by up to fourteen (14) calendar days if there is a need for additional information and that the delay is in the member's best interest.

Providers may request an "expedited plan appeal" on their patients' behalf if they believe that waiting 30 days for a resolution would put their life, health or ability to attain, maintain or regain maximum function in danger. If Sunshine Health does not feel that request qualifies as expedited, Sunshine Health will notify the member of the decision and will process the plan appeal under standard time frames. Expedited requests do not require a member's written consent for the providers to appeal on the member's behalf.

During the appeal process, the member has the right to keep getting the service that is scheduled to be reduced, suspended or terminated until a final decision is made as long as the appeal request is made within 10 days of the date of the denial letter.

Filing Grievances and Appeals

Provider

Provider on Behalf of Self Appeals Process

A Provider may request an appeal regarding Provider payment or contractual issues on his or her own behalf by mailing a letter of appeal and/or an appeal form with supporting documentation, such as medical records to Sunshine Health.

Providers have 90 calendar days from the original utilization management or claim denial to file a Provider appeal. Cases appealed after that time will be denied for untimely filing. If the Provider feels they have filed their case within the appropriate time frame, the Provider may submit documentation showing proof of timely filing. Acceptable proof of timely filing will only be in the form of a registered postal receipt signed by a representative of Sunshine Health or similar receipt from other commercial delivery services.

Sunshine Health will notify providers verbally or in writing regarding the receipt of the request for an appeal within three business days.

Sunshine Health has 60 calendar days to review the case for Medical Necessity and/or conformity to Sunshine Health guidelines.

Cases received without the necessary documentation will be denied for lack of information. It is the responsibility of the Provider to provide the requested documentation within 60 calendar days of the denial to reopen the case. Records and documents received after that time frame will not be reviewed and the case will remain closed.

Medical records and patient information shall be supplied at the request of Sunshine Health or appropriate regulatory agencies when required for appeals. The Provider is not allowed to charge Sunshine Health or the Member for copies of medical records provided for this purpose.

Reversal of Denial of Provider on Behalf of Self Appeals

If all of the relevant information is received, Sunshine Health will make a determination within 60 calendar days. If it is determined during the review that the Provider has complied with Sunshine Health protocols and that the appealed services were Medically Necessary, the denial will be overturned. The Provider will be notified of this decision in writing.

The Provider may file a claim for payment related to the appeal, if they have not already done so. If a claim has been previously submitted and denied, it will be adjusted for payment after the decision to overturn the denial has been made. Sunshine Health will ensure that claims are processed and comply with the federal and state requirements.

Affirmation of Denial of Provider on Behalf of Self Appeals

If it is determined during the review that the Provider did not comply with Sunshine Health protocols and or Medical Necessity was not established, the denial will be upheld. The Provider will be notified of this decision in writing.

For denials based on Medical Necessity, the criteria used to make the decision may be provided. The Provider may also request a copy of the clinical rationale used in making the appeal decision by sending a written request to the Appeals address listed in the decision letter.

Member

For a Member appeal, the Member, Member's representative, or a Provider acting on behalf of the Member and with the Member's written consent, may file an appeal request verbally with Member Services at the phone number below or on the back of the Member's ID card. An appeal may also be submitted in writing. All requests must be submitted within 60 calendar days from the date on the Notice of Adverse Benefit Determinations (NABD). CMS Health Plan will acknowledge in writing within five business days of receipt of appeal except in the case of an expedited request.

There is only one level for an internal appeal. For medical appeals, the Member should send the appeal request to:

CMS Health Plan
Attn: Appeals Department
P.O. Box 31368 Tampa, FL 33631-3368

Fax: **1-866-201-0657**
CMS Health Plan Telephone: **1-866-799-5321**
CMS Health Plan Hours of Operation: Monday–Friday, from 8 a.m. to 8 p.m. Eastern Time

For pharmacy appeals, the Member should send the appeal request to:

CMS Health Plan
Attn: Pharmacy Medication Appeals Department
P.O. Box 31398 Tampa, FL 33631-3398

Fax: **1-888-865-6531**
CMS Health Plan Telephone: **1-866-799-5321**
CMS Health Plan Hours of Operation: Monday–Friday, from 8 a.m. to 8 p.m. Eastern Time

If an appeal is filed verbally via CMS Health Plan Member Services, the request must be followed up with a written, signed appeal request to CMS Health Plan within 10 calendar days of the verbal filing, except when an expedited resolution has been requested. For verbal filings, the time frames for resolution begin on the date the verbal filing was received by Sunshine Health once written confirmation is received.

If the Member's request for appeal is submitted after 60 calendar days from the date on the Notice of Adverse Benefit Determination (NABD), then good cause must be shown in order for Sunshine Health to accept the late request.

Examples of good cause include, but are not limited to, the following:

- The Member did not personally receive the notice of adverse benefit determination or received the notice late
- The Member was seriously ill, which prevented a timely appeal
- There was a death or serious illness in the Member's immediate family
- An accident caused important records to be destroyed
- Documentation was difficult to locate within the time limits
- The Member had incorrect or incomplete information concerning the Appeal process

If the Member wishes to use a representative, he or she must submit a signed statement naming the person he or she wishes to represent him or her. This appointment is also required for the Member's PCP or Provider to assist with the Member's request for appeal.

Members are provided reasonable assistance in completing forms and other procedural steps for an appeal, including, but not limited to, providing interpreter services and toll-free telephone numbers with TTY capability.

Providers do not have appeal rights through the Member appeals process. However, Providers have the ability to file an authorization or claim-related appeal (dispute) on their own behalf. See *CMS Health Plan Provider on Behalf of Self Appeals Process* above for more information.

There is only one level of appeal with the plan. The Member, Member's representative or a Provider acting on the Member's behalf with the Member's consent may file for an expedited, standard pre-service or retrospective appeal determination.

Sunshine Health will not take or threaten to take any punitive action against any Provider acting on behalf or in support of a Member in requesting an appeal or an expedited appeal.

Examples of actions that can be appealed include, but are not limited to, the following:

- Denial or limited authorization of a requested service, including the type or level of service pursuant to 42 CFR 438 400(b)
- The reduction, suspension or termination of a previously authorized service
- The denial, in whole or in part, of a payment for service
- The failure to provide services in a timely manner, as defined by the Agency
- The failure of Sunshine Health to act within 60 calendar days or maximum of 90 calendar days if the grievance involves the collection of information outside of the service area; or 30 calendar days from the date Sunshine Health receives an appeal
- For a resident of a rural area with only one managed care entity, the denial of a Member's request to exercise his or her right to obtain services outside the network

Sunshine Health ensures that decision makers on appeals were not involved in previous levels of review or decision making. When deciding any of the following: (a) an appeal of a denial based on lack of Medical Necessity; (b) a grievance regarding denial of expedited resolution of an appeal; or (c) a grievance or appeal involving clinical issues. The appeal reviewers will be healthcare professionals with clinical expertise in treating the Member's condition/disease or have sought advice from Providers with expertise in the field of medicine related to the request.

Upon the receipt for a request for an appeal, the plan will acknowledge the appeal in writing within five business days from the receipt of the appeal unless the member request an expedited resolution.

Sunshine Health shall notify Members in their primary language of appeal resolutions. Sunshine Health must make a determination from the receipt of the request on a Member appeal and notify the appropriate party within the following time frames:

- Expedited Request: **48 hours**
- Standard Pre-Service Request: **30 calendar days**
- Retrospective Request: **30 calendar days**

The Standard Pre-Service and Retrospective Determination periods noted above may be extended by up to 14 calendar days if the Member requests an extension or if CMS Health Plan justifies a need for additional information and documents how the extension is in the interest of the Member. If an extension is not requested by the Member, CMS Health Plan will notify the Member verbally of the extension and provide the Member with written notice of the reason for the delay within two calendar days of the decision to extend the time frame.

Expedited Appeals Process

To request an expedited appeal, a Member or a Provider (regardless of whether the Provider is contracted with Sunshine Health) must submit a verbal or written request directly to Sunshine Health. A request to expedite an appeal of a determination will be considered in situations where applying the standard procedure could seriously jeopardize the Member's life, health, or ability to regain maximum function, including cases in which Sunshine Health makes a less than fully favorable decision to the Member.

Members who verbally request an expedited appeal are not required to submit a written appeal request as outlined in the Appeals *Member* section.

A request for payment of a service already provided to a Member is not eligible to be reviewed as an expedited appeal.

Members are also provided reasonable opportunity to present evidence and allegations of fact or law in person, as well as in writing. The timeframe to submit additional information for an expedited appeal is limited due to the short timeframe to process the file. Members may also review a copy of their case file any time during and or after the completion of the appeal review.

Denial of an Expedited Request

Sunshine Health will provide the Member with prompt verbal notification by the end of business the day of the decision being made regarding the denial of an expedited appeal and the Member's rights, and will subsequently mail to the Member within two calendar days of the verbal notification, a written letter that explains:

- That Sunshine Health will automatically transfer and process the request using the 30 calendar day timeframe for standard Appeals beginning on the date Sunshine Health received the original request and
- The Member's right to file an expedited grievance if she or he disagrees with the organization's decision not to expedite the appeal and provide instructions about the expedited grievance process and its time frames

Resolution of an Expedited Appeal

Upon an expedited appeal of an adverse determination, Sunshine Health will complete the expedited appeal and give the Member (and the Provider involved, as appropriate) notice of its decision as expeditiously as the Member's health condition requires, but no later than 48 hours after receiving a valid complete request for appeal.

Reversal of Denial of an Expedited Appeal

If Sunshine Health overturns its initial action and/or the denial, it will issue an authorization to cover the requested service and notify the Member verbally by end of business the day the decision is made, followed by written notification of the appeal decision.

Affirmation of Denial of an Expedited Appeal

If Sunshine Health affirms its initial action and/or denial (in whole or in part), it will:

- Verbally notify the Member of the decision by end of business the day the decision is made
- Issue a Notice of Notice of Plan Appeal Resolution to the Member and/or appellant
- Include in the Notice the specific reason for the Appeal decision in an easily understandable language with reference to the benefit provision, guideline, protocol or other similar criterion on which the appeal decision was based
- Inform the Member:
    - **For Title XIX members only**: Of their right to request a Medicaid Fair Hearing

within 120 calendar days of receipt of the notice of plan appeal resolution and how to do so.
    - Of their right to representation
    - Of their right to continue to receive benefits pending a Medicaid Fair Hearing
    - That they may be liable for the cost of any continued benefits if Sunshine Health's action is upheld
    - **For Title XXI members only**: Of their right to request an Independent External Review within four months (120 calendar days) of receipt of the notice of Plan Appeal Resolution and how to do so.

Standard Appeals (Pre-Service and Retrospective) Process

Member written consent, may file a standard appeal request either verbally or in writing within 60 calendar days from the date on the Notice of Adverse Benefit Determination (NABD).

If an appeal is filed verbally through Customer Service, the request must be followed up with a written, signed appeal to Sunshine Health within 10 calendar days of the verbal filing. For verbal filings, the time frames for resolution begin on the date the verbal filing was received with written confirmation of the request for appeal.

Members are also provided reasonable opportunity to present evidence and allegations of fact or law in person, as well as in writing. Members may also review a copy of their case file any time during and or after the completion of the appeal review free of charge.

Reversal of Denial of a Standard Appeal

If upon standard appeal, Sunshine Health overturns its adverse organization determination denying a Member's request for a service, then Sunshine Health will issue an authorization or payment for the request.

Sunshine Health will issue an authorization for the disputed services if the services were not furnished while the appeal was pending and the decision is to reverse a decision to deny, limit or delay services. Sunshine Health will also pay for the disputed services if the services were furnished while the appeal was pending and the disposition reverses a decision to deny, limit or delay services.

Affirmation of Denial of a Standard Appeal

If Sunshine Health affirms its initial action and/or denial (in whole or in part), it will:

- Issue a Notice of Adverse Benefit Determination (NABD) to the Member and/or appellant
- Include in the Notice the specific reason for the appeal decision in an easily understandable language with reference to the benefit provision, guideline, protocol or other similar criterion on which the appeal decision was based, as well as informs the Member:
    - **For Title XIX members only**: Of their right to request a Medicaid Fair Hearing within 120 calendar days of receipt of the notice of plan appeal resolution and how to do so.
    - Of their right to representation
    - Of their right to continue to receive benefits pending a Medicaid Fair Hearing

- That they may be liable for the cost of any continued benefits if Sunshine Health's action is upheld
- **For Title XXI members only**: of their right to request an Independent External Review within four months (120 calendar days) of receipt of the notice of Plan Appeal Resolution and how to do so.

Medicaid Fair Hearing – For Title XIX members only

For Title XIX members only, if the Member is not satisfied with Sunshine Health's appeal decision, the Member can ask for a Medicaid Fair Hearing.

Members may ask for a Fair Hearing any time up to 120 calendar days after they get the Notice of Plan Appeal Resolution letter. Members may ask for a Medicaid Fair Hearing only after they complete Sunshine Health's internal appeal process.

They may ask for a Medicaid fair hearing by calling or writing to:

Agency for Health Care Administration
Medicaid Hearing Unit
P.O. Box 60127
Fort Myers, FL 33906

Telephone: **1-877-254-1055** *(toll-free)*
Fax: **1-239-338-2642**
MedicaidHearingUnit@ahca.myflorida.com

A Member's written request for a Medicaid Fair Hearing or State Review must include the following information:

- Name
- Member number
- Medicaid ID number (Not applicable to MediKids)
- Phone number where Sunshine Health can reach Member or Member's authorized representative

Members are encouraged to include the following information if they have it:

- Why they think Sunshine Health should change the decision
- Any medical information to support the request
- Whom they would like to help them with the fair hearing

After getting a Member's Fair Hearing or State Review request, the Office of Fair Hearing will tell the Member in writing that the request was received.

Independent External Review – For Title XXI members only:

For Title XXI members only, if the Member is not satisfied with Sunshine Health's appeal decision, the Member can ask for an independent External Review with the Plan.

How to Ask for an External Review:

You may ask for an external review 120 days after you get this Notice of Plan Appeal Resolution.

You may ask for an external review by calling, writing, or faxing a request to the Plan. For

Medical Appeals, please send your request to:

CMS Health Plan
Attn: Appeals Coordinator
P.O. Box 31368 Tampa, FL 33631-3368
Fax: 1-866-201-0657

For Pharmacy Appeals, please send your request to:

CMS Health Plan
Attn: Pharmacy Appeals
P.O. Box 31398
Tampa, FL 33631-3398
Fax: 1-888-865-6531

Your written request for an External Review must include the following information:

- Your name
- Your member number
- And reason why you want an external review

You may also include the following information if you have it:

- Why you think we should change the decision
- Any medical information to support the request

After getting your external review request, the Plan will forward your information to an Independent External Reviewer for a decision.

Continuation of Benefits while the Appeal and Medicaid Fair Hearing is Pending – For Title XIX members only.

For Title XIX members, Members may ask that Sunshine Health continue to cover their medical services during the appeals process. To do this:

- Members must file their appeals with Sunshine Health within 10 calendar days of Sunshine Health mailing the Notice of Adverse Benefit Determinations (NABD) to them or within 10 days after the date the service will be reduced, suspended or stopped, whichever is later.
- The Member's appeal involves an action Sunshine Health is taking to reduce, suspend or stop a service it already had approved.
- The service must have been ordered by an authorized Provider.
- The original time period covered by the approval Sunshine Health gave has not yet ended
- Members must ask for a continuation of benefits timely.

Sunshine Health will continue a Member's benefits until one of the following happens:

1. The Member withdraws the appeal.
2. 10 days pass after Sunshine Health sends the Member the notice of adverse benefit determination letter.
3. The Fair Hearing officer issues a hearing decision adverse to the member.

If the final resolution of the appeal or hearing is adverse to the Member (i.e., Sunshine Health 's decision was upheld), Sunshine Health may recover from the Member the cost of the services furnished to the Member while the appeal was pending, to the extent that they were furnished solely because of the requirements of the contract.

If the final resolution of the appeal or hearing is reversed by the hearing decision and services were not furnished while the plan appeal was pending, The Plan will authorize or provide the disputed services promptly and as expeditiously as the enrollee's health condition requires, but no later than 72 hours from the date the Plan received the notice reversing the determination.

Grievance Process

Provider Complaints

Providers have the right to file a written complaint for issues that are non-claims related no later than 45 calendar days from the date the Provider becomes aware of the issue generating the complaint. Written resolution will be provided by Sunshine Health to the Provider within 90 calendar days from the date the complaint is received by Sunshine Health. Providers with complaints unresolved during Provider Service Resolution (PSR) process, or if the Provider makes his/her request known, may request to file a Provider complaint.

A verbal acknowledgment will be made to the Provider filing the complaint within three business days, acknowledging receipt of the complaint and the expected date of resolution.

All complaints shall be resolved within 90 calendar days of receipt and provide a written notice of the disposition and the basis of the resolution to the Provider within three business days of resolution. If the complaint is unresolved after 15 calendar days of receiving the complaint, documentation explaining why and a written notice of the status to the Provider every 15 calendar days thereafter.

A written notice of the disposition and basis of the resolution will be mailed to the Provider within:

- Three business days of the resolution

A written Provider complaint shall be mailed directly to Sunshine Health's Grievance Department.

When acting as the Member's representative, a Provider may not file a grievance on behalf of the Member without written consent from the Member.

Sunshine Health will give all Providers written notice of the Provider grievance procedures at the time they enter into contract.

For more information, see the *Grievance Submission* section.

Member

The CMS Health Plan Member, or Member's representative acting on the Member's behalf, may file a grievance. Examples of grievances that can be submitted include, but are not limited to:

- Provider Service including, but not limited to:

    - Rudeness by Provider or office staff
    - Failure to respect the Member's rights
    - Quality of care/services provided
    - Refusal to see Member (other than in the case of patient discharge from office)
    - Office conditions
- Services provided by CMS Health Plan including, but not limited to:
    - Hold time on telephone
    - Rudeness of staff
    - Involuntary disenrollment from Sunshine Health
    - Unfulfilled requests
- Access availability including, but not limited to:
    - Difficulty getting an appointment
    - Wait time in excess of one hour
    - Handicap accessibility

A CMS Member, a CMS Member's representative or any Provider acting on behalf of the Member with written consent, may file a grievance at any time.

Sunshine Health will ensure that no punitive action is taken against a Provider who, as an authorized representative, files a grievance on behalf of a Member, or supports a grievance filed by a Member. Documentation regarding the grievance will be made available to the Member, if requested.

Members are provided reasonable assistance in completing forms and other procedural steps for a Grievance, including, but not limited to, providing interpreter services and toll-free telephone numbers with TTY capability.

Grievance Submission

A verbal grievance request can be filed, toll-free, with CMS Health Plan Customer Service. A verbal request may be followed up with a written request by the CMS Health Plan Member, but the time frame for resolution begins the date the verbal filing is received by Sunshine Health.

The CMS Health Plan Member should send the grievance request to:

CMS Health Plan Grievances
P.O. Box 31384
Tampa, FL 33631-3384

Fax: **1-866-388-1769**
Telephone: **1-866-799-5321**
Hours of Operation: Monday–Friday, from 8 a.m. to 8 p.m.

Grievance Resolution

CMS Health Plan will acknowledge the CMS Health Plan Member grievances in writing within five business days from the date the grievance is received by us. Upon the grievance resolution, a letter will be mailed to the CMS Health Plan Member: (a) within 60 calendar days, but no more than 90 calendar days from the date the grievance is received by us. This resolution letter may not take the place of the acknowledgment letter, unless a decision is reached before the written acknowledgement is sent, then one letter shall be sent which includes the acknowledgement

and the decision of the grievance.

A CMS Health Plan Member has the right to request a 14-calendar day extension, if the Member has additional information to support the Member's grievance. CMS Health Plan has the right to request to extend the Member's resolution, if it is in the Member's best interest. If CMS Health Plan extends the grievance, we will provide the Member oral notification with a reason for the delay, by close of business on the day the decision is made; and in writing within two calendar days of the decision.

The acknowledgement letter includes:

- Name and telephone number of the Grievance Coordinator
- Request for any additional information, if needed to investigate the issue

The resolution letter includes:

- The results/findings of the resolution
- All information considered in the investigation of the grievance
- The date of the grievance resolution

CMS Health Plan will notify Members of grievance resolutions in their primary language.

Trending of Complaints, Grievances and Appeals

Sunshine Health documents the reasons for every complaint, grievance and appeal and uses the data to identify opportunities for internal process improvement and provider re- education. The credentialing department also uses this information as part of its recredentialing process.

Chapter 8: Case Management

Case Management Program Overview

CMS Health Plan offers comprehensive care management services to facilitate health status assessment, care planning, and advocacy to improve health and quality of life outcomes for its Members and their guardians. The CMS Health Plan Care Management Program is built around every Member's unique healthcare needs to assess their needs, facilitate their access to care, and help them when they need CMS Health Plan:

- Identify
- Reach
- Engage
- Assess
- Care
- Help

CMS Health Plan understands that care management must complement primary care, specialty

care, behavioral health services, ancillary services, outpatient and inpatient services. The Plan's care management services are specifically designed to:

- Foster the relationship between a Member and his or her providers.
- Empower Members and their guardians to take control of their health by initiating and reinforcing healthy behaviors.
- Help Members and their guardians obtain timely, effective, quality and culturally-sensitive care and minimize gaps in care
- Assist Members and their guardians with understanding and accessing their benefits to improve Member outcomes

The Plan's multidisciplinary care management team includes registered nurses (RNs) and licensed behavioral health clinicians who perform comprehensive assessments of the Members' health status, develop an individualized person and family-centered care plans with agreed-upon goals, monitor outcomes and update the care plans as necessary. Our CMS Health Plan Care Managers share the care plans and work collaboratively with Providers, schools and other relevant agencies to coordinate and facilitate access to care and services when needed. Care plans are available by mail or fax and can be accessed on the Provider Portal. CMS Health Plan requests that Providers participate as active members of the interdisciplinary care team for those Members that are engaged in case and disease management programs.

All children enrolled in the CMS Health Plan are enrolled in Care Management including children with:

- Catastrophic Conditions – Traumatic injuries, i.e., amputations, blunt trauma, spinal cord injuries, head injuries, burns and multiple traumas
- Multiple Chronic Conditions – Multiple comorbidities such as diabetes or multiple intricate barriers to quality healthcare, i.e., AIDS or a comorbid behavioral health and complex medication condition.
- Transplantation – Organ failure, donor matching, post-transplant follow-up
- Complex Needs – Children receiving skilled nursing facility services, Medical Foster Care Services, private duty nursing, and prescribed pediatric extended care.
- Special Healthcare Needs – Children who have serious medical or chronic conditions with severe chronic illnesses, physical, mental and developmental disabilities.
- At Risk Populations: Children in the State Inpatient Psychiatric Program (SIPP) as well as those with involvement, or at risk for involvement, with the justice system, DJJ or DCF.

In addition to the covered services, CMS Health Plan offers and coordinates access to quality enhancements (QEs). It is our goal to promote positive health outcomes by offering the following quality enhancements/services.

- Domestic Violence: CMS Health Plan ensures that PCPs screen members for signs of domestic violence and shall offer referral services to applicable domestic violence prevention community agencies.
- Pregnancy Prevention: CMS Health Plan conducts regularly scheduled pregnancy prevention programs and makes a good faith effort to involve members in existing

community pregnancy prevention programs, such as the Abstinence Education Program. The programs target teen members, but are open to all members, regardless of age, gender, pregnancy status or parental consent.

- Prenatal/Postpartum Pregnancy Programs: CMS Health Plan provides regular home visits, conducted by a home health nurse or aide, and counseling and educational materials to pregnant members and postpartum Members who are not in compliance with the plan's prenatal and postpartum programs. CMS Health Plan coordinates our efforts with local Healthy Start Care Coordinator/ Case Managers to prevent duplication of services.
- Behavioral Health Programs: CMS Health Plan provides outreach to homeless and other populations of members at risk of justice system involvement, as well as those members currently involved in this system, to assure that services are accessible and provided when necessary.

Other Programs and Services: CMS Health Plan actively collaborates with community agencies and organizations, including County Health Departments, local Early Intervention Programs and local school districts in offering services.

Condition-Specific Programs

Sunshine Health offers members a variety of condition-specific and/or health coaching programs. Practitioners who believe their patients would benefit from such a program may send a case management referral through the secure provider portal or call 1-844-477¬8313.

Programs for Members

- Applicable members may be referred to the following condition-specific programs:
  - Asthma
  - ADHD
- Children who are medically fragile
- COPD
- Depression
- Diabetes
- Emergency department diversion program for members who frequently visit a hospital emergency department
- Heart failure
- Hypertension
- Oncology/Palliative care
- Perinatal depression
- Pregnancy and High Risk Maternity
- Schizophrenia
- Sickle cell
- Substance use
- Transitional care for members transitioning from hospital to home
- Uncoordinated care for members with multiple diagnosis or treating providers
- Transplant

Member Incentive Program

Sunshine Health's healthy behaviors program is designed to address members' status across the continuum of health from wellness to the management of one or more chronic conditions.

Members may earn financial rewards by completing healthy behaviors, such as well child visits, dental visits, prenatal and post-partum care, diabetes management and cancer screening for women.

This member healthy rewards program is called the My Health Pays® program. For a current list of member incentives, contact your dedicated Provider Relations Representative or click on "rewards program" under "benefits and services" for each product on the Sunshine Health website.

Chapter 9: Quality Improvement Program

Quality Improvement Program Description

Sunshine Health is committed to providing a well-designed and well-implemented quality improvement program, the focus of which is to improve the health of all members. The program's systematic and objective approach to quality is the "plan, do, study, act" (PDSA) methodology, which uses reliable and valid methods of anticipation, identification, monitoring, measurement and evaluation of members' health care needs and effective action to promote quality of care.

This systematic approach to quality improvement provides a continuous cycle for assessing the quality and appropriateness of care and service.

The quality improvement program is comprehensive and addresses the unique needs of the CMS Health Plan programs. Sunshine Health's quality improvement program is updated yearly and includes an evaluation against the stated quality improvement work plan.

The evaluation considers the following:

- Coordination between physical health and behavioral health services
- Credentialing and recredentialing
- Cultural competency
- Delegated entity oversight
- Member and provider satisfaction
- Member complaints, grievances and appeals
- Outcomes of case management

- Practitioner appointment availability and access
- Performance measures, including HEDIS, potentially preventable events, birth outcomes, transition of Comprehensive members from a facility to the community and state-defined measures
- Potentially preventable admission, readmission and emergency department events
- Birth outcomes
- Preventive health and chronic condition guidelines, including behavioral health
- Quality improvement studies
- Utilization management, including pharmacy

Quality Improvement Program Goal and Activities

The goal of Sunshine Health's quality improvement program is to improve members' health status through improved quality of care, efficiency of services, member satisfaction and provider satisfaction. This includes care provided by all network or subcontracted vendors and across all care settings.

Some of the activities included in the quality improvement program are:

- Adherence to preventive and clinical practice guidelines and action plans to meet established performance targets
- Case management programs to promote improved member outcomes
- Compliance with all applicable regulatory requirements and accreditation standards
- Improvements in member satisfaction scores
- Improvements in potentially preventable events, birth outcomes, transition of Comprehensive members from a facility to the community
- Improvements in processes that enhance clinical efficiency, promote effective utilization of health care resources and focus on improved outcome management
- Integration of quality improvement activities across Sunshine Health's functional areas
- Monitoring of and collaboration with the contracted network to continuously improve the quality of care and services members receive
- Protection of member's rights and responsibilities

To attain these quality goals, Sunshine Health offers a value-based payment structure, useful reports and robust clinical support. In addition, Sunshine Health aligned these quality goals with network performance and employed a focused strategy based on strong partnerships with network providers.

Sunshine Health continues to review data to identify network provider performance and opportunities to support providers in improving member care.

The quality improvement program evaluation includes a summary of all quality improvement activities that were noted in the annual quality improvement work plan. These findings are used in developing the following year's annual quality improvement program description.

The quality improvement evaluation is reviewed and approved by Sunshine Health's quality improvement committee and board of directors. A short summary is available to providers and members at SunshineHealth.com.

Working with our Providers

Sunshine Health works with network providers to build useful and relevant analyses and reporting tools that are understandable, and utilize feedback, through local peer comparisons, to improve care. This collaborative effort helps to establish the foundation that supports continuous quality improvement activities that yield performance improvements.

Sunshine Health provides reports to providers that reflect how they are impacting quality of care and appropriate utilization of services. The reports are structured to reflect:

- Meaningfulness to the provider;
- Relevance to the populations served; and
- Information to assist the provider in impacting care

Specific provider quality standards that are measured includes: member access to care, member satisfaction, utilization of services, quality of care and service (including HEDIS and non-HEDIS measures), pharmacy utilization, and other relevant measures, as applicable.

Quality Improvement Committee and Sub- Committees

Quality Improvement Committee and Sub-Committees Overview

Quality is integrated throughout Sunshine Health's operations and represents a strong commitment to the quality of care and services provided to Sunshine Health members. Sunshine Health's board of directors oversees the development, implementation and evaluation of the quality improvement program and has the ultimate authority and accountability for oversight of the quality of care and services provided to members.

Sunshine Health's various committees, subcommittees and ad-hoc committees assist in the planning, decision making, intervention and assessment of results to support its quality improvement program.

Quality Improvement Committee

The Quality Improvement Committee (QIC) is a senior-level committee reporting to the board of directors. It is supported by the credentialing, pharmacy and therapeutics, utilization management and performance improvement committees.

Ad-hoc committees on the clinical side include peer review and specialty advisory committee. Ad- hoc committees on the non-clinical side may include regional level committees.

The quality improvement committee and Sunshine Health's board of directors review and approve the program description at least annually. The committee provides oversight and direction to the quality improvement program. This is accomplished through:

- Comprehensive, plan-wide system of ongoing, objective and systematic monitoring
- Education of members, providers and staff regarding the quality improvement,

utilization management and credentialing programs
- Identification, evaluation and resolution of process problems
- Identification of opportunities to improve member outcomes

Utilization Management Committee

The Utilization Management Committee is responsible for the review and appropriate approval of medical necessity criteria and protocols and utilization management policies and procedures.

The committee meets quarterly and coordinates annual review and revision of the utilization management program, work plan, annual program evaluation and subsequent approval by the quality improvement committee.

The Utilization Management Committee monitors and analyzes relevant data to detect and correct patterns of potential or actual inappropriate under- or over-utilization that may impact health care services, potentially preventable events, birth outcomes, transition of Comprehensive members from a facility to the community, coordination of care and appropriate use of services and resources, as well as member and practitioner/provider satisfaction with the utilization management process.

Additionally, the committee provides ongoing evaluation of the appropriateness and effectiveness of practitioner/provider quality incentive payments and assists in modifying and designing an appropriate quality incentive program.

Credentialing Committee

The Credentialing Committee is responsible for development and annual review of the credentialing program description and the program's associated policies and procedures. The Credentialing Committee has final authority for review and appropriate approval of licensed physicians and other licensed health care professionals who have an independent relationship with Sunshine Health.

In addition, the committee reviews and approves institutional and organizational providers, such as nursing facilities, home health agencies, group homes and assisted living facilities.

Pharmacy and Therapeutics Committee

The Pharmacy and Therapeutics Committee is responsible for the development and annual review of the pharmacy program description in all Sunshine Health's lines of business and products as well as the program's associated policies and procedures.

As it relates to Sunshine Health's Medicaid programs, the pharmacy and therapeutics committee meets at least quarterly to review pharmacy utilization data; evaluate and make recommendations to AHCA regarding drugs for inclusion in or removal from the preferred drug list; review and make recommendations to AHCA regarding formulary management activities, such as prior authorizations, step therapies, age restrictions, quantity limitations, mandatory generics and other activities that affect access and patient safety; and make recommendations regarding internal drug utilization review activities, such as targeted prescriber and/or member education initiatives.

Additionally, the pharmacy and therapeutics committee may assist with review of complaints and grievances regarding pharmacy issues and oversight of Sunshine Health's pharmacy benefit manager.

Peer Review Committee

The Peer Review Committee is an ad-hoc sub-committee of the quality improvement committee. The peer review committee is expected to use clinical judgment in assessing the appropriateness of clinical care and recommending a corrective action plan that best suits a provider's situation.

Provider Advisory Committee

The Provider Advisory Committee, chaired by a Sunshine Health medical director, meets at least quarterly to seek practitioner and provider input and consultation on a wide range of topics. The committee discusses topics such as practitioner and provider solutions to opportunities to improve chronic condition management and preventive care and the rates of potentially preventable events; methods for effective member engagement; methods to improve practitioner and provider performance related to Sunshine Health and AHCA clinical performance goals and related clinical and operational improvement projects and initiatives; innovative programs such as Integrated Behavioral Health Homes and Telehealth; reimbursement methodologies; practitioner and provider training; practitioner and provider satisfaction issues; and claims and billing concerns.

The Provider Advisory Committee may recommend to the QIC the need for an ad hoc special clinical focus subcommittee, to be convened when specific clinical input of clinicians with expertise in the noted type of care is required. This subcommittee reports to the QIC, which is responsible for reviewing and establishing quality standards, benchmarks, performance goals, and practice guidelines to promote appropriate, standardized quality of care and compliance, and identify deviations from standards of medical management.

Quality Improvement Activities

Monitoring Patient Safety/Quality of Care

Patient safety is a key focus of Sunshine Health's quality improvement program. Monitoring and promoting patient safety is integrated throughout many activities across Sunshine Health but primarily through identification of potential and/or actual quality-of-care events.

A potential quality-of-care issue may be any alleged act or behavior that:

- May be detrimental to the quality or safety of patient care
- Is not compliant with evidence-based standard practices of care, or
- Signals a potential sentinel event, up to and including death of a member

Sunshine Health monitors for such events – called "adverse incidents" if they involve MMA members or "critical incidents" if they involve Comprehensive members – through claims and self-reported mechanisms. An adverse or critical event is an event over which health care

personnel could have exercised control; which is associated in whole or in part with medical intervention, rather than the condition for which such intervention occurred; and which results in certain catastrophic outcomes. This may include incidents such as sexual battery, medication error, member escape or elopement, or member death that occurs while a member is in active treatment or in a residential facility. Occurrence of an adverse or critical incident in and of itself is not necessarily a significant quality-of-care event.

Sunshine Health monitors and tracks quality-of-care or quality-of-service occurrences and adverse events for trends in type, location and other factors to monitor patient safety.

Sunshine Health may investigate further and/or request a corrective action plan at any time it identifies a quality-of-care issue.

Monitoring Provider Access and Availability

Access

Sunshine Health sets standards for the numbers and geographic distribution of PCPs, specialists, hospitals and other providers while taking into consideration the special and cultural needs of its members.

Sunshine Health analyzes provider accessibility at least annually to identify and address any deficiencies in the number and distribution of various types of practitioners and providers.

➢ See PCP Access and Availability.

Availability

Sunshine Health establishes appointment wait time for various types of visits. At least quarterly, Sunshine Health assesses compliance with established appointment wait times for PCPs, specialists and behavioral health care providers to identify and address any deficiencies.

➢ See Appointment Wait Times.

Monitoring Quality Outcomes

HEDIS

Healthcare Effectiveness Data and Information Set (HEDIS), created by the National Committee for Quality Assurance (NCQA), is a tool used by more than 90 percent of America's health plans to measure performance on important dimensions of care and service. HEDIS measures are divided across five different domains of care:

- Effectiveness of care, which includes preventive health and chronic care process and outcome measures
- Access/availability of care, which is determined through member surveys
- Experience of care, which also is determined through member surveys
- Utilization and relative resource use, which includes inpatient and outpatient utilization
- Health plan descriptive information

These measures are captured through claims data or medical record review. For those identified as a medical record review, Sunshine Health reaches out to the providers to inform them of the

records selected. Many of these measures are part of the provider quality incentive program.

Sunshine Health continuously monitors the rate of compliance with the goal of improving the rates.

State Performance Measures

AHCA identifies a subset of HEDIS measures as well as its own measures for the evaluation of programs. The agency monitors plan performance differently for the programs. For Medicaid, the primary focus is based on HEDIS, CHIPRA measures or other state defined measures.

➢ See Monitoring Quality Outcomes.

AHCA sets performance targets for the measures.

Member Satisfaction Surveys

Sunshine Health uses various survey tools to determine member satisfaction. The results of these surveys are used to develop interventions to improve the members' perception of access to care and services with network providers and with Sunshine Health.

Sunshine Health uses a validated CAHPS® survey to measure member satisfaction with health care, including providers and health plans. CAHPS® examines specific measures, including "getting needed care," "getting care quickly," "how well providers communicate," "courteous and helpful office staff," and "customer service." The CAHPS® survey is administered annually to randomly selected members to complete on their own or their child's behalf.

The survey includes but is not limited to member experience with the following areas:

- Care coordination
- Doctors' communication skills
- Health plan customer service
- Obtaining needed care
- Obtaining needed care quickly
- Obtaining prescription drugs
- Rating of the health plan

Behavioral health member satisfaction is measured annually through the Substance Abuse and Mental Health Services Administration's (SAMSHA) Mental Health Statistics Improvement Program (MHSIP) consumer survey for adults and The Youth Services Survey for Families (YSS-F).

The surveys solicit independent feedback from adult members and families of youth members. The surveys measure consumers' perceptions of behavioral health services in relation to the following domains:

- Access to services
- Cultural sensitivity
- General satisfaction
- Improved functioning
- Outcomes
- Participation in treatment planning
- Service quality/appropriateness

- Social connectedness

The results of this survey are used to develop interventions to improve the members' perception of those listed domains.

Provider Satisfaction Surveys

Network Providers are contractually required to cooperate with quality improvement activities. Providers are invited to participate in the QI Program. Avenues for participation include committee representation, quality/performance improvement projects, and feedback/input via satisfaction surveys.

Quality Studies/Improvement Projects

Sunshine Health's quality improvement department continues to evaluate trends in the use of preventive services, chronic condition management and other services to identify specific quality improvement projects. Multi-disciplinary teams are formed to review data, identify barriers and develop action plans and effective interventions.

Sunshine Health performs four improvement projects annually that uses the AHCA-required "plan, do, study, act" (PDSA) methodology. The results of these projects are reported to AHCA and reviewed with the Sunshine Health provider advisory committee. The projects may vary from year to year and may involve provider participation.

Fraud, Waste and Abuse

Special Investigations Unit

Sunshine Health, in conjunction with its parent company, Centene Corporation, operates a Special Investigations Unit (SIU) to detect, investigate and prosecute fraud, waste and abuse (FWA).

Sunshine Health routinely conducts audits to ensure compliance with billing regulations, and code editing software performs systematic audits during the claims payment process.

➢ See Chapter 14: Claims Coding and Billing.

The SIU performs prepayment and retrospective audits, which, in some cases, may result in taking actions against providers who commit fraud, waste and/or abuse. These actions include but are not limited to:

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

Some of the most common FWA practices include:

- Add-on codes billed without primary CPT

- Claims for services not rendered
- Diagnosis and/or procedure codes not consistent with the member's age or gender
- Excessive use of units
- Misuse of benefits
- Unbundling of codes
- Up-coding services
- Use of exclusion codes

Providers who suspect or witness inappropriate billing or inappropriate services for a member are encouraged to call the anonymous and confidential FWA hotline at 1-866-685-8664 or contact the compliance officer by phone at 1-866-796-0530 or by email at compliancefl@centene.com.

Office of Inspector General (OIG)/ General Services Administration (GSA) Exclusion

Sunshine Health expects network providers to check the Office of the Inspector General (OIG) or General Services Administration (GSA)exclusion databases for all staff, volunteers, temporary employees, consultants, boards of directors and any contractors that would meet the requirements as outlined in §§1128 and 1128A of the Social Security Act. Network providers may not knowingly have affiliation with an individual or entity who is an affiliate, as defined in the Federal Acquisition Regulation at 48 CFR 2.101, of a person described in 42 CFR 438.610 (a)(1); or subcontractors on the discriminatory vendor list maintained by the Department of Management Services in accordance with s.287.134, F.S.

Provider Implementation of FWA Safeguards

Federal program payment may not be made for items or services furnished or prescribed by an excluded provider or entity. Plans may not use federal or state funds to pay for services, equipment or drugs prescribed or provided by a provider, supplier, employee, contractor or subcontractor excluded by the Office of the Inspector General (OIG) or General Services Administration (GSA).

Sunshine Health will review the OIG's "List of Excluded Individuals and Entities (LEIE)" and the GSA's "Excluded Parties List (EPLS)" now known as "System for Award Management (SAM)," as well as the AHCA's listing of suspended and terminated providers before hiring or contracting any new employee, temporary employee, volunteer, consultant, governing body member or subcontractor, and monthly thereafter.

False Claims Act

The False Claims Act establishes liability when any person or entity improperly receives or avoids payment to the federal government. The Act prohibits the following:

- Knowingly presenting or causing to be presented a false claim for payment or approval
- Knowingly making, using or causing to be made or used, a false record or statement material to a false or fraudulent claim
- Conspiring to commit any violation of the False Claims Act

- Falsely certifying the type or amount of property to be used by the government
- Certifying receipt of property on a document without completely knowing that the information is true
- Knowingly buying government property from an unauthorized officer of the government
- Knowingly making, using or causing to be made or used a false record to avoid or decrease an obligation to pay or transmit property to the government

For more information regarding the False Claims act, visit the Centers for Medicare and Medicaid Services website.

Healthcare Laws

Sunshine Health instructs and expects all its contractors and subcontractors to comply with applicable laws and regulations, including but not limited to the following:

- Anti-kickback statute
- State and federal False Claims Acts
- Qui Tam lawsuits (Whistleblower Protection Act)
- HIPAA
- Physician self-referral law (Stark Law)
- Social Security Act
- U.S. criminal codes

Sunshine Health requires all contractors and subcontractors to report violations and suspected violations on the part of its employees, associates, persons or entities providing care or services to all Sunshine Health members. Examples of such violations include bribery, false claims, conspiracy to commit fraud, theft or embezzlement, false statements, mail fraud, health care fraud, obstruction of a state and/or federal health care fraud investigation, money laundering, failure to provide medically necessary services, marketing schemes, prescription forging or altering, physician illegal remuneration schemes, compensation for prescription drug switching, prescribing drugs that are not medically necessary, theft of the prescriber's DEA number or prescription pad, identity theft or enrollees' medication fraud.

FWA training is available on the Sunshine Health website that providers may download in PDF format. Sunshine Health also offers FWA training in provider orientation materials.

State and federal regulations require mandatory compliance and FWA training to be completed by contractors and subcontractors, as well as their employees, within 30 days of hire/contracting and annually thereafter. Records of the training must be maintained and readily available at the request of Sunshine Health's compliance officer, AHCA, CMS or agents of both agencies. An attestation for the completion of the FWA training must be submitted as part of the credentialing process.

Providers or their employees who have not taken the compliance and/or FWA training may do so by logging onto Sunshine Health's website.

Direct Reporting of Fraud, Waste and Abuse

Providers may report suspected or confirmed fraud, waste or abuse in the state Medicaid

program through any of the following channels:

- AHCA consumer complaint hotline: 1-888-419-3456
- Florida attorney general's office: 1-866-966-7226
- Florida Medicaid program integrity office: 1-850-412-4600

Complaint forms may be found on the AHCA website.

The Division of Insurance Fraud Complaint form may be found on the Florida Department of Financial Services website.

Authority and Responsibility

Sunshine Health's senior vice president of compliance has the overall responsibility and authority for carrying out the provisions of the compliance program – especially the measures of prevention, detection, reduction, correction and reporting of fraud, waste, abuse and any other non- compliance related issues – and is committed to sanctioning and prosecuting suspected fraud, waste or abuse.

Sunshine Health's provider network development must cooperate fully in making personnel and/or subcontractor personnel available in person for interviews, consultation, grand jury proceedings, pre-trial conferences, hearings, trials, and in any other process, including investigations, at Sunshine Health or the contractor/subcontractor's own expense.

Chapter 10: Provider Roles, Rights and Responsibilities

Responsibilities of All Sunshine Health Practitioners

Contracted practitioners are responsible for providing and managing health care services for Sunshine Health members as determined by medical necessity criteria. In addition, practitioners and providers are responsible to:

- ***Notify Sunshine Health in writing of any of these changes***:
  - Changes in practice ownership, name, address, phone, national provider identifier (NPI) or federal tax identification numbers
  - The addition or departure of a physician to the practice
  - Loss or suspension of the provider's license to practice
  - Practice bankruptcy or insolvency
  - Suspension, exclusion, debarment or other sanction from a state or federally funded health care program
  - Indictment, arrest or conviction for a felony or any criminal charge related to the practice
  - Material changes in cancellation or termination of liability insurance
  - The closing of a practice to new patients and vice versa

- When terminating affiliation with Sunshine Health

- ***Not bill or balance bill members*:** Providers have a responsibility not to bill or balance bill Medicaid recipients for covered services regardless of whether they believe the amount of money they have been or will be paid by Sunshine Health is appropriate or sufficient. Providers also may not bill members for failure to appear for a scheduled appointment.
- ***Provide 24/7 coverage*:** PCPs and specialists must provide access to covered medical services 24 hours a day, seven days a week. In practice, this means member telephone calls should be answered by an answering service that is able to connect the member to someone who can render a clinical decision or reach the PCP or treating behavioral health practitioners for a clinical decision.
- ***Inform members about advance directives*:** Providers have a responsibility to inform Sunshine Health members about their right to have an advance directive and provide written information on state law about members' rights to accept or refuse treatment and the provider's own policies regarding advance directives. Providers must document in the members' medical record any results of a discussion on advance directives and include a copy of the advance directive in the patient file if a member has or completes one.

  ➢ See Advance Directives.

- ***Maintain medical records*:** Providers have a responsibility to have policies that address medical record protocol. Policies should include maintaining a single, permanent medical record for each patient that is available at each visit; protecting patient records from destruction, tampering, loss or unauthorized use; maintaining medical records in accordance with state and federal regulations; and maintaining a current patient signature of consent for treatment. Medical records should be complete and legible and follow standard practices.

  ➢ See Medical Record Documentation.

- ***Provide care*:** Providers have a responsibility to provide care within their scope of practice, in accordance with Sunshine Health's access, availability, quality and participation standards and in a culturally competent manner. Providers also should identify any member who requires translation, interpretation or sign language services and call Sunshine Health to arrange for such services.

  ➢ See Cultural Competency.

- ***Participate in quality improvement programs*:** Providers have a responsibility to participate with Sunshine Health in quality improvement initiatives and other activities associated with meeting regulatory requirements and upholding contractual obligations.

  ➢ See Quality Improvement Activities.

- ***Not discriminate*:** Providers have a responsibility to provide optimal care to members without regard to age, race, gender, religious background, national origin, disability, sexual orientation, source of payment, veteran status, claims experience, social status, health status or marital status.
- ***Supply members with complete and accurate information*:** Providers have a responsibility to give members complete and accurate information concerning a diagnosis, treatment plan, or prognosis in terms they can understand (eliminating both language and cultural barriers) and without regard to plan coverage; to inform members of non-covered treatments or services and their cost prior to rendering them; and to advise members of their right to contact Sunshine Health if they have concerns about a non-covered service or wish to file a grievance or appeal.

➢ See Chapter 7: Member Complaints, Grievances and Appeals.

➢ Cultural Competency.

➢ See Chapter 12: Member Administration.

- ***Maintain confidentiality:*** Providers have a responsibility to keep members' protected health information (PHI) strictly confidential in compliance with Health Insurance Portability and Accountability Act (HIPAA) standards and to provide necessary member PHI to Sunshine Health, also in compliance with HIPAA standards, when required for payment, treatment, quality assurance, regulatory, data collection and reporting activities. Providers are responsible to contact the Sunshine Health quality improvement department when a HIPPA violation occurs.
- ***Submit claims*****:** Providers have a responsibility to submit complete and accurate claims for their services that conform to Medicaid requirements within the time frames outlined in their contract and to provide Sunshine Health with supporting documentation when required to support a claim.

➢ See Chapter 14: Claims Coding and Billing.

- ***Participate in utilization management*****:** Providers have a responsibility to conform to Sunshine Health's referral and prior authorization policies and procedures as they relate to services provided and to cooperate with utilization management staff in providing necessary documentation or medical information.

➢ See Chapter 4: Utilization Management and Prior Authorization.

Provide continuity of care following provider termination:

Members in active treatment may continue care when such care is Medically Necessary, through the completion of treatment of a condition for which the Member was receiving at the time of the termination or until the Member selects another treating Provider, for a minimum of 60 days, not to exceed six months after the Provider termination. For pregnant Members who have initiated a course of general care, regardless of the trimester in which care was initiated, continuation shall be provided until the completion of postpartum care.

➢ See Continuity of Care Following Provider Termination.

- ***Report any adverse or critical incidents*****:** Providers are responsible for reporting to Sunshine Health any critical or adverse incidents that negatively impact the health, safety or welfare of a member. Such incidents may include abuse, neglect, exploitation, major illness or injury, involvement with law enforcement, elopement or major medication errors.

➢ See Monitoring Patient Safety/Quality of Care.

- ***Report Abuse, Neglect or Exploitation*****:** Providers are responsible for immediately reporting knowledge or reasonable suspicion of abuse, neglect or exploitation of a child, aged person or disabled adult to the Florida Abuse Hotline on the statewide toll- free telephone number (1-800-96-ABUSE or TTY 1-800-453-5145) or on the Florida Department of Children & Families website and ensure that staff mandated to report abuse, neglect and exploitation have received appropriate training in reporting abuse, neglect and exploitation. Providers should refer victims of domestic violence to the National Domestic Violence Network hotline at 800-799- SAFE for information about local domestic violence programs and shelters in Florida.

- ***Participate in training***: Providers are responsible for participating in training as mandated by regulatory authorities and/or Sunshine Health.

  ➢ See Provider Training.

PCP Responsibilities and Covered Services

PCP Responsibilities for All Members

In addition to those responsibilities outlined above, network PCPs also are required to adhere to the following responsibilities:

- Supervise, coordinate and provide all primary care to each assigned member, which includes annual physical and/or well-woman examinations, preventive care and regular immunizations
- Coordinate and/or initiate referrals for specialty care (both in and out of network), maintaining continuity of each member's health care and maintaining the member's medical record, including documentation of all services provided by the PCP, any specialty services, and screening for behavioral health or substance abuse conditions
- Arrange for other participating physicians to provide members with covered physician services as stipulated in their contract and communicate with those treating providers
- Provide all covered physician services in accordance with generally accepted clinical, legal and ethical standards in a manner consistent with practitioner licensure, qualifications, training and experience. These standards of practice for quality care are generally recognized within the medical community in which the PCP practices.
- Educate members on how to maintain healthy lifestyles and prevent serious illness
- Obtain authorizations for all inpatient and selected outpatient services as listed on the current prior authorization list, except for emergency services up to the point of stabilization
- Provide preventive and chronic care screenings, well-care and referrals to community health departments and other agencies in accordance with AHCA provider requirements and public health initiatives
- Screen members for signs of alcohol or substance use disorder as part of prevention evaluation at the following times:
  - During routine physical examinations
  - Upon initial contact
  - Upon initial prenatal contact
  - When documentation of emergency room visits suggests the need
  - When the member evidences serious over-utilization of medical, surgical, trauma or emergency services

Covered PCP Services

Network PCPs are required to provide to Sunshine Health members covered services, which include, but are not limited to, the following:

- A health risk assessment that includes:
  - Screening for tobacco use, body mass index (BMI), nutrition, exercise or other lifestyle risks.

    - Documentation and review of growth and development, safety issues and drug/alcohol use
- A treatment plan (developed collaboratively with the member, member's parent, legal guardian or other member-authorized person and other treating specialists, as appropriate) created for members seen for routine care or monitoring as well as those who need an extended or complex course of treatment
- All tests routinely performed in the PCP's office during an office visit
- Any other outpatient services and routine office supplies normally within the scope of the PCP's practice
- Assessments for gaps in preventive health screenings or visits along with evidence-based treatment of chronic conditions
- Collection of laboratory specimens
- High-cost specialty/injectable drugs as listed on the prior-authorization list
- Identification and referral of members who may benefit from Sunshine Health's case management, health management or lifestyle coaching programs
- Oversight of a member's entire drug regimen, including those prescribed by another provider, inclusive of behavioral health providers
- Periodic health assessments and routine physical examinations
- Professional inpatient and outpatient medical services provided by the PCP, nurses and other personnel employed by the PCP (Services include the administration of immunizations, but not the cost of biologicals)
- Referrals to specialty care physicians and other health providers with coordination of care and follow-up
- Supervision of home care/home infusion regimens involving ancillary health professionals provided by licensed nursing agencies
- Vision screening, hearing screenings and dental assessment
- Voluntary family planning services such as examinations, counseling, and pregnancy testing
- Well-child care and periodic health appraisal examinations, including all routine tests performed customarily in a PCP's office
    - Immunizations are to be given according to the Advisory Committee on Immunization Practices (ACIP) guidelines and in keeping with procedures outlined in this provider manual
    - Well-child exams are to be performed according to the EPSDT periodicity schedule, Sunshine Health's preventive guidelines, and recommendations of the American Academy of Pediatrics (AAP)

Provider Programs and Accountabilities

PCPs and the Patient-Centered Medical Home (PCMH)

The primary care provider, or PCP, is the cornerstone of Sunshine Health. The PCP office serves as the member's "medical home," a model of care concept that encourages a strong member-provider relationship, allows for greater access, supports care continuity and care transitions, encourages data collection and population health management, and helps to reduce redundant services among PCPs and specialists. The goal of the patient-centered medical home (PCMH)

model is the "quadruple aim" of better care and better outcomes at lower cost resulting in higher patient and physician satisfaction.

Sunshine Health's PCMH is built upon the following characteristics:

- A personal physician in a physician-directed, team-based medical practice
- Coordinated and/or integrated care assessing physical and behavioral health both and considering members' socio-economic conditions and cultural norms
- Enhanced access
- Quality and safety
- Whole person orientation

Sunshine Health has a PCMH tool that can be used to assess PCP practices' ability to function as a PCMH and as a first stop to prepare for a national certification process. Practices interested in becoming a PCMH may call Provider Services at 1-844-477-8313.

Sunshine Health accepts PCMH recognition from NCQA, The Joint Commission (TJC), the Accreditation Association for Ambulatory Health Care (AAAHC) and URAC.

Coordination Between Physical and Behavioral Health

Continuity and coordination of behavioral and medical care includes communication between medical and behavioral health professionals, appropriate diagnosis, treatment and referral of behavioral disorders commonly seen in primary care, appropriate use of psychotropic medications, management of treatment access and follow-up for members with coexisting medical and behavioral disorders, primary or secondary preventive behavioral healthcare program implementation and special needs for members with severe and persistent mental illness.

PCPs treating members with identified behavioral health needs are responsible for consulting with behavioral health/substance use disorder providers about the member's medical condition, mental status, psychosocial functioning and family situations when making referrals or during treatment, using use all available communication methods to coordinate treatment with documentation of those methods in the member's medical record.

Likewise, behavioral health practitioners are asked to refer members with known or suspected untreated physical health problems or disorders to their PCP for examination and treatment to preserve continuity of care. With appropriate written consent from the member, behavioral health practitioners are responsible for keeping the PCP apprised of the member's treatment status and progress in a consistent and reliable manner to meet the requirements set forth in 42 CFR 2.00 et seq., when applicable. If the member requests this information not be given to the PCP, the provider must document this refusal in the member's treatment record and, if possible, offer the reason.

Contracted behavioral health practitioners and providers should include all the following information in their report to the PCP:

- A copy or summary of the intake assessment
- Member's completion of treatment
- Results of an initial psychiatric evaluation and the initiation of and major changes in psychotropic medication(s) within 14 days of the visit or medication order
- Results of functional assessments
- Written notification of member's noncompliance with treatment plan (if applicable)

Practitioners should exercise caution in conveying information regarding substance use disorders, which is protected under separate federal law.

For assistance with identifying network providers, or for care management support for a member, providers should call Provider Services at 1-844-477-8313.

Identifying and Reporting Abuse or Neglect

Sunshine Health providers are to immediately report knowledge or reasonable suspicion of abuse, neglect, or exploitation of a child (including human trafficking), aged person, or disabled adult to the Florida Abuse Hotline on the statewide toll-free telephone number (1-800-96-ABUSE). It is the provider's responsibility to ensure that he/she and staff are aware and been trained that they are mandated to report abuse, neglect and exploitation.

Florida state law requires reporting by any person if he or she has "reasonable cause to believe that a child has been subjected to child abuse or acts of child abuse." Providers are to report any suspected child abuse or neglect immediately to Children's Services in the appropriate county.

Reporting can be done anonymously. Providers are also to report any injuries from firearms and other weapons to the police.

Identifying and Reporting Critical Events

Sunshine Health requires its providers and direct service providers to report adverse or critical incidents to the Plan. Sunshine Health requires its Home and Community Based Service (HCBS) providers, except for nursing facilities or assisted living facilities, to report critical incidents to the Plan to ensure reporting of such critical incidents to AHCA within twenty-four (24) hours of the incident.

Critical incidents are events that negatively impact the health, safety, or welfare of a member. Examples include:

- Death by suicide, homicide, abuse, neglect, or exploitation or otherwise unexpected
- Any condition requiring definitive or specialized medical attention which is not consistent with the routine management of the patient's case or patient's preexisting physical condition
- Any condition resulting in transfer of the patient within or outside the facility to a unit providing a more acute level of care
- Suspected abuse, neglect, or exploitation
- Any condition that results in a limitation of neurological, physical, or sensory function

which continues after discharge from the facility
- Medication errors
- Suicide attempts
- Elopement

Telemedicine

Telemedicine is defined as the practice of health care delivery by a practitioner who is located at a site other than the site where a recipient is located for the purposes of evaluation, diagnosis, or treatment. Any practitioner licensed within their scope of practice to perform the service. Florida Medicaid reimburses for telemedicine services using interactive telecommunications equipment that includes, at a minimum audio and video equipment permitting two-way, real time, interactive communication between a patient and a practitioner. A providers' telecommunication equipment and telemedicine operations must meet the technical safeguards required by 45 CFR 164.312, where applicable. Providers must include modifier GT on the CMS-1500 claim form.

The following are the requirements for providers to bill for telemedicine:

- Two-way, real time interactive communication between the patient and the physician at the distant site
- Audio and video interaction with patient
- Technology used is compliant with HIPAA privacy requirements
- Patient must be informed and provide consent to the use of telemedicine
- Patient must have the choice of whether to access services through a face to face visitor telemedicine
- Document the choice for telemedicine in the patient's medical record

Sunshine Health will not reimburse providers for:

- Telephone conversations
- Chart review
- Electronic mail messages
- Facsimile transmissions

All Sunshine Health referral, notification and prior authorization requirements apply. Providers may furnish and receive payment for covered, eligible telemedicine services, when provided at a Distant Site, in accordance with this policy and the provider's scope of practice.

Responsibilities of Network Specialists

All network specialists are responsible to:

- Coordinate the member's care with the PCP
- Maintain contact with the PCP
- Provide the PCP with reports and other appropriate records within five business days of seeing the member

A specialist may order diagnostic tests without PCP involvement. However, the specialist must

abide by the prior authorization requirements when ordering diagnostic tests. The specialist may not refer to other specialists or admit to the hospital without the approval of the member's PCP, except in a true emergency. All non-emergency inpatient admissions require prior authorization from Sunshine Health.

Responsibilities of Network Hospitals

Sunshine Health network hospitals should refer to their contract for complete information regarding the hospitals' obligations and reimbursement. In general, network hospitals shall:

- Assist Sunshine Health with identifying members at high risk for readmission and coordination of discharge planning, which includes scheduling a post-discharge follow-up appointment with the member's PCP or treating specialist before discharge
- Communicate to Sunshine Health members' clinical status to assist with the discharge planning
- Notify the PCP immediately or no later than the close of the next business day following the member's appearance in the emergency department
- Notify Sunshine Health's Utilization Management Department of all maternity admissions upon admission
- Notify Sunshine Health's Utilization Management Department of all newborn deliveries on the same day as the delivery
- Notify Sunshine Health's Utilization Management Department of all non-maternity admissions by close of the next business day
- Obtain authorizations for all inpatient emergent or urgent admissions through Sunshine Health's secure, online portal within two business days after the date of admission
- Obtain authorizations through Sunshine Health's secure, online, web portal for all inpatient and outpatient services as listed on the current prior authorization list ,except for emergency stabilization services
- Provide the health plan's utilization management staff access to the hospital's electronic medical record system when applicable
- Register hospital staff on the Sunshine Health web portal to access claims information, authorizations and eligibility

Chapter 11: Provider Administration

Provider Services and Supports

Sunshine Health has various departments and support systems to assist medical and behavioral health practitioners and providers in their treatment of Sunshine Health members. Those departments include the following:

- Provider Relations – This provider-facing department educates and trains providers regarding products and quality initiatives. The department also conducts face-to-face visits with practitioners and facilities.
- Provider Operations – This department actively advocates to resolve provider issues, such as those relating to claims or authorizations.
- Contracting team – This team negotiates contracts.
- Provider Services – This department is available from 8 a.m. to 8 p.m. Eastern, Monday through Friday to field provider concerns, trouble-shoot authorizations, obtain translation services, and assist with any other needs that may occur after hours.

Appointment Wait Times

All providers are responsible for providing appointments to Sunshine Health members within a reasonable amount of time based on the nature of the visit. Practitioners who are unable to offer an appointment within the timeframes listed below should refer the member to Sunshine Health member services for rescheduling with an alternate provider who is able to meet the access standards and the member's needs.

Adherence to these standards is monitored with telephone auditing. Providers not in compliance with the standards may be required to implement correction actions set forth by Sunshine Health.

Behavioral health practitioners are required to notify Sunshine Health when they are not available for appointments. By calling or sending an email to the Sunshine Health Provider Relations department, practitioners may place themselves in a "no referral" hold status for a certain period without jeopardizing their network status.

Practitioners must have a start date and an end date indicating when they will be available again for referrals. The "no referral" period automatically ends on the set end date.

PCP, Specialist and Transportation Wait Times

PCPs, specialists (excluding behavioral health providers) and transportation providers are responsible for providing appointments within a reasonable amount of time, not to exceed the following:

PCP Appointment Type	Access Standard
Urgent care	Within forty-eight (48) hours of the request for services that do not require prior authorization; within ninety-six (96) hours of the request for services that do require prior authorization
Sick	Within seven (7) calendar days
Routine well exam	Within 30 days of the request
Specialist Appointment Type	**Access Standard**
Urgent care	Within forty-eight (48) hours of the request for services that do not require prior authorization; within ninety-six (96) hours of the request for services that do require prior authorization
Routine well exam	Within sixty (60) days of request with appropriate referral
Routine prenatal exams	Within four weeks until week 32, every two weeks until week 36, and every week thereafter until delivery
Sick	Within seven (7) calendar days of the request
Follow-up after physical health admission	Within seven days of discharge from the hospital
Ancillary services	Within fourteen (14) days of the request
Transportation Appointment Type	**Access Standard**
Pick-up wait time – Originating site	Average monthly wait time does not exceed fifteen (15) min of scheduled time (originating site)
Pick-up wait time (scheduled medically necessary appointment)	Average monthly wait time does not exceed thirty (30) min of scheduled time
Pick-up time (will-call medically necessary appointment)	Average monthly wait time does not exceed sixty 60 min of scheduled time
Pick-up time (facility discharge)	Average monthly wait time does not exceed three hours (thirty (30) min added for every fifteen (15) miles outside of member's county of residence)
Pick-up time (urgent care)	Average monthly wait time does not exceed three (3) hours from the time of the call.

In-office waiting times for visits shall not exceed thirty (30) minutes.

PCPs are encouraged to offer after hour's appointments in the evening after 5 PM and on weekends. PCPs must provide or arrange coverage of services, consultation, or approval for referrals twenty-four (24) hours a day, seven (7) days a week. To ensure access and availability, PCPs must provide one of the following:

- A twenty-four (24) hour answering service that connects the Member to someone who can render a clinical decision or reach the PCP
- An answering system with the option to page the physician for a return call within a maximum of thirty (30) minutes
- An advice nurse with access the PCP or on-call physician within a maximum of thirty (30) minutes

Behavioral Health Practitioner Wait Times

Behavioral health practitioners must make every effort to provide appointments to Sunshine Health members within the following timeframes:

Appointment Type	Access Standard
Non-life-threatening emergency	Within six (6) hours
Urgent access	Within forty-eight (48) hours of the request for services that do not require prior authorization; within ninety-six (96) hours of the request for services that do require prior authorization
Initial visit for routine care	Within fourteen(14) business days
Follow-up routine care	Within thirty (30) calendar days
Follow up after behavioral health hospital admission	Scheduled prior to discharge

In office waiting times shall not exceed thirty (30) minutes.

Behavioral Health providers must provide or arrange coverage of services twenty-four (24) hours a day, seven (7) days a week. To ensure access and availability, Behavioral Health providers must provide one of the following:

- A twenty-four (24) hour answering service that connects the Member to someone who can render a clinical decision or reach the practitioner
- An answering system with the option to page the practitioner for a return call within a maximum of thirty (30) minutes
- An advice nurse with access the provider or on-call practitioner within a maximum of thirty (30) minutes

Provider Office Standards

Sunshine Health requires all office space to be professional, clean, free of clutter and physically safe. In addition, offices must have visible signage, a separate waiting area with adequate seating, a fully-confidential telephone line and clean restrooms.

Offices also must be compliant with the Americans for Disabilities Act (ADA) and have locked cabinets behind locked doors for storage of patient medical records, prescription pads and sample medications.

Compliance with these standards is noted during site visits.

Consumer Assistance Notice

Sunshine Health requires that all providers prominently display a consumer assistance notice in the office reception area. The consumer assistance notice must state the addresses and toll-free telephone numbers of the Agency for Health Care Administration (AHCA), the Subscriber Assistance Program (SAP) and the Department of Financial Services.

The consumer assistance notice also must clearly offer to provide upon request the address and toll-free telephone number of Sunshine Health's grievance department.

➢ See Chapter 7: Member Complaints, Grievances and Appeals.

Provider Training

Provider Training Overview

Sunshine Health offers training programs that educate and assist physical health and behavioral health providers on the unique needs of Sunshine Health members and in the appropriate exchange of medical information to support coordination of care. Trainings are developed to maintain compliance with AHCA requirements and state and federal laws while placing an emphasis on promoting high standards of care. Sunshine Health's Provider Relations facilitates provider education and helps increase HEDIS compliance rates for plan members.

Educational content areas include, but are not limited to:

- Claims and billing trainings
- New provider orientations
- Pay-for-performance (P4P) training for PCPs
- Common billing errors trainings
- Provider incentive plan (PIP) as applicable
- Provider manual and provider toolkits for expanded products
- Authorization requirement and submission
- EPSDT
- HEDIS and other quality measures
- Appointment standards

- Telemedicine
- Trauma-informed care

Providers have several options for completing initial and ongoing training: live, instructor-led trainings, specialized webinars, and/or self-paced trainings through Relias Learning, an online learning management platform.

Initial Training

During the initial training of all network providers, the Provider Relations staff offers an overview of the enrollment and credentialing process, requirements of the contract with AHCA and the special needs of enrollees, member benefits, cultural competency, the AHCA policy and procedure guidelines on general outreach and enrollment, claims processing and systems technologies.

Providers must complete this training within 30 days of joining the network.

Required Training

In addition to the initial training, network providers are required to complete the following trainings:

- Fraud, waste and abuse – Within the first 30 days of joining the network and then annually thereafter
- Anti-kickback – Within the first 30 days of joining the network and then annually thereafter
- Early and periodic, screening, diagnosis and treatment (EPSDT) training – Annually
- Abuse, neglect and exploitation
- Use of behavioral health assessment tools, assessment instruments and techniques for identifying individuals with unmet behavioral health needs, evidence-based practice and the dependency system.
- Trauma-informed care – PCPs and behavioral health providers must complete this training, available through webinar or a live training session, before being re-credentialed

Clinical Training

Additional trainings are provided, upon request, to all providers and their staff regarding the requirements of their contract and special needs of CMS Health Plan members.

Sunshine Health offers a variety of clinical training opportunities to providers that support their ability to provide quality services to members. Trainings occur at various times throughout the year and may be offered live, online or through webinar format.

Behavioral Health Clinical Training

Sunshine Health offers a variety of clinical behavioral health trainings to promote practitioner competence and opportunities to enhance skills, promote recovery and resilience, and sustain and expand the use of evidence-based practices.

Topics range from behavior management strategies and suicide risk and assessment to signs and

symptoms of mental illness, verbal de-escalation strategies for aggressive behavior, trauma-informed care basics, the effect of childhood trauma, and documentation and reporting of behavior health concerns. Clinical trainings are offered throughout the year either live or by webinar.

In addition, Sunshine Health offers a two-day trauma-focused cognitive behavioral therapy training program for behavioral health practitioners.

Provider Termination

Practitioners should refer to their Sunshine Health contracts for specific information about terminating their contracts with Sunshine Health.

In general, though, medical providers who want to terminate an individual practitioner within a practice of group should provide the termination information on office letterhead and include the practitioner's name, tax identification number, NPI, termination date and membership transfer information, if applicable. The practice or group should email its Provider Relations Representative or SunshineProviderRelations@sunshinehealth.com.

Providers also may call 1-844-477-8313 for assistance.

Behavioral health provider should perform the following:

- Behavioral health facilities and agencies are to submit a roster to the Provider Engagement department identifying professionals who have terminated employment.
- Group practitioners are to submit a provider change form to the Provider Engagement department with the name of the professional leaving the group or practice.
- Solo practitioners are to submit a provider change form to the Provider Engagement department requesting termination of their relationship with Sunshine Health.

Practitioner Addition to Existing Practice

A contracted medical or behavioral health practice that would like to add a practitioner should email all relevant documentation to practitioneradds@centene.com. The credentialing department will confirm the receipt of the email and request any additional information if necessary.

Marketing Activities by Providers

All subcontractors and providers providing marketing and/or information materials (printed, web- based etc.) that are member-facing require DOH prior to use. In such cases, the materials should be submitted to Sunshine Health who will file the materials with DOH for approval, on behalf of the subcontractor or provider.

Provider Education and Outreach

Providers may:

- Display state-approved CMS Health Plan-specific materials in-office
- Announce a new affiliation with a health plan
- Make available and/or distribute DOH-approved marketing materials as long as the Provider and/or the facility distributes, or makes available, marketing materials for all Managed Care Plans with which the Provider participates
- Co-sponsor events such as health fairs and advertise indirectly with a health plan via television, radio, posters, fliers and print advertisement

Providers are prohibited from:

- Verbally, or in writing, comparing benefits or Providers networks among health plans, other than to confirm their participation in a health plan's network
- Furnishing lists of their Medicaid patients to any health plan with which they contract, or any other entity
- Furnishing health plans' membership lists to the health plan, such as Sunshine Health, or any other entity
- Assisting with health plan enrollment or disenrollment

Provider-Based Marketing Activities

Providers may:

- Make available and/or distribute DOH-approved marketing materials as long as the Provider and/or the facility distributes or makes available marketing materials for all Managed Care Plans with which the Provider participates. If a Provider agrees to make available and/or distribute Managed Care Plan marketing materials it should do so knowing it must accept future requests from other Managed Care Plans with which it participates
- Display posters or other materials in common areas such as the Provider's waiting room

Providers must comply with the following:

- To the extent that a Provider can assist a recipient in an objective assessment of his/her needs and potential options to meet those needs, the Provider may do so
- May engage in discussions with recipients should a recipient seek advice. However, Providers must remain neutral when assisting with enrollment decisions

Providers may also:

- Provide the names of the Managed Care Plans with which they participate
- Make available and/or distribute Managed Care Plan marketing materials
- Refer their patients to other sources of information, such as the Managed Care Plan, the enrollment broker or the local Medicaid Area Office
- Share information with patients from the Agency's website or DOH's website

Providers may:

- Assist a potential enrollee in an objective assessment of his/her needs and potential options to meet those needs
- Engage in discussions with their patients should they seek advice but remain neutral when assisting with enrollment decisions
- Display posters or other materials in common areas such as the provider's waiting room
- Make available and/or display Sunshine Health marketing materials as long as the provider and/or the facility displays marketing materials from all managed care plans with which the provider participates and agrees to accept future requests to display marketing materials from other managed care plans with which the provider participates
- Provide their patients with the names of the managed care plans with which they participate
- Refer their patients to other sources of information, such as Sunshine Health, an enrollment broker or the local Medicaid office
- Share information with patients from AHCA's website or CMS' website

Providers may not:

- Accept compensation directly or indirectly from Sunshine Health for marketing activities
- Mail marketing materials on behalf of Sunshine Health
- Display or distribute marketing materials within an exam room setting
- Make phone calls or direct, urge or attempt to persuade recipients to enroll in the managed care plan based on financial or any other interests of the provider
- Offer anything of value to induce potential enrollees to select them as their provider
- Offer inducements to persuade potential enrollees to enroll in Sunshine Health
- Conduct health screening as a marketing activity
- Offer marketing/appointment forms
- Furnish to Sunshine Health lists of the provider's Medicaid patients or the membership of any managed care plan

Provider Affiliation Announcements

AHCA has strict rules regarding provider affiliation announcements.

Providers may make new affiliation announcements within the first 30 days of the new provider contract. Providers may announce new or continuing affiliation with a managed care plan through general advertising (e.g., radio, television, websites) and may make one announcement of a new affiliation that names only the managed care plan when such an announcement is conveyed through direct mail, email or phone.

Additional direct mail and/or email communications from providers to their patients regarding affiliations must include a list of all managed care plans with which the provider contracts. AHCA must approve any affiliation communication materials that include managed care plan-specific information (e.g., benefits, formularies).

Medical Record Documentation

Providers are required to follow appropriate guidelines for documenting member medical records to ensure records:

- Are kept in a manner that is current, detailed and organized
- Include the quality, quantity, appropriateness and timeliness of services performed
- Permit evaluation of effective patient care and quality reviews

Medical records must be legible, detailed and include the member's identifying information (i.e., name, identification number, date of birth, sex and legal guardianship, if any) as well as the following:

- A summary of significant surgical procedures, past and current diagnoses or problems, allergies, untoward reactions to drugs and current medications
- All services provided by practitioners, including, but not limited to: family planning services, preventive services and services for the treatment of sexually transmitted diseases
- Copies of any consent/attestation form or the court order for prescribed psychotherapeutic medication for an MMA member under the age of 13
- Documentation of referral services
- Documentation that the member was provided with written information concerning his/her rights regarding advance directives (written instructions for living will or power of attorney) and copies of any advance directives executed by the member

  ➢ See Advance Directives.

- Entries dated and signed by the appropriate party
- Entries indicating the chief complaint or purpose of the visit, the objective, diagnoses, medical findings or impression of the provider
- Entries indicating studies ordered (e.g., laboratory, x-ray, EKG) and referral reports
- Entries indicating therapies administered and prescribed
- Entries with the name and profession of the provider rendering services (e.g., MD, DO, OD) as well as the signature or initials of the provider
- Entries indicating the disposition, recommendations, instructions to the member, evidence of follow-up and outcome of services
- Immunization history
- Information relating to the member's use of tobacco products and alcohol/substance abuse
- Items related to telemedicine-related services, including:
  - Brief explanation of the use of telemedicine in each progress note
  - Documentation of telemedicine equipment used for the covered services provided
  - Signed statement from the member or the member's representative indicating the choice to receive services through telemedicine for a set period of treatment or one- time visit, as applicable
- Summaries of all emergency services and care and hospital discharges with appropriate medically indicated follow-up
- The primary language spoken by the member, any translation needs of the member and whether the member requires communication assistance in delivery of health care services

Providers must supply member medical records in support of utilization management as well as all quality activities, including HEDIS, audits, quality studies and quality improvement projects.

Cultural Competency

Sunshine Health's Cultural Competency Plan and Evaluation

Sunshine Health's cultural competency plan ensures members receive care delivered in a culturally and linguistically sensitive manner. Sunshine Health recognizes that respecting the diversity of members has a significant and positive effect on care outcomes. Sunshine Health strives to adopt the "Culturally and Linguistically Appropriate Services (CLAS)" standards developed by the Department of Health and Human Services, Office of Minority Health as guidelines for providing culturally sensitive services.

Sunshine Health assists in the reduction of racial and ethnic health disparities through contracting a culturally competent network; providing language support; and educating staff, contracted providers and vendors. To assist with the engagement of members who do not speak English as their first language or are from a culturally diverse background, Sunshine Health hires staff who speak languages prevalent among the membership and understand various cultures. Sunshine Health also makes available language interpreter services to assist members when interacting with staff and practitioners. The provider network team annually assesses members' cultural, ethnic, racial and linguistic needs through comparing data from external and internal sources to match membership needs with practitioner demographics. The network team compares the provider data with member enrollment data to ensure Sunshine Health has a culturally diverse network that will meet members' needs. The outcomes of the analysis are used to enhance the practitioner network, if necessary.

Network providers may read more about the cultural competency plan on the Sunshine Health website.

All newly credentialed practitioners and providers are invited to participate in orientation that includes comprehensive training regarding cultural competency and sensitivity.

Provider Assistance with Cultural Competency Needs

Sunshine Health member services staff or care managers may assist in arranging translation for upcoming appointments or other services. Types of translation that are available include the following:

- Face-to-face interpreters: If a member needs face-to-face interpreters for languages other than English, Sunshine Health will:
  - Place a three-way call with the interpreter service vendor
  - Provide the vendor with pertinent information regarding the member's needs
  - Schedule a time and place for an interpreter to meet with the member
- Telephonic interpreters: Sunshine Health offers language translation services through a contracted vendor. This service is available to members and to all participating network practitioners and providers.

- Assistance for members who are deaf or hearing-impaired: Sunshine Health will contact the relay service via three-way calling, provide pertinent information regarding the member's need, and schedule a time and place for an interpreter to meet with the member for the appointment. This service requires at least two working days prior to the needed appointment.

PCP Administration

PCP Access and Availability

Each PCP is responsible to maintain sufficient facilities and personnel to provide covered services and shall ensure that such services are available as needed 24 hours a day, 365 days a year. This coverage must consist of an answering service, call forwarding, provider call coverage or other customary means. The chosen method of 24-hour coverage must connect the caller to someone who can render a clinical decision or reach the provider for a clinical decision. The after-hours coverage must be accessible using the medical office's daytime telephone number. Providers shall ensure services provided are available on a 24/7 basis as the nature of the member's condition dictates. After-hour calls should be documented in a written format in either an after-hour call log or some other satisfactory method and then transferred to the member's medical record.

If a member contacts his/her PCP after hours and requires urgent or emergent care, the PCP should notify the urgent care center or emergency department. However, notification is not required before the member may receive urgent or emergent care.

Sunshine Health assesses PCP availability at least annually and computes the percentage of PCPs with panels open for new members to ensure network adequacy and accessibility. If a PCP becomes unavailable, he/she is responsible for arranging coverage with a physician who has executed a PCP services agreement with Sunshine Health.

Sunshine Health also monitors physicians' offices for 24-hour accessibility. Sunshine Health performs access audits, tracks applicable results of the Consumer Assessment of Healthcare Provider Systems Survey (CAHPS), analyzes the member experience regarding access and reviews telephone access.

Member Panel Capacity for PCPs

All PCPs reserve the right to state the number of members they are willing to accept into their panel. Sunshine Health does not guarantee that any provider will receive a defined number of members.

If a PCP does declare a specific capacity for his/her practice and wants to make a change to that capacity, the PCP must contact Sunshine Health provider services at 1-844-477-8313.

Providers shall notify Sunshine Health at least 45 days in advance of their inability to accept additional Medicaid-covered persons under Sunshine Health agreements. Sunshine Health prohibits all providers from intentionally segregating members from fair treatment and covered services provided to other non-Medicaid members.

PCPs are to attest that their total active patient load shall not exceed 3,000 active patients from all plans or services, including commercial insurances. An active patient is one that is seen by the PCP at least three times per year. Each full-time equivalent PCP is not permitted to have more than 1,500 Medicaid patients, and each full-time equivalent advanced registered nurse practitioner is not permitted to have more than 750 patients in total.

Referrals by PCPs

PCPs are to coordinate healthcare services and are encouraged to refer a member to the appropriate network provider when medically necessary care is needed that is beyond their scope. However, members may self-refer for all services, including referrals to specialists and behavioral health providers. Prior authorization may be required for some services. Except for emergency and family planning services, services must be obtained through network providers unless prior authorization for out-of-network providers is obtained.

PCPs and obstetricians/gynecologists are required to notify Sunshine Health promptly when providing prenatal care to a Sunshine Health member.

➢ See Notice of Pregnancy.

PCPs must communicate with all specialty providers to discuss ongoing and follow-up care. Likewise, Sunshine Health requires specialists to communicate their findings to the PCP and notify the PCP if there is a need for a referral to another participating specialist, rather than making such a referral themselves. This allows the PCP to better coordinate their members' care and to make sure the referred specialist is a participating provider with Sunshine Health.

Providers are prohibited from making referrals for designated health services to healthcare entities with which the provider or a member of the provider's family has a financial relationship.

Member Dismissal from a Panel

A PCP may request that a member be removed from his/her panel and transferred to another practice for any of the following reasons:

- Disruptive, unruly, threatening or uncooperative behavior by the member or member's parent/legal guardian, particularly if such behavior is not caused by a physical or behavioral condition
- Personality conflicts between the PCP/PCP staff and the member
- Repeated disregard of medical advice
- Repeated disregard of member rights

A PCP may never request a member be disenrolled for the following reasons:

- A previous inability to pay medical bills or outstanding account balances before the member's enrollment with Sunshine Health
- Adverse change in the member's health status or utilization of services that are medically necessary for the treatment of a member's condition
- Member's race, color, national origin, sex, age, disability, political beliefs or religion

The PCP must first send a letter by certified mail to the member advising the member of the PCP's request to dismiss the member from the panel. The PCP then should forward all documentation to Sunshine Health member advocacy to determine the course of action.

Documentation should include the PCP's letter to the member along with the certified mail receipt. Letters should be sent to:

Sunshine Health Member Services Department Attention: Member Advocacy
P.O. Box 459089
Fort Lauderdale, FL 33345-9089

Upon receipt, the member advocacy department may do any or all of the following:

- Interview the member
- Interview the provider or staff who is requesting the disenrollment, as well as any additional relevant providers
- Involve other Sunshine Health departments as appropriate to resolve the issue
- Review any relevant medical records

Unable-to-Locate Members

PCPs who have made three documented, unsuccessful attempts to contact members in their panel must request assistance from Sunshine Health case management through the online provider portal. Case management will respond with information regarding its investigation.

If case management is unable to contact the member or connect the member to the PCP, the PCP must send a letter by certified mail to the member requesting the member contact the PCP. If the member does not contact the PCP, the PCP then should send all documentation regarding attempts to contact the member to Sunshine Health member advocacy to determine the course of action. The documentation should include the PCP's letter to the member along with the certified mail receipt. Letters should be sent to:

Sunshine Health Member Services Department Attention: Member Advocacy
P.O. Box 459089
Fort Lauderdale, FL 33345-9089

Provider Coordination with Carve-out Public Health Services

Sunshine Health is required to coordinate with entities providing public health, carve-out services that are covered by Medicaid but not Sunshine Health. Providers should inform their patients of those services, which include the following:

- ***Applied Behavior Analysis (ABA)*:** These services by community behavioral health providers, iBudget development disability waiver providers and/or early intervention service providers are highly structured interventions with the goal of targeting and decreasing maladaptive behaviors for Medicaid recipients under the age of 21 who have a diagnosis of autism or autism spectrum disorder.

- ***Child Health Service Targeted Case Management*:** Medicaid reimburses for services under the Child Health Services Targeted Case Management (TCM) program for recipients from birth up to 3 years of age who are receiving services through the Department of Health Children's Medical Services Early Steps program or recipients up to 21 years of age who are receiving services through the Department of Health Children's Medical Services foster care contractors. These services assist Medicaid recipients in gaining access to medical social, educational, and other support services.
- ***County Health Department (CHD) Certified Match Program*:** This program provides reimbursement to county health departments for medically necessary nursing, medication, administration and social work services provided in a school setting to Medicaid eligible students under the age of 21.
- ***Developmental Disabilities Individual Budgeting (iBudget) Home and Community-Based Services (HCBS) Services Waiver*:** The iBudget Waiver provides home and community-based supports and services to eligible persons age 3 and older with developmental disabilities living at home or in a home-like setting to promote, maintain and optimize health, delay institutionalization and foster the principles and appreciation of self-determination.
- ***Early Intervention Services (EIS) for Recipients Birth to Three Years of Age*:** These services are designed to identify, as early as possible, the presence of a developmental delay or condition that could result in a developmental delay in Medicaid recipients under the age of 3 and provide services to optimize functioning capacity.
- ***Familial Dysautonomia (FD) Home and Community-Based Services Waiver*:** The FD Waiver provides home and community-based supports and services to eligible persons age 3 and older with Familial Dysautonomia living in their own homes or family homes to promote, maintain and optimize health and delay or prevent institutionalization.
- ***Intermediate Care Facility Services for Individuals with Intellectual Disabilities (ICF/IID)*:** ICF/IID services provide 24-hour medical, rehabilitative and health-related services to recipients diagnosed with an intellectual disability or related condition and who reside in an intermediate care facility.
- ***Medicaid Certified School Match (MCSM) Program*:** The MCSM program provides reimbursement for medically necessary services – such as behavioral, nursing, occupational/physical therapy, speech-language pathology and transportation – provided by a school district to disabled students under the age of 21.
- ***Medical Foster Care (MFC)*:** Florida Medical Foster Care (MFC) services enable children and youth under the age of 21 with complex medical needs and who are in the custody of DCF, extended foster care or voluntary placement agreement to live and receive medical care and support in a home-like environment.
- ***Model Home and Community-Based Services Waiver*:** The Model Waiver provides home and community-based services designed to delay or prevent institutionalization to eligible children under the age of 21 who are medically complex/medically fragile or diagnosed with degenerative spinocerebellar disease.
- ***Newborn Hearing Services*:** These screenings test all Medicaid eligible newborns (from birth through 12 months) for hearing impairment. A second screening may be performed only if the recipient does not pass the initial hearing screening test in one or both ears.

- ***Prescribed Pediatric Extended Care (PPEC)*:** These services provide non-residential short-term, long-term or intermittent skilled nursing interventions to Medicaid eligible children from birth through age 20 with medically-complex conditions who require skilled nursing and are medically stable.
- ***Program for All-Inclusive Care for Children (PACC)*:** The Florida Medicaid PACC provides specialized palliative care support services to provide comfort for children under age 21 diagnosed with a life-threatening illness and their families. This program is also referred to as Partners in Care: Together for Kids (PIC: TFK) and is operated by the Department of Health.
- ***Substance Abuse County Match Program*:** The Substance Abuse County Match program enables eligible counties to receive federal matching funds for three Medicaid-funded substance abuse services, including services to identify recipients at risk for substance use disorders and to maintain recovery when treatment is successfullycompleted.
- ***Hemophilia Factor-Related Drugs Distributed through the Comprehensive Hemophilia Disease Management Program*:** Members who need prescribed drugs as treatment for hemophilia or von Willebrand disease receive those drugs through the Comprehensive Statewide Hemophilia Disease Management Program (DMOH assignment plan).

Provider Complaints

For non-claims complaints, providers must file within 45 days from the date of the incident. This can be in email, mail, fax, provider portal, or a call to the Provider Service department. For claims issues, the provider must submit in writing to Sunshine Health, within 90 days from the date of final determination for claims-related issues. Sunshine Health provides an acknowledging of the provider within three business days of receipt.

Non-claims complaints may be filed verbally from 8 a.m. to 8 p.m. Eastern, Monday through Friday by calling 1-844-477-8313.

Claims related complaints must be filed in writing to the following addresses:

Sunshine Health Provider Relations Unit
P.O. Box 459089
Fort Lauderdale, FL 33345-9089

Providers must include the original claim number on the complaint and include any relevant supporting documentation.

➢ See Process for Claims Reconsiderations and Disputes.

Sunshine Health acknowledges both types of complaints within three business days and offers a status report within 15 days of receipt and every 15 days thereafter, if necessary.

During that time, Sunshine Health thoroughly investigates each provider complaint using applicable statutory, regulatory, contractual and provider contract provisions, collecting all pertinent facts from all parties and applying Sunshine Health's written policies and procedures. Sunshine Health ensures that health plan executives with the authority to require corrective action are involved in the provider complaint process.

Sunshine Health sends a written notification to the provider acknowledging the resolution of the complaint within three business days of the resolution.

Chapter 12: Member Administration

Member Rights

As a recipient of Medicaid and a member in a Plan, members also have certain rights. They have the right to:

- Be treated with courtesy and respect
- Have their dignity and privacy considered and respected at all times
- Receive a quick and useful response to their questions and requests
- Know who is providing medical services and who is responsible for their care
- Know what member services are available, including whether an interpreter is available if they do not speak English
- Know what rules and laws apply to their conduct
- Be given easy to follow information about their diagnosis, the treatment they need, choices of treatments and alternatives, risks, and how these treatments will help them
- Make choices about their health care and say no to any treatment, except as otherwise provided by law
- Be given full information about other ways to help pay for their healthcare
- Know if the provider or facility accepts the Medicare assignment rate
- To be told prior to getting a service how much it may cost them
- Get a copy of a bill and have the charges explained to them
- Get medical treatment or special help for people with disabilities, regardless of race, national origin, religion, handicap, or source of payment
- Receive treatment for any health emergency that will get worse if they do not get treatment
- Know if medical treatment is for experimental research and to say yes or no to participating in such research
- Make a complaint when their rights are not respected
- Ask for another doctor when they do not agree with their doctor (second medical opinion)
- Get a copy of their medical record and ask to have information added or corrected in their record, if needed
- Have their medical records kept private and shared only when required by law or with their approval
- Decide how they want medical decisions made if they can't make them themselves (advanced directive)
- To file a grievance about any matter other than a Plan's decision about their services.

- To appeal a Plan's decision about their services
- Receive services from a provider that is not part of our Plan (out-of-network) if we cannot find a provider for you that is part of our Plan
- Speak freely about their healthcare and concerns without any bad results
- Freely exercise their rights without the Plan or its network providers treating them badly
- Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation
- Request and receive a copy of their medical records and ask that they be amended or corrected

Member Responsibilities

As a recipient of Medicaid and a member in a Plan, members also have certain responsibilities. They have the responsibility to:

- Give accurate information about their health to the Plan and providers
- Tell their provider about unexpected changes in their health condition
- Talk to their provider to make sure they understand a course of action and what is expected of them
- Listen to their provider, follow instructions and ask
- Keep their appointments or notify their provider if they will not be able to keep an appointment
- Be responsible for their actions if treatment is refused or if you do not follow the healthcare provider's instructions
- Make sure payment is made for non-covered services they receive
- Follow healthcare facility conduct rules and regulations
- Treat healthcare staff with respect
- Tell us if they have problems with any healthcare staff
- Use the emergency room only for real emergencies
- Notify their case manager if they have a change in information (address, phone number, etc.)
- Have a plan for emergencies and access this plan if necessary for their safety
- Report fraud, abuse and overpayment

Advance Directives

PCPs and other practitioners who deliver care to CMS Health Plan members must ensure adult members 18 and older receive information on advance directives (written instructions for living will or power of attorney) and are informed of their right to execute advance directives.

Practitioners are directed to document such information in the member's permanent medical record. All medical records must contain documentation that the member was provided written information concerning the member's rights regarding advance directives and whether the member has executed an advance directive.

Neither Sunshine Health nor its practitioners or providers will condition the authorization or

provision of care or otherwise discriminate against a member based on the presence or lack of an advance directive. Sunshine Health will facilitate communications between a member or member's representative and the member's practitioner or provider if/when the need is identified to ensure that they are involved in decisions to withhold resuscitative services or to forgo or withdraw life-sustaining treatment.

Sunshine Health recommends that PCPs and other practitioners take the following steps regarding advance directives:

- During the first appointment, the office should ask if the member has executed an advance directive. The member's response should be documented in the medical record. If the member does not have an advance directive, the office should ask the member if he/she desires more information about an advance directive and document that information in the member's medical record.
- Education/information should be provided and documented in the member's medical record if the member requests further information.
- The practice should ask members with advance directives to bring a copy of the document to the office and note the request in the member's medical record.
- If an advance directive exists, it should be included as part of the member's medical record, including mental health directives. In addition, the practitioner should discuss potential medical emergencies with the member and/or designated person named in the advance directive and document the discussion in the member's medical record.

Providers should educate the member on the importance of sharing the advance directive with the member's PCP, treating specialists, ancillary provider, hospitals, and applicable family members or caregivers.

Any member complaints related to practitioners or providers not following a member's advance directive or treatment decision are reviewed as part of the Sunshine health quality-of-care process.

More information about advance directives is available on the Sunshine Health website along with a description of state law concerning advance directives on the Florida Health Care Association website. The link allows for timely updating and viewing of any revisions or enhancements to the form or education, based on applicable changes in state laws.

Chapter 13: Pharmacy Program

Pharmacy Benefit

CMS Health Plan covers prescription drugs and certain over-the-counter (OTC) drugs ordered by CMS Health Plan providers. Some medications require prior authorization or have limitations on dosage, maximum quantities or the member's age. Sunshine Health follows AHCA's preferred drug list (PDL), also referred to as a formulary.

In addition to drugs available from a retail pharmacy, CMS Health Plan covers specialty injectable drugs or pharmaceuticals that can be administered in a physician's office or member's home.

These injectable drugs do not include immunizations provided in the PCP's office. AcariaHealth is the preferred provider of biopharmaceuticals and specialty injectables for CMS Health Plan.

While most drugs are covered through a member's prescription drug benefit, some drugs may be covered through a member's medical benefit. Please refer to AHCA's Provider Reimbursement Schedules and Billing Codes website for a list of physician administered drug. Some of those drugs require prior authorization. Providers may search for prior authorization requirements for drugs processed through a member's medical benefits by using the Pre-Auth check tool on our website.

Pharmacy Benefit Manager

CMS Health Plan contracts with CVS/Caremark to administer the prescription drug benefit for Sunshine Health members. Pharmacy Services performs prior authorization for certain prescription drugs subject to quantity limits (QL), age limits or requirements (AL) or other clinical considerations to be approved for payment. Providers should refer to the Sunshine Health preferred drug list (PDL) for medication coverage limitations and prior authorization requirements. Pharmacy Services comprises the pharmacy benefit management segment of the business and AcariaHealth, the specialty pharmacy arm of the business.

Pharmacy claims are processed by CVS/Caremark. Pharmacies may call the CVS/Caremark help desk at 1-800-311-0539 any time or day.

Pharmacy Services performs the following functions:

- Benefit design consultation
- Drug utilization review
- Prior Authorization
- Specialty and mail order pharmacy services

CVS/Caremark is a pharmacy benefits manager that performs the following functions:

- Claims processing
- Pharmacy network management
- Specialty and mail order pharmacy services

AcariaHealth

AcariaHealth is the preferred provider of biopharmaceuticals and specialty injectables for CMS Health Plan. Many high-cost specialty injectables require prior authorization to be approved.

Preferred Drug List

The CMS Health Plan preferred drug list (PDL) describes the circumstances under which contracted pharmacies are reimbursed for medications dispensed to members covered under the program.

The PDL does not:

- Require or prohibit the prescribing or dispensing of any medication
- Substitute for the independent professional judgment of the physician/clinician or pharmacist
- Relieve the physician/clinician or pharmacist of any obligation to the member or others

The CMS Health Plan PDL may be found on the Pharmacy page of our website. CMS Health Plan may be less restrictive than AHCA's PDL but not more restrictive. Sunshine Health posts a supplemental PDL guide and a supplemental diabetic supply PDL guide on the pharmacy page, as well.

Unapproved Use of Preferred Medications

Medication coverage is limited to non-experimental indications as approved by the FDA. Drugs for other indications also may be covered if they are accepted as safe and effective using current medical and pharmaceutical reference texts and evidence-based medicine. Experimental drugs, investigational drugs and drugs used for cosmetic purposes are excluded from coverage.

Newly Approved Medications

Newly approved drug products are not normally placed on the preferred drug list during their first six months on the market. During this period, access to these medications is considered through the prior authorization review process.

➢ See Prior Authorization Process for Medications.

DESI or IRS Drugs

CMS Health Plan does not cover Drug Efficacy Study Implementation (DESI) and Identical, Related and Similar (IRS) drugs, which are classified as ineffective.

Controlled Substances

Prescribers of controlled substances must register and access the state "Prescription Drug Monitoring Program" (PDMP) database called E-FORCSE. Once prescribers register, they may access E-FORCSE to check a member's utilization history for controlled substances.

At a minimum, prescribers or their designees are required to review the database before prescribing a controlled substance (except for a non-opioid Schedule V) for a member 16 years of age or older. Providers may access E-FORCSE on the Florida Health website.

Hemophilia Medications

For hemophilia factor-related drugs for Title XIX, CMS Health Plan coordinates the care of its members with the Agency's Comprehensive Hemophilia Disease Management Program. For Title XXI, hemophilia factor-related drugs are covered directly through the plan.

Dispensing Limits

Drugs may be dispensed up to a 34-day supply on most medications and up to a 100-day supply on some maintenance medications. A total of 80 percent of the days supplied must have elapsed before the prescription may be refilled.

Age limits (AL) and quantity limits (QL) are noted on the PDL and/or summary of drug limitations, found on the Pharmacy page of our website.

Over-the-Counter (OTC) Items

The CMS Health Plan PDL covers a few over-the-counter (OTC) medications. Members may fill them through their prescription drug benefit by taking a valid prescription to a network pharmacy.

In addition, CMS Health Plan offers an enhanced OTC benefit, which may include first aid supplies, cold/cough medications, eye drops, toothpaste, pain relievers, vitamins and personal care items.

Pharmacy and Therapeutics Committee Review of PDL

For CMS Health Plan, the Sunshine Health Pharmacy and Therapeutics Committee continually evaluates the medications included in the supplemental PDL and prior authorization criteria not specified by the state. The committee is comprised of the Sunshine Health chief medical director, vice president of pharmacy operations, other Sunshine Health clinical staff, and several community-based primary care providers and specialists.

The primary purpose of the committee is to assist in developing and monitoring the CMS Health Plan PDL and to establish programs and procedures that promote the appropriate and cost-effective use of medications. The committee schedules meetings at least quarterly during the year and coordinates therapeutic class reviews with the parent company's national pharmacy and therapeutics committee.

Prior Authorization Process for Medications

Prior medications requiring authorization are listed on the PDL with a "PA" notation. Medications not listed on the PDL may also require prior authorization.

Most injectables require prior authorization. However, preferred self-injectable medications such as some insulin products, glucagon, epinephrine anaphylactic kits, as well as provider-administered medroxyprogesterone IM do not require prior authorization.

Prior Authorization Requests for Non-Specialty/Retail Medications

To efficiently process prior authorization requests for non-specialty/retail medications, providers should follow these steps:

- Submit requests electronically through CoverMyMeds (preferred method)
- Send a fax to Pharmacy Services at 1-86-865-6531
- Call 1-833-399-0928 from 8 a.m. to 8 p.m. Eastern, Monday through Friday with questions

Pharmacy Services will respond by fax or phone within the contracted turnaround time. If more information is required, we will respond to the prescriber by fax and request additional information. If the request is denied, information about the denial will be provided to the clinician. A notice of adverse benefit determination letter also is sent to the member and requesting provider with reasons for the denial and member appeal rights.

Prior Authorization Requests for Specialty Medications

To efficiently process prior authorization requests for specialty medications (i.e., biopharmaceuticals and high-cost specialty injectables), providers should complete the Prior Authorization Form for Specialty Medication or Buy and Bill (PDF) and fax it to the appropriate phone number listed on the form based on the type of request.

Non-specialty home infusion medications including TPN and IV antibiotics may be obtained through a contracted home infusion provider, which may be found through our Find A Provider tool.

72-Hour Emergency Supply Policy

State law requires that a pharmacy offers to dispense a 72-hour (three-day) supply of certain medications to a member awaiting a prior authorization determination. The purpose is to avoid interruption of current therapy or delay in the initiation of therapy. All participating pharmacies are reimbursed for the medication, whether or not the prior authorization request is ultimately approved or denied.

The pharmacy may call CVS/Caremark Help Desk at 1-844-274-5433 for questions on submitting a 72-hour medication supply.

Exclusions to the 72-Hour Emergency Supply

The following drug categories are not part of the CMS Health Plan PDL and are not covered by the 72-hour emergency supply policy:

- Anorectics: Drugs used for weight loss (unless prescribed for an indication other than obesity)
- Anti-hemophilia products (billed as fee-for-service to Florida Medicaid)
- Cough and cold medications for members 21 and over
- DESI ineffective drugs as designated by CMS
- Drugs covered under Medicare Part B and/or Medicare Part D
- Drugs used to treat infertility
- Experimental/investigational pharmaceuticals or products
- Erectile dysfunction products prescribed to treat impotence
- Hair growth restorers and other drugs used for cosmetic purposes
- Immunizing agents (except for influenza vaccine)
- Injectable drugs or infusion therapy and supplies (except those listed in the PDL)
- Injectable/oral drugs administered by the provider in the office, in an outpatient clinic and/or infusion center, or in a mental health center
- Nutritional supplements
- Oral vitamins and minerals (except those listed in the PDL)
- OTC drugs (except those listed in the PDL)
- Prostheses, appliances and devices (except products for diabetics and products used for contraception)

Additional exceptions to the 72-hour emergency supply policy:

- The attempt to refill is early
- The rejection is due to an error only the pharmacist can correct
- There are clinical issues that must be resolved
- The individual is not eligible for Medicaid
- There would be a medical danger, in the pharmacist's clinical judgement, if temporary supply is dispensed.

Psychotropic Medications

Providers should perform a comprehensive evaluation to include a thorough health history, psychosocial assessment, mental status exam and physical exam before prescribing a psychotropic medication. Psychotropic medications include the following:

- Antipsychotics
- Antidepressants
- Antianxiety medications
- Mood stabilizers

CMS Health Plan follows AHCA's PDL for psychotropic medications.

Providers should consider the role of non-pharmacological interventions before prescribing a psychotropic medication, except in urgent situations such as suicidal ideation, psychosis, self-

injurious behavior, physical aggression acutely dangerous to others, or severe impulsivity endangering the member or others or when there is marked disturbance of psycho-physiological functioning (such as profound sleep disturbance), marked anxiety, isolation or withdrawal.

Moreover, providers especially should consider non-pharmacological interventions before prescribing a psychotropic medication for children. Sunshine Health monitors the prescribing of psychotropic medications for all children. In addition, any prescription for a psychotropic medication for an CMS Health Plan member under the age of 13 must be accompanied by the express written and informed consent of the member's parent or legal guardian.

Every new prescription for the members noted above requires a new informed consent form. This informed consent form does not replace a prior authorization if Sunshine Health has noted that a prior authorization is needed for that drug.

The physician ordering the medication must document the consent in the member's medical record and provide the pharmacy with a signed attestation of consent (PDF) with the prescription.

Anticonvulsants and attention-deficit/hyperactivity disorder (ADHD) medications (stimulants and non-stimulants) are not included on the list of medications requiring informed consent.

Chapter 14: Claims Coding and Billing

Risk Adjustment

Risk adjustment is a process used by the Centers for Medicare and Medicaid Services (CMS) in the Medicare Advantage and Marketplace programs and by state Medicaid agencies to account for expected differences in cost of treatment of members who have varying health status.

Accurate calculation of risk adjustment requires specificity in diagnostic coding. Providers should, at all times, document and code according to CMS regulations and follow all applicable coding guidelines for ICD-10-CM, CPT and HCPCs code sets. Providers should note the following guidelines:

- Code all diagnoses to the highest level of specificity, which means assigning the most precise ICD code that most fully explains the symptom or diagnosis
- Ensure medical record documentation is clear, concise, consistent, complete, legible and meets CMS signature guidelines (each encounter must stand alone)
- Submit claims and encounter information in a timely manner
- Alert Sunshine Health of any erroneous data submitted and follow Sunshine Health's policies to correct errors in a timely manner
- Provide medical records as requested in a timely manner
- Provide ongoing training to staff regarding appropriate use of ICD coding for

reporting diagnoses

Accurate and thorough diagnosis coding is imperative to Sunshine Health's ability to manage members, comply with risk adjustment data validation and audit requirements. Claims submitted with inaccurate or incomplete data may require retrospective chart review.

Clinical Lab Improvement Act (CLIA) Billing Instructions

Clinical Lab Improvement Act (CLIA) numbers are required for CMS 1500 claims where CLIA-certified or CLIA-waived services are billed. If the CLIA number is not present, the claim is rejected.

EDI

If a single claim is submitted for those laboratory services for which CLIA certification or waiver is required, report the CLIA certification or waiver number in: X12N 837 (HIPAA version) loop 2300, REF02. REF01 = X4.

If a claim is submitted with both laboratory services for which CLIA certification or waiver is required and a non-CLIA covered laboratory test, in the 2400 loop for the appropriate line, report the CLIA certification or waiver number in: X12N 837 (HIPAA version) loop 2400, REF02. REF01 = X4.

The billing laboratory submits, on the same claim, tests referred to another (referral/rendered) laboratory, with modifier 90 reported on the line item and reports the referral laboratory's CLIA certification or waiver number in: X12N 837 (HIPAA version) loop 2400, REF02. REF01 = X4.

Consult the 5010 implementation guides for the appropriate loops to enter the CLIA number. If a claim has services requiring an authorization number and CLIA services, only the CLIA number must be provided.

Web

Complete box 23 with CLIA certification or waiver number as the prior authorization number for those laboratory services for which CLIA certification or waiver is required.

Paper Claims

If a claim has services requiring an authorization number and CLIA services, only the CLIA number must be provided in Box 23.

An independent clinical laboratory that elects to file a paper claim form shall file CMS 1500 claim form for a referred laboratory service (as it would any laboratory service). The line item services must be submitted with a modifier 90. An independent clinical laboratory that submits claims in paper format may not combine non-referred (i.e., self-performed) and referred services on the same CMS 1500 claim form. When the referring laboratory bills for both non-referred and referred tests, it shall submit two separate claims – one claim for non-referred tests and another

for referred tests.

If billing for services that have been referred to more than one laboratory, the referring laboratory shall submit a separate claim for each laboratory to which services were referred (unless one or more of the reference laboratories are separately billing). When the referring laboratory is the billing laboratory, the reference laboratory's name, address and ZIP code shall be reported in item 32 on the CMS 1500 claim form to show where the service (test) was performed. The NPI shall be reported in item 32a. Also, the CLIA certification or waiver number of the reference laboratory shall be reported in item 23 on the CMS-1500 claim form.

Provider Billing Information

Required Provider Information

All providers who have rendered services for Sunshine Health members may file claims. Providers should confirm with the provider services department or the practice's dedicated Provider Relations Representative that the following information is current:

- Provider name (as noted on current W-9 form)
- National provider identifier (NPI)
- Group national provider identifier (NPI), if applicable
- Tax identification number (TIN)
- Physical location address as noted on current W-9 form
- Billing name and address as noted on current W-9form

Changes in Billing Information

Providers should notify Sunshine Health at least 60 days but no later than 30 days in advance of changes pertaining to billing information.

If the change in billing information affects the address to which the end of the year 1099 IRS form is to be mailed, providers are required to submit a new W-9 form.

Providers may not use a claim form or 277 electronic file to make changes to their TIN or billing address.

Billing Reminders

Written descriptions, itemized statements, and invoices may be required for non-specific types of claims or at the request of Sunshine Health.

Newborn services provided in the hospital are reimbursed separately from the mother's hospital stay. A separate claim needs to be submitted for the mother and her newborn.

Billing from independent provider-based rural health clinics (RHC) and federally qualified health centers (FQHC) for covered RHC/FQHC services furnished to members should be made with specificity regarding diagnosis codes, accurate location codes, and procedure code/modifier combinations.

Code all documented conditions that coexist at the time of the encounter/visit and that require

or affect patient care treatment or management. Do not code conditions that were previously treated and no longer exist. However, history codes may be used as secondary codes if the historical condition or family history has an impact on current care or influences treatment.

Coordination of Benefits

Processing by Other Insurance

Before seeking reimbursement for a service from Sunshine Health, providers should determine if their CMS Health Plan members have any other medical insurance. If so, providers should submit the claim to that insurance as CMS Health Plan is always the payer of last resort. If an authorization is required, the providers still must obtain Sunshine Health authorization for the Medicaid portion of the bill.

Providers may check eligibility and identify if a member has other insurance through the Sunshine Health secure provider portal. This is particularly important if a member has Medicare coverage through a managed care plan or Medicare fee for service.

This entire process also applies to other applicable medical insurance carriers.

Coordination of Benefits Processing

To ensure the proper processing of claims requiring coordination of benefits, Sunshine Health recommends that providers validate the membership number and supplementary or primary carrier information for every claim.

Sunshine Health requires that 837I COB be submitted at the claim level loop (2300), 837P at the detail level (2400) for all COB transactions.

All sum of paid amount (AMT02 in loop 2320) and all line adjustment amounts (CAS in 2320 and 2340) must equal the total charge amount (CLM). Additionally, the service charge amount must equal the value of all drug charges (sum of CTP03 and CTP04 in 2410).

If the claim was adjudicated by another payer identified in the 2330B loop, the “AMT payer paid amount” or “AMT remaining patient liability” fields must be completed.

Primary and secondary coverage for the same claim will not be processed simultaneously. Claims that contain both primary and secondary coverage must be broken down into two claims.

Submitters should file the primary coverage first and submit the secondary coverage after the primary coverage claim has been processed. Submitters can be assured that the primary coverage claim has been processed upon receipt of the EOP or ERA. A secondary coverage claim that is submitted prior to the processing of its preceding primary coverage claim will be denied based on the need for primary insurance information.

Claim Submission

In general, CMS Health Plan follows CMS billing requirements for paper, electronic data interchange (EDI) and secure web-submitted claims. Sunshine Health is required by state and federal regulations to capture specific data regarding services rendered to its members. The provider must adhere to all billing requirements to ensure timely processing of claims and to avoid unnecessary upfront rejections or denials. Claims will be rejected or denied if not submitted correctly.

The appropriate CMS billing forms for paper and EDI claim submissions are CMS 1450 for facilities and CMS 1500 for professionals.

Initial Claim Payment Process

CMS Health Plan sends providers written notification via an explanation of benefits for each claim that is denied, including the reason(s) for the denial, the date the contractor received the claim, and a reiteration of the outstanding information required from the provider to adjudicate the claim.

Providers should check their audit report to verify that CMS Health Plan has accepted their electronically submitted claim.

Non-Nursing Facility and Non-Hospice Claims

Clean claims are finalized as paid or denied within 20 calendar days for electronic data interchange (EDI) submissions or 40 calendar days for paper claim submissions.

If an initial claim does not meet clean claim requirements, Sunshine Health pends the claim and requests providers submit the appropriate additional information within 15 calendar days following the health plan's receipt of the claim. All requested information must be submitted timely as claims pended for additional information are closed (paid or denied) by 35 calendar days following the date the claim is pended.

➢ See Clean Claim vs. Unclean Claim.

Nursing Facility and Hospice Claims

Claims are finalized as paid or denied within 10 business days.

Billing Forms

Providers are to use standardized claim forms whether filing on paper or electronically. For paper filing, providers are to submit claims for professional services and durable medical equipment (DME) on a CMS 1500 form. Information commonly required of a clean claim on a CMS 1500 form is:

- Member name and date of birth
- Member identification number

- Complete service level information, including:
  - Date of service
  - Diagnosis
  - Place of service
  - Procedural coding (appropriate CPT-4, ICD-10 codes)
  - Charge information and units
- Servicing provider's name, address and Medicaid number
- Provider's federal tax identification number
- All mandatory fields must be complete and accurate.

Hospital-based inpatient and outpatient services as well as swing bed services are to be submitted on a UB 04 form.

Billing the Member

CMS Health Plan reimburses only services that are medically necessary and covered through Medicaid. Providers may not bill Medicaid recipients for covered services, also known as "balance bill," regardless of whether they believe the amount of money they have been or will be paid by CMS Health Plan is appropriate or sufficient.

Verification Procedures

All claims filed with CMS Health Plan are subject to verification procedures. These include, but are not limited to, the following:

- All required fields are completed on an original CMS 1500 claim form, CMS 1450 (UB-
- 04) claim form, EDI electronic claim format or claims submitted on the secure provider portal, individually or batched.
- All claim submissions are subject to 5010 validation procedures based on CMS industry standards.
- Claims must contain the CLIA number when CLIA-waived or CLIA-certified services are provided.
  - Paper claims must include the CLIA certification in Box 23 when CLIA-waived or CLIA-certified services are billed
  - For EDI submitted claims, the CLIA certification number must be placed in X12N 837 (5010 HIPAA version) loop 2300 (single submission) REF segment with X4 qualifier or X12N 837 (5010 HIPAA version) loop 2400 REF segment with X4 qualifier (both laboratory services for which CLIA certification is required and non- CLIA covered laboratory tests)
- All diagnosis, procedure, modifier, location (place of service), revenue, type of admission and source of admission codes are valid for:
  - Member's age, date of birth and sex for the date of service billed
  - Bill type
  - Date of service
  - Provider type and/or provider specialty billing
- All diagnosis codes must be to the highest number of available digits

- National Drug Code (NDC) is billed in the appropriate field on all claim forms when applicable, including quantity and type with type limited to the following list:
  - F2 – International unit
  - GR – Gram
  - ME – Milligram
  - ML – Milliliter
  - UN – Unit
- Principal diagnosis billed reflects an allowed principal diagnosis as defined in the volume of ICD-9-CM (for dates of service before Oct. 1, 2015) and/or ICD-10-CM (for dates of service after Oct. 1, 2015).
  - On a CMS 1500 claim form, principal diagnosis criteria look at all procedure codes billed and the applicable pointers. If a procedure points to a diagnosis that is not valid as a primary diagnosis code, the service line may deny.
  - Inpatient facilities are required to submit a "present on admission" (POA) indicator. Inpatient claims will be denied (or rejected) if the POA indicator is missing or invalid. Providers should reference CMS billing guidelines regarding POA for more information and for excluded facility types. Valid 5010 POA codes are N (No), Y (Yes) or blank.
  - Interim Billing Requirements - The Plan requires that hospital Providers billing first-time claims for interim inpatient stays that exceed one hundred (100) consecutive days use Inpatient Type of Bill Code 0112 Interim. For each subsequent inpatient hospital billing, the previous interim claim is voided by being recouped and replaced with the new claim type of bill code 0117.
- Member is eligible for services under Sunshine Health during the time period in which services were provided.
- Services were provided by a participating provider or, if provided by anon-participating provider, authorization was received to provide services to the eligible member. (This guideline excludes services by an out-of-network provider for an emergency medical condition; however, authorization requirements apply for post- stabilization services.)
- Third party coverage was clearly identified, and appropriate COB information was included with the claim submission.

Clean Claim vs. Unclean Claim

A clean claim means a claim for payment of healthcare expenses that is submitted on a CMS 1500 or a UB04 claim form in a format required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) with all required fields completed in accordance with Sunshine Health's published claim filing requirements.

Unclean claims are submitted claims that require further investigation or development beyond the information contained therein. The errors or omissions in claims result in the request for additional information from the provider or other external sources to resolve or correct data omitted from the bill; review of additional medical records; or the need for other information necessary to resolve discrepancies. In addition, unclean claims may involve issues regarding medical necessity and include claims not submitted within the filing deadlines.

To obtain clean claim submission protocols and standards, including instructions and all

information required for a clean or complete claim, see our Sunshine Health website.

Upfront Rejection vs. Denial

Upfront Rejection

An upfront rejection is defined as an unclean claim that contains invalid or missing data elements required for acceptance of the claim into the claim processing system. These data elements are identified in CMS 837 companion guide (PDF) available on the CMS website.

Common causes for upfront rejections include but are not limited to:

- Unreadable information (Ink is faded, too light, too bold, bleeding into other characters or beyond the box, or too small)
- Missing member date of birth
- Missing member name or identification number
- Missing provider name, taxpayer identification number (TIN), or national practitioner identification (NPI) number
- Missing attending provider information from Loop 2310A on institutional claims when CLM05-1 (Bill Type) is 11, 12, 21, 22, or 72 or missing from box 48 on the paper UB claim form
- Date of service is not prior to the received date of the claim (future date of service)
- Date of service occurred before member's effective date
- Missing date of service or date span from required fields, e.g., "Statement From" or "Service From" dates
- Invalid bill type
- Missing, invalid or incomplete diagnosis code
- Missing service line detail
- Missing admission type (Inpatient facility claims – UB-04, field 14)
- Missing patient status (Inpatient facility claims – UB-04, field 17)
- Missing or invalid occurrence code/date
- Missing or invalid revenue code
- Missing or invalid CPT/procedure code
- Missing CLIA number in Box 23 or a CMS 1500 for CLIA or CLIA waived service
- Incorrect form type

Upfront rejections will not enter the claims adjudication system, so there will be no explanation of payment (EOP) for these claims. Instead, the provider will receive a letter or a rejection report if the claim was submitted electronically.

Denial

If all edits pass and the claim is accepted, it is entered into the system for processing. If the claim has been billed with invalid or inappropriate information, the claim is denied. An EOP is then sent to the provider with the denial reasons.

Timely Claim Submission

Providers must submit claims in a timely manner as indicated in the following table.

Initial Claim*		**Reconsiderations or Claim Dispute****		**Coordination of Benefits*****	
Participating	Non-Participating	Participating	Non-Participating	Participating	Non-Participating
180 days	365 days	90 days	180 days	90 days	90 days

*In an initial claim, days are calculated from the date of service to the date received by Sunshine Health.

** In a reconsideration or claim dispute, days are calculated from the date of the explanation of payment/correspondence issued by Sunshine Health to the date the reconsideration is received by Sunshine Health.

*** For coordination of benefits, days are calculated from the date of explanation of payment from the primary payer to the date received by Sunshine Health.

The filing limit for Medicare claims crossing over to Medicaid is the greater of 36 months from the date of service or 12 months from Medicare's adjudication date.

Electronic Claim Submission

Electronic Claim Submission Overview

Providers are encouraged to participate in Sunshine Health's electronic claims/encounter filing program. Sunshine Health can receive an ANSI XS12N 837 professional, institutional or encounter transaction. In addition, Sunshine Health can generate an ANSI X12N 835 electronic remittance advice known as an explanation of payment (EOP).

For more information on electronic filing, contact Sunshine Health's EDI department by calling

1-844-477-8313, or send an email to EDIBA@sunshinehealth.com.

Providers who bill electronically are responsible for filing claims within the same filing deadlines as providers filing paper claims. Providers who bill electronically must monitor their error reports and evidence of payments to ensure all submitted claims and encounters appear on the reports.

Providers are responsible for correcting any errors and resubmitting the affiliated claims and encounters.

Sunshine Health can receive coordination of benefits (COB) or secondary claims electronically. Sunshine Health follows the 5010 X12 HIPAA companion guides for requirements on submission of COB data. A list of applicable clearinghouses is available on our website.

Electronic Claim Flow Description

To send claims electronically to Sunshine Health, all EDI claims must first be forwarded to one of Sunshine Health's clearinghouses. This can be completed via a direct submission to a clearinghouse or through another EDI clearinghouse. Once the clearinghouse receives the transmitted claims, the clearinghouse validates them against their proprietary specifications and plan-specific requirements.

Claims not meeting the requirements are immediately rejected and sent back to the sender via a clearinghouse error report. Providers should review this error report daily to identify any claims that were not transmitted to Sunshine Health. The name of this report can vary based upon the provider's contract with his/her intermediate EDI clearinghouse. Accepted claims are passed to Sunshine Health, and the clearinghouse returns an acceptance report to the sender immediately.

Claims forwarded to Sunshine Health by a clearinghouse are validated against provider and member eligibility records. Claims that do not meet provider and/or member eligibility requirements are upfront rejected and sent back daily to the clearinghouse. The clearinghouse in turn forwards the upfront rejection back to its trading partner – either the intermediate EDI clearinghouse or provider. Providers should review this report of rejected claims daily as these claims must be reviewed and corrected timely. Claims passing eligibility requirements are then passed to the claim processing queues.

Providers are responsible for verification of EDI claims receipts. Acknowledgements for accepted or rejected claims received from the clearinghouse must be reviewed and validated against transmittal records daily. Because the clearinghouse returns acceptance reports directly to the sender, submitted claims not accepted by the clearinghouse are not transmitted to Sunshine Health.

For assistance in resolving submission issues reflected on either the acceptance or claim status reports, providers should contact the clearinghouse or vendor customer service department.

Rejected electronic claims may be resubmitted electronically once the error has been corrected. Providers should clearly mark the claim as a corrected claim per the instruction provided in the corrected claim section.

➢ See Corrected Claim Process.

Online Claim Submission

Providers who have Internet access and choose not to submit claims via EDI or on paper may submit claims directly to Sunshine Health on the secure provider portal at SunshineHealth.com. Providers must request access to the secure site by registering for a username and password.

Providers then may file first-time claims individually or submit first-time batch claims. Providers also have the capability to find, view and correct any previously processed claims.

Detailed instructions for submitting via secure provider portal are also stored on the website. Providers must login to the secure site for access to this manual.

Paper Claim Submission

Address for Filing Paper Claims

Sunshine Health encourages all providers to submit claims electronically. The companion guides for electronic billing are available on the Sunshine Health website. Paper submissions are subject to the same edits as electronic and web submissions.

The mailing address for first-time medical claims is:

Sunshine Health
Attn: Claims Department
P.O. Box 3070
Farmington, MO 63640-3823

The mailing address for first-time behavioral health claims is:

Sunshine Health
P.O. Box 6900
Farmington, MO 63640-3818

Providers should use the same mailing address for corrected claims and requests for reconsideration but send it to the attention of "Adjustment/Reconsideration/Disputes."

Edit Requirements

All paper claims sent to the claims office must first pass specific edits prior to acceptance. Claim records that do not pass these edits are invalid and will be rejected or denied. If a paper claim has been rejected, providers should submit the rejection letter with the corrected claim.

Acceptable Forms and Font

Sunshine Health only accepts the most current CMS 1500 and CMS 1450 (UB-04) paper claims forms. Other claim form types will be rejected and returned to the provider.

All paper claim forms must be completed with Times New Roman font in either 10 or 12 point and on the required original red-and-white version to ensure clean acceptance and processing. Black- and-white forms or handwritten forms will be rejected and returned to the provider. To reduce document handling time, providers should not use highlights, italics, bold text or staples for multiple page submissions.

Corrected Claim and Requests for Reconsideration/Claim Disputes

Definitions

The definition of a corrected claim is when a provider needs to change information on a previously submitted initial claim.

The definition of a request for reconsideration/claim dispute is when a provider disagrees with the original claim outcome, such as payment amount or denial reason, and resubmits additional information for review.

Corrected Claim Process

Providers must indicate the correction in one of the following ways:

- By submitting a corrected claim via the secure provider portal and following the instructions on the portal for submitting a corrected claim
- By submitting a corrected claim electronically via a clearinghouse
  - For institutional claims (UB): Field CLM05-3=7 and ref*8 = original claim number
  - For professional claims (CMS): Field CLM05-3=7 and ref*8 = original claim number

Upon submission of a corrected paper claim, the original claim number must be typed in field 22 (CMS 1500) and in field 64 (UB-04) with the corresponding frequency codes in field 22 of the CMS 1500 and in field 4 of the UB-04 form.

Process for Claims Reconsiderations and Disputes

All requests for corrected claims or reconsiderations/claim disputes must be received within 90 days from the date of the original explanation of payment or denial.

Prior processing will be upheld for corrected claims or claim disputes received following the 90-day period unless there is a qualifying circumstance and appropriate documentation to support the qualifying circumstance.

Qualifying circumstances may include:

- A catastrophic event that substantially interferes with normal business operation of the provider or damage or destruction of the provider's business office or records by a natural disaster
- Provider documentation showing member refused or was unable to provide member identification card and provider was unaware the member was eligible for services at the time services were rendered

If the request for reconsideration is related to a code audit, code edit or authorization denial, supporting documentation must accompany the request for reconsideration.

Reconsiderations should be submitted by completing the Provider Claim Adjustment Request Form (PDF). All formal requests for reconsideration/dispute must include the appropriate form. Reconsideration/disputes received with a missing or incomplete form will not be processed and returned to sender.

When the request for reconsideration results in an overturn of the original decision, the provider will receive a revised explanation of payment (EOP). If the original decision is upheld, the provider will receive either a revised EOP or a letter detailing the decision.

Statewide Provider and Health Plan Claim Dispute Resolution Program/Capitol Bridge

Claim Dispute Resolution Program Overview

CMS Health Plan makes reasonable efforts to resolve claim disputes. If, following multiple requests, a provider continues to disagree with the Plan's final adjudication decisions, a provider may consider using a claim dispute resolution program offered through the state of Florida.

AHCA has contracted with Capitol Bridge, an independent dispute resolution organization, to aid healthcare providers and health plans for resolving claim disputes. Claim disputes must have been submitted by the provider or the health plan and they must have been denied in full or in part or were presumed to have been underpaid or overpaid.

While the program initially was only designed to resolve disputes between providers and Health Maintenance Organizations (HMOs), the 2002 Legislative extended the program to other health plans effective October 2002. The statutory authority for the program may be found in Chapter 408.7057, F.S., and Rule 59A-12.030, Florida Administrative Code (F.A.C).

Application forms and instructions on how to file claims are available from Capitol Bridge by emailing FLCDR@capitolbridge.com or calling Capitol Bridge directly at 1-800-889-0549.

Eligible Claims

The following claim disputes may be submitted by physicians, hospitals, institutions, other licensed healthcare providers, HMOs, prepaid health clinics, prepaid health plans and exclusive provider organizations (EPOs):

- Claim disputes for services rendered after Oct. 1, 2000 (the effective date of the legislation)
- Claim disputes related to payment amounts only in which the provider disputes the payment amount received, or the HMO disputes the payback amount; claim disputes related exclusively to late payment are not eligible
- Hospitals and physicians are required to aggregate claims (for one or more patients for the same insurer) by type of service to meet certain minimum thresholds:
  - Hospital inpatient claims (contracted providers) – $25,000
  - Hospital inpatient claims (non-contracted providers) – $10,000
  - Hospital outpatient claims (contracted providers) – $10,000
  - Hospital outpatient claims (non-contracted providers) – $3,000
  - Physicians/dentists – $500
  - Rural hospitals – None
  - Other providers – None

Ineligible Claims

The following types of claims are ineligible for the claim dispute resolution program:

- Claims for less than minimum amounts listed above for each type of service
- Claim disputes that are the basis for an action pending in state/federal court
- Claim disputes that are subject to an internal binding managed care organization's resolution process for contracts entered before Oct. 1, 2000
- Claims solely related to late payment and/or late processing
- Interest payment disputes
- Medicare claim disputes that are part of Medicare managed care internal grievance or that qualify for Medicare reconsideration appeal
- Medicaid claim disputes that are part of a Medicaid fair hearing
- Claims related to health plans not regulated by the state of Florida
- Claims filed more than 12 months after final determination by Sunshine Health or the provider

Capitol Bridge Review Process/Time Frames

Capitol Bridge has 60 days to resolve claim disputes and make recommendations to the Agency after receipt of the appropriate forms and documentation. The filing party must submit a copy of the documentation to the adversely affected party at the same time.

Capitol Bridge has the right to request additional documentation from both parties. The total review time shall not exceed 90 days following receipt of the initial claim dispute.

The Agency has 30 days to issue a final order based on the recommendation made by Capitol Bridge.

Review Cost

The Florida Legislature did not provide any funding for this program except for funding for one Agency attorney.

Pursuant to Florida statutes, the full review costs must be paid by the non-prevailing party. If both parties prevail in part, the review cost will be apportioned based on the disputed claim amount.

If the non-prevailing party or parties fail(s) to pay the ordered review costs within 35 days following the agency's final order, the non-paying party or parties are subject to a fine of

$500 per day. Entities filing a claim that is settled prior to any decision rendered by Capitol Bridge must pay the full review costs.

The Agency has no fine authority to enforce payment of the disputed claim amount. However, the agency has authority to enforce its final order based on section 641.52(1) (e), Florida statutes.

Fee Schedule

As each claim dispute is different and of varying complexity, the contractor will not be able to estimate the full cost in advance. Capitol Bridge will provide a review cost estimate in advance, if requested, at no additional charge beyond the initial review fee. However, review costs based on the final order from AHCA must be paid directly to Capitol Bridge.

Claims Payment: EFT and ERA

Sunshine Health partners with specific vendors to provide an innovative web-based solution for electronic funds transfers (EFTs) and electronic remittance advices (ERAs). This service is provided at no cost to providers. Providers can enroll online after they have received their completed contract or submitted a claim.

More information is available on the PaySpan - EFT/ERA page of our website.

Chapter 15: Code Editing

Code Editing Overview

Sunshine Health uses HIPAA-compliant clinical claims editing software for physician and outpatient facility coding verification. The software detects, corrects and documents coding errors on provider claim submissions prior to payment. The software contains clinical logic that evaluates medical claims against principles of correct coding using industry standards and government sources. These principles are aligned with a correct coding "rule." When the software edits a claim that does not adhere to a coding rule, a recommendation known as an "edit" is applied to the claim. When an edit is applied to the claim, a claim adjustment should be made.

While code editing software is a useful tool to ensure provider compliance with correct coding, a fully automated code editing software application will not wholly evaluate all clinical patient scenarios. Consequently, Sunshine Health uses clinical validation by a team of experienced nursing and coding experts to further identify claims for potential billing errors.

Clinical validation allows for consideration of exceptions to correct coding principles and may identify where additional reimbursement is warranted. For example, clinicians review all claims billed with modifiers 25 and 59 for clinical scenarios that justify payment above and beyond the basic service performed.

Moreover, Sunshine Health may have policies that differ from correct coding principles. Accordingly, exceptions to general correct coding principles may be required to ensure adherence to health plan policies and to facilitate accurate claims reimbursement.

CPT and HCPCS Coding Structure

CPT codes are a component of the Healthcare Common Procedure Coding System (HCPCS). The HCPCS system was designed to standardize coding to ensure accurate claims payment and consists of two levels of standardized coding.

Current procedural terminology (CPT) codes belong to the Level I subset and comprise the terminology used to describe medical terms and procedures performed by healthcare professionals. CPT codes are published by the American Medical Association (AMA) and are updated (added, revised and deleted) annually.

Level I HCPCS Codes

This code set comprises CPT codes that are maintained by the AMA. CPT codes are a five-digit uniform coding system used by providers to describe medical procedures and services rendered to a patient. These codes are then used to bill health insurance companies.

Level II HCPCS Codes

The Level II subset of HCPCS codes is used to describe supplies, products and services that are not included in the CPT code descriptions (durable medical equipment, orthotics and prosthetics, behavioral health assessments, etc.). Level II codes are an alphabetical coding system and are maintained by CMS. Level II HCPCS codes are updated annually.

Miscellaneous/Unlisted Codes

The codes are a subset of the Level II HCPCS coding system and are used by a provider or supplier when there is no existing CPT code to accurately represent the services provided.

Claims submitted with miscellaneous codes are subject to a manual review. To facilitate the manual review, providers are required to submit medical records with the initial claims submission. If the records are not received, the provider will receive a denial indicating that medical records are required.

Providers billing miscellaneous codes must submit medical documentation that clearly defines the procedure performed including, but not limited to, office notes, operative report, pathology report and related pricing information. Once received, a registered nurse reviews the medical records to determine if there was a more specific code(s) that should have been billed for the service or procedure rendered.

Clinical validation also includes identifying other procedures and services billed on the claim for correct coding that may be related to the miscellaneous code. For example, if the miscellaneous code is determined to be the primary procedure, then other procedures and services that are integral to the successful completion of the primary procedure should be included in the reimbursement value of the primary code.

Temporary National Codes

These codes are a subset of the Level II HCPCS coding system and are used to code services when no permanent, national code exists. These codes are considered temporary and may only be used until a permanent code is established. These codes consist of G, Q, K, S, H and T code ranges.

HCPCS Code Modifiers

Providers use modifiers to include additional information about the HCPCS code billed. Occasionally certain procedures require more explanation because of special circumstances. For example, modifier 24 is appended to evaluation and management services to indicate that a patient was seen for a new or special circumstance unrelated to a previously billed surgery for which there is a global period.

International Classification of Diseases (ICD-10)

International Classification of Diseases-10 (ICD-10) is the 10th revision of the International Statistical Classification of Diseases and Related Health Problems (ICD), a medical classification list by the World Health Organization. Healthcare providers use ICD-10 codes to classify diseases, signs and symptoms, abnormal findings, complaints, social circumstances, and external causes of injury or diseases.

The code set in the base classification allows for more than 14,400 different codes and permits the tracking of many new diagnoses compared to ICD-9. By using optional sub- classifications, the number of codes can be expanded to over 16,000.

With the transition to ICD-10, in the United States, ICD-9 codes are segmented into ICD-10- CM and ICD-10-PCS codes. The "CM" in ICD-10-CM codes stands for clinical modification.

ICD-10-CM codes were developed by the Centers for Disease Control and Prevention in conjunction with the National Center for Health Statistics (NCHS) for outpatient medical coding and reporting in the United States.

The "PCS" in ICD-10-PCS codes stands for the procedural classification system. ICD-10-PCS is a separate medical coding system from ICD-10-CM, containing an additional 87,000 codes for use only in United States inpatient, hospital settings. The procedure classification system (ICD-10-PCS) was developed by CMS in conjunction with 3M Health Information Management (HIM).

Revenue Codes

These codes represent the location where a member had services performed or the type of services received. These codes are billed by institutional providers. HCPCS codes may be required on the claim in addition to the revenue code.

Edit Sources

The claims editing software application contains a comprehensive set of rules addressing coding inaccuracies such as unbundling, frequency limitations, fragmentation, up-coding, duplication, invalid codes, mutually exclusive procedures and other coding inconsistencies. Each rule is linked to a generally accepted coding principle. Guidance surrounding the most likely clinical scenario is applied.

The software applies edits that are based on the following sources:

- CMS National Correct Coding Initiative (NCCI) for professional and facility claims. The NCCI edits include column 1/column 2, medically unlikely edits (MUE), exclusive and outpatient code editor (OCE) edits. These edits were developed by CMS to control incorrect code combination billing contributing to incorrect payments.
- CMS claims processing manual
- CMS Medicaid NCCI policy manual
- State provider manuals, fee schedules, periodic provider updates (bulletins/transmittals)
- CMS coding resources such as HCPCS coding manual, national physician fee schedule, provider benefit manual, claims processing manual, Medicare Learning Network(MLN) and provider transmittals
- AMA resources, including:
  - AMA website
  - Coding with modifiers
  - CPT assistant
  - CPT assistant archives
  - CPT insider's view
  - CPT manual
  - CPT procedural code definitions
  - HCPCS procedural code definitions
  - Principles of CPT coding
- Billing guidelines published by specialty provider associations
  - Global maternity package data published by the American Congress of Obstetricians and Gynecologists (ACOG)
  - Global service guidelines published by the American Academy of Orthopedic Surgeons (AAOS)
- State-specific policies and procedures for billing professional and facility claims
- Sunshine Health policies and provider contract considerations

Code Editing and the Claims Adjustment Cycle

Code editing is the final stage in the claims adjudication process. Once a claim has completed all previous adjudication phases (such as benefits and member/provider eligibility review), the claim is ready for analysis.

As a claim progresses through the code editing cycle, each service line on the claim is processed through the code editing rules engine and evaluated for correct coding. As part of this evaluation, the prospective claim is analyzed against other codes billed on the same claim as

well as previously paid claims found in the member/provider history.

The software makes the following recommendations depending upon the code edit applied:

- **Deny:** Code editing rule recommends the denial of a claim line. The appropriate explanation code is documented on the provider's explanation of payment along with reconsideration/appeal instructions.
- **Pend:** Code editing recommends that the service line pend for clinical review and validation. This review may result in a pay or deny recommendation. The appropriate decision is documented on the provider's explanation of payment along with reconsideration/appeal instructions.
- **Replace and pay:** Code editing recommends the denial of a service line and a new line is added and paid. In this scenario, the original service line is left unchanged on the claim and a new line is added to reflect the software recommendations. For example, if an incorrect CPT code is billed for the member's age, the software will deny the original service line billed by the provider and add a new service line with the correct CPT code, resulting in a paid service line. This action does not alter or change the provider's billing as the original billing remains on the claim.

Code Editing Principles

The following principles are not an all-inclusive list of available code editing principles but, rather, a sample of edits applied to practitioner and/or outpatient facility claims.

Unbundling

CMS National Correct Coding Initiative

CMS developed the correct coding initiative to control erroneous coding and help prevent inaccurate claims payment. CMS has designated certain combinations of codes that should never be billed together. These are also known as Column 1/Column II edits. The column I procedure code is the most comprehensive code and reimbursement for the column II code is subsumed into the payment for the comprehensive code. The column I code is considered an integral component of the column II code.

The CMS NCCI edits consist of "procedure-to-procedure" (PTP) edits for physicians and hospitals and the "medically unlikely" edits for professionals and facilities. While these codes should not be billed together, there are circumstances when an NCCI modifier may be appended to the column 2 code to identify a significant and separately identifiable or distinct service. When these modifiers are billed, clinical validation is performed.

CMS offers a more complete explanation of the unbundling initiative on its website.

PTP Practitioner and Hospital Edits

Some procedures should not be reimbursed when billed together. CMS developed the "procedure- to-procedure" (PTP) edits for practitioners and hospitals to detect incorrect claims submitted by medical providers. PTP practitioner edits are applied to claims submitted by physicians, non- physician practitioners and ambulatory surgical centers (ASC). The PTP hospital

edits apply to hospitals, skilled nursing facilities, home health agencies, outpatient physical therapy and speech- language pathology providers and comprehensive outpatient rehabilitation facilities.

Medically Unlikely Edits (MUEs) for Practitioners, DME Providers and Facilities

Medically unlikely edits (MUEs) reflect the maximum number of units that a provider would bill for a single member on a single date of service. These edits are based on CPT/HCPCs code descriptions, anatomic specifications, the nature of the service/procedure, the nature of the analyte, equipment prescribing information and clinical judgment.

Code Bundling Rules Not Sourced to CMS NCCI Edit Tables

Many specialty medical organizations and health advisory committees have developed rules concerning the proper use of codes in their area of expertise. These rules are published and are available for use by the public. Procedure code definitions and relative value units are considered when developing these code sets. Rules are specifically designed for professional and outpatient facility claims editing.

Procedure Code Unbundling

Two or more procedure codes are used to report a service when a single, more comprehensive should have been used. The less comprehensive code is denied.

Mutually Exclusive Editing

These are combinations of procedure codes that may differ in technique or approach but result in the same outcome. The procedures may be impossible to perform anatomically. Procedure codes may also be considered mutually exclusive when an initial or subsequent service is billed on the same date of service. The procedure with the highest relative value unit (RVU) is considered the reimbursable code.

Incidental Procedures

These are procedure code combinations that are considered clinically integral to the successful completion of the primary procedure and should not be billed separately.

Global Surgical Period Editing/Medical Visit Editing

CMS publishes rules concerning payment of an evaluation and management service during the global surgical period of a procedure. The global surgery data is taken from the CMS Medicare Fee Schedule Database (MFSDB).

Procedures are assigned a 0-day, 10-day or 90-day global surgical period. Procedures assigned a 90-day global surgery period are designated as major procedures. Procedures assigned a 0- or 10- day global surgical period are designated as minor procedures. Evaluation and management services for a major procedure (90-day period) that are reported one-day preoperatively, on the same date of service or during the 90-day post- operative period, are not recommended for separate reimbursement.

Evaluation and management services that are reported with minor surgical procedures on the

same date of service or during the 10-day global surgical period are not recommended for separate reimbursement.

Evaluation and management services for established patients that are reported with surgical procedures that have a 0-day global surgical period are not recommended for reimbursement on the same day of surgery because there is an inherent evaluation and management service included in all surgical procedures.

Global Maternity Editing

Global periods for maternity services are classified as “MMM” when an evaluation and management service is billed during the antepartum period (270 days), on the same date of service or during the postpartum period (45 days). Certain procedures are not recommended for separate reimbursement if the procedure code includes antepartum and postpartum care.

Diagnostic Services Bundled to the Inpatient Admission (Three-Day Payment Window)

This rule identifies outpatient diagnostic services that are provided to a member within three days of the date of an inpatient admission, up to and including the date of admission. When these services are billed by the same admitting facility or an entity wholly owned or operated by the admitting facility, they are considered bundled into the inpatient admission and, therefore, are not separately reimbursable.

Multiple Code Rebundling

This rule analyzes if a provider billed two or more procedure codes when a single, more comprehensive code should have been billed to represent all of the services performed.

Frequency and Lifetime Edits

The CPT and HCPCS manuals define the number of times a single code can be reported. There also are codes that are allowed a limited number of times on a single date of service, over a given period or during a member’s lifetime. State fee schedules also delineate the number of times a procedure can be billed over a given period or during a member’s lifetime. Code editing will fire a frequency edit when the procedure code is billed more than these guidelines.

Duplicate Edits

Code editing evaluates prospective claims to determine if there is a previously paid claim for the same member and provider in history that is a duplicate to the prospective claim. The software also determines if another provider was paid for the same procedure for the same member on the same date of service. Finally, the software analyzes multiple services within the same range of services performed on the same day.

National Coverage Determination Edits

CMS establishes guidelines that identify whether some medical items, services, treatments, diagnostic services or technologies can be paid under Medicare. These rules evaluate diagnosis

to procedure code combinations.

Anesthesia Edits

This rule identifies anesthesia services that have been billed with a surgical procedure code instead of an anesthesia procedure code.

Invalid Revenue to Procedure Code Editing

This rule identifies revenue codes billed with incorrect CPT codes.

Assistant Surgeon

This rule evaluates claims billed as an assistant surgeon that normally do not require the attendance of an assistant surgeon. Modifiers are reviewed as part of the claims analysis.

Co-Surgeon/Team Surgeon Edits

CMS guidelines define whether an assistant, co-surgeon or team surgeon is reimbursable and the percentage of the surgeon's fee that can be paid to the assistant, co-surgeon or team surgeon.

Add-on and Base Code Edits

Rules look for claims in which the add-on CPT code was billed without the primary service CPT code. If the primary service code is denied, then the add-on code is also denied. This rule also looks for circumstances where the primary code was billed in a quantity greater than one when an add-on code should have been used to describe the additional services rendered.

Bilateral Edits

This rule looks for claims where the modifier 50 has already been billed but the same procedure code is submitted on a different service line on the same date of service without the modifier 50.

Missing Modifier Edits

This rule analyzes service lines to determine if a modifier should have been reported but was omitted. For example, professional providers would not typically bill the global (technical and professional) component of a service when performed in a facility setting. The technical component is typically performed by the facility and not the physician.

Administrative and Consistency Rules

These rules are not based on clinical content and serve to validate code sets and other data billed on the claim. These types of rules do not interact with historically paid claims or other service lines on the prospective claim.

Examples include the following:

- Procedure code invalid rules: Evaluates claims for invalid procedure and revenue or diagnosis codes
- Deleted codes: Evaluates claims for procedure codes which have been deleted
- Modifier to procedure code validation: Identifies invalid modifier to procedure code combinations. This rule analyzes modifiers affecting payment. Examples are modifiers 24, 25, 26, 57, 58 and 59.
- Age rules: Identifies procedures inconsistent with member's age
- Incomplete/invalid diagnosis codes: Identifies diagnosis codes incomplete or invalid

Prepayment Clinical Validation

Clinical validation is intended to identify coding scenarios that historically result in a higher incidence of improper payments. An example of Sunshine Health's clinical validation services is modifier 25 and 59 review. Some code pairs within the CMS NCCI edit tables are allowed for modifier override when they have a correct coding modifier indicator of "1."

Furthermore, specialty organization edits may also be considered for override when they are billed with these modifiers.

When these modifiers are billed, the provider's billing should support a separately identifiable service (from the primary service billed, modifier 25) or a different session, site or organ system, surgery, incision/excision, lesion or separate injury (modifier 59).

Sunshine Health's clinical validation team uses the information on the prospective claim and claims history to determine whether it is likely that a modifier was used correctly based on the unique clinical scenario for a member on a given date of service.

CMS supports this type of prepayment review. The clinical validation team uses nationally published guidelines from CPT and CMS to determine if a modifier was used correctly.

Modifier 59

The National Correct Coding Initiative (NCCI) states the primary purpose of modifier 59 is to indicate that procedures or non-evaluation and management (E/M) services that are not usually reported together are appropriate under the circumstances. The CPT manual defines modifier 59 as follows: "Modifier 59: Distinct Procedural Service: Under certain circumstances, it may be necessary to indicate that a procedure or service was distinct or independent from other non-E/M services performed on the same day."

Modifier 59 is used to identify procedures/services, other than E/M services, that are not normally reported together, but are appropriate under the circumstances. Documentation must support a different session, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same individual.

Some providers routinely assign modifier 59 when billing a combination of codes that will result in a denial due to unbundling. Modifier 59 is often misused when related to the portion of the definition that allows its use to describe "different procedure or surgery." NCCI guidelines state

that providers should not use modifier 59 solely because two different procedures/surgeries are performed or because the CPT codes are different procedures. Modifier 59 should only be used if the two procedures/surgeries are performed at separate anatomic sites, at separate patient encounters or by different practitioners on the same date of service. NCCI defines different anatomic sites to include different organs or different lesions in the same organ. However, it does not include treatment of contiguous structures of the same organ.

Sunshine Health uses the following guidelines to determine if modifier 59 was used correctly:

- The diagnosis codes or clinical scenario on the claim indicate multiple conditions or sites were treated or are likely to be treated
- Claim history for the patient indicates that diagnostic testing was performed on multiple body sites or areas that would result in procedures being performed on multiple body areas and sites
- Claim history supports that each procedure was performed by a different practitioner or during different encounters or those unusual circumstances are present that support modifier 59 were used appropriately

To avoid incorrect denials, providers should assign to the claim all applicable diagnosis and procedure codes used and all applicable anatomical modifiers designating the areas of the body that were treated.

Modifier 25

Both CPT and CMS in the NCCI policy manual specify that by using a modifier 25 the provider is indicating that a “significant, separately identifiable evaluation and management service was provided by the same physician on the same day of the procedure or other service.” Additional CPT guidelines state that the evaluation and management service must be significant and separate from other services provided or above and beyond the usual pre-, intra- and postoperative care associated with the procedure that was performed.

The NCCI policy manual states that: “If a procedure has a global period of 000 or 010 days, it is defined as a minor surgical procedure.” (Osteopathic manipulative therapy and chiropractic manipulative therapy have global periods of 000.)

The decision to perform a minor surgical procedure is included in the value of the minor surgical procedure and should not be reported separately as an E&M service. However, a significant and separately identifiable E&M service unrelated to the decision to perform the minor surgical procedure is separately reportable with modifier 25. The E&M service and minor surgical procedure do not require different diagnoses. If a minor surgical procedure is performed on a new patient, the same rules for reporting E&M services apply. The fact that the patient is “new” to the provider is not sufficient alone to justify reporting an E&M service on the same date of service as a minor surgical procedure. NCCI does contain some edits based on these principles, but the Medicare carriers and A/B MACs processing practitioner service claims have separate edits.

Sunshine Health uses the following guidelines to determine whether or not modifier 25 was used appropriately. If any one of the following conditions is met then, the clinical nurse reviewer will recommend reimbursement for the E/M service:

- The E/M service is the first time the provider has seen the patient or evaluated a major condition
- A diagnosis on the claim indicates that a separate medical condition was treated in addition to the procedure that was performed
- The patient's condition is worsening as evidenced by diagnostic procedures being performed on or around the date of services
- Other procedures or services performed for a member on or around the same date of the procedure support that an E/M service would have been required to determine the member's need for additional services.

To avoid incorrect denials providers should assign all applicable diagnosis codes that support additional E/M services.

Payment and Coverage Policy Edits

Payment and coverage policy edits are developed to increase claims processing effectiveness, to better ensure payment of only correctly coded and medically necessary claims, and to provide transparency to providers regarding these policies. It encompasses the development of payment policies based on coding and reimbursement rules and clinical policies based on medical necessity criteria, both to be implemented through claims edits or retrospective edits.

These policies are posted on the provider portal when appropriate.

Claim Reconsiderations Related to Code Editing and Other Editing

Claim reconsiderations resulting from claim editing are handled per the provider claims reconsideration process outlined in this manual. When submitting claims reconsiderations, providers should submit medical records, invoices and all related information to assist with the reconsideration review.

Providers who disagree with a code edit or other edit and request claim reconsideration should submit medical documentation (medical record) related to the reconsideration. If medical documentation is not received, the original code edit or other edits will be upheld.

Code Editing Assistant

Sunshine Health offers a web-based code editing assistant reference tool designed to "mirror" the way in which the code editing product(s) evaluates code and code combinations during the editing of claims. The tool is available for providers who are registered on Sunshine Health's secure provider portal. Providers may access the tool in the claims module by clicking "claim editing tool."

This tool offers many benefits, including:

- Prospectively accessing appropriate coding and supporting clinical edit clarifications

for services before claims are submitted
- Proactively determining the appropriate code/code combination representing the service for accurate billing purposes

The tool reviews the data entered and determines if the code or code combinations are correct based on the age, sex, location, modifier (if applicable) or other code(s) entered. The code editing assistant is intended for use as a "what if" or hypothetical reference tool. It is meant to apply coding logic only. The tool does not take into consideration historical claims information that may be used to determine if an edit is appropriate.

Disclaimer: This tool is used to apply coding logic ONLY. It does not consider individual fee schedule reimbursement, authorization requirements or other coverage considerations. Whether a code is reimbursable or covered is separate and outside of the intended use of this tool.

Third-Party Liability

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

Medicaid is always the payer of last resort. Sunshine Health providers shall make reasonable efforts to determine the legal liability of third parties to pay for services furnished to Sunshine Health members. If the provider is unsuccessful in obtaining necessary cooperation from a member to identify potential third-party resources, the provider shall inform Sunshine Health that efforts have been unsuccessful. Sunshine Health will make every effort to work with the provider to determine liability coverage.

If third party liability coverage is determined after services are rendered, Sunshine Health will coordinate with the provider to pay any claims that may have been denied for payment due to third party liability.