Hospice Provider Quick Reference Guide

Important Contact Information

Service Name	Product	Phone Number	Hours of operation
Provider Services	All products	1-844-477-8313	Monday-Friday from 8 a.m. to 8 p.m. Eastern
Pharmacy Services	All products	1-800-460-8988, option 2	24 hours a day, 7 days a week
Member Services	MMA, SMI, LTC	1-866-796-0530	Monday-Friday from 8 a.m. to 8 p.m. Eastern
Member Services	CWSP	1-855-463-4100	Monday-Friday from 8 a.m. to 8 p.m. Eastern

Verifying Member Eligibility

These suggestions are not a guarantee of coverage.

- Verify member eligibility by using the Sunshine Health Secure Provider Portal.
- 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 Medicaid ID number and date of birth.
    - Ensure you're selecting the correct plan type.
- Alternatively, you can call Provider Services at 1-844-477-8313. Supply the member's name and date of birth or the member's Medicaid identification number and date of birth.

Authorizations

Prior authorization is required for certain services. To determine which services require authorization, please refer to our Pre-Auth Check Tool.

Prior-authorization requests are processed by Sunshine Health's Utilization Management (UM) Department.

- **Standard requests:** Determination within 7 calendar days of receipt of request.
- **Urgent requests:** Please call 1-844-477-8313. Urgent requests are made when the member or his/her physician believes that waiting for a decision under the standard timeframe could place the enrollee's life, health, or ability to regain maximum function in serious jeopardy.

Submit authorization requests via one of the following:

- **Online:** via the Sunshine Health Secure Provider Portal
- **Telephonically:** 1-844-477-8313
- **Medical Fax:** 1-866-796-0526
- **Pharmacy Services Fax:** 1-833-546-1507

Note: Find the Treatment/Service Request Forms for fax submission online.

Utilization Management

Utilization Management Phone number: 1-844-477-8313 and follow prompts for services required.

- **Standard hours of operation:** Monday to Friday from 8 a.m. to 8 p.m. Eastern.
- **Weekend and After-Hours on Call-Numbers:** (all products): 1-844-477-8313.

Claims

Core Services:

The following services, included in the per diem payment, must be provided in accordance with 42 CFR 418.64:

- Counseling services
- Medical social services
- Nursing services
- Physician services

Non-Core Services:

The following services, included in the per diem payment, must be provided when specified in the recipient's plan of care and in accordance with 42 CFR 418.70-78 and 42 CFR 418.106-108:

- Hospice aide services
- Medical supplies and durable medical equipment
- Pharmacy services
- Therapy services
- Volunteer services
- Any other item or service specified in the plan of care as reasonable and necessary for the palliation and management of the recipient's terminal illness or related condition in accordance with 42 CFR 418.202

Hospice Services in a Nursing or Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID)

- Florida Medicaid reimburses providers for nursing facility and ICF/IID room and board in addition to the per diem payment when a resident recipient elects hospice.

Physician Services

Florida Medicaid reimburses for the following separately, in addition to the per diem payment, in accordance with the applicable Florida Medicaid fee schedule(s) when rendered by a practitioner licensed within the scope of their practice:

- Consultations provided by a physician whose opinion or advice regarding the evaluation or management of a specific problem is requested by another physician or the hospice
- Hospital services for the evaluation and management of initial hospital admission, subsequent care, and discharge services
- Nurse practitioner services in accordance with 42 CFR 418.304(2)
- Office and home visits

For more information regarding covered services refer to AHCA at Hospice Coverage Policy.

Description of the Specialty: An entity that provides a continuum of palliative and supportive care for the terminally ill patient and patient's family.

Billing: The following codes are included below for informational purposes only and are subject to change without notice. Inclusion or exclusion of a code does not constitute or imply subscriber coverage or provider reimbursement. The codes listed below are not a complete list. Please refer to your contract with Sunshine Health to determine all contracted/covered codes for each membership group.

Billing Codes and Modifiers					
Service Type	**Units of Measurements**	**Procedure code**	**Modifier**	**Procedure Code Description**	**Units**
Hospice Service - Routine	Per Hospice Admission:* Days 0-60 = High Rate Days 61+ = Low Rate	0651		Routine home care	Unit
Hospice Service - Continuous	Per unit	0652		Continuous home care	Unit
Hospice Service - Service Intensity Add-On	15-minute units up to 4 hours total per day, combined **	0551***		Service Intensity Add-On (SIA) - Medical Social Service Visit During Routine Home Care	Unit
Hospice Service - Inpatient	Per unit	0658		Room and board (nursing facility)	Unit

*To assist in claim adjudication, providers need to bill days 0-60 and 61+ on separate lines.

**SIA (0551/G0299, 0561/G0155) care hours are combined and cannot exceed four hours total per day. Hours provided concurrently count separately.

***Florida Medicaid reimburses for SIA (0551/G0299, 0561/G0155) care in addition to routine home care (0651) during the last seven days of an eligible recipient's life.

Please refer to the Medicaid Fee Schedule and the Billing and Procedure Coding Guide for a list of approved modifier codes.

Important Links

- Provider Reimbursement Schedules and Billing Codes
- Hospice Room & Board Rates
- Hospice Regulations (AHCA)
- Hospice Coverage Policy
- Sunshine Health – Multiple Claim Submission Wizard
- Sunshine Health Provider Billing Manual

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.

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

Claim Payment Disputes
(Related to untimely filing, incidental procedure, unlisted procedure code)

Before Oct. 1, 2021	On or after Oct. 1, 2021
WellCare Health Plans **Claim Payment Disputes** P.O. Box 31370 Tampa, FL 33631-3370	**Sunshine Health** **Attn: Adjustments/Reconsiderations/Disputes** P.O. Box 3070 Farmington, MO 63640-3823

Provider on Behalf of Self – Medical Appeals

- Providers can request an appeal for the following types of denials:
  - No authorization claims denials.
  - Authorization denials due to member not meeting medical necessity authorization denials and medical necessity, in addition to, benefits exhausted and non-covered procedures.

Before Oct. 1, 2021	On or after Oct. 1, 2021
WellCare Health Plans **ATTN: Appeals Department** P.O. Box 31368 Tampa, FL 33631-3368	**Sunshine Health** **Attn: Adjustments/Reconsiderations/Disputes** P.O. Box 3070 Farmington, MO 63640-3823

Provider Changes

Adding Providers to Existing Group or Practice

- A contracted medical or behavioral health practice that would like to add a practitioner should email all relevant documentation to practitioneradds@centene.com and include the following:
  - List of Affiliated Providers (LOAP)/Practitioner Roster (for additions only)
  - Disclosure of Ownership Form
  - Access our LOAP (roster) template to utilize as a guide when submitting these types of requests.
- The Practitioner Adds Mailbox is equipped with an Auto Response Email to alert the submitter that their request has been received.

Demographic Updates and Changes

- A contracted medical or behavioral health practice that would like to update or make any changes to their demographic information should direct their request to SunshineProviderRelations@SunshineHealth.com.
- Please include all detailed information to assist in making the appropriate changes.
- Providers can also initiate changes like this by visiting Secure Provider Portal.
  - Select “Modify Demographic Information about a specific TIN.”
- Providers can also submit their request via the Contact form.

Provider Terminations

Providers should refer to their contracts for specific information about terminating their contracts with Sunshine Health. In general, providers are required to notify the health plan within 90 days of terminating a provider or providers from a group or contract. Providers who want to terminate an individual practitioner within a practice or group should:

1. 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; AND
2. Email the request to SunshineProviderRelations@SunshineHealth.com and notify your Provider Relations Representative.

Remittances and PaySpan

Access explanation of payment statements (EOPs), change bank account information register for electronic funds transfers.

If you are currently receiving paper checks and would like to register for EFT, please view a copy of a current paper check. It should contain a Payee ID. This is the Plan Number which will be needed when registering.

- The registration for PaySpan is easy and it only takes a few minutes.
- Visit PaySpan online, call 1-877-331-7154 or email providersupport@payspanhealth.com.
- If your address is incorrect in PaySpan, please update to the correct address. Also, contact Sunshine Health at 1-844-877-8313 to update your address in our systems.

Case Management

Our Case Management team can be reached Monday to Friday from 8 a.m. to 8 p.m. at the phone numbers below. For after hours or weekend assistance, use option 7.

- Children's Medical Services (CMS) Specialty Plan: 1-866-799-5321, option 2.
- Medicaid (MMA), Serious Mental Illness Specialty Plan (SMI) and Long-Term Care (LTC): 1-866-796-0530, option 2.
- Child Welfare Specialty Plan (CW): 1-855-463-4100, option 2.

24-Hour Nurse Advice Line

The Nurse Advice Line can assist providers with checking member eligibility. It can also connect members to telemedicine for urgent care visits. Hours of operation are 24 hours a day, 7 days a week.

- CMS: 1-866-799-5321 and follow prompts for Nurse Advice Line, Option 1, then Option 7.
- MMA, SMI and LTC: 1-866-796-0530 and follow prompts for Nurse Advice Line, Option 1, then Option 3, then Option 7.
- CWSP: 1-855-463-4100 and follow prompts for Nurse Advice Line, Option 1, then Option 2, then Option 7.

Telemedicine

- Members have 24/7 access to receive services virtually through our telehealth vendor, Teladoc. Members can also download the Teladoc app or call 1-800-TELADOC.
- Providers may furnish and receive payment for covered, eligible telemedicine services, in accordance with this policy and the provider's scope of practice.

Additional Resources:

Access and Availability Timeframe Standards:

Sunshine Health establishes and assesses compliance with appointment wait times for various types of visits. Please view our Access and Availability Timeframe Standards.

Find A Provider (FAP) Tool

If you need assistance locating a specialist or facility for a member, please visit our Find a Provider Tool. Here you will be able to search by provider name, NPI and specialty type.

Find My Administrator Tool

Locate your Provider Engagement Administrator (PEA) by clicking the banner on our provider home page.

Community Resources

Our Sunshine Health Community Resource Database connects members and caregivers in need with local programs and supports.

For Providers Page

Stay up to date on provider communication by visiting our For Providers Landing Page and Provider News Page.

Vendors Page

Contact information for Sunshine Health's subcontractors and vendors.