sunshine health™

PROVIDER MANUAL

Medicaid (MMA), Comprehensive Long Term Care (LTC), Child Welfare Specialty Plan (CWSP) and Serious Mental Illness (SMI) Specialty Plan

1-844-477-8313
Provider Services

SunshineHealth.com
SH_7709

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Chapter 1:
Welcome to Sunshine Health

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

SunshineHealth.com contains a wealth of tools, including 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 updated frequently.

For important updates, please check our For Providers page and Provider News articles.

Key Contacts and Important Phone Numbers

Sunshine Health provides a 24-hour help line to respond to requests for prior authorization. In addition, Sunshine Health staff is available Monday through Friday from 8 a.m. to 8 p.m. Eastern 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 can provide callers with information about operating hours and instructions on how to verify enrollment for a member with an emergency or urgent medical condition. The

requirement that Sunshine Health 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.

The following are key services that you may have questions about 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	1-866-399-0928
AcariaHealth Specialty Pharmacy	1-855-535-1815
Advanced imaging	1-866-214-2569
Arranging covered transportation for Medicaid and Child Welfare Specialty Plan members	1-877-659-8420
Arranging covered transportation for Serious Mental Illness members	1-877-659-8412
Arranging covered transportation for Long Term Care and Comprehensive Long Term Care members	1-888-863-0248

Medicaid in Florida

Funded by both the state and federal governments, Medicaid provides health coverage for low-income families and individuals. It also assists the elderly and people with disabilities with the costs of nursing facility care and other medical and long-term care expenses. Its purpose is to improve the health of people who might otherwise go without medical care for themselves and their children.

In 2011, the Florida Legislature established the Florida Medicaid program as a statewide, integrated managed care program for all covered services, including long-term care. This program is referred to as the Statewide Medicaid Managed Care (SMMC) program, which is administered by the Florida Agency for Health Care Administration (AHCA). Most Florida Medicaid recipients are enrolled in the SMMC program.

The SMMC program includes Managed Medical Assistance (MMA) and several specialty plans.

Sunshine Health has a Child Welfare specialty plan, called the Child Welfare Specialty Plan (CWSP) for children in or adopted from the child welfare system. Sunshine Health is approved by AHCA to administer MMA, Comprehensive and Child Welfare Specialty Plan in all regions of the state.

Medicaid recipients who qualify and become enrolled in the Florida MMA program receive all healthcare services, including LTC services through their selected Medicaid health plan.

The minimum required MMA services, as specified by AHCA, include the following:

- Advanced registered nurse practitioner
- Ambulatory surgical center services
- Assistive care services
- Behavioral health services
- Birth center and licensed midwife services
- Clinic services
- Chiropractic services
- Dental services
- Child health check-ups
- Immunizations
- Emergency services
- Emergency behavioral health services
- Family planning services and supplies
- Healthy Start services
- Hearing services
- Home health services and nursing care
- Hospice services

Hospital services:

- Laboratory and imaging services
- Medical supplies, equipment, prostheses and orthoses
- Optometric and vision services
- Physician assistant services
- Physician services
- Podiatric services
- Prescribed drug services
- Renal dialysis services
- Therapy services
- Transportation services

The minimum required LTC services, as specified by AHCA, include the following:

- Adult companion care
- Adult day health care
- Assistive care services
- Assisted living
- Attendant care
- Behavioral management
- Caregiver training
- Care coordination/case management
- Home accessibility adaptation services
- Home-delivered meals
- Homemaker services
- Hospice
- Intermittent and skilled nursing
- Medical equipment and supplies
- Medication administration

- Medication management
- Nutritional assessment/risk reduction services
- Nursing facility services
- Personal care
- Personal emergency response systems (PERS)
- Respite care
- Occupational therapy
- Physical therapy
- Respiratory therapy
- Speech therapy
- Transportation

In addition to AHCA-required benefits, Sunshine Health offers enhanced and In Lieu of Services (ILOS). These are services that can be used as a substitute for a covered AHCA benefit. If a provider feels a member may benefit from an in lieu of service, the member must consent. These enhanced and in lieu of services have been selected to assist our providers in managing the unique needs of our members and to help avoid the need for a higher level of care or more costly services in the future. To see a list of benefits as well as those services requiring prior authorization, visit Sunshine Health's Pre-Auth Check Tool.

AHCA contracts with various health plans to provide MMA and Comprehensive services in some — but not necessarily all — 11 regions in Florida.

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 Florida counties. For more than 30 years, Centene has provided comprehensive managed care services to Medicaid populations and operates health plans throughout the United States.

Sunshine Health utilizes 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.

Managed Medical Assistance (MMA)

Sunshine Health Managed Medical Assistance, hereafter referred to as MMA, is a managed care plan contracted with AHCA to provide Medicaid and enhanced benefits to Florida residents of all ages whose income or resources are insufficient to pay for healthcare.

Individuals must be eligible for the Statewide Medicaid Managed Care program to be eligible for this plan and reside in one of the regions in which Sunshine Health is contracted. Sunshine Health does not determine eligibility.

Child Welfare Specialty Plan (CWSP)

Sunshine Health serves children and youth up to the age of 21 years who are enrolled in Medicaid and have an open case in the Florida Safe Families Network (FSFN), including children receiving a Florida adoption subsidy. Sunshine Health operates the state's only specialty plan designed to serve children in the child welfare system.

The Sunshine Health Child Welfare Specialty Plan, hereafter referred to as CWSP, is a model integrated with the state's child welfare system and Community-Based Care (CBC) lead agencies.

Serious Mental Illness (SMI)

Sunshine Health addresses serious mental illness by helping members take control of every part of their health. Our Serious Mental Illness (SMI) Specialty Plan offers coordinated behavioral, medical and pharmacy services and utilizes a team-based approach, including behavioral and medical providers, licensed health clinicians and pharmacists. Members can depend on us to connect them to social support services such as access to healthy foods, secure housing and reliable transportation to appointments. We provide extra benefits for our SMI members that go beyond healthcare.

Comprehensive (includes MMA and Long Term Care Services)

Sunshine Health is contracted with AHCA to deliver services for members who are eligible for Medicaid and Long Term Care (LTC) programs, hereafter referred to as the Comprehensive program. The purpose of the Comprehensive program is to maintain the member in the least restrictive environment as safely as possible, leveraging Medicaid and LTC benefits through one managed care plan. All Comprehensive members qualify for nursing-home level of care. They may live in a nursing home, a private home or apartment, an adult family care home or various types of assisted living facilities (ALFs).

Members who live at home or in a facility receive LTC and Medicaid-covered benefits and care coordination through our Comprehensive care managers. The member's LTC benefits are delivered through an extensive network of Sunshine Health-contracted providers.

Comprehensive members may be 18 years or older, and their needs may be complex (i.e. on ventilators, aging out of Children's Medical Services, require total care, etc.) or comprehensive (i.e. members eligible for a combination of Medicaid, Medicare and/or LTC services). Some Comprehensive members may also have other insurance, particularly Medicare. The member's care manager is responsible for coordinating care with all plans.

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 also partners with long-term care providers to offer support services to meet and address challenges faced by long-term care members.

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 that successful managed care is delivered via appropriate, medically necessary services rendered in the appropriate setting – not by eliminating 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 to manage chronic conditions and provide 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 programs, policies and procedures are designed to minimize administrative responsibilities in the management of care, enabling providers to focus on the health 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 its processes, policies and procedures 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.

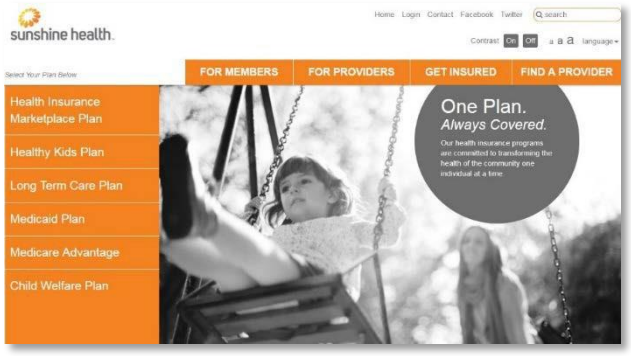
Sunshine Health follows the Section 1557 nondiscrimination provision of the federal Affordable Care Act (ACA). Sex discrimination includes, but is not limited to, discrimination based on an individual's sex, including pregnancy, medical related conditions, termination of pregnancy, gender identity and 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 via mail, email or fax
- New provider orientation
- Secure Provider Portal to verify member eligibility, manage claims and authorizations
- 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



Providers can visit 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 billing manual (PDF)
- Access billing and claims Quick Reference Guides (QRGs)
- Access provider directories
- Access vendor information
- Complete required trainings using the Provider Training website
- Access the link for Availity to see gaps in care; including HEDIS
- Register to access Sunshine Health's Secure Provider Portal at SunshineHealth.com/login
- Sign up for electronic funds transfers (EFT) via vendors
- Utilize the Find Your Administrator tool to identify the Provider Engagement Administrator assigned to your practice, group or facility

Secure Provider Portal

Sunshine Health allows providers and their office staff to register for the Secure Provider Portal via SunshineHealth.com/login. 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
- Submit demographic changes through Manage Practice tab (User must have Account Manager access)
- 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 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

Member Benefits

Sunshine Health provides an extensive menu of benefits and expanded benefits, which vary from product to product. Expanded benefits are extra goods or services we provide at no cost to members. In addition, some covered services require prior authorization. To see a list of benefits and expanded benefits as well as those services requiring prior authorization, go to SunshineHealth.com.

Chapter 2: Member Eligibility

Eligibility Determination

Medicaid eligibility in Florida is determined by the Department of Children and Families (DCF) or the Social Security Administration (SSA), which determines eligibility for individuals receiving Supplemental Security Income (SSI). DCF determines Medicaid eligibility for:

- Parents and caretaker relatives of children
- Children
- Pregnant women
- Former foster care individuals
- Non-citizens with medical emergencies
- Aged or disabled individuals not currently receiving Supplemental Security Income (SSI)

MMA and CWSP

Until the actual date of enrollment with Sunshine Health, the health plan is not financially responsible for services the prospective member receives. In addition, Sunshine Health is not financially responsible for services members receive after coverage is terminated. However,

Sunshine Health is responsible for anyone who is a Sunshine Health member at the time of a hospital inpatient admission and changes health plans during that confinement.

SMI

The SMI Plan is designed to help members age 6 years and up who may have one of the following conditions:

- Psychotic Disorders
- Bipolar Disorders
- Major Depression
- Schizoaffective Disorder
- Delusional Disorders
- Obsessive-Compulsive Disorder (OCD)

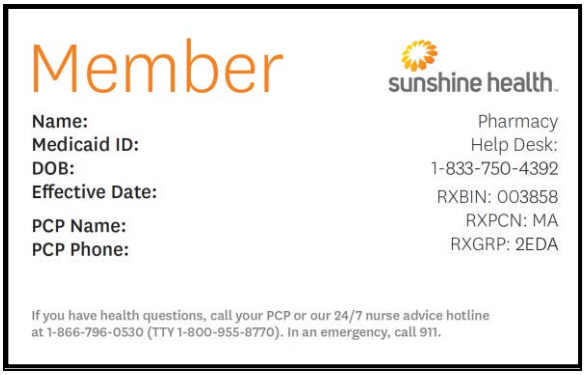
Comprehensive

Sunshine Health is responsible for providing LTC services once the Florida Department of Elderly Affairs determines an enrollee meets the medical requirements for nursing home care and the enrollee formally selects the Sunshine Health Comprehensive plan through AHCA's Choice Counseling. Following that selection, the Department of Children and Family Services (DCF) determines if the member meets the financial criteria. Once AHCA receives confirmation of eligibility, AHCA notifies Sunshine Health of the member's effective enrollment date. Coverage typically lasts for a year until DCF recertifies the member.

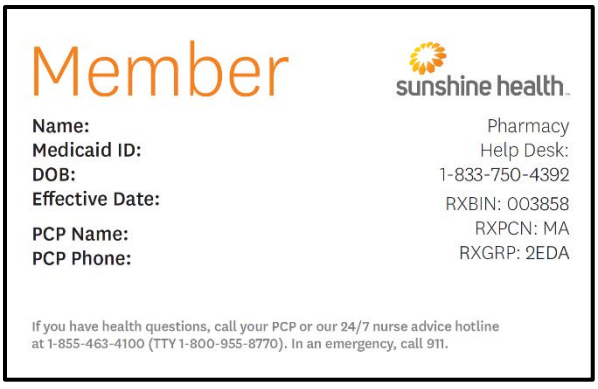
Member ID Cards

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

MMA, SMI or Comprehensive Member Identification Card



CWSP Member Identification Card



Verifying Member Eligibility

Sunshine Health recommends providers verify eligibility before providing services for our MMA, SMI and CWSP members and at least monthly for Comprehensive members. Providers may use the provider portal to verify member eligibility or use the tools and resources provided by AHCA.

➢ 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.

Sunshine Health must authorize all services before providers render any LTC-covered service for Comprehensive members.

Methods to Verify Eligibility

Preferred Method

Providers are asked to verify member eligibility by using the Sunshine Health secure provider portal found at SunshineHealth.com. Using the portal, registered providers are able to quickly check member eligibility by using member name and date of birth or Medicaid 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 NPI and Tax ID number for their verification. For the member, they will need to provide the Member ID or last four SSN along with the member DOB.

If the secure portal or IVR lines are unavailable, providers may call the Provider Services number and speak to a representative.

Providers will be asked to supply the member's name and date of birth or the member's Medicaid 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 of experienced, licensed providers and 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 Florida Agency for Health Care Administration (AHCA), the National Committee for Quality Assurance (NCQA) and Sunshine Health.

The Sunshine Health Credentialing Department is responsible for verifying the information from all medical, long-term care and behavioral health practitioners and providers seeking to contract with Sunshine Health. The department performs credentialing for all lines of business. The credentialing process for all lines of business – except LTC specific non-traditional providers – follows similar policies and procedures.

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, durable medical equipment providers, home delivery meal providers, homemaker and companion services, hospice facilities, adult day care centers, adult family care homes, assisted living facilities and contractors for pest control, home modification and other services.

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, Drug Enforcement Administration registration number, 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 spaces
- Medical/treatment record-keeping criteria

Site visits are conducted for:

- Unaccredited facilities
- Primary Care Physicians
- Obstetrics/Gynecology
- During initial credentialing and recredentialing
- After a complaint 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 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 MMA and CWSP Practitioners and Providers

The credentialing and recredentialing processes ensure participating practitioners and providers meet the criteria established by Sunshine Health, government regulations and the standards of accrediting bodies. To maintain a current 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 (not older than 120 days) 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 problems; mental and physical competence; and the ability to perform the essential functions of the position, with or without accommodation
- 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 including month and year
    - Disclosure of ownership form per practice location; listing any individuals or facilities having ownership or control of the entity of 5% 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

Sunshine Health verifies the following information submitted for credentialing/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 it is received, Sunshine Health 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

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 including expiration dates, amounts of coverage, name of the liability carrier, insurance effective and expiration

dates (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 24j of the claim form that is different than the facility's billing NPI (box 33a: 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 Requirements for LTC Providers

Providers must submit, at a minimum, the following information when applying for participation with Sunshine Health for LTC covered services:
- A completed facility provider application, signed and dated within last six months, which includes active NPI, tax identification number, service location and active Medicaid and Medicare identification numbers, if available
- Current licensing: Medical, facility and/or business tax receipt, as applicable to provider type
- No revocation, moratorium or suspension of the provider's state license by AHCA or the Department of Health, if applicable
- License number for home health aide; also a certificate of training if home health aide provides medication administration/management
- License numbers for physical/occupational/speech/respiratory therapists, certified nursing assistant, registered nurse, licensed practical nurse or certified nursing assistant
- Level II background result completed within the past five years
- Affidavit of attestation of compliance and AHCA level II background screening results for facility administrator, owner or individual in charge
- Current general and professional liability cover sheet and workers' compensation face sheet, or exemption sheet, as applicable, indicating coverage limits and expiration dates, showing facility name and licensed service location address
- Current disclosure of ownership form per facility location, listing any individuals or facilities having an ownership or control in the entity of 5% or greater
- Current Medicaid identification number or, if not enrolled with Medicaid, submission of registration number or documentation of submission of the Medicaid provider registration form
- Explanation for any sanctions imposed on the provider by Medicare or Medicaid
- Behavioral management service attestation form (for home health agencies)
- Current W-9 form

Sunshine Health verifies the following information submitted for LTC credentialing and/or recredentialing purposes:

- State license through appropriate licensing agency
- Board certification or residency training and/or medical education
- Sanction activity from Medicare/Medicaid via the OIG/LEIE, SAM database as well as AHCA for any sanctions/exclusions
- Completion of a site visit for all assisted living facilities, adult family care homes and adult day care centers.
- Background check with the AHCA clearinghouse for all administrators, owners or responsible individuals for the facility

Once the credentialing/recredentialing process is completed, the Sunshine Health credentialing committee makes a final decision on acceptance/continuance following its next regularly scheduled meeting. Providers are notified of the decision within 60 days from the date of the committee meeting.

Credentialing Committee

The credentialing committee is responsible for establishing the criteria for practitioner and provider participation and 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 the types of procedures or plan 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% or greater must be completed prior to finalization of the credentialing process. If the practitioner scores less than 80%, 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 state Office of Inspector General to identify any network practitioners/providers who have been newly sanctioned or excluded from participating 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 expire 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 no longer meets 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/ recredentialing applications. This includes information obtained from any outside primary source such as the National Practitioner Data Bank, malpractice insurance carriers, 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 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. Upon receiving 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. The 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 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 with 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.

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. Please keep in mind, all PCPs are required to complete a Total Patient Load Attestation (TPAL) form.

Adding Facilities to an Existing Contract Applicable to: Hospital, Ancillary and Behavioral Health Facilities

1. Please complete the appropriate Facility & Ancillary or Behavioral Health Credentialing Application below:


MMA Sunshine Health Facility Ancillar


BH Facility Application.pdf

   - Ensure attached W-9 has been signed in the last 12 months
   - Ensure Application must be signed within the last 6 months of Credentialing

2. On Company Letterhead, please dictate:
   - Location Address of Performed Services
   - Billing Address of Performed Services
   - Main Phone # of location
   - If location should be listed in health plan directory
   - Specify all Health Plan Products the location should be added to.
     - **Please Note:** Required to have an existing participating contract for the requested Line of Business (LOB)
       - **LOB Examples:** Sunshine Medicaid (including Child Welfare Specialty Plan (CWSP), Long Term Care (LTC), Serious Mental Illness (SMI)

3. Please complete the LOAP (List of Affiliated Providers)
   - Only if the Facility needs to add practitioners to this group/location

4. Email practitioneradds@CENTENE.COM to include the following documents:
   - Credentialing Application
   - Disclosure of Ownership (DOO) – 1 per Tax ID
   - Copy of Certificate of Insurance (COI) with dates of group liability coverage. Should not expire within the next 90 days of being provided.
   - Supporting Documents
   - Letterhead to: practitioneradds@CENTENE.COM
   - Please utilize Email Subject Line of ***Facility, Ancillary or BH Add***

What Are My Next Steps?

- Once your email is received, you will receive an automated email acknowledging your request from practitioneradds@CENTENE.COM
- Once the credentialing process is completed, the Credentialing Specialist emails the confirmation w/approval letters and the effective date to the initial requester (via email)

Submitting Demographic Changes Applicable to: Hospital, Ancillary and Behavioral Health Facilities

Email demographic changes to the Sunshine Provider Relations email box: Sunshine_Provider_Relations@sunshinehealth.com. Include a copy of the updated LOAP/updates you're requesting.

The Secure Provider Portal allows Account Managers to make these updates via the self-service feature under the "Manage Practice" tab.

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 delivery of high-quality and cost-effective services

Sunshine Health does not discriminate in providing 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 and CWSP products, 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 reports of 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 Monday through Friday from 8 a.m. to 8 p.m. Eastern. Providers should call Provider Services at 1-844-477-8313 and select the prompt for authorization. Weekend and After-Hours on Call-Number: (all products): 1-844-477-8313.

Clinical Practice Guidelines

Sunshine Health adopts preventive and clinical practice guidelines from evidence-based sources to provide 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 healthcare 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

Sunshine Health covers emergency services by a qualified provider — and non-participating providers — until the member is stabilized. If Sunshine Health determines a medical emergency does not exist, Sunshine Health 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, Sunshine Health 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 Sunshine Health, 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.

Sunshine Health 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

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.

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 a determination must be based upon the information available at the time the goods or services were provided.

MMA and CWSP Members

In general, prior authorization for MMA and CWSP members is required for non-emergency inpatient admissions, selected outpatient surgeries, durable medical equipment, home care, hospice services, out-of-network services and providers, high-tech radiology and specific behavioral health outpatient services. The same applies for the MMA benefits for a Comprehensive member.

Comprehensive Members

Prior authorization is required for all LTC services except custodial facility stays and transportation to LTC-covered services.

Submitting Prior Authorization Requests

Medical practitioners and providers are to submit requests for inpatient or outpatient authorizations – except for home-health requests and DME related to hospital discharges – through the Secure Provider Portal unless otherwise previously approved by Sunshine Health. Behavioral health providers are to submit requests for inpatient psychiatric services through the Secure Provider Portal, by calling 1-844-477-8313 or via fax at 1-866-796-0526. All other medical and behavioral health authorization requests submitted via phone 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 do not require prior authorization. Providers should use 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 the Sunshine Health member is enrolled in. To validate which services require prior authorization, it's best practice to utilize our Secure Provider Portal.

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 faxed to Coastal Care Services. Exceptions to Coastal include HHC for CMS members, LTC, infusion, wound vacs and PDN related to a discharge should then be faxed to 1-844-801-8413. This process was established to assist with prompt reviews of services related to 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 24 hours following 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 Sunshine Health 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 receiving the request. If Sunshine Health is unable to issue a decision due to matters beyond its control, it may extend the decision time

frame 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 will notify the requesting provider in writing within one business day. Written notification to the provider and member occurs within the same day or within the authorization review time frame. The notification 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. An initial determination is issued within 48 hours of receipt of the request or 72 hours if additional information has been requested.

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 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 will review 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 or LTC 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 will review 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 1-844-427-8313 ext. 6032912.

Medical Necessity of Services Under CHCUP/EPSDT

The Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program provides comprehensive and preventive healthcare services to children under age 21 years 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 and/or mental condition.

➢ See Credentialing Requirements for MMA and CWSP 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 that 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:

- Sunshine Health 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
- Sunshine Health may approve services in the most cost-effective mode if the less expensive service is equally effective and available
- Sunshine Health 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

Sunshine Health 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 outpatient services requiring authorization
- Planned transplant that has not yet occurred
- Hospice Therapy for members under age 21 years

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

Sunshine Health 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

Sunshine Health does not make retrospective review determinations for services already rendered. Medical providers may submit the claim for processing, which will be denied as "services not authorized," and may initiate the provider dispute (1st level) 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 (2nd level) 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.

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.

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

Sunshine Health coordinates physical health and behavioral health services for all new members. This process ensures continuous care for members with a previous authorization or who are undergoing an active course of treatment. This includes care previously authorized to a non-participating provider.

The continuity-of-care (COC) period is 60 days for new MMA, SMI and Comprehensive members and 90 days for new CWSP members.

Ongoing medical and behavioral health services or treatment may include the following:

- Behavioral health services
- Obstetrical care: regardless of a woman's trimester, Sunshine Health approves all prenatal care, delivery and post-partum care with the current maternity provider and delivering facility

- Prescriptions
- Prior existing orders (including transplant services through the first year of the transplant and the current round of radiation and/or chemotherapy services for the current round of treatment)
- Provider appointments, e.g. surgeries, etc.

Continuity of Care Following Provider Termination

Providers who terminate their affiliation with Sunshine Health have a responsibility to provide medically necessary care for members at least 60 days following their termination date for all lines of business.

Sunshine Health permits members to continue receiving medically necessary services from a not-for-cause terminated provider and continues to process provider claims at least for 60 days or until members select another provider.

Sunshine Health must issue a prior authorization for continuity of care when a provider is terminated.

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 30 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. Once in the portal, click on the "Assessments" tab. To earn the maternity incentive, providers must ensure the Tax ID Number (TIN) is entered in the OB Provider ID field. Failing to input the TIN properly could delay payment.

Providers can visit Sunshine Health's Notice of Pregnancy (NOP) web page to learn how to submit an NOP.

This information is used to identify members eligible to join 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 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 Monday through Friday from 8 a.m. to 8 p.m. Eastern and selecting the case management prompt.

Prenatal Vitamins Benefit

Sunshine Health members receive an over-the-counter (OTC) medication benefit that includes prenatal vitamins. Additionally, the Sunshine Health 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 Sunshine Health members ages 13 and older. Doulas receive referrals from Primary Care Physicians (PCP's) and Obstetrical and Gynecology (OB/GYN) providers. Doula services no longer require prior authorization and members have an unlimited number of visits.

Florida Healthy Start Program

The Florida 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 years 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 in 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 years 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 risky conditions

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 state 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 test positive for the Hepatitis B surface antigen HBsAg 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 state health department in the county where the prenatal screen was completed
  - 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 to 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 surface 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, 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, and 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 local state 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 state health department indicating member demographics, race, ethnicity, test results and immunization dates

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 years 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 the 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 have routine health screenings

combined with appropriate diagnosis, treatment, referrals and follow up. This schedule is available on the Sunshine Health 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 years 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 time frames 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 years 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 laws relating to religious or other exemptions

Vaccines for Children Program

Sunshine Health requires contracted practitioners who administer vaccines to children to participate in Florida's Vaccines for Children (VFC) program. The Florida VFC program provides routine vaccines to children from birth through age 18 years who meet program eligibility, at no cost to the member or physicians, and eliminates the physicians' need to refer children to the local state health department. 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 their practice, the PCP may refer the child to the member's local state 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, it 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, centralized, statewide 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 Department of Health VFC website for more information about VFC.

Vaccines for Adults Program

In accordance to the Inflation Reduction Act (IRA) of 2022 (P.L. 117-169) beginning October 1, 2023, Medicaid and Children's Health Insurance Program (CHIP) programs must cover vaccines that are approved by the FDA for use by adult populations and administered in accordance with the Advisory Committee on Immunization Practices (ACIP) recommendations. Coverage must be provided without member cost-share and must include any administration fees. The ACIP develops

recommendations on how to use vaccines to control disease in the United States. The recommendations include the age(s) when the vaccines should be given, the number of doses needed, the amount of time between doses, and precautions and contraindications. Sunshine Health will follow these recommendations and contraindications established by the ACIP, unless:

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

Sunshine Health requires contracted practitioners who administer vaccines to adults to participate in Florida's Vaccines for Adult's (VFA) program. The Florida VFA program provides vaccines to our adult population to prevent infection with one of potentially devastating diseases.
To be eligible to receive VFA vaccine, one must be an:

- Uninsured adult aged 19 years and older
- Underinsured adult aged 19 years and older

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 years 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: Provider Requirements for CWSP Members

Partnership with Community-Based Care (CBC) Lead Agencies

Sunshine Health partners with community based care (CBC) lead agencies across the state to facilitate the integration of medical, behavioral and social services. Sunshine Health contracts with the CBCs to provide care coordination for Sunshine Health's Child Welfare Specialty Plan (CWSP) members by nurse care coordinators and behavioral health care coordinators at local CBCs.

Sunshine Health works with CBCs to assure quality physical health and behavioral health services are provided to all CWSP members. This coordination includes joint operational and clinical processes focused on coordinating with individual CBC lead agencies supporting the continuum of care and providing care coordination services using a Trauma-Informed Care Model.

➢ See Trauma-Informed Care

Child Welfare Specialty Provider Network

Sunshine Health embraces evidence-based interventions targeting the complex and comprehensive needs of children in the child welfare system. To offer appropriate and effective services to these children, many of whom have experienced neglect, abuse and/or trauma, Sunshine Health developed a trauma-informed care specialty provider network of clinical providers with expertise in evidence-based interventions aligned with the National Child Traumatic Stress Network's guidelines.

Providers trained in trauma-informed care should contact their Provider Engagement Administrator using the Find Your Administrator tool to determine if they meet the national traumatic stress network's guidelines. Sunshine Health also offers trauma-informed care training consistent with those guidelines. Interested providers should contact their Provider Engagement Administrator.

➢ See Trauma-Informed Care

Authorized Callers

CBC Identification of Medical Consenters

CBC lead agencies identify the authorized caller(s) for children in Sunshine Health's Child Welfare Specialty Plan and provide that information to Sunshine Health daily. Sunshine Health maintains that information in a database accessible to Sunshine Health care managers, providers and designated health plan staff to safely and effectively coordinate care for CWSP members.

Additionally, CBC lead agencies assist Sunshine Health with providing names of authorized callers who may have access to the CWSP member's health information and who may speak to Sunshine Health's member services team, case management team and other necessary health plan staff.

Exceptions to Medical Consent for CWSP Members

The CWSP adheres to certain mandatory exceptions to accepting medical consent for children under age 18 who are under the legal care and custody of DCF. These exceptions are:

- Abortion
- Administration of psychotropic medication
- Admission to residential mental health treatment facility
- Aversive conditioning
- Drug research program
- Early Childhood Intervention (ECI) or Independent School District (ISD)
- Electroconvulsive therapy (ECT)
- Organ donation/anatomical gifts
- Sterilization
- Withholding or withdrawing life sustaining treatment

Trauma-Informed Care

The Sunshine Health CWSP includes specialized services for members who may have been exposed to various forms of trauma as well as required trauma-informed care training for providers.

Children and youth in the child welfare system often have comprehensive and complex needs resulting from histories of multiple and recurring trauma and abuse. Physical health conditions may, and often do, exacerbate mental health conditions or can trigger mental health issues, such as depression resulting from asthma or diabetes, coupled with trauma and removal from the home. Mental health conditions may, and often do, impact physical health conditions. These individuals may sometimes have higher utilization of psychotropic medications and an over diagnosis of mental health issues versus interventions for behavioral issues resulting from abuse, neglect, and trauma. The treatment and medication regimens for physical and mental health conditions may negatively interact.

Sunshine Health offers a brief overview of trauma-informed care as part of the initial training for a Sunshine Health network practitioner. In addition, network PCPs and behavioral health

practitioners are required to complete trauma-informed care training, available through webinar or a live training session, before recredentialing. To register, visit our Florida Child Welfare Webinar Series web page and select the appropriate courses.

For behavioral health practitioners, Sunshine Health offers a two-day trauma-focused cognitive behavioral therapy (TF-CBT) workshop, which is an evidence-based practice for treating individuals who have experienced trauma. The free training program is available at multiple locations and times throughout the year. Support through full TF-CBT certification is also offered to behavioral health providers who complete the initial two-day training, at no cost.

Additionally, Sunshine Health promotes the implementation of the National Child Traumatic Stress Network's Child Welfare Trauma Training Toolkit throughout the provider network and the Child Welfare system in Florida. Providers may visit the National Child Traumatic Stress Network's website for clinical guidelines and practice toolkits to support a trauma informed clinical approach.

Behavioral Health Screening and Assessment

Sunshine Health providers are expected to conduct behavioral health screenings and assessments according to best practices and clinical guidelines. Providers may visit SunshineHealth.com for guidelines, assessment tools, and related training. Behavioral Health screening tools, including the Patient Health Questionnaire (PHQ-9) PDF and CAGE Questionnaire PDF are available for reference. Additionally, Sunshine Health offers training on various behavioral health screening and assessment tools including the SBIRT (Screening, Brief Intervention, and Referral for Treatment) PDF. Providers can visit our Assessment Tools page, which contains the various evidence based screening tools that can be used.

Comprehensive Behavioral Health Assessment

All children entering out-of-home care ages birth through 17 years who are Medicaid eligible must be provided a Comprehensive Behavioral Health Assessment (CBHA). Sunshine Health's network includes behavioral health providers throughout the state that conduct these required assessments which are used to provide specific information about the child's behavioral health needs. CBHAs also provide child-specific recommendations that should be addressed to promote placement stabilization, emotional wellbeing and permanency.

Medication Management for CWSP Members

Sunshine Health covers medications for CWSP members and follows AHCA's Florida Medicaid Preferred Drug List (PDF).

- See Preferred Drug List

Prescribing Psychotropic Medications for CWSP Members

Any prescription written for a psychotropic medication for a CWSP member under the age of 18 years must be accompanied by the express written and informed consent of the member's parent or legal

guardian or with a court order. A dependency case manager, child protective investigator or child's foster parents may not provide express and informed consent.

- See Psychotropic Medications.

When prescribing psychotropic medications for children who do not reside with their parent or legal guardian, and the provider is unable to locate the parent or legal guardian for a signature, the prescribing physician must complete a 6-page DCF medical report, Prescribing Psychotropic Medication for Children in Out-of-Home Care (Form 5339) (PDF).

In an emergency or in the absence of the parent or legal guardian's consent, the prescribing physician must submit this completed and signed medical report to the court. The form may be used in lieu of a court appearance by the physician.

If the child's prescribing physician certifies in the report that delay in providing a prescribed psychotropic medication would more likely than not cause significant harm to the child, the medication may be provided in advance of the issuance of the court order under these circumstances:

- The medical report must provide the specific reasons the child may experience significant harm and the nature and extent of the potential harm
- The department must submit a motion seeking continuation of the medication and the medical report to the court, the child's guardian ad litem and all other parties within three business days after the department begins providing the medication to the child
- The department must seek a court order authorizing continuation of the medication at the next regularly scheduled court hearing or within 30 days after the date the prescription was picked up, whichever occurs sooner (unless a party objects to the motion; then the hearing will be held within seven days after the objection is made)
- The physician must complete this medical report when prescribing any new psychotropic medication or changing dosage. The medical report must include:
- A statement that the physician has reviewed all medical information is provided
- A statement indicating that the psychotropic medication, at its prescribed dosage, is appropriate for treating the child's diagnosed condition as well as the behaviors and symptoms the medication is expected to address
- An explanation of the nature and purpose of the treatment, the recognized side effects, risk, contraindications, drug-interaction precautions, possible side-effects of stopping the medication, and how the treatment should be monitored; followed by a statement that this explanation was provided to the child (if age appropriate) and to the child's caregiver
- Documentation addressing whether the psychotropic medication will replace or supplement any other currently prescribed medication or treatments; the length of time the child is expected to be taking the medication; and any additional medical, mental health, behavioral, counseling or other services the physician recommends
- Acknowledgment that the parent may revoke any consent given for treatment orally or in writing before or during the treatment period

Contraceptive Services

Any CWSP member may request and receive any contraceptive service except sterilization without the consent of the child's parents, caregivers or legal guardian at the member's local Florida County Health Department.

Sterilization and abortion services for children in the child welfare system in Florida require a court order or consent from the parent or legal guardian. In no case shall DCF or the CBC lead agency consent to a child's sterilization or abortion.

Chapter 8: 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 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 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 time frames.

Definitions of a Member Complaint, Grievance and Appeal

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 become 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 believe 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

A member may file a Grievance or Appeal verbally or in writing at any time by:

- Email sunshine_appeals@centene.com
- Fax 1-866-534-5972
- Pharmacy Appeals 1-833-909-0765
- Call Member Services Monday through Friday from 8 a.m. to 8 p.m. Eastern at the following numbers based on the member's line of business:
  - MMA and Comprehensive members: 1-866-796-0530
  - CWSP members: 1-855-463-4100
  - TTY line for all members: 1-800-955-8770
- Send a written request by mail to:
  Grievance and Appeals Coordinator
  Sunshine Health
  P.O. Box 459087
  Fort Lauderdale FL 33345-9087

A member may file an appeal orally. Oral appeals may be followed with a written notice within 10 calendar days of the oral filing. The date of oral notice shall constitute the date of receipt.

Medicaid Fair Hearing

Medicaid fair hearings may be requested any time up to 120 days following the date on the notice of plan appeal resolution. The member must finish the appeal process first.

Medicaid fair hearings may be requested through any of the following methods:

- Email: MedicaidHearingUnit@ahca.myflorida.com
- Fax 1-239-338-2642
- Phone 1-877-254-1055
- Mail a written request to the following address: Agency for
  Health Care Administration
  Medicaid Hearing Unit
  P.O. Box 60127
  Fort Myers, FL 33906

For more information, visit the Sunshine Health Grievances and Appeals web page

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 9: Case Management

Case Management Program Overview

Sunshine Health adheres to the Case Management Society of America (CMSA) definition of case management: “a collaborative process of assessment, planning, facilitation, care coordination, evaluation, and advocacy for options and services to meet an individual’s and family’s comprehensive health needs through communication and available resources to promote quality cost effective outcomes.”

Sunshine Health also abides by the principles of case management practice, as described in CMSA’s “Standards of Practice for Case Management.”

The case management program and tools used to manage care were developed using evidence-based clinical practice guidelines and preventive health guidelines adopted by Centene Corporation and Sunshine Health.

The mission of Sunshine Health's case management program is to:

- Assist members by facilitating timely receipt of appropriate services in the most appropriate setting
- Assist members in achieving optimum health, functional capability and quality of life through improved management of their disease or condition
- Assist members in determining and accessing available benefits and resources
- Maximize benefits and resources through oversight and cost-effective utilization management
- Work collaboratively with members, family and significant others, providers, and community organizations to develop goals and assist members in achieving those goals

Case management staff is available Monday through Friday from 8 a.m. to 5 p.m. Eastern at:

- MMA/SMI:1-866-796-0530
- Child Welfare: 1-855-463-4100

After-hours calls go to the 24-hour nurse advice line.

Integrated Medical and Behavioral Health Approach

Sunshine Health's case management program is structured on an interdisciplinary approach that allows for the input of staff, members, caregivers and treating providers. Sunshine Health staff may include physical health and behavioral health care managers, social workers, pharmacists, health coaches and medical director.

Once an assessment determines a member has both medical and behavioral health needs, applicable case management staff – supported by this integrated team – is assigned to the member. Members identified as severe and persistently mentally ill, or members in an emergency behavioral admission, are automatically referred to a behavioral health case manager, who is a licensed behavioral health clinician.

This model of integration extends to CWSP members and involves a partnership with community-based care (CBC) lead agencies in Florida. CBC lead agencies work collaboratively with Sunshine Health to provide quality physical health and behavioral health services to all CWSP members. This coordination includes joint operational and clinical processes focused on coordination with the various individual CBC lead agencies, supporting the continuum of care and providing case management support using a trauma-informed care model.

Identification of Members for Case Management and Condition Management

Sunshine Health has developed a population-based algorithm that uses claims, authorizations, admission, discharge and transfer data (ADT), social determinates of health data and information from our care management assessments to identify members for case management programs. In addition, the case management department relies on referrals from Sunshine Health staff, including utilization management and member services, members and/or their caregivers,

community agencies, and providers or practitioners.

Sunshine Health uses Centelligence Population Health Management (CPHM), a comprehensive population health management platform for population segmentation, risk stratification and cost trending. This guides Sunshine Health in identifying the right case management integrated team or health and wellness program that best supports each member's needs. The algorithm, which is run monthly, stratifies the population into four intervention tiers based on risk (severity), which helps determine appropriate clinical programs and targeted interventions.

Practitioners may send a case management referral through the secure provider portal or by calling 1-844-477-8313.

Case Management Levels for Members

The population health algorithm stratifies the population into four intervention tiers, with members in Tier 1 through Tier 3 identified for a case management program and members in Tier 4 identified for targeted health and wellness program interventions. Members may move through those stratification levels or move to a higher or lower level of intervention as their conditions change.

Tier 1 – Complex Case Management

These members require our highest-intensity case management to address consistent, frequent utilization of high levels of care due to fragmentation while managing multiple chronic conditions.

Tier 2 – Emerging Complex Case Management

These members require support to address a pattern of care suggesting instability and presenting as an emerging risk of engaging higher levels of member care.

Tier 3 – Chronic Condition Management

These members have prevalent chronic conditions requiring targeted education, medication adherence support, health coaching, and/or other interventions to ensure access to recommended care.

Tier 4 – Health and Wellness Management

These members are overall healthy who are utilizing self-management techniques to maintain their health status. May require support to close preventive care gaps or to address anticipatory needs, but otherwise have no ongoing coordination or management needs.

Case Management for Comprehensive Members

Members enrolled in Sunshine Health's Comprehensive program — defined as having MMA and Long-Term Care (LTC)— have care management provided in an efficient manner that supports person-centered care planning, ensures multidisciplinary clinical integration and produces quality outcomes.

The community-based LTC care coordinator will be the member's contact. When a member has complex medical and/or behavioral health needs, a medical and/or behavioral health care manager will be assigned to work closely with the field-based care coordinator. Medical and behavioral health care managers are integrated within the Comprehensive care team and are available to support the LTC care coordinator and member as needed.

The care coordinator meets all new members as soon as possible following notification of enrollment by AHCA to complete an initial comprehensive assessment. The care coordinator collaborates with the member, authorized representative, family member, PCP and network and non-network providers to develop, implement and monitor a person-centered plan of care based on the member's strengths, needs, goals, preferences and informal/natural supports.

The care coordinator performs a face-to-face reassessment of member needs at least every 90 days. The care coordinator makes monthly contact by phone or in person to ensure the member's safety and well-being and determine if additional services are needed. Care plan adjustments are based on changes in the member's overall condition and medical necessity. Services may be decreased based on improvement or identification of alternative community resources. During all member contacts, the care coordinator discusses the member's satisfaction with and quality of care received from each provider. If the member wishes to change providers, the care coordinator assists the member in locating a new provider.

The case management team also identifies Comprehensive members residing in a nursing facility who are appropriate to transition from the nursing home to a less restrictive environment. A nursing home transition unit then implements the transition. This special unit comprises transitional care coordinators who oversee discharge planning, member-centered care planning and transitional needs to provide the member with a safe and high-quality transition.

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
- Chronic Obstructive Pulmonary Disease (COPD)
- Dementia
- Depression
- Diabetes
- Emergency department diversion program for members who frequently visit hospital emergency departments
- 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 diagnoses or treating providers
- Transplant

CWSP members also are eligible for the following CWSP-specific programs:

- Human trafficking
- Integrated diabetes program
- Intellectual and developmental disabilities
- Transitioning youth

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 Engagement Administrator using the Find Your Administrator tool or click on "rewards program" under "benefits and services" for each product on SunshineHealth.com.

Chapter 10: Quality Improvement Program

Quality Improvement Program Description

Sunshine Health is committed to providing a well-designed and well-implemented quality improvement program focused on improving 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 members enrolled in the MMA, SMI, Comprehensive, LTC and CWSP 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 Healthcare Effectiveness Data and Information Set (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 by improving 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
- Improvement in member satisfaction scores
- Improvement in potentially preventable events, birth outcomes, transition of Comprehensive members from a facility to the community
- Improvement 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 reach 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 utilizes 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
- 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 LTC 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 the peer review and specialty advisory committees. 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 underutilization or overutilization 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 the development and annual review of the credentialing program description and its 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 responsibilities of the Centene National Pharmacy & Therapeutics Subcommittee (P&T) include the review of new drugs, indications, and pharmacy policies. The P&T Committee and/or Centene Pharmacy Services Joint Operating Committee (JOC) addresses quality and utilization issues related to provision of the pharmacy benefit. 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. The Health Plan Pharmacy Department in conjunction with Centene Pharmacy Services maintains compliance with the AHCA Preferred Drug List (PDL), state requirements, and discusses pharmacy quality initiatives such as e-prescribing and opioid prescribing practices. This health plan pharmacy team provides reports to the QIC quarterly. Voting members of the Centene National P&T Committee will includes practitioners and pharmacists representing various clinical specialties that adequately represent the needs of health plan members. The community-based practitioners must be independent and free of conflict with respect to and pharmaceutical manufacturers.

Spacers for Inhalers

Sunshine Health covers select spacers / aerosol-holding chambers for Medicaid members that will be covered through the pharmacy benefit. Members may receive one of the select spacers/chambers per year without prior authorization.

Peer Review Committee

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

Child Welfare Advisory Committee

The Child Welfare Advisory Committee convenes to obtain feedback from key child welfare stakeholders on the clinical care model; access to physical health, behavioral health, pharmacy and dental services; monitoring of clinical and service outcomes; and refinement of the program.

Serious Mental Illness (SMI) Provider Advisory Committee

The Serious Mental Illness (SMI) Provider Advisory Committee communicates the health plan's programs and processes to its provider network, allowing for collaboration and feedback through discussion with the providers. The purpose of the SMI Provider Advisory Committee is to provide input on the health plan provider profiling and incentive programs, and other administrative practices, and support development of the provider scorecard indicators, useful analyses of the data, and effective means of helping providers improve their performance. Responsibilities include:

- Provide the health plan with feedback regarding programs and processes from a community provider-based perspective
- Allow providers to make recommendations related to the programs and processes
- Assist the health plan to identify key issues related to programs that may affect community SMI providers.

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. They discusses topics such as practitioner and provider solutions; opportunities to improve chronic condition management, 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.

Comprehensive Member Advisory Committee

The Comprehensive Member Advisory Committee, launched in 2017, comprises LTC staff and members who meet at least twice a year in locations around the state. The committee's goal is to create service and delivery improvements. Meetings are hosted by Sunshine Health leadership and staff in partnership with Aging and Disability Resource Centers (ADRCs) in those communities.

The team solicits feedback regarding satisfaction with care, problem identification and suggestions for improving the service delivery system. Sunshine Health uses the feedback to identify barriers and interventions, both short-term and long- term, to ensure members are served adequately, equally and with the highest level of satisfaction.

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
- 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 or CWSP 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; 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 assault, medication error, member escape or elopement, or a member death that occurs while the 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 times 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% 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 those rates.

State Performance Measures

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

➢ See Monitoring Quality Outcomes

For Comprehensive members, the primary focus is the plan’s ability to provide timeliness of service, to maintain people safely in their home or in the community, and to transition recipients who wish to go home from an institutional setting to a community setting.

➢ See LTC Provider Timeliness

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 is sent to MMA, SMI Comprehensive and CWSP members. Learn more about the CAHPS® survey.

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

Sunshine Health uses the AHCA member satisfaction survey to determine the Comprehensive members' satisfaction with the LTC services. This survey assesses the members' satisfaction with their care manager and the LTC services they receive from their providers. The survey includes, but is not limited to, members' experiences in the following areas:

- LTC services received from providers
- Member care coordinator
- Member care 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 members' perception of those listed domains.

Provider Satisfaction Surveys

Recognizing that HEDIS and CAHPS® both focus on member experience with health care providers and health plans, Sunshine Health conducts two provider satisfaction surveys each year. One survey focuses on MMA, Comprehensive and CWSP providers, while the other focuses on LTC providers. Sunshine Health relies on these surveys to identify improvement areas pertaining to the provider network and develop interventions to improve provider communication, program structure and operational processes.

Providers are encouraged to complete the surveys.

MMA, Comprehensive and CWSP Provider Satisfaction Survey

The MMA, Comprehensive and CWSP provider satisfaction survey include, but is not limited to, assessment of the provider experience in the following areas:

-
- Health plan call center staff
- Network/coordination of care
- Overall satisfaction with Sunshine Health
- Pharmacy
- Provider relations
- Utilization management and case management

LTC Provider Satisfaction Survey

The LTC provider satisfaction survey includes, but is not limited to, assessment of the provider experience in the following areas:

- Authorization/claim processing
- Overall satisfaction
- Provider Relations Representatives

LTC Quality Facility Site Reviews

The quality improvement department performs site reviews of all contracted assisted living facilities and adult family care homes every two years or more often if the facility fails to receive a compliance score of at least 80%.

Quality improvement coordinators perform these regularly scheduled visits to determine compliance with environmental issues and regulations regarding member care and documentation. Coordinators also investigate complaints about assisted living facilities, adult family care homes and nursing homes and report any adverse results to the Sunshine Health credentialing department

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 use 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 (FWA)

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 uses code editing software to perform systematic audits during the claims payment process.

➢ See Chapter 15: 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 billing irregularity
- Termination of provider agreement or other contractual arrangements

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 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 of the Florida Public Entities crime Act.

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 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.

Health Care 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)
- Health Insurance Portability and Accountability 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. Training records 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 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.

Authority and Responsibility

Sunshine Health's senior vice president of compliance has the overall responsibility and authority to carry out the provisions of the compliance program – especially 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 the expense of Sunshine Health or the contractor/subcontractor.

Chapter 11: Provider Roles, Rights and Responsibilities

Responsibilities of All Sunshine Health Practitioners

Contracted practitioners are responsible for providing and managing healthcare 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 8: Member Complaints, Grievances and Appeals
  - See Cultural Competency
  - See Chapter 13: 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 15: 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 the necessary documentation or medical information.

  ➢ See Chapter 4: Utilization Management and Prior Authorization

- ***Provide continuity of care following provider termination*:** Providers who are terminating their affiliation with Sunshine Health have a responsibility to provide medically necessary care for members at least 60 days following their termination date for MMA, SMI and Comprehensive members and 90 days for CWSP members. Sunshine Health permits members to continue receiving medically necessary services from a non-for-cause terminated provider and continues to process provider claims at least for 60 days (90 days for CWSP) or until members select another provider.

  ➢ 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 at 1-800-962-2873 (TTY 1-800-453-5145) or online via the Florida Department of Children & Families website. Providers are also responsible for ensuring 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 call the National Domestic Violence Network hotline at 1-800-799-7233 or use the text and chat features at thehotline.org to seek 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 the 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 records, 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 illnesses
- 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 there is evidence of 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 and 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)

Additional PCP Responsibilities for CWSP Members

Sunshine Health has contracted with providers who are familiar with the unique needs of children who have been removed from their home. We have developed training that is specific to the unique needs and situations of these children. Trainings include: trauma informed care, trauma focused cognitive behavioral therapy, sexual health in foster care children, human trafficking and the Baker Act.

Due to the abuse or neglect and trauma that these children have experienced, PCPs are encouraged to complete specific assessments to assist in identifying issues that may need to be addressed, such as the PHQ-A for depression, Ohio Scales for Functioning and Problem Severity, and Child Report of Post Traumatic Symptoms (CROPS).

Sunshine Health has developed specific evidence-based clinical practice guidelines that address the prevalent conditions of these children, such as attention deficient disorders, depression and asthma.

Providers who treat CWSP members must complete training on: the behavioral health assessment tool; assessment instruments; techniques for identifying individuals with unmet behavioral health needs; evidence-based practices, the dependency system and trauma informed care.

As part of our credentialing process, providers who treat CWSP members must complete training on trauma informed care prior to their next recredentialing period.

Network PCPs who treat CWSP members also are responsible for the following:

- Physical health screening within 72 hours (or immediately, if required) for all enrolled

children and adolescents taken into protected custody, emergency shelter or the foster care program by the Department of Children and Families (DCF)
  - ➢ Screening does not require prior authorization.
- Behavioral health screening and treatment within the appropriate scope of practice with referrals for treatment to a network behavioral health practitioner, if appropriate
- Communication with behavioral health providers regarding initial and interim summary reports of a member's medical and behavioral health status
- Reports between PCP and behavioral health providers may be required more frequently if clinically indicated, directed by the Sunshine Health service management team or court-ordered
- Reports must include information required for dependency court judicial review of medical care under Florida law
- Providers may fax reports to the Sunshine Health Medical Management Department at 1-866-796-0526
- Follow EPSDT requirements. As children are screened, identify any special needs of the child and refer the child to the applicable specialty provider, including behavioral health, or needed therapies, equipment or ancillary services for covered services. If the child needs preventive or dental treatment, refer to the child's dental health plan.
- As children are evaluated, identify if the child could benefit from services offered through other programs, including Medicaid, such as PPEC or behavioral analysis services. Provide applicable medical records and certifications and coordinate the referral with the applicable agency, including a Medicaid agency.
- Refer members who may require additional education or support to care management for engagement in applicable programs
- Coordinate care with DCF and Community-Based Care (CBC) lead agencies (with special emphasis during transition periods when a child moves between custodians or placements) and:
  - o Assist in scheduling medical or behavioral health appointments as needed or requested by DCF or the CBC lead agency
  - o Provide periodic written updates on treatment status of members as required by DCF or the CBC lead agency
  - o Provide medical records to DCF or the CBC lead agency upon request
  - o Participate, when requested by DCF or the CBC lead agency, in planning to establish permanent homes for members
  - o Testify in court for child protection litigation as required by DCF
  - o Comply with DCF policy regarding medical consenter and release of confidential information
  - o Report suspected cases of abuse or neglect to DCF
  - o Participate in Sunshine Health's training activities regarding DCF/CBC lead agency coordination

PCPs treating CWSP members 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 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 Part 2, 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 why.

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.

Sunshine Health has developed a care management approach that is specifically structured to support the needs of children in foster care and their caregivers. The care management team is dedicated to our CWSP members. Through a Sunshine Health partnership, our care management team is supported by physical and behavioral health care coordinators located in every Community Based Care (CBC) agency across the state. These coordinators serve as a "bridge" communicating with the child's dependency care manager and their caregivers. This support assists Sunshine Health and our providers in helping the child access care and assists the caregivers in learning how to manage the care for that child.

The care management staff develop a unique person-centered care plan, based on the child's and caregivers' stated goals. The care management staff will contact providers to discuss the care plan and obtain feedback in the care plan development. For children with complex needs, an integrated care team meeting may be held. A provider may be asked to join that meeting. To request care management support for a CWSP member, call 1-844-477-8313.

For assistance with CWSP member issues, providers should call Provider Services at 1-844-477-8313 Monday through Friday from 8 a.m. to 8 p.m. Eastern.

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, 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 Monday through Friday from 8 a.m. to 8 p.m. Eastern.

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 Part 2, 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 Monday through Friday from 8 a.m. to 8 p.m. Eastern.

Identifying and Reporting Abuse or Neglect

Sunshine Health providers must 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 at 1-800-962-2873. It is the provider's responsibility to ensure that they and their 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 they have "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 law enforcement.

Identifying and Reporting Critical Events

Sunshine Health requires its providers and direct service providers to report adverse or critical incidents to the Health Plan. Sunshine Health requires its Home and Community Based Service (HCBS) providers — with the exception of 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 their 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 limitation of neurological, physical or sensory functions

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

Telemedicine

Telemedicine is defined as the practice of healthcare 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 can perform this 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 patient and 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 visit or 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.

During your standard visits or meetings with Provider Engagement staff, they will explain where to locate the Sunshine Health Telemedicine Attestation Form. We will review the importance of obtaining a member's consent prior to telehealth services being provided and share where Telehealth requirements and trainings can be located under our Sunshine Health Telemedicine page.

Responsibilities of Network Specialists

All network specialists are responsible for:

- Coordinating the member's care with the PCP
- Maintaining contact with the PCP
- Providing 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 the member to a 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 hospital 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 Provider Portal within two business days after the date of admission
- Obtain authorizations through Sunshine Health's Secure Provider 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

Participating Children's Hospitals with a multidisciplinary clinic will provide coordination of care in a multidisciplinary clinic for medically complex children with:

a. One or more chronic conditions that cumulatively affect three or more organ systems and severely reduces cognitive or physical functioning (such as the ability to eat, drink, or breathe independently) and that also requires the use of medication, durable medical

equipment, therapy, surgery, or other treatments, or
b. One life-limiting illness or rare pediatric disease (as defined in Section 529(a)(3) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 360ff(a)(3)).

Responsibilities of Long-Term Care Providers

General Requirements for All LTC Providers

In addition to the general responsibilities outlined for all Sunshine Health network providers, the LTC provider is responsible for supervising, coordinating and providing all authorized care to each assigned member. In addition, the provider is responsible for ensuring the receipt of an authorization for all services from the member's care coordinator, maintaining continuity of each member's care and maintaining the member's medical record, which includes documentation of all services provided by the provider as well as the member or responsible party's signature for receipt of covered services.

LTC providers also are required to maintain a facility that promotes member safety and ensure adequate staff coverage to maintain service delivery standards to members.

Additional Responsibilities for Home and Community-Based Providers

Assisted Living Facilities

Assisted living facilities are to support the member's community inclusion and integration by working with Sunshine Health's care manager and member to facilitate the member's personal goals and community activities.

Additionally, waiver members residing in assisted living facilities must be offered services with the following options unless medical, physical, or cognitive impairments restrict or limit the exercise of these options:

- Choice of the following:
  - Access to telephone and length of use
  - Eating schedule
  - Locking door to living unit
  - Private or semi-private rooms
  - Roommate for semi-private rooms
- Participation in facility and community activities
- Snacks as desired and the ability to prepare snacks
- The ability to maintain a personal sleep schedule
- Unlimited visitation, if desired

Adult Day Health Care (ADHC) Providers

Adult day health care (ADHC) providers shall conform to the home and community-based settings requirements required by AHCA. These providers are to support the member's community inclusion and integration by working with the care manager and member to facilitate the

member's personal goals and community activities.

Members shall be offered services with the following options unless medical, physical or cognitive impairments restrict or limit exercise of these options:

- Access to a telephone and unlimited length of use
- Scheduled activities and participation in facility and community activities
- Daily activities
- Eating schedule
- Freedom from coercion and restraint
- Opportunities to express oneself through individual initiative, autonomy and independence
- Physical environment
- People with whom they may interact

Covered LTC Services

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

- Adult companion
- Adult day/adult day health care services
- Adult day health care (ADHC)
- Assistive care services
- Assisted living
- Attendant care
- Behavioral management
- Caregiver training services
- Home accessibility adaptation services
- Home delivered meals
- Hospice
- Intermittent and skilled nursing
- Homemaker services
- Medical equipment and supplies
- Medication management/administration services
- Nutritional assessment/risk reduction services
- Nursing facility services
- Occupational therapy
- Personal care services
- Personal emergency response system (PERS)
- Physical therapy
- Respiratory therapy
- Respite care services
- Speech therapy
- Transportation to LTC-covered services

For an explanation of each covered service, providers may refer to the Statewide Medicaid Managed Care Long-Term Care Program Coverage Policy.

Failure to obtain authorization for services may result in payment denials.

Provider Incentives:

Sunshine Health offers providers options to receive incentive payments. These programs reward providers for engaging members in needed care, such as timely follow-up care after an inpatient behavioral health admission, or following evidenced-based guidelines for monitoring children and adolescents who are taking antipsychotic medications. Sunshine Health providers are automatically enrolled in these incentive programs and payment will be calculated based on claims of provided care.

For additional information about provider incentives, please contact your dedicated Provider Engagement Administrator or visit the Value-Based Incentive Programs webpage.

Chapter 12: Provider Administration

Provider Services and Supports

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

- Provider Engagement – This provider-facing department educates and trains providers about different products, processes and quality incentives. The department also conducts face-to-face visits with practitioners and facilities. Locate your Provider Engagement Administrator by using the Find Your Administrator tool.
- 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 by calling 1-844-477-8313 Monday through Friday from 8 a.m. to 8 p.m. Eastern to field provider concerns, troubleshoot 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. Those obligations are detailed in Sunshine Health's Provider Standards for Appointment Scheduling (PDF). Practitioners unable to offer an appointment within the time frames listed below should refer the member to Sunshine Health Member Services which can be reached by calling 1-866-796-0530 (TTY at 1-800-955-8770) Monday through Friday from 8 a.m. to 8 p.m. Eastern 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 via 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 Engagement 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 and 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 hours appointments after 5 p.m. on office days 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 members 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 to the PCP or an 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 time frames:

Appointment Type	Access Standard
Non-life-threatening emergency	Within six (6) hours, or direct member to crisis center or ER
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 ten (10) business days
Follow-up routine care	Within thirty (30) calendar days
Follow up after behavioral health hospital admission	Within seven (7) calendar days

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 members 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 to the provider or on-call practitioner within a maximum of thirty (30) minutes

Provider Office Standards

Sunshine Health requires all office spaces 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 must also clearly offer to provide, upon request, the address and toll-free telephone number of Sunshine Health's grievance department.

➢ See Chapter 8: 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 Engagement department facilitates provider education and helps increase HEDIS compliance rates for plan members.

Educational content includes, but is 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 trainings: live, instructor-led trainings, specialized webinars, and/or self-paced trainings through Relias Learning, an online learning management platform. The registration instructions for Relias Learning can be located by visiting our Provider Training web page. Providers with questions should email reliaslms@centene.com.

Initial Training

During initial training of all network providers, the Provider Engagement staff offers an overview of the enrollment and credentialing process, requirements of the contract with AHCA, 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 initial training, network providers are required to complete the following training sessions:

- Fraud, waste and abuse – Within the first 30 days of joining the network and annually thereafter
- Anti-kickback – Within the first 30 days of joining the network and 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 via webinar or a live training session, before being recredentialed

Clinical Training

Additional trainings are provided, upon request, to all providers and their staff regarding the requirements of their contract and special needs of MMA, LTC, SMI and CWSP 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 in real-time both in-person and via webinars.

Behavioral Health Clinical Training

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

Topics include behavior management strategies, suicide risk assessment, 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 in real-time, either in-person or via webinar.

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

➢ See Trauma-Informed Care

Training of Administrators and Staff at Assisted Living Facilities (ALF)

Training is offered to staff and administrators in assisted living facilities, which includes:

- Abuse, neglect, exploitation and incident reporting standards
- Behavior management strategies

- Documentation and reporting of behavior health concerns
- Identification of suicide risk and management
- Signs and symptoms of mental illness
- Trauma-informed care
- Verbal de-escalation strategies for aggressive behavior

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 or 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 provider, practice or group should contact its Provider Engagement Administrator or email SunshineProviderRelations@sunshinehealth.com. Providers can also call Sunshine Health Provider Services at 1-844-477-8313 Monday through Friday from 8 a.m. to 8 p.m. Eastern.

Behavioral health providers 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.

Marketing Activities by Providers

Sunshine Health's contract with AHCA determines how Sunshine Health and its providers present and advertise the program. AHCA requires providers to submit to Sunshine Health samples of any community outreach materials they intend to display or send to members, and to obtain state approval prior to distribution or display. Providers should send all these materials to Sunshine Health, which will submit the materials to AHCA within two business days of receipt and send providers written notice of approval or changes required by AHCA within two business days of receiving notice from AHCA.

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

Long-term care facilities also are permitted to provide materials in admission packets announcing all managed care plan contractual relationships.

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 or a CWSP member under the age of 18
- 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 and 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 prescribed and administered
- 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 their 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, the member's translation needs 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 its 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 Office of Minority Health (OMH) at the Department of Health and Human Services (HHS) as guidelines for providing culturally sensitive services.

Sunshine Health assists in the reduction of racial and ethnic health disparities by 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 who 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 thepractitioner 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 and/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 needs, 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.
- For non-urgent requests for a sign language or foreign language interpreter for a medical appointment, providers have two options:
  - Contact Provider Services to assist in arranging for this service through a locally
  - contracted vendor. Provider Services can be reached at 1-844-477- 8313, 8 a.m. to 8 p.m. Eastern, Monday through Friday.
  - OR
  - Complete and return the translation request form located under "Forms" of the Manuals, Forms and Resources page and email it to InterpreterRequests@centene.com
  - Please request interpreter services at least 5 days in advance.
- Live, in-person translation is preferred to telephonic translation in non-urgent cases. Telephonic services will only be used when an interpreter for the required language cannot be found in or near the particular area.

PCP Administration

PCP Access and Availability

Each PCP is responsible for maintaining 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. 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, they are 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 declares a specific capacity for their practice and wants to make a change to that capacity, the PCP must contact Sunshine Health Provider Services at 1-844-477-8313 Monday through Friday from 8 a.m. to 8 p.m. Eastern.

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 make 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 health care 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 their 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:

- 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 and 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

LTC Provider Administration

LTC Provider Access and Availability

Sunshine Health's goal of ensuring members receive service in a timely manner relies on providers' commitment to serve members in the areas identified in their Sunshine Health contracts. In addition, LTC providers are required to have a system for receiving calls after hours from members and Sunshine Health.

Several processes ensure Sunshine Health can maintain a sufficient number, mix and geographic distribution of providers to offer comprehensive services and benefits to meet members' clinical needs. The Provider Engagement and Quality Improvement departments analyze provider availability to make sure the network has sufficient facilities and service locations; and they monitor the network for sufficient types and distribution of LTC providers as well as appropriate staffing levels. Such providers include those who are accepting new Medicaid patients as specified in s. 1932(b)(5) of the Social Security Act, as enacted by s. 4707(a) of the Balanced Budget Act of 1997. Sunshine Health does not discriminate against providers who serve high-risk populations or specialize in conditions requiring costly treatments.

LTC Provider Accountability

Sunshine Health has implemented an electronic visit verification (EVV) system to monitor LTC provider visits for selected services. EVV monitors visits in real time and alerts providers when a visit is not initiated when scheduled. Providers then are responsible for fulfilling the visit within three hours of the original start time. EVV also captures missed services based on gaps between an authorization and a submitted claim.

Providers are required to call Sunshine Health's LTC Care Management at 1-866-796-0530 Monday through Friday from 8 a.m. to 8 p.m. Eastern and follow the prompts for providers if they are unable to provide service to a member or if they have any issues related to a member's care.

LTC Referrals

LTC providers are responsible for collaborating with a member's Sunshine Health comprehensive care coordinator to identify and authorize appropriate services. The care coordinator also coordinates with service providers to assure a thorough discharge planning process and transition case management.

The care coordinators also work in partnership with community agencies if a member requires services not covered by the Medicaid or LTC program. Sunshine Health care coordinators can provide community referral information and assistance with applying for available services and resources.

LTC Provider Timeliness

Sunshine Health attempts to authorize services before the effective date of a member's enrollment and identify an appropriate provider. Upon receipt of authorization, LTC providers are required to confirm staff availability promptly, but no later than, one business day.

This allows sufficient time for providers to initiate services as soon as, but not before, the member is enrolled. The service start date of the authorization begins on or after the effective date of enrollment.

If a member is transitioning to a new provider, the new provider is to initiate services within one calendar day, particularly if the member is at risk. Providers and Sunshine Health case management staff are to coordinate the transition to prevent service gaps and maintain member safety.

Sunshine Health collects data on service timeliness to members as a performance measure reported to AHCA and serves as one of the criteria for the LTC provider network.

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 years 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 local state 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 years.
- ***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 years 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 3 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 years 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 years 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 years.
- ***Medical Foster Care (MFC)*:** Florida Medical Foster Care (MFC) services enable children and youth under the age of 21 years with complex medical needs and who are in the custody of the Department of Children and Families (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 years 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 years 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 years 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 successfully completed.
- ***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 (VWD) 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 done via email, mail, fax, the Secure Provider Portal or by calling Provider Services. 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 by calling Provider Services at 1-844-477-8313 Monday through Friday from 8 a.m. to 8 p.m. Eastern.

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

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

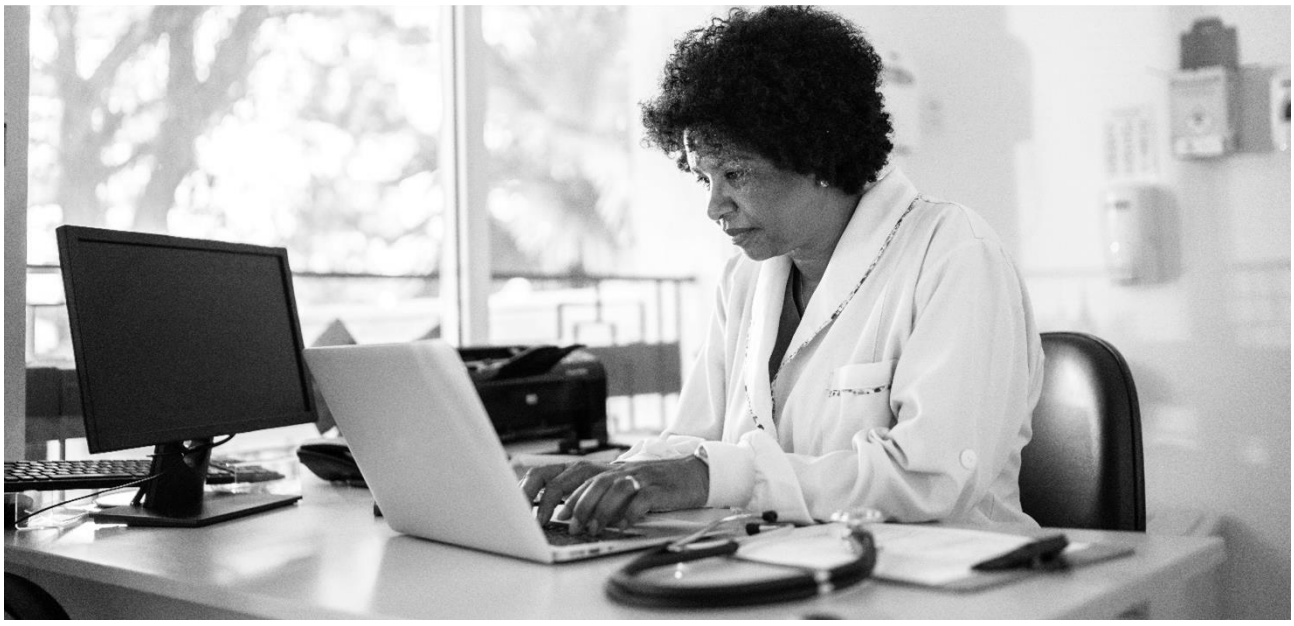
Providers must include the original claim number on the complaint and include any relevant supporting documentation.

- 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 13: Member Administration

Member Rights

As a recipient of Medicaid and a member in a Plan, members 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 health care
- Know if the provider or facility accepts the Medicare assignment rate
- 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 records and ask to have information added or corrected in their records, 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 those decisions themselves (advanced directive)
- File a grievance about any matter other than a Plan's decision about their services.
- 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

LTC Members have the right to:

- Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation
- Receive services in a home-like environment regardless where they live
- Receive information about being involved in their community, setting personal goals and how they can participate in that process
- Be told where, when and how to get the services they need
- To be able to take part in decisions about their health care
- To talk openly about the treatment options for their conditions, regardless of cost or benefit

Choose the programs they participate in and the providers that give them care

Member Responsibilities

As a recipient of Medicaid and a member in a Plan, members 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 to 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 questions
- 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 they do not follow the healthcare provider's instructions
- Make sure payment is made for non-covered services they receive
- Follow health care facility conduct rules and regulations
- Treat health care staff with respect
- Tell us if they have problems with any health care 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 utilize this plan if necessary for their safety
- Report fraud, abuse and overpayment

LTC Members have the responsibility to:

Tell their case manager if they want to disenroll from the Long Term Care program agree to and participate in the annual face-to-face assessment, quarterly face-to-face visits and monthly telephone contact with their case manager.

Advance Directives

PCPs and other practitioners who deliver care to Sunshine Health members must ensure adult members ages 18 years 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 they desire 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.

Sunshine Health has more information about advance directives available online 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 14: Pharmacy Program

Pharmacy Benefit

Sunshine Health covers prescription drugs and certain over-the-counter (OTC) drugs ordered by Sunshine Health 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, Sunshine Health 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 Sunshine Health.

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 drugs. 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 Sunshine Health Pre-Auth Check Tool.

Pharmacy Benefit Manager

Sunshine Health contracts with <Express Scripts> to administer the prescription drug benefit for Sunshine Health members. Centene Pharmacy Services performs prior authorization for certain prescription drugs subject to quantity limits (QL), age limits (AL), requirements 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. <Express Scripts> is the contracted pharmacy benefit management segment of the business and AcariaHealth is the specialty pharmacy arm of the business.

Pharmacy claims are processed by <Express Scripts>. Pharmacies may call the <Express Scripts> help desk at <1-833-750-4392>.

Sunshine Health performs the following functions:

- Benefit design consultation
- Prior Authorization
- Drug Utilization Review

<Express Scripts> is a PBM that performs the following functions:

- Benefit design consultation
- Claims processing
- Drug utilization review
- Pharmacy network management
- Mail order pharmacy services

AcariaHealth

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

Preferred Drug List

The Sunshine Health 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 Sunshine Health PDL may be found on the Pharmacy page our website. Sunshine Health may be less restrictive than Medicaid's PDL but not more restrictive.

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

Sunshine Health 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 via the Florida Department of Health.

Hemophilia Medications

For hemophilia factor-related drugs, Sunshine Health coordinates the care of its members using the agency's Comprehensive Hemophilia Disease Management Program.

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

Prenatal Vitamins Benefit

Sunshine Health members have an over-the-counter medication benefit that includes prenatal vitamins. Additionally, the Sunshine Health PDL covers some prenatal vitamins.

➢ See Chapter 5: Provider Requirements for Pregnant Members and Newborns

Prior Authorization Process for Medications

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

Most injectables require prior authorization. However, preferred self-injectable medications such as some insulin products, glucagon, epinephrine anaphylactic kits and 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 <1-833-546-1507>
- Call <1-866-399-0928, 8 a.m. to 9 p.m. Eastern, Monday through Friday if you have questions>

Sunshine Health responds by fax or phone within the contracted turnaround time. If more information is required, Sunshine Health 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 form on the Pharmacy page of our website 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 offer 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 us at 1-833-750-4392 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 Sunshine Health 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 age 21 years 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 a temporary supply is dispensed.

Psychotropic Medications

Providers should perform a comprehensive evaluation of a member that includes 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

Sunshine Health follows AHCA's PDL for psychotropic medications.

Providers should consider the role of non-pharmacological interventions before prescribing a psychotropic medication. The exception should be 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 MMA member under the age of 13 years or a CWSP member under the age of 18 years must be accompanied by the express written and informed consent of the member's parent or legal guardian.

➢ See Prescribing Psychotropic Medications for CWSP Members

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 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 15: 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 by 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 a 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 by using the 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 Provider Engagement or the practice's dedicated Provider Engagement Administrator 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-9 form

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.

- All W-9s should be e-mailed to Sunshine_Provider_Relations@sunshinehealth.com.
- W-9s should be sent to the health plan each time the payment address changes or annually, whichever comes first.

If Sunshine Health does not have the updated W-9 information, this could lead to a misdirection of payment.

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 but 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 Sunshine Health MMA, SMI, Comprehensive or CWSP patients have any other medical insurance, including Medicare, Veterans Administration and commercial insurance. If so, providers should submit the claim to that insurance as Medicaid 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.

If the needed service is covered by Medicare, the provider must first process the payment through the Medicare payer and follow applicable authorization rules. For covered Medicare services, the provider does not need to obtain an authorization form Sunshine Health. If a balance remains following the Medicare payment, the provider may submit the Medicare evidence of payment to Sunshine Health for consideration of additional payment under the member's Medicaid benefits with the appropriate additional authorization, if applicable.

If the needed service is a not a covered Medicare benefit or the benefit limit has been exhausted, the provider should follow Sunshine Health prior authorization requirements and applicable billing procedures. For benefits that have been exhausted, the provider must send the explanation of benefits (EOB) that specifies the benefit exhaustion.

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 atthe 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, Sunshine Health 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

Sunshine Health sends providers written notification via an explanation of benefits for each claim that is denied, including 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 Sunshine Health 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

Sunshine Health only reimburses services that are medically necessary and covered through Medicaid. Providers may not bill Medicaid recipients for covered services, also known as "balance billing," regardless of whether they believe the amount they were paid or will be paid by Sunshine Health is appropriate or sufficient. The Balance Billing FAQ (PDF) has more information about this practice and why balance billing is inappropriate and prohibited.

Verification Procedures

All claims filed with Sunshine Health 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 age, date of birth and gender 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 looks 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 left blank.
  - Interim Billing Requirements – The Plan requires that hospital providers billing first-time claims for interim inpatient stays that exceed 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 during which services were provided.
- Services were provided by a participating provider or, if provided by a non-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 UB-04 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. Errors or omissions in claims will 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, visit the Sunshine Health PaySpan – EFT/ERA web page.

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 will be denied. An EOP will 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 ANSI XS12N 837 professional, institutional or encounter transactions. 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 Electronic Transactions (EDI) department by calling 1-800-225-2573, ext. 8025525, 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, it then 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, Requests for Reconsideration/Claim Disputes

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 by using the Secure Provider Portal. 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:

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

The mailing address for first-time behavioral health claims:

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:

- Submit a corrected claim via the secure provider portal and follow instructions on the portal for submitting a corrected claim
- Submit 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 operations of the provider or damage or destruction of the provider's business office or records due to 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

Sunshine Health makes reasonable efforts to resolve claim disputes. If, following multiple requests, a provider continues to disagree with Sunshine Health'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 in 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 a 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 AHCA 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.

AHCA has 30 days to issue a final order based on recommendations made by Capitol Bridge.

Review Cost

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

Pursuant to Florida statutes, 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 receive their completed contract or submitted a claim.

More information is available on the Sunshine Health PaySpan – EFT/ERA web page.

Chapter 16: 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 are used to describe supplies, products and services that are not included in the CPT code descriptions (durable medical equipment (DME), orthotics and prosthetics, CWSP 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 along with the initial claim 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 codes 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 (CDC) 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 2 edits. The Column 1 procedure code is the most comprehensive code and reimbursement for the Column 2 code is subsumed into the payment for the comprehensive code. The Column 1 code is considered an integral component of the Column 2 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 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 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 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 on 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 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

In the NCCI policy manual, both CPT and CMS 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. The clinical nurse reviewer will recommend reimbursement for the E/M service if any one of the following conditions are met:

- 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 website 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 payor 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.