

Provider Manual



WELCOME TO SUNSHINE HEALTH

Healthy Kids Provider Manual

SunshineHealth is a managed care organization (MCO) contracted with the Florida Healthy Kids Corporation to serve the full pay Healthy Kids state-wide membership. Our number one priority is the promotion of healthy lifestyles through preventive healthcare. Sunshine Health works to accomplish this goal by partnering with the primary care providers (PCP) who oversee the healthcare of Sunshine Health's Healthy Kids members.

The Florida Healthy Kids Corporation (FHKC) was founded in 1990 by the State of Florida. It is a not-for-profit organization dedicated to providing low-cost health coverage for children ages five through eighteen. Its purpose is to improve the health of children who might otherwise go without medical care. Healthy Kids is one component of Florida's KidCare (SCHIP) program.

Centene Corporation® (Centene) provides managed care services to members in designated counties of Florida as Sunshine Health through different product offerings such as Medicaid, Child Welfare, Long Term Care, Medicare Advantage, Health Care Exchange, and the Healthy Kids program. Centene and its wholly owned health plans have a long and successful track record offering Medicaid, government sponsored programs and managed care services. For more than 20 years, Centene has provided comprehensive managed care services through these various programs and currently operates health plans in a number of states, including Georgia, Indiana, Ohio, Massachusetts, South Carolina, Texas, Mississippi, Wisconsin, and others. Sunshine Health serves our Florida members consistent with our core philosophy that quality healthcare is best delivered locally. Sunshine Health is a physician-driven organization that is committed to building collaborative partnerships with providers.

Sunshine Health has been designed to achieve the following goals:

- Ensure access to primary and preventive care services
- Ensure care is delivered in the best setting to achieve an optimal outcome
- Improve access to all necessary healthcare services
- Encourage quality, continuity and appropriateness of medical care
- Provide medical coverage in a cost-effective manner by supporting the primary care office as the member's medical home

At Sunshine Health, we strive to provide our members with improved health status and outcomes. We strive to improve member and provider satisfaction in a managed care environment.

All of our programs, policies, and procedures are designed with these goals in mind. We hope that you will assist Sunshine Health in reaching these goals and look forward to your active participation.

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Important Information

SUNSHINE HEALTH GUIDING PRINCIPLES

The Sunshine Health structure has been built to support these guiding principles:

- High quality, accessible, cost-effective member healthcare.
- Integrity, operating at the highest ethical standards.
- Mutual respect and trust in our working relationships.
- Communication that is open, consistent, and two-way.
- Diversity of people, cultures, and ideas.
- Innovation and encouragement to challenge the status quo.
- Teamwork and meeting our commitments to one another.

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

SUNSHINE HEALTH APPROACH

Recognizing that a strong health plan is predicated on building mutually satisfactory associations with providers, Sunshine Health is committed to:

- Working as partners with participating providers.
- Demonstrating that healthcare is a local issue.
- Performing its administrative responsibilities in a superior fashion.

All of Sunshine Health's programs, policies, and procedures are designed to minimize the administrative responsibilities in the management of care, enabling the provider to focus on the healthcare needs of his or her patients, our members.

SUNSHINE HEALTH SUMMARY

Sunshine Health's philosophy for Florida Healthy Kids members is to provide access to high quality, culturally sensitive healthcare services by combining the talents of PCPs and specialty providers with a highly successful, experienced managed care administrator, all working in collaboration with the member's parent or guardian. Sunshine Health believes that successful managed care is the delivery of appropriate, medically necessary services, rendered in the appropriate setting -- not the elimination of such services.

It is the policy of Sunshine Health to conduct its business affairs in accordance with the standards and rules of ethical business conduct and to abide by all applicable federal and state laws.

Sunshine Health takes the privacy and confidentiality of our members' health information seriously. We have processes, policies, and procedures to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and state privacy law requirements. If you have any questions about Sunshine Health's privacy practices, please contact our Privacy Officer at **1-844-477-8313** or our anonymous and confidential hotline at **1-866-685-8664**.

IVR SYSTEM

Our Interactive Voice Response (IVR) system is designed to make our great provider service even better. What's great about the IVR system?

- It's free and easy to use
- Provides you with greater access to information, including eligibility and claims status
- Available 24 hours, seven days a week
- Is easily accessible and ready to be utilized by calling **1-844-477-8313**

WEBSITE

By visiting www.sunshinehealth.com you can find information on:

- Our Online Provider Directory
- Preferred Drug List
- List of Prior Authorization Services
- Preventive and Clinical Practice Guidelines
- Quality Improvement Activities and HEDIS
- Frequently Used Forms
- EDI Companion Guides
- Billing Manual
- Provider Office Manual
- Submit Claims Online
- Managing EFT

Sunshine Health also offers our contracted providers and their office staff the opportunity to register for our secure provider website in just **three easy steps**. Here, we offer tools that make obtaining and sharing information easy! **Through the secure site you can:**

- View and print member eligibility
- Check claim status
- Submit claims
- Request and view prior-authorizations
- Contact us securely and confidentially

We are continually updating our website with the latest news and information, so save www.sunshinehealth.com to your favorites, and check our site often.

The benefit coverage details are presented in the following Summary of Benefits and Exclusions. Please note that there are associated copayments due for certain services. However, there are no co-pays for Primary Care and Gynecology well visits in order to promote access to medical care for our Sunshine Health Stars members.

SUNSHINE HEALTH STARS SUMMARY OF BENEFITS AND EXCLUSIONS

Summary of Benefits

The following describes the benefits available to Sunshine Health Stars members.

The summary also gives information on any out of pocket expenses, including copayments, coinsurance amounts, and deductible amounts. These are the amounts that members must pay for specific services.

The description of out-of-pocket expenses is provided below:

Benefit year – Means the twelve-month period following the initial enrollment date in Sunshine Health Stars.

Copayment – Means the payment required of the member at the time of obtaining the services.

Co-Insurance – Means a member's share of the cost of a covered health service, calculated as a percent of the allowed amount for the service. Co-Insurance is in addition to Deductibles and Copayments but is subject to an out of pocket maximum.

Deductible – Means the annual amount a member pays for covered health services before Sunshine Health starts to pay.

- The Medical Deductible includes the charges for covered inpatient stays (for medical, mental health or substance abuse), maternity services and newborn care, skilled nursing facility stays, any service in outpatient facilities (including physician charges for Emergency Department visits), durable medical equipment and prosthetic devices and specialty drugs provided in the doctor's office or in your home.
- The Pharmacy Deductible includes all preferred brand and non-preferred drugs provided at a retail pharmacy. It also includes specialty drugs provided from the specialty pharmacy vendor.

The annual period is the same as the benefit year and begins the first month that the member is enrolled in Sunshine Health Stars.

Out of Pocket Maximum – Means the amount of expenses for covered health benefits that the parent or legal guardian of the member must pay before Sunshine Health begins to pay for any health benefits. The Out of Pocket Maximum also includes any Copayments, Coinsurance, or annual Medical Deductible or Pharmacy Deductible amounts that are the member's responsibility. Once the Out of Pocket Maximum amount for each member is reached in a benefit year, no additional copayments will apply during that benefit year.

Deductibles

The annual Medical and Pharmacy Deductibles are described below:

Type of Deductible	Amount
Medical	\$3,000 per member
Pharmacy	\$1,500 per member

Maximum Out of Pocket Expenses

The annual Maximum out of Pocket expenses are described below:

Type of Deductible	Amount
Medical	\$4,250 per child
Pharmacy	\$2,350 per child

Hospital Services

Medical Admissions: Admissions to a licensed inpatient facility for a medical or surgical reason or for maternity care are covered.

Mental Health Admissions: Admissions to a licensed mental health or a substance abuse facility for mental or nervous disorders or substance abuse for drug and alcohol abuse are covered. Coverage for mental and nervous disorders are those conditions listed in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association.

Sunshine Health must prior authorize any hospital stay unless it is an emergency. Inpatient services after the emergency situation has stabilized must be approved by Sunshine Health. Sunshine Health may request that the member be transferred to a participating hospital when the member's condition has stabilized.

Covered Hospital Services include:

- Physician services, psychiatric evaluations, licensed mental health or addiction professional services, and medically necessary services of other health professionals, including the services needed to evaluate or stabilize an emergency medical condition.
- Room and board limited to semi-private rooms, unless a private room is medically necessary or a semi-private room is not available, and patient meals.
- General nursing care.
- Private duty nursing is limited to situations where this level of care is medically necessary.
- Nursery charges and initial pediatric or neonatal examination, including circumcisions.
- Use of anesthesia, operating room and related facilities, intensive care unit and services, and labor and delivery room and services.
- Laboratory, pathology, radiology, and other diagnostic tests.
- Chemotherapy, occupational therapy, physical therapy, radiation therapy, respiratory therapy, and speech therapy.

- Organ transplants for non-experimental transplants including, bone marrow, cornea, heart, intestinal/ multivisceral, kidney, liver, lung, and pancreas.
- Drugs, medications, biologicals, and oxygen services.
- Administration of whole blood plasma.

Limitations include:

- Except for an emergency admission, all admissions must be to a Sunshine Health participating facility.
- Sunshine Health review of the hospital admission shall determine the approved length of stay based on the medical necessity of the admission and appropriate level of care.
- The infant born to a Sunshine Health member is covered for up to three days following birth or until the infant is transferred to another medical facility, whichever occurs first.
- Admissions for rehabilitation and physical therapy are limited to 21 days per benefit year.
- Admission to a Statewide Inpatient Psychiatric Program (SIPP), which is a 24-hour inpatient residential treatment program that provides mental health services to Medicaid recipients under the age of 21 are not covered.
- An admission for any experimental or investigational biological product, device, drug, procedure, organ transplant or treatment is not covered.

The Copayment or Coinsurance amounts for Hospital Services are:

Services	Amount
Hospital Services, including medical, mental health, substance abuse, organ transplant services, maternity services, and newborn care	25% Coinsurance after the Medical Deductible has been met

Skilled Nursing Facility Services

Sunshine Health covers services in a Skilled Nursing Facility for those members who need rehabilitation services after they are discharged from a hospital. A member may also be sent directly to a Skilled Nursing Facility, if medically necessary. Skilled Nursing Facility services must be prior authorized by Sunshine Health.

Covered Skilled Nursing Facility services include:

- Physician services.
- Room and board limited to semi-private rooms, unless a private room is medically necessary or a semi-private room is not available, and patient meals.
- General nursing care.
- Rehabilitation services, drugs and biologicals, medical supplies, and the use of appliances and equipment that is furnished by the Skilled Nursing Facility.

Limitations include:

- Skilled Nursing Facility stays are limited to 100 calendar days per benefit year.
- Admissions to a Skilled Nursing Facility for rehabilitation and physical therapy are limited to 15 calendar days per benefit year.
- Services provided in specialized treatment centers and independent kidney disease treatment centers are not covered.
- Private duty nurses, television, and custodial care are not covered.

The Copayment or Coinsurance amounts for Skilled Nursing Facility services are:

Service	Amount
Covered Skilled Nursing Facility services	25% Coinsurance after the Medical Deductible has been met

Emergency Room Visits

Coverage for emergency room visits is determined under the prudent layperson standard, which is defined as: A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of an individual (or, with respect to a pregnant woman, the health of the woman or the unborn child) in serious jeopardy, serious impairments to bodily functions, or serious dysfunction of any bodily organ or part.

- Emergency room services do not need to be provided by a Sunshine Health participating hospital.
- Emergency room services are covered if the member is traveling out of the Sunshine Health service area.
- If the member is admitted from the emergency room, the emergency room visit copayment is waived.

The Copayments for Emergency Room visits (applied to the facility charges) are:

Service	Amount
Emergency room visit	\$100 per visit

Ambulance services

Ambulance services are covered when using a specially equipped vehicle used only for transporting a member (by ground, air or water) who is sick or injured to the nearest hospital able to treat the condition, between hospitals, and between hospitals and skilled nursing facilities. Ambulance services are not covered for transportation for routine healthcare services.

The Copayments for ambulance transportation services are described below:

Service	Amount
Ambulance transportation	\$10 Copayment per trip

Urgent Care Visits

Urgent care means the level of care that is required within a 24-hour period to prevent a condition from requiring emergency care.

Urgent care centers provide access to medical treatment when a Sunshine Health member is sick or injured during hours when their primary care provider (PCP) is not available. Physicians and other health professionals at urgent care centers evaluate and treat urgent conditions.

Visits to a Sunshine Health participating urgent care center are covered. Visits to an urgent care center when the member is outside the Sunshine Health service area are covered. Routine care outside the Sunshine Health service area is not covered. No services are covered out of the continental United States of America.

The Copayments for visits to an urgent care center are:

Service	Amount
Urgent care visit	\$40 per visit

Doctor Visits

Sunshine Health provides coverage for primary care providers and specialists. The description of what is covered and any limitations are outlined in this section.

Primary Care Provider (PCP) Services

Covered preventive and sick visits and other PCP services include:

- Routine physical exams
- Well-child checkups
- Sick visits
- Hearing, vision, autism and developmental screenings
- Covered diagnostic tests in the office
- Allergy injections in the office
- Immunizations
- Consultations in the hospital or nursing home

The Copayments for PCP visits are:

Service	Amount
PCP well visits	\$0 per visit
PCP sick visits	\$25 per visit

Note: Copayments do not apply to consultations or visits in the hospital. If an allergy injection is done with an office visit, the Copayment above applies. If allergy injections, immunizations, or diagnostic tests are done without a PCP office visit, there is no Copayment.

Preventive Health Services

Preventive health services are regular health checkups that are designed to catch problems before they start. We cover all items or services recommended by the United States Preventive Services Task Force (USPSTF) as a Grade A or B, the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC), and the Health Resources and Services Administration (HRSA). We also cover the services in the schedule of wellness visits for infants, children and adolescents recommended by the American Academy of Pediatrics (AAP).

Specialist Visits

Sunshine Health has many participating specialists that can care for our members. We encourage members to discuss the need for a specialist visit before an appointment is scheduled. The member's PCP can assist in identifying if the care of a specialist is needed (and the correct type of specialist) and can communicate with that specialist.

Covered specialists services include:

- Office visit
- Pre-transplant, transplant, and post discharge services and treatment for covered transplants
- Covered diagnostic tests performed in the office
- Allergy serum
- Allergy injections in the office
- Splints or casts applied in the office
- Consultation in the hospital or nursing home
- Outpatient surgery

Limitations include:

- Chiropractic visits are limited to 26 visits per benefit year, and are part of a combined outpatient limit of 35 visits for cardiac rehabilitation and occupational, physical, speech and massage therapies and spinal manipulations per benefit year.
- Podiatry visits are limited to 1 visit per day, totaling 2 visits per month for specific foot disorders.
- Oral surgeon services are limited to the medically necessary reconstructive dental surgery as a result of an injury sustained while a Sunshine Health Stars member.

The Copayments for Specialist visits are:

Service	Amount
Specialist visits	\$40 per visit

Note: Copayments do not apply to consultations or visits in the hospital. If an allergy injection is done during an office visit, the Copayment above applies. If allergy injections are done without a specialist office visit, there is no Copayment.

Obstetricians and Gynecologists

Sunshine Health has many participating obstetricians and gynecologists that can care for our members. A referral is not needed from the PCP to see a participating obstetrician or gynecologist. The PCP should know that the member is seeing an obstetrician or gynecologist so the PCP can coordinate the care.

Covered obstetrician and gynecologist services include:

- Annual gynecological exam (well woman)
- Breast exam
- Maternity care for pregnancy (prenatal and postpartum visits)
- Mammogram
- Family planning and counseling services
- Other office visits for gynecological conditions
- Covered diagnostic tests performed in the office
- Outpatient surgery
- Hospital consultations or visits

Limitations include:

- Abortions are covered in the following situations:
 - If the pregnancy is the result of an act of rape or incest, or
 - When a physician has found that the abortion is necessary to save the life of the mother.

The Copayments for Obstetrician or Gynecologist services provided in the office are:

Service	Amount
Gynecology well visits	\$0 per visit
Gynecology sick visits	\$25 per visit
Obstetrical maternity visits (prenatal and postpartum)	\$0 per visit

Note:

- For maternity and newborn care provided in the hospital, a 25% Coinsurance (after the Medical Deductible is met) applies.
- There is no Copayment for other obstetrician or gynecologist consultations or visits in the hospital, or for outpatient surgery performed by an obstetrician or gynecologist.

Outpatient Mental Health and Substance Abuse Outpatient Services

Sunshine Health has many participating mental health and substance abuse providers who can care for our members. Coverage for mental and nervous disorders includes those conditions listed in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association.

A referral is not needed from the member's PCP to see a participating mental health or substance abuse provider. The PCP should know that the member is seeing a mental health or substance abuse provider so the PCP can coordinate the care.

Different types of outpatient mental health and substance abuse services are covered based on the needs of the member. Please note that some of these mental health and substance abuse services do require a prior authorization by Sunshine Health.

Covered mental health and substance abuse outpatient services include:

- Outpatient office visit
- Intensive outpatient session
- Partial hospitalization session
- Psychological or psychiatric evaluation
- Psychological and neuropsychological testing
- Residential services
- Group psychotherapy session
- Medication checks

Limitations include:

- Applied behavioral analysis (ABA) is not covered.
- Behavioral health day services are not covered.
- Behavioral health overlay services are not covered.
- Electroconvulsive therapy (ECT) is not covered.
- Psychosocial rehabilitation services are not covered.
- Targeted case management services are not covered.
- Therapeutic behavioral onsite services are not covered.
- Therapeutic group care services are not covered.
- Specialized therapeutic foster care services are not covered.

The Copayments for Outpatient Mental Health and Substance Abuse Services are:

Service	Amount
Mental Health Visit	\$25 per
Substance Abuse Visit	\$25 per

Telemedicine

Sunshine Health provides coverage for services provided through telemedicine, when appropriate, to the same extent the services would be covered if provided through a face-to-face (in person) service with a provider. Telemedicine can include pediatric primary care, urgent care, specialty care, child psychiatry, and other behavioral health visits available on a smartphone, tablet, or laptop. Please contact the Provider Call Center at 1-844-477-8313 (TDD/TTY 1-800-955-8770) for additional information on accessing these services.

Outpatient Services

Outpatient services are those done in a hospital outpatient clinic or facility, a freestanding ambulatory surgical center, or a freestanding diagnostic center. These include services provided by a physician in an Emergency Department. Please note that some of these outpatient services do require a prior authorization from Sunshine Health.

Services that are covered under outpatient services include:

- Cardiac studies:
 - o EKG
 - o Cardiac stress tests
- Imaging studies:
 - o Advanced imaging services, such as MRIs, CT scans, and PET scans
 - o Nuclear Medicine
 - o Sonograms
 - o Ultrasounds
 - o X-rays
- Genetic testing
- Laboratory tests
- Other diagnostic tests
- Medical therapy services:
 - o Chemotherapy
 - o Dialysis
 - o Radiation therapy
- Specialty drugs administered in an outpatient setting that were not dispensed by a pharmacy
- Outpatient surgery

Limitations:

There is a combined outpatient limit of 35 visits for cardiac rehabilitation and occupational, physical, speech and massage therapies and spinal manipulations per benefit year.

The Copayment and Coinsurance for Outpatient Services are:

Service	Amount
Outpatient Services	25% Coinsurance after the Medical Deductible has been met

Therapy Services

Sunshine Health covers therapies in a hospital outpatient clinic or facility, freestanding therapy facility, in the home, or an office setting. Therapies are covered for short-term rehabilitation when significant improvement in the member's condition will result. Habilitative therapy services (including, but not limited to, speech and occupational therapy) are also covered, if medically necessary, to achieve age-appropriate development. The coverage of habilitative services includes members with Autism Spectrum Disorders. Therapies provided in the home require a prior authorization by Sunshine Health.

Covered therapy services include:

- Occupational therapy
- Physical therapy
- Respiratory therapy
- Speech therapy

Limitations:

- Therapy services provided in schools or daycare centers are not covered.

The Copayments for therapies are:

Service	Amount
Therapy visits	\$40 per visit

Home Health Services

Sunshine Health covers home health nursing services in the member's home. Home Health Services require a prior authorization by Sunshine Health.

Covered home health services include:

- Skilled nursing care by a registered nurse or licensed practical nurse. Skilled nursing services include wound care and the administration of intravenous (IV) medications.
- Services that are on a part-time intermittent basis.
- Private duty nursing, if medically necessary.

Limitations include:

- Meals are not covered.
- Housekeeping services are not covered.
- Personal care services are not covered.
- Personal comfort items are not covered.
- Home health aide services are not covered.

The Copayments for Home Health Services are:

Service	Amount
Home Health visits	\$25 per visit

Hospice Services

Hospice services are those palliative medical care and services to help meet the physical, social, mental health, emotional, and spiritual needs of terminally ill members and their families. Hospice care focuses on these support services instead of treatments for the terminal illness. Hospice services can be provided in the member's home or in a hospital facility. If hospice services are provided in a hospital facility, the hospital related Copayments and Coinsurance amounts apply.

Services to treat conditions that are not related to the terminal condition are covered as outlined in this Benefits section.

The Copayments for Hospice Services are:

Service	Sunshine Health Stars
Hospice visits	\$40 per visit

Durable Medical Equipment and Prosthetic Devices

Sunshine Health covers Durable Medical Equipment and Prosthetic Devices. These services may require prior authorization by Sunshine Health.

Durable Medical Equipment is any item that is medically necessary and prescribed by a Sunshine Health physician. Durable Medical Equipment is equipment that can stand repeated use, is used to serve a medical purpose, and is not useful to a person if they did not have an illness or injury. Not all items considered Durable

Medical Equipment are covered by Sunshine Health.

Prosthetic devices are custom-made artificial limbs or other assistive devices for people who have lost limbs as a result of traumatic injuries, vascular disease, diabetes, cancer or congenital disorders.

Examples of covered Durable Medical Equipment include:

- Catheters
- Dressings and gauze for wounds
- Drug infusion supplies
- Enteral formulas
- Glucose monitors and testing strips
- Hospital beds and mattresses
- Infusion pumps
- Slings and splints
- Wheelchairs

Prosthetic devices include:

- Artificial eyes
- Artificial limbs
- Braces
- Other artificial aids

Limitations include:

- Telescopic lenses are not covered
- Hearing aids are covered only when medically necessary to assist in the treatment of a medical condition.
- Cochlear implants are not covered.
- Diabetic supplies are covered under the pharmacy benefit.

Copayments and Coinsurance for Durable Medical Equipment and Prosthetic Devices is:

Service	Amount
Durable Medical Equipment and Prosthetic Devices	25% Coinsurance after the Medical Deductible has been met

Vision Exams and Corrective Glasses

Sunshine Health covers routine eye examinations by a participating optometrist or ophthalmologist to determine the need for corrective lenses.

The Vision benefits include:

- A routine eye exam once in a benefit year
- One pair of corrective lenses and frames or contact lenses every benefit year. The frames must be selected from the Sunshine Health standard frames options. If the member's head size or prescription changes for which an additional pair of corrective lenses and frames, or new contact lens prescription is needed, an additional pair of corrective lenses and frames or contact lenses can be covered.
- Prescription lenses and frames or contact lenses, including the fitting and adjustment, are also covered for a diagnosis of Aniseikonia, Aniridia, Anisometropia, Aphakia, Cataract, Corneal Disorders, Irregular Astigmatism, Keratoconus, Pathological Myopia, Post-traumatic Disorders, and Low Vision Services.
- Lenses include choice of glass or plastic lenses, all lens powers (single vision, bifocal, trifocal, lenticular), fashion and gradient tinting, ultraviolet protective coating, oversized and glass-grey #3 prescription sunglass lenses, and scratch resistant coating.
- Polycarbonate lenses are covered in full for children, monocular patients and patients with prescriptions $\geq \pm 6.00$ diopters.

Limitations include:

- Any additional cost for lens options or frames that are not a Sunshine Health standard frame are not covered.
- Vision therapy (orthoptics and pleoptics) are not covered.
- Non-prescription lenses are not covered.
- Orthoptics, vision training, subnormal vision aids, and radial keratotomy are not covered.
- Photochromatic (transition) lenses and progressive lenses are not covered.
- Procedures related to providing eyeglasses that are performed in a custodial care facility or a recipient's home are not covered.
- Replacement of lost, stolen, or broken or damaged lenses or frames, or contact lenses, are not covered.

Copayments for vision services are:

Service	Amount
Vision exam	\$5 Copayment
Corrective lenses	\$10 Copayment

Drugs

Sunshine Health covers drugs that are included in the Sunshine Health drug formulary. Sunshine Health has many participating community retail pharmacies where a member can get his or her drugs filled. Diabetic supplies and some over the counter drugs, such as vitamins and pain relievers, are covered under Sunshine Health's drug formulary. These drugs are only covered if a physician or dentist prescribes the over the counter drug. Sunshine Health Stars members must present the prescription at the retail pharmacy for the over the counter drug to be covered.

In addition to drugs that members can get at a retail pharmacy, Sunshine Health covers specialty or injectable drugs that can be provided in your office or in the member's home. This does not include immunizations provided in the PCP's office.

Some specialty drugs can be sent to the member's home. If the member needs to have drugs administered intravenously (IV) in the home by a nurse, covered drugs can be administered by a participating home care agency, if medically necessary.

Copays and deductibles paid for specialty drugs that are dispensed through a pharmacy will be applied towards the pharmacy deductible and the pharmacy maximum out of pocket cost. Copays and deductibles paid for specialty drugs that are dispensed through a physician's office or other non-pharmacy outpatient setting will be applied towards the medical deductible and the medical maximum out of pocket cost.

If the member's Healthy Kids dentist prescribes a drug, the member can take the prescription to a participating retail pharmacy. The Sunshine Health formulary will be used to determine the coverage of the prescribed drug.

Formulary limitations include:

- Drugs considered investigational or experimental are not covered.
- Sunshine Health has prior authorization requirements for some drugs. For those drugs, payment will be made only if the drug was prior authorized.
- Some drugs may require that the member tries one or more drugs before certain drugs are approved by Sunshine Health. This is called step therapy.
- A maximum of a 31-day supply can be given at one time.
- Other quantity limits for specific drugs may also apply.
- When a generic drug is available, the brand-name drug will not be covered without prior authorization. If you or the member's dentist feels a brand-name drug is medically necessary, you or the member's dentist can ask for a prior authorization.

The details on the covered drugs, specialty drugs that require a prior authorization or step therapy, and those with any quantity limits are provided in the Sunshine Health formulary, located at www.sunshinehealth.com. Click on For Providers, then Pharmacy, then Healthy Kids.

The Copayments or Coinsurance for Drugs are:

Service	Amount
Drugs	\$5 Copay for generic drug
	\$25 copay for preferred brand drug, after Pharmacy Deductible has been met
	\$50 Copay for non-preferred brand drug, after Pharmacy Deductible has been met
	25% coinsurance for a Specialty drug after Pharmacy Deductible has been met

Other Limitations or Exclusions

Alternative medicine services are not covered. This includes, but is not limited to, acupuncture and acupressure, aromatherapy, aversion therapy, ayurvedic medicine, bioenergetic therapy, carbon dioxide therapy, confrontation therapy, crystal healing therapy, cult deprogramming, electric aversion therapy for alcoholism, expressive therapies such as art or psychodrama, guided imagery, herbal medicine, homeopathy, hyperbaric therapy, massage therapy, nacrotherapy, naturopathy, orthomolecular therapy, primal therapy, relaxation therapy, transcendental meditation and yoga, and equestrian therapy.

Assisted Fertilization is not covered. This includes artificial conception processes, such as but not limited to, GIFT, ZIFT, embryo transplants, and in vitro fertilization.

Behavioral Health Services not covered include:

- Behavioral health or substance abuse services not expected to result in demonstrable improvement in the member's condition and/or level of function and chronic maintenance therapy, except in the case of serious and persistent mental illness or disorders.
- Services related to intellectual disability, pervasive development disorder, or autism that extends beyond traditional medical management.
- Long-term residential treatment services.
- Marriage or family counseling, except when provided in connection with services provided for a treatable mental disorder.
- Methadone maintenance and administration for the treatment of chemical dependency.
- Psychiatric or psychological and neuro-psychological testing for: learning disabilities or problems, school-related issues, purposes of obtaining or maintaining employment, purposes of submitting a disability application for a mental or emotional condition, and any other testing that does not require administration by a licensed behavioral health professional.
- Psychoanalysis or other therapies that are not short-term or crisis-oriented and do not relate to treatable and defined mental disorders according to the most recent version of DSM.
- Sensitivity training.

- Treatment for personality disorders as the primary diagnosis, learning disabilities, or behavioral health problems for those conditions.
- Treatment of organic disorders, including but not limited to, organic brain disease.
- Treatment of chronic behavioral health conditions once the member has been restored to the pre-crisis level of function. Coverage is provided until the behavioral health condition is stable with no chance of improvement.
- Treatment by chronic pain management programs or any related services under the behavioral health benefit when the primary diagnosis is pain.
- Treatment of stress, co-dependency, sexual addiction, and sedative action electrostimulation therapy.
- Treatment for truancy or disciplinary problems without a behavioral health diagnosis.
- Twelve step model program as sole therapy for problems, including, but not limited to eating disorders or addictive gambling.
- Vagus nerve stimulation for the treatment of depressive disorders.

Comfort or Convenience Items are not covered. This includes but is not limited to air conditioning, air purifiers, beauty salon services, dehumidifiers, exercise equipment, telephones, televisions, home or automobile modifications, or whirlpools.

Corrective Appliances are not covered. This includes corrective appliances for athletic purposes or corrective shoes, arch supports, back braces, special clothing or bandages, shoe inserts, or orthopedic shoes. Shoe inserts and orthopedic shoes are only covered for members with diabetes.

Cosmetic Surgery or Other Cosmetic Procedures are not covered. Cosmetic surgery or procedures to repair or reshape a body structure for the improvement of the member's appearance or for psychological or emotional reasons, including removal of birth marks, scar revisions, removal of tattoos, augmentation procedures or reduction procedures (including male gynecomastia), rhinoplasty, or otoplasty are not covered.

Court Ordered services are not covered. If the court ordered service is not a covered benefit or a covered benefit but not medically necessary, that court ordered service is not covered.

Dental Services are not covered. Dental services are provided through Florida Healthy Kids, not Sunshine Health.

Drugs. Experimental and investigational drugs, Drug Efficacy Study Implementation (DESI) drugs, factor replacement for Hemophilia A and Hemophilia B (except for emergency stabilization, during a covered inpatient stay, or when needed before a surgical procedure is performed), any hemostatic agents used in the treatment of Hemophilia A and Hemophilia B, Exondys 51, Spinraza, weight loss drugs, infertility drugs, anabolic steroids, blood or blood plasma, drugs used for cosmetic purposes including hair growth, impotency drugs are not covered. There is no coverage for lost or stolen drugs, or prescriptions that are dispensed after one year.

Durable Medical Equipment. Only the Durable Medical Equipment items listed as covered by Sunshine Health will be covered. Incontinence supplies are not covered.

Experimental and Investigational Procedures are not covered. These are those drugs, biological products, devices, medical treatments or procedures that meet any one of the following as defined by Sunshine Health. **Reliable evidence shows the drug, biological product, device, medical treatment, or procedure when applied to the needs of the member is:**

- Subject to ongoing phase I, II or III clinical trials, or
- Under study with a written protocol to determine maximum tolerated dose, toxicity, safety, efficacy, or efficacy in comparison to conventional alternatives, or
- Being delivered or should be delivered subject to the approval and supervision of an Institutional Review Board (IRB) as required and defined by federal regulations, particularly those of the U.S. Food and Drug Administration or the Department of Health and Human Services.

Forms. Charges for completion of any specialized report, forms including but not limited to school or athletic forms and copying medical records are not covered.

Medically Necessary or Medical Necessity. The provision of covered services must meet the following conditions:

- Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain;
- Be individualized, specific and consistent with symptoms, or confirm diagnosis of the illness or injury under treatment and not in excess of the member's needs;
- Be consistent with the generally accepted professional medical standards as determined by Sunshine Health and not be experimental or investigational;
- Be reflective of the level of service that can be furnished safely and for which no equally effective and more conservative or less costly treatment is available statewide, and
- Be furnished in a manner not primarily intended for the convenience of the member, the member's parent, legal guardian or caregiver, or the provider.

For those services in a hospital or an inpatient setting, medical necessity means that appropriate medical care cannot be effectively furnished more economically on an outpatient basis or in an inpatient facility of a different type.

The fact that a provider has prescribed, recommended, or approved medical, allied, or long-term care goods or services does not, in itself, make such care, goods, or services medically necessary, a medical necessity, or a covered service or benefit.

Nutritional Supplements. Blenderized food, baby food, regular shelf food, infant formulas, food, food supplements, special medical foods, other nutritional and over-the-counter electrolyte supplements are not covered.

Physical Examinations. A physical examination or evaluation or any mental health or chemical dependency evaluation requested to meet a requirement of a third party, including but not limited to requirements for employers, camp, school, sports activity, driver's license or other insurance purposes are not covered.

Private Duty Nursing. Private duty nursing is covered when medically necessary for skilled registered nurse or skilled license practical nurse services only, up to a limit of 16 hours per day.

Services Related to Motor Vehicle Accidents or Workers Compensation. The cost of any covered service that is a result of a motor vehicle accident, as applicable under law, or accident or injury at work that is covered by workers compensation is not covered. Sunshine Health may ask for information that verifies the status of coverage under an applicable motor vehicle insurance policy or workers compensation prior to paying for any services which may appear to be related to a motor vehicle accident or injury at work.

Transplants or Organ Donation. Experimental or investigational transplants are not covered. Services required by a member related to organ transplants for the evaluation, actual transplant and post-transplant care including related drugs are covered. Costs associated with the organ donor are not covered. No payment will be made for human organs that are sold rather than donated.

Other Services not covered.

The following services are not covered:

- Care for conditions that federal, state, or local law require to be treated in a public facility or services furnished by any level of government, unless coverage is required by law.
- Circumcision after birth, unless medically necessary.
- Non-emergency services provided by a provider who is not participating with Sunshine Health unless prior authorized before the services were provided.
- Oral surgery services related to the correction of an occlusal defect or orthognathic or prognathic surgical procedures.
- Services provided before the member's effective date or after the date of termination from Sunshine Health, unless the member is in an inpatient facility on the date of termination. Sunshine Health will continue to cover that inpatient admission until discharge.
- Services provided by a provider who is a member of the member's immediate family. This includes the member's parents, siblings, stepchildren, current or former spouse or domiciliary partner, mother-in-law, father-in-law, sister-in-law, brother-in-law, or grandparent.
- Services for which the member would have no legal obligation to pay.
- Services that were submitted by two different professional providers who provided the same services on the same date for the same member (except individual and group therapy for mental health or substance abuse services).
- Sex reassignment services and procedures.
- Sterilization procedures and reversal of sterilization procedures and related services.
- Surgery to correct the following vision problems: myopia, hyperopia, astigmatism and radial keratotomy.
- Surrogate motherhood services and supplies, including those required for prenatal care and postpartum care for the member acting as the surrogate mother.
- Routine transportation.
- Weight reduction programs, including related diagnostic testing and other services, bariatric surgery, anti-obesity drugs

Nonpayment of Copayments, Deductibles, and Co-insurance amounts. If the Copayments, Deductibles, and Co-insurance amounts are not fully paid, a notice from Sunshine Health will be sent to the member's parent or legal guardian. The notice will inform that Sunshine Health is not responsible to pay for non-emergency or non-urgent care until those Copayments, Deductibles, and Co-insurance amounts are fully paid.

Provider Responsibilities

PRIMARY CARE PROVIDER

The primary care provider (PCP) is the cornerstone of Sunshine Health. The PCP serves as the “medical home” for the member. All members are assigned a PCP upon initial enrollment; however, the member may change his or her PCP as frequently as he or she desires. The “medical home” concept assists in establishing a member- provider relationship, supports continuity of care, leads to elimination of redundant services and ultimately more cost effective care and better health outcomes. Establishment of a medical home is particularly important for the child population. Adopting healthy habits and establishing a relationship with a primary care provider can be learned life-long behaviors for our Sunshine Health Stars members.

The PCP is required to adhere to the responsibilities outlined below.

COVERED SERVICES

The PCP is responsible for supervising, coordinating, and providing all primary care to each assigned member. In addition, the PCP is responsible for coordinating and/or initiating referrals for specialty care (both in and out of network), maintaining continuity of each member’s healthcare, and maintaining the member’s medical record, which includes documentation of all services provided by the PCP as well as any specialty services, including an initial assessment for behavioral health. The PCP shall arrange for other participating physicians to provide members with covered physician services as stipulated in their contract. Each participating PCP provides 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.

PCP AVAILABILITY

Availability is defined as the extent to which Sunshine Health contracts with the appropriate type and number of PCPs necessary to meet the needs of its members within defined geographical areas. Sunshine Health has implemented several processes to monitor its network for sufficient types and distribution of PCPs.

PCP availability is analyzed annually by the Quality Improvement (QI) Department. At least annually, the QI department computes the percentage of PCPs with panels open for new members versus those PCPs accepting only members who are already-existing patients in their practice. The QI Department analyzes member surveys and member complaint data to address state Healthy Kids requirements regarding the cultural, ethnic, racial, and linguistic needs of the membership. The QI Department tracks and trends member and provider complaints quarterly and monitors other data (such as appointment availability audits, after hours use of the member hotline, and member and provider satisfaction surveys) that may indicate the need to increase network capacity.

Summary information is reported to the Quality Improvement Committee (QIC) for review and recommendation and is incorporated into Sunshine Health’s annual assessment of quality improvement activities. The QIC will review the information for opportunities for improvement.

PCP ACCESSIBILITY

Accessibility is the extent to which a patient can obtain available services at the time they are needed. This refers to both telephone access and ease of scheduling an appointment, if applicable. Sunshine Health monitors access to services by performing access audits, tracking applicable results of the satisfaction survey, analyzing member complaints regarding access, and reviewing telephone access.

24-HOUR ACCESS

Each PCP is responsible for maintaining sufficient facilities and personnel to provide covered physician 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 PCP for a clinical decision. The after-hours coverage must be accessible using the medical office's daytime telephone number. The PCP or covering medical professional must return the call within 30 minutes of the initial contact.

Sunshine Health will monitor physicians' offices through phone calls.

PCP COVERAGE

The PCP shall arrange for coverage with a physician who has executed a Primary Care Physician Services Agreement with Sunshine Health. If the participating physician is capitated for primary care services, compensation for the covering physician is considered to be included in the capitation payment. If the participating physician is paid a fee-for-service by Sunshine Health, the covering physician is compensated in accordance with the fee schedule in his/her agreement.

APPOINTMENT ACCESS STANDARDS

The following schedule should be followed regarding appointment availability:

- **Emergency care** – immediately
- **Urgent care** – within 24 hours
- **Routine care** (not for emergency or urgent care) – within seven calendar days of the member's request for services
- **Routine physical exams** – within four weeks of the member's request for services
- **Follow-up care** – based on provider recommendations
- **Post hospital care** – within seven calendar days of discharge from the hospital

Sunshine Health will monitor appointment and after-hours availability on an on-going basis through its QI program.

TELEPHONE ARRANGEMENTS

Providers are required to develop and use telephone protocol for all of the following situations:

- Answering the member's telephone inquiries on a timely basis;
 - Response time for telephone call-back waiting times; same day for non-symptomatic concerns.
- Prioritizing appointments.
- Scheduling a series of appointments and follow-up appointments as needed by a member.
- Identifying and rescheduling broken and no-show appointments.
- Identifying special member needs while scheduling an appointment (e.g., wheelchair and interpretive linguistic needs, or for non-compliant individuals or those people with cognitive impairments).
- Scheduling continuous availability and accessibility of professional, allied, and supportive personnel to provide covered services within normal working hours; protocols shall be in place to provide coverage in the event of a provider's absence.
- 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.

Note: If after-hour urgent care or emergent care is needed, the PCP or his/her designee should contact the urgent care center or emergency department in order to notify the facility. Notification is not required prior to member receiving urgent or emergent care.

Sunshine Health will monitor appointment and after-hours availability on an on-going basis through its QI program.

REFERRALS

It is Sunshine Health's preference that the PCP coordinates healthcare services. However, members are allowed to self-refer for certain services (see below). PCPs are encouraged to refer a member when medically necessary care is needed that is beyond the scope of the PCP. Those referrals which require authorization by the plan are listed below under prior authorization. For out of network referrals see information described herein. A provider is also required to notify Sunshine Health promptly when they are rendering prenatal care to a Sunshine Health Healthy Kids member. All teen pregnant members are considered high risk and assigned to a Sunshine Health Start Smart for Your Baby care manager.

PCPs do not need to issue a paper referral for specialty services. However, PCPs must ensure communication with all specialty providers to discuss ongoing and follow-up care. There are some services that require Prior Authorization, which can be found on the Sunshine Health website located at www.sunshinehealth.com under the Provider Resources section.

Requests for services that require Sunshine Health's prior authorization after normal business hours can be made through Envolve PeopleCare™, our 24/7 Nurse Line. Envolve PeopleCare™ may be reached through Sunshine Health's telephone number.

To verify whether an authorization is necessary or to obtain a prior authorization, call:

Medical Management/Authorization Department Phone 1-844-477-8313

Medical Prior Authorization Fax (844) 418-7298

Mental Health and Substance Abuse Fax Authorization (866) 694-3649

www.sunshinehealth.com

SELF-REFERRALS

The following services do not require PCP authorization or referral:

- Prescription drugs, including certain prescribed over-the-counter drugs.
- Emergency services, including emergency ambulance transportation.
- OB services, including those of a Certified Nurse Midwife (CNM).
- GYN services, including those of a Certified Nurse Midwife (CNM).
- Women's health services provided by a Federally Qualified Health Center (FQHC) or certified Nurse Practitioner (CNP).
- Initial visit for mental health and chemical dependency/substance abuse services.
- Family Planning Services and supplies from a qualified family planning provider.
- Routine eye care.
- Dental care (through the Healthy Kids dental program).

Except for emergency services, the above services must be obtained through network providers or prior authorized out-of-network providers.

MEMBER PANEL CAPACITY

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 set number of members.

If a PCP does declare a specific capacity for his/her practice and wants to make a change to that capacity, the PCP must contact the Sunshine Health Provider Services Department at 1-844-477-8313. A PCP shall not refuse to treat members as long as the physician has not reached his or her requested panel size.

Providers shall notify Sunshine Health at least 45 days in advance of their inability to accept additional Healthy Kids 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-Healthy Kids members.

PROVIDER TERMINATION

Providers should refer to their Sunshine Health contract for specific information about terminating from Sunshine Health.

OTHER PCP RESPONSIBILITIES

The following are additional PCP responsibilities:

- Educate members on how to maintain healthy lifestyles and prevent serious illness.
- Provide culturally competent care.
- Maintain confidentiality of medical information.
- 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 to state, federal, local, and Sunshine Health clinical guidelines, Healthy Kids requirements, and any applicable public health requirements.
- Collect applicable copayments, coinsurance, and deductible amounts from the member.
- Refrain from balance billing the member for amounts not related to copayments, coinsurance, and deductible amounts, which are the member's financial responsibility.
- Report immediately knowledge or reasonable suspicion of abuse, neglect, or exploitation of a child, aged person, or disabled adult to the Florida Abuse Hotline on the statewide toll-free telephone number (1-800-96ABUSE). Ensure that staff mandated to report abuse, neglect, and exploitation have received appropriate training in reporting abuse, neglect, and exploitation.
- Participate in any other training as mandated by regulatory authorities and/or Sunshine Health.
- Follow Sunshine Health's medical record documentation policy.
- Follow Sunshine Health's QI and UM program.

Sunshine Health providers should refer to their contract for complete information regarding their PCP obligations and reimbursement.

SPECIALIST RESPONSIBILITIES

Selected specialty services require a formal referral from the PCP. The specialist may order diagnostic tests without PCP involvement by following Sunshine Health's referral guidelines. The specialist must abide by the prior authorization requirements when prescribing medications, ordering diagnostic tests, ordering therapies, home care, durable medical equipment, surgical procedures, or other services which require a prior authorization.

However, the specialist may not refer to other specialists or admit to the hospital without the approval of a PCP, except in a true emergency situation. All non-emergency inpatient admissions require prior authorization from Sunshine Health.

The specialist provider must:

- Maintain contact with the PCP.
- Obtain referral or authorization from the member's PCP and/or Sunshine Health's Utilization Management Department as needed before providing services.
- Coordinate the member's care with the PCP.
- Provide the PCP with consult reports and other appropriate records within five business days of seeing the member.

- Be available for or provide on-call coverage through another source 24 hours a day for management of member care.
- Maintain the confidentiality of medical information.
- Collect applicable copayments, coinsurance and deductible amounts from the member.
- Not balance bill the member for amounts not related to copayments, coinsurance and deductible amounts, which are the member's financial responsibility.
- Report immediately knowledge or reasonable suspicion of abuse, neglect, or exploitation of a child, aged person, or disabled adult to the Florida Abuse Hotline on the statewide toll-free telephone number (1-800-96ABUSE).
- Ensure that staff mandated to report abuse, neglect and exploitation have received appropriate training in reporting abuse, neglect and exploitation.
- Participate in any other training as mandated by regulatory authorities and/or Sunshine Health.
- Follow Sunshine Health's medical record documentation policy.
- Follow Sunshine Health's QI and UM program.

Sunshine Health providers should refer to their contract for complete information regarding providers' obligations and mode of reimbursement.

HOSPITAL RESPONSIBILITIES

Sunshine Health utilizes a network of hospitals to provide services to Sunshine Health members.

Hospitals must:

- Cooperate and comply with Sunshine Health's policies and procedures.
- Notify the PCP immediately or no later than the close of the next business day after the member's appearance in the Emergency Department.
- Obtain authorizations for all inpatient and selected outpatient services as listed on the current Prior Authorization list, except for emergency stabilization services.
- Notify Sunshine Health's Utilization Management Department of all maternity admits upon admission and all other admissions by close of the next business day.
- Notify Sunshine Health's Utilization Management Department of all newborn deliveries on the same day as the delivery.
- Assist Sunshine Health with identifying members at high risk for readmission and with coordination of discharge planning.
- Support a consistent effort to effectively communicate to Sunshine Health the clinical status of members to assist with the discharge planning.
- Provide the health plan's utilization management staff access to the hospital's electronic medical record system when applicable.

- Report immediately knowledge or reasonable suspicion of abuse, neglect, or exploitation of a child, aged person, or disabled adult to the Florida Abuse Hotline on the statewide toll-free telephone number (1-800-96ABUSE). Ensure that staff mandated to report abuse, neglect, and exploitation have received appropriate training in reporting abuse, neglect and exploitation.
- Participate in any other training as mandated by regulatory authorities and/or Sunshine Health.
- Sunshine Health's hospitals should refer to their contract for complete information regarding the hospitals' obligations and reimbursement.

ADVANCE DIRECTIVES

Sunshine Health is committed to ensure that its members know of, and are able to avail themselves of, their rights to execute advance directives. Sunshine Health is equally committed to ensuring that its providers and staff are aware of and comply with their responsibilities under federal and state law regarding advance directives.

PROVIDER ASSISTANCE WITH PUBLIC HEALTH SERVICES

Sunshine Health is required to coordinate with public health entities regarding the provision of public health services. **Providers must:**

- Comply with public health reporting requirements regarding communicable diseases and/or diseases which are preventable by immunization as defined by state law.
- Assist in the notification or referral of any communicable disease outbreaks involving members to the local public health entity, as defined by state law.
- Refer to the local public health entity for tuberculosis contact investigation, evaluation, and the preventive treatment of persons with whom the member has come into contact.
- Refer members to the local public health entity for STD/HIV contact investigation, evaluation, and preventive treatment of persons whom the member has come into contact.
- Provide all women of childbearing age HIV counseling and offer them HIV testing at the initial prenatal care visit and again at 28 to 32 weeks. All women who are infected with HIV are counseled about and offered the latest antiretroviral regimen.
- Screen all pregnant members for the Hepatitis B surface antigen and ensure that infants born to HBsAg-positive members receive Hepatitis B Immune Globulin and Hepatitis B vaccine once they are stable, and ongoing testing for HBsAg.
- Assist in the coordination and follow-up of suspected or confirmed cases of childhood lead exposure.
- Assist in the collection and verification of race/ethnicity and primary language data.

Cultural Competency

CULTURAL COMPETENCY OVERVIEW

Cultural competency within the Sunshine Health Network is defined as “the willingness and ability of a system to value the importance of culture in the delivery of services to all segments of the population. It is the use of a systems perspective which values differences and is responsive to diversity at all levels in an organization.

Cultural competency is developmental, community focused, and family oriented. In particular, it is the promotion of quality services to understand, racial/ethnic groups through the valuing of differences and integration of cultural attitudes, beliefs and practices into diagnostic and treatment methods and throughout the system to support the delivery of culturally relevant and competent care. It is also the development and continued promotion of skills and practices important in clinical practice, cross-cultural interactions, and systems practices among providers and staff to ensure that services are delivered in a culturally competent manner.”

Sunshine Health is committed to the development, strengthening, and sustaining of healthy provider/member relationships. Members are entitled to dignified, appropriate, and quality care. When healthcare services are delivered without regard for cultural differences, members are at risk for sub-optimal care. Members may be unable or unwilling to communicate their healthcare needs in an insensitive environment, reducing effectiveness of the entire healthcare process.

Sunshine Health, as part of its credentialing and site visit process, will evaluate the cultural competency level of its network providers and provide access to training and tool kits to assist providers in developing culturally competent and culturally proficient practices.

Network providers must ensure the following:

- Members understand that they have access to medical interpreters, signers, and TDD/TTY services to facilitate communication without cost to them. Family and friend interpreters should be discouraged and permitted only if the member expresses this preference after being advised that interpreters will be provided free of charge to the member.
- Care is provided with consideration of the members' race/ethnicity and language and its impact/influence on the members' health or illness.
- Office staff that routinely come in contact with members have access to and participate in cultural competency training and development.
- Office staff responsible for data collection make reasonable attempts to collect race and language specific member information. Staff will also explain race/ethnicity categories to the member's parent or legal guardian so that they are able to identify the race/ethnicity of their child/children.
- Treatment plans are developed and clinical guidelines are followed with consideration of the member's race, country of origin, native language, social class, religion, mental or physical abilities, heritage, acculturation, age, gender, sexual orientation, and other characteristics that may result in a different perspective or decision-making process.
- Office sites have posted and printed materials in English, Spanish, and all other prevalent non-English languages.

NEED FOR CULTURALLY COMPETENT SERVICES

The Institute of Medicine report entitled “Unequal Treatment” along with numerous research projects reveal that when accessing the healthcare system, people of color are treated differently. Research also indicates that a person has better health outcomes when he or she experiences culturally appropriate interactions with medical providers. The path to developing cultural competency begins with self-awareness and ends with the realization and acceptance that the goal of cultural competency is an ongoing process. Providers should note that the experience of a member begins at the front door. **Failure to use culturally competent and linguistically competent practices could result in the following:**

- Feelings of being insulted or treated rudely
- Reluctance and fear of making future contact with the office
- Confusion and misunderstanding
- Non-compliance
- Feelings of being uncared for, looked down on and devalued
- Parents resisting to seek help for their children
- Unfilled prescriptions and missed appointments
- Misdiagnosis due to lack of information sharing
- Wasted time
- Increased grievances or complaints

PREPARING CULTURAL COMPETENCY DEVELOPMENT

The road to developing a culturally competent practice begins with the recognition and acceptance of the value of meeting the needs of your patients. Sunshine Health is committed to helping you reach this goal. **Take into consideration the following as you provide care to the Sunshine Health’s Healthy Kids membership:**

- What are your own cultural values and identity?
- How do or can cultural differences impact your relationship with your patients?
- How much do you know about your patient’s culture and language?
- Does your understanding of culture take into consideration values, communication styles, spirituality, language ability, literacy, and family definitions?
- Do you embrace differences as allies in your patients’ healing process?

Facts about Health Disparities

- Persons with lower income and less education face many barriers to receiving timely care.
- Households headed by Hispanics are more likely to report difficulty in obtaining care.
- Many minorities are more likely to experience long wait times to see healthcare providers.
- African Americans experience longer waits in emergency departments and are more likely to leave without being seen.
- Many racial and ethnic minorities of lower socioeconomic position are less likely to receive timely prenatal care, more likely to have low birth weight babies, and have higher infant and maternal mortality.
- Low-income minority children are less likely to receive childhood immunizations.
- Patient race, ethnicity, and socioeconomic status are important indicators of the effectiveness of healthcare.

***The complete Sunshine Health Cultural Competency Plan can be viewed at www.sunshinehealth.com.

Medical Records

MEDICAL RECORDS

Sunshine Health providers must keep accurate and complete medical records. Such records will enable providers to render the highest quality healthcare service to members. They will also enable Sunshine Health to review the quality and appropriateness of the services rendered. To ensure the member's privacy, medical records should be kept in a secure location. Sunshine Health requires providers to maintain all records for members for at least 13 years (for minors). See the Member Rights section of this manual for policies on member access to medical records.

REQUIRED INFORMATION

Medical records mean the complete, comprehensive member records including, but not limited to, x-rays, laboratory tests, results, examinations and notes, and consultation summaries, accessible at the site of the member's participating primary care physician or provider, that document all medical services received by the member, including inpatient, ambulatory, ancillary, and emergency care, prepared in accordance with all applicable Healthy Kids rules and regulations, and signed by the medical professional rendering the services. Medical records are audited every two years for PCP providers and results may be reported to Healthy Kids.

If the member is over the age of 18, all records must contain documentation that the member was provided written information concerning the member's rights regarding advance directives (written instructions for living will or power of attorney) where age appropriate and whether or not the member has executed an advance directive. Providers shall not, as a condition of treatment, require the member to execute or waive an advance directive.

Providers must maintain complete medical records for members, including a prominent notation of any spoken language translation or communication assistance in accordance with the following standards:

- Member's name and/or medical record number are/is present on all chart pages.
- Personal/biographical data is present (i.e. home telephone number, parent or legal guardian, primary language, etc.).
- All entries must be legible and maintained in detail.
- All entries must be dated and signed, or dictated by the provider rendering the care.
- Significant illnesses and/or medical conditions are documented on the problem list and all past and current diagnoses.
- Medication, allergies, and adverse reactions are prominently documented in a uniform location in the medical record; if no known allergies, NKA or NKDA are documented.
- An up-to-date immunization record is established for pediatric members.
- Evidence that preventive screening and services are offered in accordance with Sunshine Health's clinical practice guidelines.

- Appropriate subjective and objective information pertinent to the member's presenting complaints is documented in the member's history and physical record.
- Past medical history (for members seen three or more times) is easily identified and includes any serious accidents, operations and/or illnesses, discharge summaries, and emergency room visits; past medical history relating to prenatal care, birth, any operations and/or childhood illnesses.
- Working diagnosis is consistent with findings.
- Treatment plan is appropriate for diagnosis.
- Documented treatment prescribed, therapy prescribed, and drug administered or dispensed including instructions to the member.
- Documentation of prenatal risk assessment for pregnant women is present.
- Required consent forms are signed and dated.
- Unresolved problems from previous visits are addressed in subsequent visits.
- Laboratory and other studies ordered as appropriate.
- Abnormal lab and imaging study results have explicit notations in the record for follow up plans; all entries should be initialed by the PCP to signify review.
- Referrals to specialists and ancillary providers are documented including follow up of outcomes and summaries of treatment rendered elsewhere including family planning services, preventive services, and services for the treatment of sexually transmitted diseases.
- Health teaching and/or counseling is documented.
- For members 10 years and over, appropriate notations concerning use of tobacco, alcohol and substance use (for members seen three or more times substance abuse history should be queried) are present.
- Documentation of failure to keep an appointment is present.
- Encounter forms or notes have a notation, when indicated, regarding follow-up care calls or visits. The specific time of return should be noted as weeks, months or as needed.
- Evidence that the member is not placed at inappropriate risk by a diagnostic or therapeutic problem is present.
- Confidentiality of member information and records are protected.
- Evidence that an advance directive has been offered to adults 18 years of age and older is present.
- Pre-birth selection form is present.

MEDICAL RECORDS RELEASE

All member medical records shall be confidential and shall not be released without the written authorization of the member's parent or guardian, or if member is considered an adult, the member. When the release of medical records is appropriate, the extent of that release should be based upon medical necessity or on a need to know basis.

Written authorization is required for the transmission of the medical record information of a current or former Sunshine Health Stars member to any physician not connected with Sunshine Health.

Sunshine Health providers may not charge members for copies of their medical records. In addition, providers may not charge Sunshine Health or any contracted vendor for copies of medical records requested by a Utilization Management, Quality Improvement or other Sunshine Health department.

MEDICAL RECORDS TRANSFER FOR NEW MEMBERS

All PCPs are required to document in the member's medical record attempts to obtain historical medical records for all newly assigned Sunshine Health Stars members. If the member's parent or legal guardian is unable to remember where they obtained medical care, or they are unable to provide addresses of the previous providers then this should also be noted in the medical record.

MEDICAL RECORDS AUDITS

Medical records may be audited to determine compliance with Sunshine Health's standards for documentation and regulations. Audits are performed by the Sunshine Health Quality Improvement Department. The coordination of care and services provided to members, including over/under utilization of specialists, as well as the outcome of such services also may be assessed during a medical record audit.

Overview and Medical Necessity

OVERVIEW AND MEDICAL NECESSITY

The Sunshine Health Utilization Management Department hours of operation are Monday through Friday (excluding holidays) from 8:00 a.m. to 7:00 p.m. The list of services that require a prior authorization is available at www.sunshinehealth.com, under the Provider Resources tab.

Providers may submit requests for a prior authorization using multiple methods:

- Medical Request- Complete the Healthy Kids outpatient request fax form and fax to **1-844-418-7298**
- Complete through the Sunshine Health website **www.sunshinehealth.com**
- Call Sunshine Health at **1-844-477-8313** during normal business hours
- Behavioral Health and Substance Abuse- Complete the Healthy kids outpatient request form and fax to **1-866-694-3649**

Utilization management staff member will process the request using standard Sunshine Health criteria to determine medical necessity. If the applicable criteria is not met, the request is referred to a Sunshine Health medical director for review and determination.

Medically Necessary or Medical Necessity.

The provision of covered services must meet the following conditions:

- Be necessary to protect life, to prevent significant illness or significant disability or to alleviate severe pain;
- Be individualized, specific and consistent with symptoms or confirm diagnosis of the illness or injury under treatment and not in excess of the member's needs;
- Be consistent with the generally accepted professional medical standards as determined by Sunshine Health, and not be experimental or investigational;
- Be reflective of the level of service that can be furnished safely and for which no equally effective and more conservative or less costly treatment is available statewide, and
- Be furnished in a manner not primarily intended for the convenience of the member, the member's parent, legal guardian or caregiver, or the provider.

For those services in a hospital or an inpatient setting, medical necessity means that appropriate medical care cannot be effectively furnished more economically on an outpatient basis or in an inpatient facility of a different type.

The fact that a provider has prescribed, recommended, or approved medical, allied, or long-term care goods or services does not, in itself, make such care, goods, or services medically necessary, a medical necessity, or a covered service or benefit.

Information necessary for authorization of covered services may include, but is not limited to:

- Member's name and Sunshine Health ID number.
- Physician's name and telephone number.
- Facility name, if the request is for an inpatient admission or outpatient facility services.
- Service type requested.
- Provider location if the request is for an ambulatory or office procedure.
- Reason for the authorization request – primary and secondary diagnoses, planned surgical procedures, and surgery date.
- Relevant clinical information – proposed treatment plan, past treatment plan and outcome, results of relevant diagnostic studies, results of medication treatments, if applicable, special member conditions or need, and past surgical procedures, to support the appropriateness and level of service proposed.
- Admission date or proposed surgery date, if the request is for a surgical procedure.
- Requested length of stay, if the request is for an inpatient admission.
- Discharge plans.
- For obstetrical admissions, the date and method of delivery, estimated date of confinement, and information related to the newborn or neonate.

If additional clinical information is required, a Sunshine Health nurse or other utilization management staff will notify the requestor of the specific information needed to complete the authorization process.

Sunshine Health affirms that Utilization Management decision making is based only on appropriateness of care and service and the existence of coverage. Sunshine Health does not specifically reward practitioners or other individuals for issuing denials of service or care. Sunshine Health's utilization management program is not structured to provide incentives to deny, limit, or discontinue medically necessary services to any member.

Failure to obtain authorization for services that require Sunshine Health prior approval may result in payment denials. The requesting provider should notify the member or, if under age 18, the member's parent or legal guardian of an approved service.

VENDOR RELATIONSHIPS

Sunshine Health has contracted with certain specialty vendors. Please contact these vendors directly to obtain Prior Authorization and network information:

National Imaging Associates (NIA) - NIA provides utilization services for non-emergent advanced, high tech imaging services rendered to Sunshine Health members. There are two ways to obtain Prior Authorization from NIA: either through NIA's web site at **www.RadMD.com** or by calling 1-877-807-2363.

Envolve Vision of Florida - Provides utilization management services for Optometry and Ophthalmology care, including eye wear for Sunshine Health members. For specific individual member benefits and eligibility, log into their "Eye Health Manager" provider portal at **visionbenefits.envolvehealth.com/logon.aspx** or call Envolve Vision's Customer Relations at 1-888-282-6284. For authorization requests, contact the Utilization Management Department at **1-800-465-6972** and a Clinical Reviewer will assist you.

PRIOR AUTHORIZATION

Inpatient

1. All non-emergent, non-urgent elective or scheduled inpatient admissions except for normal newborn deliveries require the physician office to call Sunshine Health's utilization management department for plan approval at least 10 business days before the proposed admission date and the hospital to call within two business days of the actual date of admission.
 - This requirement includes admission to any level of acute or sub-acute care, behavioral health or substance abuse unit, skilled nursing facilities, rehabilitation admissions, transplant services including evaluation, pre and post-transplant services and all other inpatient facility type admissions. This requirement also includes transition of care between different levels of care within or between facilities (i.e. transfer from acute hospital to a skilled nursing facility or transfer to a different facility).
2. All emergent or urgent inpatient admissions require the hospital to notify Sunshine Health's utilization management department within two business days after the date of admission. Newborn deliveries must be called in by the next business day. Clinical admission information must be provided.
3. All observation admissions require the hospital to notify Sunshine Health's utilization management department within the first 48 hours following an observation admission. Clinical admission information must be provided.
4. Sunshine Health's utilization management department should be notified of an admission as soon as possible for any non-participating, out-of-network, out of state facility, vendor or provider (following stabilization of emergency care).

With the exception of normal deliveries, Sunshine Health requires thorough ongoing clinical updates throughout every admission to determine continued medical necessity and level of care. Sunshine Health will apply InterQual decision support criteria.

Prior authorization is required for certain services/procedures/diagnostic tests that frequently are over or underutilized, that are costly services, or which may be considered a cosmetic procedure. Some surgical or interventional procedures performed in outpatient or ambulatory surgical settings require prior authorization. For the most recent version of services requiring prior authorizations, please visit the web, or contact your Provider Relations Representative.

In accordance with Section 329 of the Public Health Services Act or in the case of a community health center funded under Section 330 of the Public Health Services Act, other services may be provided without a prior authorization:

- Diagnosis and treatment of sexually transmitted diseases and other communicable diseases, such as tuberculosis and human immunodeficiency syndrome.
- The provision of immunizations.
- Family planning services and related pharmaceuticals.
- School health services as above.
- County health department for the cost of administration of vaccines in the event that a vaccine-preventable disease emergency is declared.

Utilization Management Decision Timeframes

Standard Service Authorization—Prior authorization decisions for non-urgent services shall be made within seven calendar days of receipt of the request for services. An extension to the response time may be granted for an additional seven calendar days if the member or the provider requests an extension or if Sunshine Health justifies a need for additional information and the extension is in the member's best interest.

Expedited Service Authorization—In the event the provider indicates and Sunshine Health determines that following the standard timeframe could seriously jeopardize the member's life or health, Sunshine Health will make an expedited authorization determination and provide notice within 48 hours after receipt of the request. Sunshine Health may extend the timeframe for expedited requests by up to two additional business days if the member or the provider requests an extension or if Sunshine Health justifies a need for additional information and the extension is in the member's interest.

Sunshine Health's Utilization Management Department may be contacted at:

1-844-477-8313

Medical Prior Authorization Fax 1-844-418-7298

Behavioral Health and Substance Abuse Prior Authorization Fax 1-866-694-3649

www.sunshinehealth.com

REFERRAL PROCESS

The PCP should coordinate healthcare services. PCPs should refer members when medically necessary services are beyond their scope of practice. Services that require authorization by Sunshine Health are listed under Prior Authorization. Members are allowed to self-refer for certain specific services (for example, family planning), as stated elsewhere in this manual.

Sunshine Health requires specialists to communicate to the PCPs the need for a referral to another specialist, rather than making such a referral themselves. This allows the PCPs to better coordinate their members' care, and to make sure the referred specialist is a participating provider with Sunshine Health.

Providers must notify Sunshine Health's case management department of their maternity risk assessment within five days of the first prenatal visit. The completed Notice of Pregnancy Form can be faxed to 866-681-5125.

Providers should include the estimated date of confinement and delivery facility in the form.

For requests for any non-emergency care by an out-of-network provider, Sunshine Health's utilization management department must be contacted. This includes non-participating physicians, hospitals outpatient facilities, or ancillary services.

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

Home Health Services, Durable Medical Equipment and Prosthetics

Sunshine Health has contracted with many providers for home health care, home infusion, and durable medical equipment. Some of these services or items require a prior authorization. If the service or item requires a prior authorization, the outpatient authorization form may be completed. The request can be completed on the website (www.sunshinehealth.com). The prior authorization request can be faxed to 1-866-534-5978.

Therapy Services

Sunshine Health covers evaluations and individual physical, speech-language occupational, and respiratory therapy services. These services must be provided in an outpatient setting, freestanding outpatient office, or a home setting. Therapies provided in schools or daycare centers are not covered.

Covered physical, speech, occupational, and respiratory therapy services in a freestanding outpatient office or facility do not need a prior authorization. If the service is provided in a home setting, the request should be sent to Sunshine Health's utilization management department. The request can be completed on the website or the request can be faxed to 1-866-534-5978.

INPATIENT NOTIFICATION PROCESS

Inpatient facilities are required to notify Sunshine Health for emergent and urgent admissions, including maternity deliveries within two business days following the admission. The notification process includes maternity admissions and post stabilization. Notification is required to track inpatient utilization, enable care coordination, discharge planning, and ensure timely claim payment. To provide notification and, when applicable, obtain prior authorization, please contact Sunshine Health's utilization management department at 1-844-477-8313 or fax the request to 1-844-418-7298.

CONCURRENT REVIEW

The Sunshine Health utilization management department will concurrently review the treatment and status of all members who are inpatient through contact with the hospital's utilization and discharge planning departments and, when necessary, the member's attending physician. An inpatient stay will be reviewed as indicated by the member's diagnosis and response to treatment. The review will include evaluation of the member's current status, proposed care plan, discharge plans, and any subsequent diagnostic testing or procedures.

The hospital must notify the plan within 48 hours of delivery with complete information regarding the delivery status and condition of the newborn. Infants born to Sunshine Health Stars members are only covered for the first 3 days or until the infant is transferred, whichever occurs first.

DISCHARGE PLANNING

Discharge planning activities are expected to be initiated upon admission. Sunshine Health's utilization management department will coordinate the discharge planning efforts with the hospital's utilization and discharge planning departments and when necessary the member's attending physician/PCP in order to ensure that members receive appropriate post hospital discharge care.

The Sunshine Health utilization management department will assist in arranging for post discharge care, such as home care, home infusion or durable medical equipment. A Sunshine Health Care Manager may assist the member in making appointments for follow-up care and services.

RETROSPECTIVE REVIEW

Retrospective review is an initial review of services provided to a member, but for which authorization and/or timely plan notification was not obtained. Sunshine Health's process for retrospective reviews is described below:

Post Service Decisions - (Retrospective Reviews) is an initial review of services provided to a member, but authorization and/or timely notification to Sunshine Health's utilization management department did not occur. It can also be related to concurrent cases where a lack of clinical information necessitates a retrospective review.

Timely notification is defined as

- For non-emergent, non-urgent pre-scheduled services requiring prior authorization, the practitioner or provider must notify Sunshine Health within 14 calendar days prior to the requested service date.
- Prior authorization is not required for emergent or urgent care services or services to stabilize an emergent or urgent service. However once the member is stable (post stabilization) Sunshine Health plan requires notification within two calendar days in order to conduct the review.

If the following services are delivered without prior authorization by Sunshine Health or if they did not meet the timely notification to Sunshine Health, the utilization management department will complete a retrospective medical necessity review only for the following:

- Inpatient admissions when the member is still hospitalized
- Outpatient services when the patient is still receiving the out-patient services requiring authorization
- Planned transplants which have not yet occurred

For any of these requests, the Sunshine Health utilization management department will follow the same process as urgent pre-service decisions. A determination will be made 14 days post request.

For requests regarding authorization of services that are untimely and the services have been received by the member, the practitioner or provider will be advised that Sunshine Health will not make retrospective review determinations for services that have already been rendered. They will also be instructed that they may

submit the claim for processing, which will be denied as “services not authorized”. After the practitioner or provider receives the denied claim notice, they may initiate the provider appeal process.

OBSERVATION BED GUIDELINES

In the event that a member’s clinical symptoms do not meet the criteria for an inpatient admission but the treating physician believes that allowing the patient to leave the facility would likely put the member at serious risk, the member may be admitted to the facility for an observation period. Observation Bed Services are those services furnished on a hospital’s premises, including use of a bed and periodic monitoring by a hospital’s nurse or other staff. Observation admissions must be authorized by Sunshine Health’s utilization management department. Observation admissions must be medically necessary to:

- Evaluate an acutely ill patient’s condition.
- Determine the need for a possible inpatient hospital admission.
- Provide aggressive treatment for an acute condition.

An observation admission may last up to a maximum of 48 hours. In those instances where a member begins his or her hospitalization in an observation status and the member is upgraded to an inpatient admission, all incurred observation charges and services will be rolled into the acute reimbursement rate, or as designated by the contractual arrangement with Sunshine Health, and cannot be billed separately. It is the responsibility of the hospital to notify Sunshine Health’s utilization management department of the inpatient admission. Providers should not substitute observation admissions for medically appropriate inpatient hospital admissions.

UTILIZATION MANAGEMENT CRITERIA

Sunshine Health has adopted utilization review criteria developed by McKesson InterQual Products. InterQual appropriateness criteria are developed by specialists representing a national panel from community-based and academic practice. InterQual criteria cover medical and surgical admissions, outpatient procedures, referrals to specialists, and ancillary services. Criteria are established and periodically evaluated and updated with appropriate involvement from physician members of the Sunshine Health Utilization Management Committee. InterQual is utilized as a screening guide and is not intended to be a substitute for practitioner judgment. Utilization review decisions are made in accordance with currently accepted medical or healthcare practices, taking into account special circumstances of each case that may require deviation from the norm stated in the screening criteria. Criteria are used for the approval of medical necessity but not for the denial of services. A Sunshine Health medical director reviews all decisions that are a potential denial or reduction of what was requested. For substance abuse diagnosis, we use the American Society of Addiction Medicine (A.S.A.M.). All potential denial or reduction of service requests for behavioral health or substance abuse services are made by a licensed behavioral health clinician.

Providers may obtain the criteria used to make a specific decision by contacting the Utilization Management Department at 1-844-477-8313. Practitioners also have the opportunity to discuss any medical or behavioral health utilization management decision to deny or reduce services with a physician or other appropriate reviewer at the time of notification to the requesting practitioner/facility of an adverse determination. A Sunshine Health medical director or behavioral health clinician may be contacted by calling Sunshine Health at 1-844-477-8313 and asking for the medical director.

The member's parent or guardian or member if considered an adult, other designated member representative or healthcare professional, with member's consent, may request an appeal related to a medical necessity decision made during the authorization, pre-certification or concurrent review process orally or in writing to:

**Sunshine Health Appeals/Grievance Department 1301 International Parkway
Suite 400
Sunrise, FL 33323
Fax 1-866-534-5972**

SECOND OPINION

The member's parent or guardian or member if considered an adult, other designated member representative, or healthcare professional, with member's consent, may request and receive a second opinion from a qualified professional within Sunshine Health's network. If there is not an appropriate provider to render the second opinion within the network, the member may obtain the second opinion from an out-of-network provider at no cost to the member.

ASSISTANT SURGEON

Reimbursement is provided to assistant surgeons when medically necessary. Sunshine Health utilizes guidelines for assistant surgeons as set forth by the American College of Surgeons. Hospital medical staff by-laws that require an Assistant Surgeon be present for a designated procedure are not grounds for reimbursement. Medical staff by-laws alone do not constitute medical necessity, nor is reimbursement guaranteed when the patient or family requests an Assistant Surgeon be present for the surgery. Coverage and subsequent reimbursement for an Assistant Surgeon's service is based on the medical necessity of the procedure itself and the Assistant Surgeon's presence at the time of the procedure.

CONTINUITY OF CARE

When a new member enrolls in Sunshine Health, they have a 30 day continuity of care period. This allows the member to continue seeing previous providers who were actively treating the member until they can transition his or her care to a Sunshine Health participating provider. Sunshine Health will cover care by a non-participating provider for new members during this 30 day continuity of care period, provided the care provided is a covered service. After that time period, the member must be seen by a participating Sunshine Health Provider, unless the member is pregnant. In those cases the member may continue care with the non-participating provider for the prenatal, delivery, and postpartum care.

In addition to the continuity of care for new members, Sunshine Health will allow members in active treatment to continue care with a terminated treating provider when such care is medically necessary. This is for 60 days, after the date of the provider's termination, or until the member selects another Sunshine Health participating provider.

Sunshine Health will allow pregnant members who have initiated a course of prenatal care with a terminated provider, regardless of the trimester care was initiated, to continue care with that provider until the completion of postpartum care.

SUNSHINE HEALTH CASE MANAGEMENT SERVICES

Whole-Person Approach

Sunshine Health employs a whole-person approach to coordination of care and case management support to include covered services, limited services, carved out services, non-covered services such as social services and services provided by local community agencies. Our case management model includes complex case management, case management for specific conditions, and coordination of services, including coordination with the Healthy Kids dental plan, through an integrated, multidisciplinary care management team. The team is comprised of medical and behavioral health nurses, social workers, disease managers, pharmacists, medical directors, the member and their parent or legal guardian, and the member's providers. This multidisciplinary team ensures coordination across the continuum of care for our members. Sunshine Health's case management staff helps to support the process of regular communication between primary care providers, specialists, behavioral health providers, and dental service providers.

The goals of case management are to:

- Assist the member, their parent or legal guardian in understanding their benefits and how to access them.
- Provide education on well child care.
- Provide education and support related to understanding chronic health conditions, management of those conditions and understanding the treatment and importance of adherence to those treatments.
- Assist the member through transitions in multiple settings, such as emergency room care or inpatient care, by helping to arrange appointments or other services, and coordinate communication and care among the member's treating providers.
- Develop a member-centric care plan that has goals established by the member's parent or legal guardian and the member.
- Monitor the care plan for progress and identify new barriers or goals.

The case management staff focus on linking the member to a medical home that meets their needs, identifying barriers to accessing care and managing any conditions, early symptom identification and actions, and identifying community agencies or supports that may assist the member, his or her parents, or caregivers.

COMPLEX CASE MANAGEMENT

Sunshine Health's complex case management program focuses on members with special healthcare needs, those with chronic or complex conditions, or those that may be a high risk for using acute care services. The Sunshine Health care manager will work with all involved providers to coordinate care, provide referral assistance, and other support as required, and assist the member by coordinating care needs including behavioral health needs, and identifying and obtaining supportive community resources.

As part of the member's care plan, the care manager will assess if the member and his or her parent or legal guardian may benefit from a health management program to provide more support in managing his or her condition. The health management programs reflect the applicable clinical practice guidelines and protocols for members with chronic conditions, including chronic conditions such as asthma and diabetes.

Integrated Physical Health and Behavioral Health Clinical Model

Recognizing that multiple co-morbidities often exist in members with special needs and that the level of support required by these individuals is likely to change over time, Sunshine Health delivers case management services through an Integrated Care Team (IC Team) approach. This team includes staff from Sunshine Health and Envolv PeopleCare™, our affiliated disease management subcontractor, and is staffed differently for members with behavioral health or physical health conditions. Co-location of the IC Team facilitates regular, in-person communication about the member's care and achieves a level of coordination and integration that voice mails and emails among multiple case managers cannot. Our program includes a systematic approach for early identification of eligible members, needs assessment, development and implementation of an individualized care plan that includes member/family education and actively links the member to providers and support services, as well as outcomes monitoring. **The teams support and complement the PCP, specialist medical providers and the behavioral health provider in the following ways:**

- Supporting the provider's treatment plan
- Improving member appointment show rate
- Facilitating communication and integration between behavioral health and medical provider
- Coordinated discharge planning
- Facilitating member access to non-covered community resources

START SMART FOR YOUR BABY® MATERNITY PROGRAM

The Start Smart for Your Baby® program is a case management program designed for our pregnant members and for moms who have just had a baby. The objective of Start Smart is to reduce the risk of pregnancy complications, premature delivery, and infant disease. Identifying pregnant members as early as possible will allow the Start Smart for Your Baby® program to best use our resources and services to help you and your patient achieve a healthy pregnancy outcome.

This comprehensive program covers all aspects of managing the pregnancy and newborn period. We provide education through mailings, phone, online, and face-to-face contact. Sunshine Health considers any teen pregnancy to be high risk and appropriate for this program. Our care managers assist in educating patients about what to expect in normal as well as high risk pregnancies, identify undetected problems that may put them at risk, and help assure compliance with ante partum and postpartum visits.

Sunshine Health offers a premature delivery prevention program. When a physician determines that a member is a candidate for 17-hydroxyprogesterone (17-P), which use has shown a substantial reduction in the rate of recurrent preterm delivery among women who were at a particularly high risk for preterm delivery, he/she will write a prescription for 17-P. A Sunshine Health care manager can help coordinate the ordering and delivery of the 17-P directly to the physician's office. The care manager will contact the member and do an assessment regarding compliance and remain in contact with the member and the

prescribing physician during the entire treatment period. Contact the Sunshine Health case management department if you would like to refer a member to our Start Smart for your Baby program.

BEHAVIORAL HEALTH AND SUBSTANCE ABUSE PROGRAMS

Sunshine Health has developed programs to support children and their families manage their behavioral health or substance abuse conditions. Care managers can help our members get services, understand his/her conditions, understand the importance of medications and other treatments. Care managers work closely with the child's mental health or substance abuse provider to make a plan of care that works.

Sunshine Health provides health management programs to support your child's health and wellbeing. Those programs are for:

- Depression
- Anxiety
- Eating disorders (such as anorexia or bulimia)
- Substance abuse (such as drug and alcohol problems)
- Bi-polar disorder
- Other mental health conditions

Other case management programs include:

- Emergency room diversion
- General case management or care coordination
- Palliative care
- Pre and post-transplant

Providers are asked to contact a Sunshine Health care manager to refer a member identified in need of any of our case management programs. Referrals can be by phone by calling 1-844-477-8313, and selecting the case management prompt or by fax at 1-866-796-0527.

COORDINATION OF DENTAL SERVICES

Sunshine Health Case Managers are trained in Sunshine Health Stars benefits, including dental services. They will be able to assist the member and their parent/guardian in understanding the dental coverage available through the Florida Healthy Kids Corporation dental vendor and the limited dental benefits provided under Sunshine Health, and help them to access those services. As part of the case management process, the staff will identify if the member needs a routine dental appointment or may be having dental issues that need to be addressed. The case management staff can assist the member's parents or legal guardians in finding a dental provider that meets their needs and help to coordinate any needed medical services.

ENVOLVE PEOPLECARE™

Sunshine Health offers a nurse advice line to our members, through Envolve PeopleCare™.

Envolve PeopleCare™ has registered nurses who can provide basic health education, nurse triage, and answer questions about urgent or emergency access 24 hours a day. In addition, Envolve PeopleCare™ refers members with chronic problems like asthma or diabetes to our Sunshine Health care managers for education and assistance in understanding and accessing their benefits.

The Envolve PeopleCare™ staff is conversant in both English and Spanish and can offer the Language Line for additional translation services. The nurses document their calls in a web-based data system using Barton Schmitt, M.D. triage protocols for pediatrics and McKesson proprietary products to perform triage services for members over age 18. These protocols are widely used in nurse call centers and have been reviewed and approved by physicians from around the country.

We provide this service to support your practice and offer our members access to Envolve PeopleCare™ every day. If you have any additional questions, please call Provider Services at **1-844-477-8313**.

SUNSHINE HEALTH DISEASE MANAGEMENT PROGRAMS

As a part of the Sunshine Health clinical program, disease management programs are offered to members. Components of the programs include, but are not limited to:

- Increasing coordination between the medical, social and educational communities.
- Severity and risk assessments of the population.
- Profiling the population and providers for appropriate referrals to providers, including behavioral health providers.
- Ensuring active and coordinated physician/ specialist participation.
- Identifying modes of delivery for coordinated care services such as; home visits, clinic visits, and phone contacts depending on the circumstances and needs of the member and his/her family.
- Increasing the member's and caregiver's ability to self-manage chronic conditions.
- Coordination with Sunshine Health Case Manager and intensive Case Management Department.

ASTHMA PROGRAM

The Asthma program is designed to help the member's parents or legal guardians and the member, when applicable to identify and address issues and barriers that impact their understanding and management of the child's asthma. The program also helps the family identify and address the triggers that can increase their child's asthma symptoms. The health coach contacts the member's parent or legal guardian by phone to provide education and support to assist them and their child in managing asthma.

Components of the program include:

- Asthma medications and how to take them
- Managing symptoms
- Proper use and maintenance of respiratory equipment
- Improving exercise tolerance
- Education to enhance understanding and compliance
- Special consults with a program registered respiratory therapist, if needed.

DIABETES PROGRAM

The diabetes program is designed to help the member's parents or legal guardians and the member, when applicable to identify and address issues and barriers that impact their understanding and management of the child's diabetes. The diabetes program is based on pediatric diabetes guidelines.

Components of the program include:

- Importance of understanding and taking diabetes medications
- Self-blood sugar testing
- Recognizing signs of low and high blood sugar levels
- Diet and activity counseling
- Recommended diabetes testing
- Special consults with a program certified dietitian, if needed.

WEIGHT MANAGEMENT

Raising Well is a child weight management program. The program is for children age 2 and older with a body mass index at or above the 85th percentile for their age and gender. A health coach who is a registered dietitian will help set up healthy habits for members through:

- Personalized one-on-one health coaching
- Tailored exercise interventions for the member and their parent or legal guardian
- Online peer support and group discussions facilitated by health professionals
- Educational resources and activities including tip sheets, games, and recipes

TOBACCO CESSATION

The tobacco cessation program is designed to help members ages 16 and older who are using tobacco and have said they want to stop using tobacco within 30 days. The Puff Free Pregnancy program is available for any pregnant member who smokes. **The health coach will help the member to:**

- Make a Quit Plan that works for him/her
 - o Identify coping strategies and problem solving skills
 - o Talk about getting ready to set a quit date, set the quit date and make the quit plan
- Learn problem solving skills that can help him/her stay on track with their quit plan

- Identify coping and problem-solving skills that works for him/her
 - o Understand withdrawal symptoms
 - o Learn about smoking and successful quitting
 - o Get daily physical activity
- Learn tips on how to not start smoking again

PREVENTIVE AND CLINICAL PRACTICE GUIDELINES AND PROTOCOLS, INCLUDING CHRONIC CARE

Sunshine Health preventive and clinical practice guidelines are based on the health needs and opportunities for improvement identified as part of the Quality Improvement Program (QIP). The guidelines are based on valid and reliable clinical evidence formulated by nationally recognized professional organizations or government institutions, such as the NIH or a consensus of healthcare professionals in the applicable field. The guidelines consider the needs of the members, are adopted in consultation with network providers; and are reviewed and updated periodically as appropriate. Sunshine Health preventive and clinical practice guidelines are available on our website at www.sunshinehealth.com. The guidelines are also available to the parents or legal guardians of the members on the website or they can request that a copy be mailed. Sunshine Health routinely reviews the guidelines and how they may apply to utilization management, case management, member education, coverage of services, and other areas to ensure our programs are consistent with these guidelines. These guidelines are used for both preventive services as well as for the management of chronic diseases.

Preventive and Chronic disease guidelines include, but are not limited to:

- Guidelines for Diagnosis and Management of Asthma
- Clinical Practice Guidelines for General Diabetes Care
- Clinical Practice Guidelines for Pediatric Preventive Screening and Care
- Clinical Practice Guidelines for Preventive Health Maintenance of Sickle Cell Patients
- Guidelines for Detection of ADHD
- Guidelines for Routine Ante partum Care

The Sunshine Health website provides access to new clinical practice guidelines as well as any updates or revisions to existing guidelines.

NEW TECHNOLOGY

Sunshine Health evaluates the inclusion of new technology and the new application of existing technology for coverage determination. This may include medical procedures, drugs, and/or devices. The medical director and/or utilization management staff may identify relevant topics for review pertinent to the Sunshine Health population. The Centene Clinical Policy Committee (CPC) reviews all requests for coverage and makes a recommendation regarding any benefit changes that are indicated. Sunshine Health's utilization management committee reviews recommendations from the CPC and provides comments to Sunshine Health's clinical leadership.

In the instance where a request is made for coverage for new technology which has not been reviewed by the CPC, the Sunshine Health Medical Director will review all information and make a one-time determination within two business days of receipt of all information. This new technology request will then be reviewed at the next regular meeting of the CPC. If you need a new technology benefit determination or have an individual case review for new technology, please contact the Utilization Management Department at **1-844-477-8313**.

Eligibility and Enrollment

ELIGIBILITY FOR SUNSHINE HEALTH STARS

The Florida Healthy Kids Corporation has the sole responsibility for determining eligibility for the Healthy Kids program participation.

VERIFYING ENROLLMENT

Providers are responsible for verifying Sunshine Health Stars eligibility every time a member schedules an appointment, and when they arrive for services. PCPs should also verify that a member is their assigned member.

Call 1-844-477-8313 to reach the IVR System for quick eligibility verification or check online at www.sunshinehealth.com (must have provider login).

Sunshine Health has the capability to receive an ANSI X12N 270 health plan eligibility inquiry, and generate an ANSI X12N 271 health plan eligibility response transactions through Sunshine Health. Providers also may verify member enrollment through Sunshine Health's website at **www.sunshinehealth.com**. **For more information on conducting these transactions electronically, please contact:**

Sunshine Health
c/o Centene EDI Department
1-800-225-2573
or by email at: EDIBA@centene.com

Until the actual date of enrollment with Sunshine Health Stars, Sunshine Health is not financially responsible for services the prospective member receives. In addition, Sunshine Health is not financially responsible for services members receive after their coverage has been terminated.

ENROLLMENT/COMMUNITY OUTREACH GUIDELINES FOR SUNSHINE HEALTH PROVIDERS

Sunshine Health's contract with Florida Health Kids Corporation (FHKC) defines how Sunshine Health and its providers present and advertise the program. Sunshine Health requires providers to submit samples of any community outreach materials they intend to distribute, and to obtain FHKC's approval prior to distribution or display. The provider should send any of these materials to Sunshine Health's Provider Relations staff.

Sunshine Health will submit these materials to FHKC within two business days of receipt, and will send providers written notice of approval or of any changes required by FHKC within two business days of receiving notice from FHKC.

Sunshine Health Provider Relations staff will give an overview of the community outreach plan to all network physicians and their staff and review the Florida Health Kids Corporation contractual guidelines on general outreach and enrollment. This will define what a provider may or may not do in regards to reaching out to Sunshine Health Stars members. Sunshine Health will also use approved communication tools to educate providers on plan-specific information such as claims processing and systems technologies.

Provider communications

Sunshine Health uses many ways to inform our providers of new programs, requirements and tools that may help them manage our members. Provider communication tools include brochures, directories, booklets, handbooks, newsletters, letters, and videos. Some specific examples of the tools Sunshine Health might use include:

- Provider orientation meetings/town hall meetings
- Provider newsletters
- Quarterly site visits
- Provider manual
- Provider directory
- Informational letters and flyers to be included in EOP and other mailings
- Claims material describing how to accurately file claims
- Provider resources on the web
- Interactive Web portal

Provider Outreach Material Do's and Don'ts

- Providers may display health plan specific materials in their own office.
- Providers may announce a new affiliation with a health plan and give their patients a list of health plans with which they contract.
- Healthcare providers may co-sponsor events; such as health fairs and advertise with Sunshine Health in indirect ways; such as TV, radio, posters, fliers, and print advertisement.
- Providers may distribute information about non-health plan specific healthcare services and the provision of health, welfare and social services by the state of Florida or local communities as long as any inquiries from prospective members are referred to member services or the agency's choice counselor/enrollment broker.
- Providers cannot orally or in writing compare benefits or provider networks among health plans other than to confirm whether they participate in a health plan network.
- Providers cannot furnish lists of their Healthy Kids patients to health plans with which they contract or any other entity. Nor can providers furnish other health plans membership list to any health plan, nor can providers assist with health plan enrollment.

Non-compliant Enrollees

NON-COMPLIANT ENROLLEES

There may be instances when a PCP feels that a member should be removed from his or her panel. A PCP may request a member be transferred to another practice for any of the following reasons:

- Repeated disregard of medical advice.
- Repeated disregard of member responsibilities.
- Personality conflicts between physician and/or staff with member.

Examples of reasons that a PCP may request to remove a member from their panel could include, but is not limited to, a member or a member's parent or legal guardian being disruptive, unruly, threatening or uncooperative. Additionally, a provider may remove a member who seriously impairs the provider's ability to provide services to the member or to other members and if the member's behavior is not caused by a physical or behavioral condition.

All requests to remove a member from a panel must be made in writing, contain detailed documentation, and must be directed to:

**Sunshine Health
Member Services Department Attention: Member Services Director 1301 International Parkway
Suite 400
Sunrise, FL 33323
1-844-477-8313**

Upon receipt of such request, the Member Services Director may:

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

A PCP should never request a member be disenrolled for any of the following reasons:

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

Sunshine Health Well-child Check-up Services and Standards

The focus of well-child care is to maintain health by providing early intervention to discover and treat health problems. The preventive care benefits include well child visits that follow the age appropriate periodicity schedule, screenings, diagnostic testing, and medically necessary follow-up care.

PCPs are required to perform well child check-ups in their entirety and at the required intervals. All components of exams must be documented and included in the medical record of each member. Initial well-child exams are to be completed within 90 days of the initial effective date of membership. Referrals to appropriate providers must be made within four weeks of the examination for further assessment and treatment of conditions found during the examination.

The components of these visits include the following:

- *Comprehensive health and developmental history* – Including assessment of both physical and mental health development.
- Comprehensive unclothed physical exam.
- *Appropriate immunizations* – According to the schedule established by the Advisory Committee on Immunization Practices (ACIP) for pediatric vaccines.
- *Laboratory tests* – Including blood level assessments appropriate for age and risk factors.
- *Anticipatory Guidance/Health Education* – Health education is a required component of screening services and includes anticipatory guidance. At the outset, the physical screening provides the initial context for providing health education. Health education and counseling to both parents (or guardians) and children is required and is designed to assist in understanding what to expect in terms of the child's development and to provide information about the benefits of healthy lifestyles and practices as well as accident and disease prevention.
- *Vision Screening* – Vision should be assessed at each screening. At ages five and above, objective measurement using the age-appropriate Snellen Chart, Goodlite Test, or Titmus Test should be done and recorded. If needed, a referral should be made to an ophthalmologist or optometrist.
- *Screening and Other Necessary Healthcare Services* – Providers must provide hearing and other age appropriate developmental screenings, diagnostic test, referrals for dental care, and other measures to treat any physical and mental illnesses and conditions discovered by the screening services.
- Referrals for a dental examination should be completed annually.

Sunshine Health Stars members are eligible to receive comprehensive annual well child visits from ages five through 18 years.

IMMUNIZATIONS

Children must be immunized during medical checkups according to the Sunshine Health child and adolescent preventive guidelines, which are based on the ACIP periodicity table by age and immunizing agent, and immunization guidelines recommended by the Centers for Disease Control (CDC), the Advisory Committee on Immunization Practices (ACIP), the American Academy of Family Physicians (AAFP), the American Academy of Pediatrics (AAP), and Florida law.

An assessment of the child's immunization status should be made at each screening and immunizations administered as appropriate. If the 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. An appointment should be given to return for administration of immunization at a later date.

NOTE: SUNSHINE HEALTH STARS MEMBERS ARE NOT ELIGIBLE FOR THE VACCINES FOR CHILDREN PROGRAM. YOU MAY BILL SUNSHINE HEALTH FOR THE VACCINE AS WELL AS THE ADMINISTRATION OF THE VACCINE. PRIMARY CARE PROVIDERS MUST BE ENROLLED WITH THE STATE OF FLORIDA ONLINE TRACKING SYSTEM (SHOTS) AND THE STATE OF FLORIDA ONLINE IMMUNIZATION REGISTRY.

DOMESTIC VIOLENCE

Sunshine Health Stars members may include individuals at risk for becoming victims of child abuse, domestic, or family violence. Thus, it is especially important that providers are vigilant in identifying these members. Sunshine Health's case management staff may assist member's parent or legal guardian to identify community resources for families dealing with child or domestic violence.

For Florida residents, you may refer victims of domestic violence to the National Domestic Violence Network hotline, at **1-800-799-SAFE (7233)** for information about local domestic violence programs and shelters within the state of Florida.

Providers should report all suspected domestic violence as described. **State law requires reporting by any person if he or she has "reasonable cause to believe that a child has been subjected to child abuse or acts of child abuse."** Such reporting can be done anonymously. Report any injuries from firearms and other weapons to the police. Report any suspected child abuse or neglect immediately to Children's Services in the appropriate county.

Billing and Claims

GENERAL BILLING GUIDELINES

Physicians, other licensed health professionals, facilities and ancillary providers contract directly with Sunshine Health for payment of covered services.

It is important that providers ensure Sunshine Health has accurate billing information on file. Please confirm with your Provider Services Department that the following information is current in our files:

- **Provider Name** (as noted on his/her current W-9 form)
- **Provider National Provider Identifier (NPI)**
- **Physical location address** (as noted on current W-9 form)
- **Billing name and address** (if different)
- **Tax Identification Number**

Providers must bill with their NPI number in box 24J. Sunshine Health will return claims when billing information does not match the information that is currently in our files. **Claims missing the requirements in bold will be returned**, and a notice sent to the provider, creating payment delays. Such claims are not considered “clean” and therefore cannot be entered into the system.

We recommend that providers notify Sunshine Health in advance of changes pertaining to billing information. Please submit this information on a W-9 form. Changes to a Provider’s Tax Identification Number and/or address are NOT acceptable when conveyed via a claim form.

Claims eligible for payment must meet the following requirements:

- The member is effective on the date of service
- The service provided is a covered benefit under the member’s contract on the date of service
- Referral and prior authorization processes were followed

Payment for service is contingent upon compliance with referral and prior authorization policies and procedures, as well as the billing guidelines outlined in this manual and the provider billing manual.

Providers must submit all claims and encounters within 180 days of the date of service, unless Sunshine Health or its vendors created the error. The filing limit may be extended for newborn claims, and where the eligibility has been retroactively received by Sunshine Health, up to a maximum of 365 days. When Sunshine Health is the secondary payer, Sunshine Health must receive the claim within 90 days of the final determination of the primary payer.

All requests for reconsideration or adjustment to paid claims must be received within 45 calendar days from the date the notification of payment or denial is received.

ELECTRONIC CLAIMS SUBMISSION

Network providers are encouraged to participate in Sunshine Health's Electronic Claims/Encounter Filing Program. The plan has the capability to receive an ANSI X12N 837 professional, institution or encounter transaction. In addition, it has the ability to generate an ANSI X12N 835 electronic remittance advice known as an Explanation of Payment (EOP). **For more information on electronic filing, contact:**

**Sunshine Health
c/o Centene EDI Department
1-800-225-2573, extension 25525
or by e-mail at: EDIBA@centene.com**

Providers that bill electronically are responsible for filing claims within the same filing deadlines as providers filing paper claims.

Providers that 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.

ONLINE CLAIM SUBMISSION

For participating providers who have internet access and choose not to submit claims via Electronic Data Interchange (EDI), Sunshine Health has made it easy and convenient to submit claims directly to us on our website at www.sunshinehealth.com.

You must request access to our secure site by registering for a user name and password and have requested Claims access. If you do not have an ID, sign up to obtain one today. Requests are processed within two business days.

Once you have access to the secure portal you may file first time claims individually or submit first time batch claims. You will also have the capability to find, view, and correct any previously processed claims. There are five easy steps to submitting a claim. You may view web claims, allowing you to re-open and continue working on saved, un-submitted claims and this feature allows you to track the status of claims submitted using the web site.

You may register to attend provider webinars featuring "co-browsing" that enables providers and their staff to watch in real time as the host trainer demonstrates online claims, authorizations, eligibility verification or other processes. Providers and their staff can interact with the host trainer via conference call or instant messaging. The Sunshine Health Provider Education Program (PEP) Webinar will guide providers and their staff through our online claims submission process via our secure Provider Portal, including correcting claims and testing billing codes prior to submission to avoid errors.

NATIONAL PROVIDER IDENTIFIER (NPI)

Sunshine Health requires claims to be submitted with a provider's National Provider Identifier (NPI). Sunshine Health will require this on all electronic and paper claim submissions. Providers must send a copy of the confirmation letter from the Enumerator to Sunshine Health to ensure that the NPI is loaded correctly into our claims payment database. Providers may register for an NPI at <https://nppes.cms.hhs.gov/NPPES/>. Providers may download forms at <http://www.cms.hhs.gov/cmsforms/downloads/cms100114.pdf>.

PAPER CLAIMS SUBMISSION

For Sunshine Health Stars members, all claims and encounters should be submitted to:

**Sunshine Health
P.O. BOX 3070
Farmington, MO 63640-3823
ATTN: CLAIMS DEPARTMENT**

IMAGING REQUIREMENTS

Sunshine Health uses an imaging process for claims retrieval. To ensure accurate and timely claims capture, please observe the following claims submission rules:

Do's

- Use the correct PO Box number.
- Submit all claims in a 9" x 12", or larger envelope.
- Type all fields completely and correctly.
- Use black or blue ink only.
- Submit on a proper form (CMS 1500 or UB04).

Don'ts

- Submit handwritten claim forms.
- Use red ink on claim forms.
- Circle any data on claim forms.
- Add extraneous information to any claim form field.
- Use highlighter on any claim form field.
- Submit photocopied claim forms.
- Submit carbon copied claim forms.
- Submit claim forms via fax.

CLEAN CLAIM DEFINITION

A clean claim means a claim received by Sunshine Health for adjudication, in a nationally accepted format in compliance with standard coding guidelines and which requires no further information, adjustment, or alteration by the provider of the services in order to be processed and paid by Sunshine Health.

NON-CLEAN CLAIM DEFINITION

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

WHAT IS AN ENCOUNTER VERSUS A CLAIM?

You are required to submit an encounter or claim for each service that you render to a Sunshine Health member.

- If you are the PCP for a Sunshine Health member and receive a monthly capitation amount for services, you must file a “proxy claim” (also referred to as an “**encounter**”) on a CMS 1500 for each service provided. Since you will have received a pre-payment in the form of capitation, the “proxy claim” or “**encounter**” is paid at zero dollar amounts. **It is mandatory that your office submits encounter data.** Sunshine Health utilizes the encounter reporting to evaluate all aspects of quality and utilization management, and it is required by the state of Florida and by Centers for Medicare and Medicaid Services (CMS).
- A **claim** is a request for reimbursement either electronically or by paper for any medical service. A claim must be filed on the proper form, such as CMS 1500 or UB 04. A **claim** will be paid or denied with an explanation for the denial. For each claim processed, an Explanation of Payment (EOP) will be mailed to the provider who submitted the original **claim**.

PROCEDURES FOR FILING A CLAIM/ENCOUNTER DATA

Sunshine Health encourages all providers to file claims/encounters electronically. See “Electronic Claims Submission” on Page 58 for more information on how to initiate electronic claims/encounters.

Please remember the following when filing your claim/encounter:

- All documentation **must** be legible.
- PCPs and all participating providers must submit claims or encounter data for every member visit, even though they may receive a monthly capitation payment.
- Provider must ensure that all data and documents submitted to Sunshine Health, to the best of your knowledge, information and belief, are accurate, complete or truthful.
- All claims and encounter data must be submitted on either form CMS 1500, CMS1450, (UB 04), or by electronic media in an approved format.
- Review and retain a copy of the error report that is received for claims that have been submitted electronically, then correct any errors and resubmit with your next batch of claims.
- Providers must submit all claims and encounters within 180 days of the date of service, unless Sunshine Health or its vendors created the error.

- All requests for reconsideration or adjustment to paid claims must be received within 45 days from the date the notification of payment or denial is received.
- When submitting claims where other insurance is involved, a copy of the EOB or rejection letter from the other insurance carrier must be attached to the claim.
- Sunshine Health Stars members must never be billed by any provider for **covered services** unless the criteria listed under “Billing the Member” is met.
- In a worker’s compensation case for which Sunshine Health is not financially responsible, the provider should directly bill the employer’s worker’s compensation carrier for payment.

For all contracts with reimbursement for Healthy Kids services that is based on the Florida’s Agency for Health Care Administration’s (AHCA) Medicaid fee for service rates, please note the following.

Any reference to the “Medicaid fee for service rates,” “Medicaid fee schedule,” “Medicaid state exempt rates” or similar term contained in any contract is a reference to the applicable fee schedule used by AHCA as of the date of service to determine payment under the Medicaid fee-for-service program.

Updates to such Medicaid fee schedules (for all provider types and in any form, including but not limited to, Medicaid Bulletins) shall become effective (“Fee Change Effective Date”) (1) the first day of the month following 30 days after publication by AHCA of such fee schedule updates or (2) the effective date of such fee schedule updates as determined by AHCA. Medicaid fee schedule rate revisions shall be applied by Sunshine Health.

CLAIM RESUBMISSIONS, ADJUSTMENTS AND DISPUTES

All requests for claim reconsideration or adjustment must be received within 90 calendar days from the date of notification of payment or denial. Prior processing will be upheld for reconsiderations or adjustments received outside of the 90-day timeframe, unless a qualifying circumstance is offered and appropriate documentation is provided to support the qualifying circumstance. **Qualifying circumstances include:**

- Catastrophic event that substantially interferes with normal business operations of the provider or damage or destruction of the provider’s business office or records by a natural disaster.
- Pending or retroactive member eligibility. The claim must have been received within 6 months of the eligibility determination date.
- Mechanical or administrative delays or errors by Sunshine Health or Florida Healthy Kids Corporation.
- The member was eligible; however, the provider was unaware that the member was eligible for services at the time services were rendered.

Consideration is granted in this situation only if all of the following conditions are met:

- The provider’s records document that the member refused or was physically unable to provide their card or information.
- The provider can substantiate that he or she continually pursued reimbursement from the patient until Healthy Kids eligibility was discovered.

- The provider can substantiate that a claim was filed within 180 days of discovering Healthy Kids program eligibility.
- No other paid claims filed by the provider prior to the receipt of the claim under review.

When submitting a paper claim for review or reconsideration of the claims disposition, a copy of the EOP must be submitted with the claim, or the claim must clearly be marked as **“RE-SUBMISSION”** and include the **original claim number**. Failure to **boldly** mark the claim as a resubmission and include the claim number (or include the EOP) may result in the claim being denied as a duplicate, or for exceeding the filing limit deadline. The Claim Dispute Form can be located on the provider website at www.sunshinehealth.com/files/2008/12/SH_CLAIM_ADJUSTMENT_REQUEST_FORM_0112pdf.pdf

Mail Requests for Reconsideration to:
Sunshine Health
Attn: Reconsideration PO Box 3070
Farmington, MO 63640-3823

Providers may submit in writing, with all necessary documentation (including the EOP), for consideration of additional reimbursement.

A response to an approved adjustment will be provided by way of check with an accompanying EOP. All disputed claims will be processed in compliance with the claims payment resolution procedure as described in this Provider Manual.

COMMON BILLING ERRORS

In order to avoid rejected claims or encounters always remember to:

- Always bill the primary diagnosis in the first field.
- Use SPECIFIC CPT-4 or HCPCS codes. Avoid the use of non-specific or “catch-all” codes (i.e. 99070).
- Use the most current CPT-4 and HCPCS codes. Out-of-date codes will be denied.
- Use the 4th or 5th digit when required for all ICD-10 codes.
- Submit all claims/encounters with the proper provider number.
- Submit all claims/encounters with the member’s complete Identification number.
- Verify other insurance information entered on claim.
- Submit the National Drug Code (NDC) in the appropriate fields on all claim forms as required by the state for pricing Physician Injectable Drugs and for Outpatient Hospitals and Renal Dialysis Centers per the Deficit Reduction Action (DRA) of 2005.

CODE AUDITING AND EDITING

Sunshine Health uses code-auditing software to assist in improving accuracy and efficiency in claims processing, payment and reporting, as well as meeting HIPAA compliance regulations.

The software will detect, correct, and document coding errors on provider claims prior to payment by analyzing CPT, HCPCS, modifier, and place of service codes. Claims billed in a manner that does not adhere to the standards of the code editing software will be denied. The code editing software contains a comprehensive set of rules addressing coding inaccuracies such as unbundling, fragmentation, up-coding, duplication, invalid codes, and mutually exclusive procedures.

The software offers a wide variety of edits that are based on:

- American Medical Association (AMA) – the software utilizes the CPT Manuals, CPT Assistant, CPT Insider's View, the AMA web site, and other sources.
- Centers for Medicare & Medicaid Services' (CMS) National Correct Coding Initiative (NCCI), which includes column 1/column 2, mutually exclusive and outpatient, code editor (OCE0 edits).
- In addition to using the AMA's CPT manual, the NCCI coding policies are based on national and local policies and edits, coding guidelines developed by national societies, analysis of standard medical and surgical practices, and a review of current coding practices.
- Public domain specialty society guidance (i.e., American College of Surgeons, American College of Radiology, and American Academy of Orthopedic Surgeons).
- Clinical consultants who research, document, and provide edit recommendations based on the most common clinical scenario.
- In addition to nationally-recognized coding guidelines, the software has added flexibility to its rule engine to allow business rules that are unique to the needs of the individual product lines.

The following provides conditions where code-auditing software will make a change on submitted codes:

Duplicate services – Submission of the same procedure more than once on the same date for services that cannot or are normally not performed more than once on the same date.

Example: excluding a duplicate CPT:

Code	Description	Status
72010	Radiologic exam, spine, entire, survey study, anteroposterior &	Allow
72010	Radiologic exam, spine, entire, survey study, anteroposterior &	Disallow

- Procedure 72010 includes radiologic examination of the lateral and anteroposterior views of the entire spine that allow views of the upper cervical vertebrae, the lower cervical vertebrae, the thoracic vertebrae, the lumbar vertebrae, the sacrum, and the coccyx.
- It is clinically unlikely that this procedure would be performed twice on the same date of service.

Evaluation and Management Services—Submission of an evaluation and management (E/M) service either within a global surgery period or on the same date of service of another E/M service.

Global surgery

Procedures that are assigned a 90-day global surgery period are designated as major surgical procedures; those assigned a 10-day or zero-day global surgery period are designated as minor surgical procedures.

- Evaluation and management services, submitted with major surgical procedures (90-day) and minor surgical procedures (10-day), are not recommended for separate reporting because they are part of the global service.
- Effective for service dates in 2003, evaluation and management services, submitted with minor surgical procedures (zero-day) are not recommended for separate reporting or reimbursement because these services are part of the global service unless the service is a service listed on the state fee schedule with an asterisk.

Example: Global Surgery Period

Code	Description	Status
27447 DOS=05/20/07	Arthroplasty, knee, condyle, and plateau; medial and lateral compartments with or without patella resurfacing (total knee arthroplasty).	Allow
99213 DOS=06/02/07	Office or other outpatient visit for the evaluation and management of an EST patient, which requires at least two of these three key components: an expanded problem focused history; an expanded problem focused examination; medical decision making of low complexity. Counseling and coordination of care with other providers or agencies are provided consistent with nature of problem(s) and the patient's and/or family's needs. Problem(s) are low/moderate severity. Physicians spend 15-minute face-to-face with patient	Disallow

Explanation:

- Procedure code 27447 has a global surgery period of 90 days.
- Procedure code 99213 is submitted with a date of service that is within the 90-day global period.
- When a substantial diagnostic or therapeutic procedure is performed, the evaluation and management service is included in the global surgical period.

Example: Evaluation and Management service submitted with minor surgical procedures

Code	Description	Status
11000 DOS=01/23/07	Debridement of extensive eczematous or infected skin; up to 10% of body surface	Allow

99213 DOS=01/23/07	Office or other outpatient visit for the evaluation and management of an EST patient, which requires at least two of these three key components: an expanded problem focused history; an expanded problem focused examination; medical decision making of low complexity. Counseling and coordination of care with other providers or agencies are provided consistent w/ nature of problem(s) and patient's and/or family's needs. Problem(s) are low/moderate severity. Physicians spend 15-minute face- to-face with patient	Disallow
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Explanation:

- Procedure 11000 (zero-day global surgery period) is identified as a minor procedure.
- Procedure 99213 is submitted with the same date of service.
- When a minor procedure is performed, the evaluation and management service is considered part of the global service.

Same Date of Service

One evaluation and management service is recommended for reporting on a single date of service.

Example: Same date of service

Code	Description	Status
99215	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: a comprehensive history; a comprehensive examination; medical decision making of high complexity. Counseling &/or coordination of care w/ other providers or agencies are provided consistent w/ nature of problem(s) & patient's &/or family's needs. Usually, problem(s) are moderate/high severity. Physicians spend 40 min face-to-face w/ patient &/or family.	Allow
99242	Office consultation for a new or established patient, which requires these three key components: an expanded problem focused history; an expanded problem focused examination; and straightforward medical decision-making. Counseling/coordination of care w/ other providers or agencies are provided consistent w/ nature of problem(s) and the patient's/family's needs. Presenting problem(s) are low severity. Physicians spend 30-minute face-to-	Disallow

Explanation:

- Procedure 99215 is used to report an evaluation and management service provided to an established patient during a visit.
- Procedure 99242 is used to report an office consultation for a new or established patient.
- Separate reporting of an evaluation and management service with an office consultation by a single

provider indicates a duplicate submission of services. Interventions, provided during an evaluation and management service, typically include the components of an office consultation.

NOTE:

Modifier -24 is used to report an unrelated evaluation and management service by the same physician during a post-operative period.

Modifier -25 is used to report a significant, separately identifiable evaluation and management service by the same physician on the same day of a procedure.

Modifier -79 is used to report an unrelated procedure or service by the same physician during the post-operative period.

When modifiers -24 and -25 are submitted with an evaluation and management service on the same date of service or during the post-operative period by the same physician, the evaluation and management service is questioned and a review of additional information is recommended.

When modifier -79 is submitted with an evaluation and management service on the same date of service or during the post-operative period by the same physician, separate reporting of the evaluation and management service is recommended.

Modifiers - Modifiers are added to the main service or procedure code to indicate that the service has been altered in some way by a specific circumstance.

Modifier -26 (professional component)

Definition: Modifier -26 identifies the professional component of a test or study.

- If modifier -26 is not valid for the submitted procedure code, the procedure code is not recommended for separate reporting.
- When the place of service is an inpatient setting, modifier -26 will be recommended to be appended to valid procedure codes submitted without modifier -26.
- When the place of service is an outpatient setting, procedure codes submitted with modifier -26 are recommended for separate reporting.

Example:

Code	Description	Status
78278 POS=Inpatient	Acute gastrointestinal blood loss imaging	Disallow
78278-26 POS=Inpatient	Acute gastrointestinal blood loss imaging	Allow

Explanation:

- Procedure code 78278 is valid with modifier -26.
- Modifier -26 will be added to procedure code 78278 when submitted without modifier -26.

Modifier -50 (bilateral procedures)

Definition: Modifier -50 edit applies to bilateral procedures submitted with or without a modifier -50. (Bilateral procedures are those that can be performed on both sides of the patient in the same operative session.)

Example:

Code	Description	Status
69436	Tympanostomy (requiring insertion of ventilating tube), general anesthesia	Allow
69436	Tympanostomy (requiring insertion of ventilating tube), general anesthesia	Disallow
69436-50	Tympanostomy (requiring insertion of ventilating tube), general anesthesia	Allow

Explanation:

- Procedure code 69436 was performed bilaterally and submitted twice without modifier -50.
- The second submission of procedure code 69436 is not recommended for separate reporting, but modifier -50 is recommended to be added to this procedure code to indicate a bilateral performance of the procedure.

Modifier -80, -81, -82, and -AS (assistant surgeon)

Definition: The Assistant Surgeon edit identifies procedures not requiring an assistant-at-surgery.

Many surgical procedures require aid in prepping and draping the patient, monitoring visualization, keeping the wound clear of blood, holding and positioning the patient, assisting with wound closure, and/or casting (if required). This assistance does not require the expertise of a surgeon. A qualified nurse, orthopedic technician or resident physician can provide the necessary assistance.

Example:

Code	Description	Status
42820-81	Tonsillectomy and adenoidectomy; under age 12	Disallow

Explanation:

- Procedure code 42820 is not recommended for assistant surgeon reporting because a skilled nurse or surgical technician can function as the assistant in the performance this procedure.

Unbundling—Submission of a comprehensive code along with incidental procedure codes that are an inherent part of performing the global procedure code. The unbundled procedure code(s) will be rebundled to the comprehensive procedure code.

Example:

Code	Description	Status
20102	Exploration of penetrating wound (separate procedure), abdomen/flank/back	Disallow
44120	Enterectomy, resection of small intestine; single resection and anastomosis	Allow

Explanation:

- Procedure 20102 is an exploratory procedure for a penetrating wound that when performed with procedure 44120 represents unbundling because exploration is considered to be a component of the more comprehensive procedure 44120.
- Unbundled procedure codes are re-bundled and paid as a single procedure.

Fragmentation—Billing all incidental codes or itemizing the components of procedures separately when a more comprehensive code is available.

Example:

Code	Description	Status
82465	Cholesterol, serum,	Replaced
83718	Lipoprotein, direct measurement, high density cholesterol	Replaced
84478	Triglycerides	Replaced
80061	Lipid panel	Added

Explanation:

- Procedure 82465, 83718 and 84478 are part of a more comprehensive code – 80061. The definition of 80061 includes procedures 82465, 83718, and 84478.
- Fragmented procedure codes are replaced and paid as the single comprehensive procedure.

The code auditing software is updated regularly to incorporate the most recent medical practices, coding practices, annual changes to the AMA's CPT-4 Manual and other industry standards.

Sunshine Health uses only standard diagnosis and procedure codes to comply with the Health Information Portability and Accountability Act (HIPAA) Transactions and Code Sets Standards.

CPT® Category II Codes

CPT Category II codes are supplemental codes developed to assist in the collection and reporting of information regarding performance measurement, including HEDIS. Submission of CPT Category II codes allows data to be captured at the time of service, thus reducing the need for retrospective medical record review.

Use of these codes is optional and are not required for correct coding and may not be used as a substitute for Category I codes. However, as noted above, submission of these codes can minimize the administrative burden on providers and health plans by greatly decreasing the need for medical record review.

The following are CPT Category II codes applicable for HEDIS measures:

Comprehensive Diabetes Care (CDC)

CPT Category II codes: 3044F, 3045F, 3046F, 3047F (codes to identify HbA1c levels); 2022F, 2024F, 2026F, 3072F (codes to identify diabetic eye exams); 3048F, 3049F, 3050F (codes to identify LDL-C Screening and LDL-C Levels); 3060F, 3061F (codes to identify nephropathy screening tests); 3074F, 3075F, 3076F, 3077F (codes to identify systolic blood pressure levels) and 3078F, 3079F, 3080F (codes to identify diastolic blood pressure levels)

Prenatal and Postpartum Care

CPT Category II codes: 0500F, 0501F, 0502F (codes to identify prenatal visits); 0503F (code to identify postpartum visits)

CODE EDITING ASSISTANT

A web-based code auditing reference tool designed to “mirror” how Sunshine Health’s code auditing product(s) evaluate code combinations during the auditing of claims is available for participating providers. This allows Sunshine Health to share with our contracted providers the claim auditing rules and clinical rationale we use to pay claims.

This tool offers many benefits:

- *Prospectively* access the appropriate coding and supporting clinical edit clarifications for services before claims are submitted.
- *Proactively* determine the appropriate code/code combination representing the service for accurate billing purposes.
- *Retrospectively* access the clinical edit clarifications on a denied claim for billed services after an EOP has been received.

The tool will review what was entered and will determine if the code or code combinations are correct based on the age, sex, location, and modifier (if applicable) or other code(s) entered.

BILLING CODES

It is important that providers bill with codes applicable to the date of service on the claim. Billing with obsolete codes will result in a potential denial of the claim and a consequent delay in payment. Submit professional claims with current and valid CPT-4, HCPCS, or ASA codes and ICD-10 codes. Submit institutional claims with valid Revenue Codes and CPT-4 or HCPCS (when applicable), ICD-10 codes and DRG codes (when applicable).

Providers will also improve the efficiency of their reimbursement through proper coding of a member's diagnosis. We require the use of valid ICD-10 diagnosis codes, to the ultimate specificity, for all claims. This means that ICD-10 codes must be carried out to the fourth or fifth digit when indicated by the coding requirements in the ICD-10 Manual (Note: not all codes require a fourth or fifth digit). The highest degree of specificity, or detail, can be determined by using the Tabular List (Volume One) of the ICD-10 coding manual in addition to the Alphabetic List (Volume Two) when locating and designating diagnosis codes. The Tabular List gives additional information such as exclusions and subdivisions of codes not found elsewhere in the manual. Any three-digit code that has subdivisions must be billed with the appropriate subdivision code(s) and be carried out to the fifth digit if appropriate. Ancillary providers (e.g. Labs, Radiologists, etc.) and those physicians interpreting diagnostic testing may use V72.6 for Laboratory Exam, V72.5 for Radiological Exam, NEC and V72.85 for Other Specified Exam as the principal diagnosis on the claim. Please consult your ICD-10 manual for further instruction. Failure to code diagnoses to the appropriate level of specificity will result in denial of the claim and a consequent delay in payment. Ancillary providers (e.g., Labs, Radiologists, etc.) and those physicians interpreting diagnostic testing may use V72.6 for Laboratory Exam, V72.5 for Radiological Exam, NEC and V72.85 for Other Specified Exam as the principal diagnosis on the claim.

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

CLAIMS PAYMENT

Clean claims will be adjudicated (finalized as paid or denied) within 20 days EDI and 40 days paper of the receipt of the claim.

No later than the 15th business day after the receipt of a provider claim that does not meet Clean Claim requirements, Sunshine Health will pend the claim and request additional information through the Sunshine Health Explanation of Benefits for all outstanding information such that the claim can be deemed clean. Upon receipt of all the requested information from the provider, Sunshine Health will complete processing of the claim within 30 days.

Claims pended for additional information must be closed (paid or denied) by the 35th calendar day following the date the claim is pended if all requested information is not received prior to the expiration of the 35-day period. Sunshine Health will send providers written notification via the Explanation of Benefits for each claim that is denied, including the reason(s) for the denial, the date contractor received the claim, and a reiteration of the outstanding information required from the provider to adjudicate the claim.

Sunshine Health shall process, and finalize, all appealed claims to a paid or denied status within 30 business days of receipt of the Appealed Claim. Sunshine Health shall finalize all claims, including appealed claims. Appealed claims mean claims regarding which a provider files a request for informal claims payment adjustment or a claim complaint with Sunshine Health.

Note: It is the provider's responsibility to check their audit report to verify that Sunshine Health has accepted their electronically submitted claim.

BILLING FORMS

Providers submit claims using standardized claim forms whether filing on paper or electronically. The process below is for paper claims.

Submit claims for professional services and durable medical equipment on a CMS 1500. The following areas of information on CMS 1500 claim forms are common submission requirements of a clean claim accepted for processing.

- Full member name
- Member's date of birth
- Valid member identification number
- Complete service level information:
 - o Date of service
 - o Diagnosis
 - o Place of service
 - o Procedural coding (appropriate CPT-4 or ICD-10 codes)
 - o Charge information and units
- Servicing provider's name, address and Healthy Kids provider ID number
- Provider's federal tax identification number
- All mandatory fields must be complete and accurate

Submit claims for hospital based inpatient and outpatient services as well as swing bed services on a UB04 form.

THIRD PARTY LIABILITY

Third party liability refers to any other health insurance plan, carrier (e.g., individual, group, employer-related, self-insured or self-funded, commercial carrier, automobile insurance, and worker's compensation) or program that is, or may be, liable to pay all or part of the healthcare expenses for the member.

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.

COMPLETING A CMS-1450 (UB 04) FORM

All medical claims must be submitted on the CMS 1450. The CMS 1500 claim form is required for the following:

- All professional services “including specialists”
- Individual practitioners
- Non-hospital outpatient clinics
- Transportation providers
- Ancillary Services
- Durable Medical Equipment
- Non-institutional expenses
- Professional and/or technical components of hospital based physicians and Certified Registered Nurse Anesthetists (CRNAs)
- Home Health Services

CMS 1500 STANDARD PLACE OF SERVICE CODES

Place of Service Codes

00-10	Not in Use
11	Office
12	Home
13 - 20	Not in Use
21	Inpatient Hospital
22	Outpatient Hospital
23	Emergency Room - Hospital
24	Ambulatory Surgical Center
25	Birthing Center
26	Military Treatment Facility
27-30	Not in Use
31	Skilled Nursing Facility
32	Nursing Facility
33	Custodial Care Facility
34	Hospice
35-40	Not in Use
41	Not Valid
42	Not Valid
51	Inpatient Psychiatric Facility
52	Psychiatric Facility Partial
53	Community Mental Health Center

54	Not in Use
55	Office
56	Home
57-60	Not in Use
61	Inpatient Hospital
62	Outpatient Hospital
63, 64	Emergency Room - Hospital
65	Ambulatory Surgical Center
66-70	Birth Center
71	Military Treatment Facility
72	Not in Use
73-80	Skilled Nursing Facility
81	Nursing Facility
82-98	Custodial Care Facility
99	Hospice

COMPLETING A CMS-1450 (UB 04) CLAIM FORM

A UB 04 is the only acceptable claim form for submitting inpatient or outpatient hospital (technical services only) charges for reimbursement by Sunshine Health. In addition, a UB 04 form is required when billing for nursing home services, swing bed services with revenue and occurrence codes, ambulatory surgery centers (ASC), and dialysis services.

Incomplete or inaccurate information will result in the claim/encounter being rejected or denied for corrections.

CMS-1450 (UB 04) INPATIENT DOCUMENTATION

The following information should be submitted along with the UB 04 form.

- Consent forms for hysterectomies, abortions, and sterilizations
- Specific additional information upon request by Sunshine Health

CMS-1450 (UB 04) HOSPITAL OUTPATIENT CLAIMS/AMBULATORY SURGERY

The following information applies to outpatient and ambulatory surgery claims.

- Professional fees must be billed on a CMS 1500 claim form
- Include the appropriate CPT-4 code next to each revenue code

BILLING THE MEMBER

Sunshine Health reimburses only services that are medically necessary and set forth in its contract with the Florida Healthy Kids Corporation. Providers can bill a Sunshine Health Stars member for services that are not Healthy Kids program benefits or for any applicable copayment co-insurance or deductible per the coverage specifications.

MEMBER ACKNOWLEDGEMENT STATEMENT

A provider may bill a member for a claim denied as not being medically necessary, not a covered benefit, or the member has exceeded the program limitations for a particular service only if the following condition is met.

Prior to rendering services, the provider must have the member acknowledge and sign the following **Member Acknowledgement Statement**. This signed statement must be retained in the provider's records.

*"I understand that, in the opinion of **(provider's name)**, the services or items that I have requested to be provided to me on **(dates of service)** may not be covered under my Sunshine Health Stars coverage as being reasonable and medically necessary for my care. I understand that Sunshine Health through its contract with the Florida Healthy Kids Corporation determines the medical necessity of the services or items that I request and receive. I also understand that I am responsible for payment of the services or items I request and receive if these services or items are determined not to be reasonable and medically necessary for my care."*

Credentialing

CREDENTIALING REQUIREMENTS

Fax: 1-866-796-0540

The credentialing and re-credentialing process exists to ensure that participating providers meet the criteria established by Sunshine Health, as well as government regulations and standards of accrediting bodies.

Notice: In order to maintain a current provider profile, providers are required to notify Sunshine Health of any relevant changes to their credentialing information in a timely manner.

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

- Complete signed and dated Sunshine Health Standardized Credentialing Form.
- Signed attestation of the correctness and completeness of the application, history of loss of license and/or clinical privileges, disciplinary actions, and/or felony convictions; lack of current illegal substance and/or alcohol abuse; mental and physical competence, and ability to perform the essential functions of the position, with or without accommodation.
- 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 current Drug Enforcement Administration (DEA) registration certificate.
- Copy of W-9.
- Copy of current unrestricted Medical License to practice in the state of Florida.
- Current copy of specialty/board certification certificate, if applicable. Please note board certification is required for Pediatricians and Family Practice physicians. Primary care physicians who have recently completed a National Board for Certification of Training Administrators of Graduate Medical Education Programs approved residency program in pediatrics or family practice and are eligible for board certification but have not yet achieved board certification may apply and are expected to be Board Certified within the first three years of initial credentialing.
- Curriculum vitae listing, at minimum, a five-year work history.
- Signed and dated release of information form.
- Proof of highest level of education – copy of certificate or letter certifying formal post-graduate training.
- Disclosure of Ownership Form (CMS1513) per practice location.
- Copy of enumeration letter issued by National Plan and Provider Enumeration System (NPPES), depicting the providers' unique National Provider Identifier (NPI).

Sunshine Health will initiate a background check with the Florida Agency for Health Care Administration Clearing House for all providers not currently enrolled in the Medicaid Fee-For-Service program.

Sunshine Health will verify the following information submitted for credentialing and/or re-credentialing:

- State license through appropriate licensing agency
- DEA license through issuing agency
- Board certification, or residency training, or medical education
- National Practitioner Data Bank (NPDB) and HIPDB
- Hospital privileges in good standing at a participating Sunshine Health hospital
- Review five years' work history
- Review sanction activity from Medicare/Medicaid (Office of Inspector General, SAM)
- NPI Number verification
- PCMH designation if applicable

Once the application is completed, the Sunshine Health Credentialing Committee will render a final decision on acceptance following its next regularly scheduled meeting. Providers will be notified of the decision within 60 days from the date of the committee meeting.

Providers must be credentialed prior to accepting or treating members. PCPs cannot accept member assignments until they are fully credentialed.

CREDENTIALING COMMITTEE

The Credentialing Committee has the responsibility to establish and adopt, as necessary, criteria for provider participation and termination and direction of the credentialing procedures, including provider participation, denial, and termination.

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

FAILURE OF AN APPLICANT TO ADEQUATELY RESPOND TO A REQUEST FOR ASSISTANCE MAY RESULT IN TERMINATION OF THE APPLICATION PROCESS.

Site visits are performed at all practitioner offices during the initial credentialing process and at re-credentialing if new office location exist or change in office locations has occurred. This review is conducted for all PCPs, Pediatricians, OB/GYN's, and high-volume behavioral health providers. A satisfactory review (>80%) 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.

RE-CREDENTIALING

To comply with Accreditation Standards, Sunshine Health conducts the re-credentialing process for providers at least every three years from the date of the initial credentialing decision. The purpose of this process is to identify any changes in the practitioner's licensure, sanctions, certification, competence or health status, which may affect the ability to perform services the provider is under contract to provide. This process includes all practitioners (including primary care providers and specialists), ancillary providers, and/or facilities previously credentialed to practice within the Sunshine Health network.

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

A provider's agreement may be terminated if at any time it is determined by Sunshine Health's Board of Directors or the Credentialing Committee that credentialing requirements are no longer being met.

RIGHT TO REVIEW AND CORRECT INFORMATION

All providers participating with Sunshine Health have the right to review information obtained by Sunshine Health to evaluate their credentialing and/or re-credentialing application. This includes information obtained from any outside primary source such as the National Practitioner Data Bank-Healthcare Integrity and Protection Data Bank, malpractice insurance carriers and the State of 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 provider believe any of the information used in the credentialing/re-credentialing process to be erroneous, or should any information gathered as part of the primary source verification process differ from that submitted by a practitioner, he or she has the right to correct any erroneous information submitted by another party. To request release of such information, a written request must be submitted to the Sunshine Health Credentialing Department. Upon receipt of this information, the provider will have 21 days to provide a written explanation detailing the error or the difference in information to Sunshine Health. Sunshine Health's Credentialing Committee will then include this information as part of the credentialing/re-credentialing process.

RIGHT TO APPEAL ADVERSE CREDENTIALING DETERMINATIONS

New provider applicants who are declined participation for reasons such as quality of care or liability claims issues have the right to request a reconsideration of the decision in writing within 30 days of formal notice of denial. All written requests should include additional supporting documentation in favor of the applicant's reconsideration for participation in Sunshine Health. Reconsiderations will be reviewed by the Credentialing Committee at the next regularly scheduled meeting, but in no case later than 30 days from the receipt of the additional documentation. The applicant will be sent a written response to his/her request within 60 days of the final decision.

Quality Improvement

QUALITY IMPROVEMENT PROGRAM

Phone 1-844-477-8313

Fax 1-866-796-0528

Sunshine Health's culture, systems, and processes are structured around its mission to improve the health of all enrolled members. The Quality Improvement Program (QIP) utilizes a systematic approach to quality using reliable and valid methods of monitoring, analysis, evaluation and improvement in the delivery of healthcare provided to all members, including those with special needs. This systematic approach to quality improvement provides a continuous cycle for assessing the quality of care and service among plan initiatives including preventive health, acute and chronic care, behavioral health, over- and under-utilization, continuity and coordination of care, patient safety, and administrative and network services. The purpose of the QIP program is to plan, implement, and monitor ongoing efforts that demonstrate improvements in member safety, health and satisfaction.

Sunshine Health recognizes its legal and ethical obligation to provide members with a level of care that meets recognized professional standards and is delivered in the safest, most appropriate settings. The utilization management program has been designed to support those processes. Sunshine Health will provide for the delivery of quality care with the primary goals of improving the health status of its members and improving their experience with care. Sunshine Health will implement case management programs to assist members in managing their health conditions and to assist them in accessing covered services. The case management programs will include the identification of members at risk of developing conditions, the implementation of appropriate interventions, and designation of adequate resources to support the interventions. Whenever possible, Sunshine Health's QIP supports these processes and activities that are designed to achieve demonstrable and sustainable improvement in the health status of its members.

PROGRAM STRUCTURE

The Sunshine Health Board of Directors has the ultimate authority and accountability for the oversight of the quality of care and service provided to Members. The BOD oversees the QIP and has established various committees and ad-hoc committees to monitor and support the QIP.

The Quality Improvement Committee (QIC) is a committee with physician representation that is directly accountable to the Board. The purpose of the QIC is to provide oversight and direction in assessing the appropriateness of care and service delivered, customer experience with care, and to continuously enhance and improve the quality of care and services provided to members. This is accomplished through a comprehensive, plan-wide system of ongoing, objective, and systematic monitoring; the identification, evaluation, and resolution of process problems, the identification of opportunities to improve member outcomes, and the education of members, providers and staff regarding the QI, UM, and Credentialing programs.

The following sub-committees report directly to the Quality Improvement Committee:

- Credentialing Committee
- Pharmacy and Therapeutics Committee
- Utilization Management/Physician Performance Committee
- Peer Review Committee (Ad Hoc committee)
- Specialty Advisory Committees (Ad Hoc committee)

QUALITY IMPROVEMENT PROGRAM GOALS AND OBJECTIVES

Sunshine Health's primary quality improvement goal is to improve members' health status and customer experience through a variety of meaningful quality improvement activities implemented across all care settings and aimed at improving quality of care and services delivered.

Quality Improvement Program goals include, but are not limited to, the following:

- A high level of health status and quality of life will be experienced by Sunshine Health members.
- Network quality of care and service will meet industry-accepted performance standards.
- Sunshine Health member services will meet industry-accepted standards of performance.
- Fragmentation and/or duplication of services will be minimized through integration of quality improvement processes across Sunshine Health's functional areas.
- Member satisfaction will meet Sunshine Health's established performance targets.
- Preventive and clinical practice guideline compliance will meet established performance targets. This includes, but is not limited to, compliance with age appropriate immunizations, well child care, prenatal care, diabetes, and asthma.
- Compliance with all applicable regulatory requirements and accreditation standards will be maintained.

Sunshine Health's Quality Improvement Program objectives include, but are not limited to, the following:

- To establish and maintain a health system that promotes continuous quality improvement.
- To adopt evidence-based clinical indicators and practice guidelines as a means for identifying and addressing variations in medical practice.
- To select areas of study based on demonstration of need and relevance to the population served.
- To develop standard performance measures that are clearly defined, objective, measurable, and allow tracking overtime.
- To utilize Management Information Systems (MIS) in data collection, integration, tracking, analysis and reporting of data that reflects performance on standard health outcome measures.
- To allocate personnel and resources necessary to:
 - o Support the quality improvement program, including data analysis and reporting;
 - o Meet the educational needs of members, providers and staff relevant to quality improvement efforts.
- To seek input and work with members, providers and community resources to improve quality of care.
- To oversee peer review procedures to address deviations in medical management and healthcare practices and devise action plans to improve care quality.

- To establish a system to provide frequent, periodic quality improvement information to participating providers to support them in their efforts to provide high quality healthcare.
- To recommend and institute “focused” quality studies in clinical and non-clinical areas, where appropriate.

QUALITY IMPROVEMENT PROGRAM SCOPE

The scope of the QIP is comprehensive and addresses both the quality of clinical care and the quality of service provided to Sunshine Health’s members. Sunshine Health’s QIP incorporates all demographic groups, care settings, and services in QI activities, including preventive care, primary care, specialty care, acute care, short-term care, long-term care (depending upon Sunshine Health’s products), and ancillary services, along with Sunshine Health operations. **To that end, Sunshine Health’s QIP monitors the following:**

- Compliance with preventive health guidelines and practice guidelines.
- Acute and chronic care management.
- Provider network adequacy and capacity.
- Selection and retention of providers (credentialing and re-credentialing).
- Trends in behavioral health within Healthy Kids benefits services.
- Delegated entity oversight.
- Continuity and coordination of care.
- Utilization management, including under and over utilization.
- Effectiveness of case management programs.
- Compliance with member confidentiality laws and regulation.
- Employee and provider cultural competency.
- Provider appointment availability.
- Provider and health plan after-hours telephone accessibility.
- Member satisfaction.
- Provider satisfaction.
- Member complaint, grievance and appeal trends
- Provider complaints.
- Member enrollment and disenrollment.
- PCP changes.
- Department performance and service.
- Patient safety.
- Pharmacy trends.
- Marketing practices, if applicable.

INTERACTION WITH FUNCTIONAL AREAS

The QI Department maintains strong working relationships with key functional areas within Sunshine Health, such as utilization management, case management, pharmacy, operations, network services, member and provider services, data analytics, and regulatory compliance. Quality is integrated throughout Sunshine Health, and represents the strong commitment to quality of care and services for members.

- **Data analytics** and the QI Department work together to ensure that data integrity is maintained in the study design of quality initiatives and reported data is accurate, timely and validated.
- **Provider Network Services** and the QI Department work together to verify that clinical materials distributed to providers are understandable and useful, and that providers understand the members' rights and responsibilities and treat enrolled members accordingly. These departments also coordinate efforts for appropriate access and availability through ongoing monitoring.
- **Members Services, case management, network services**, and QI staffs collaborate in relation to member experience activities, including performance improvement projects. The QI department works collaboratively with these departments to maintain performance data related to member outreach activities and any other QI activities related to member services functions, including call center functions, are tracked, trended, and used as a tool to identify opportunities for performance improvement, as appropriate.
- **Health Services** provides utilization management, case management and disease focused services to members. Utilization management and case management staff identify and refer quality concerns to the QI department for investigation, recommend program enhancements or new programs benefits enhancements, and participate in QI activities and projects.
- **Regulatory Compliance** and the QI Department work together so Sunshine Health's operational and clinical areas comply with the Healthy Kids contract and accreditation requirements for NCQA.
- **Complaint, appeal and grievance** staff and the provider relations department work closely with the QI department so that: any quality of care issue is promptly investigated; appeals, grievances and second- level reviews are handled timely; data collection and reporting is in compliance with relevant contractual and regulatory requirements; and reporting to appropriate quality committees occurs.

PRACTITIONER INVOLVEMENT

Sunshine Health recognizes the integral role practitioner involvement plays in the success of its quality improvement program. Practitioner involvement in various levels of the process is highly encouraged through provider representation. Sunshine Health encourages PCP, Behavioral Health, Pediatrics, and OB/ GYN representation on key quality committees such as, but not limited to, the QIC, Utilization Management Committee, Credentialing Committee, P&T Committee, Peer Review Committee, and select ad-hoc committees.

PERFORMANCE IMPROVEMENT PROCESS

Sunshine Health's QIC reviews and adopts an annual QI program and QI Work Plan. These documents are updated to reflect the trends seen in the populations served and to evaluate the programs that are put in place to address the needs of the members. The QIC adopts traditional quality/risk/utilization management approaches to problem identification with the objective of identifying improvement opportunities. As part of this approach, the Senior Medical Director, Senior Vice President of Health Services, and Vice President of Quality Improvement in conjunction with the leaders of quality, utilization management, case management, pharmacy, operations, key network and other departments determine the scope and frequency of QI initiatives (clinical and non-clinical performance improvement projects, focus studies, etc.). Most often, initiatives are selected based on data that indicates the need for improvement in a particular clinical or non-clinical area, and includes targeted interventions that have the greatest potential for improving health outcomes, access to services or improving customer experience. Other initiatives may be selected to test an innovative strategy. Each initiative topic will reflect distinctive regional emphasis on

populations and cultures. Once a QI topic is selected, the QI Department, in conjunction with specific functional areas as appropriate, will present the proposed QI initiative to the QIC for approval. The QIC will select those initiatives that have the greatest potential for improving health outcomes or the quality of service delivered to plan's members and network providers.

Performance improvement projects, focused studies, and other QI initiatives are designed and implemented in accordance with principles of sound research design and appropriate statistical analysis. Results of these studies are used to evaluate the appropriateness and quality of care and services delivered against established standards and guidelines for the provision of that care or service. Each QI initiative is also designed to allow the plan to monitor improvement over time.

The QIC continues to monitor progress of clinical PIPs as well as other quality initiatives. The Sunshine Health QI program allows for continuous performance of quality improvement activities through the Plan, Do, Study and Act (PDSA) quality process. This analysis process recommends improvements regarding the delivery of healthcare to all members, and employs mechanisms to track new issues over time.

Annually, Sunshine Health develops a QI work plan for the upcoming year. The QI work plan serves as a working document to guide quality improvement efforts on a continuous basis. The work plan integrates QI activities, reporting and studies from all areas of the organization (clinical and service) and includes timelines for completion and reporting to the QIC as well as requirements for external reporting. Studies and other performance measurement activities and issues to be tracked over time are scheduled in the QI work plan.

The QI work plan is used by the QI Department to manage projects and by the QIC and sub-committees, and ultimately by Sunshine Health's Board to monitor progress. The work plan is modified and enhanced throughout the year with approval from the QIC. Modifications are reported to the Board and appropriate QI sub-committees.

At any time, Sunshine Health providers may request information on Sunshine Health's quality program, including a description of the QIP and a report on Sunshine Health's progress in meeting the QIP goals by contacting Sunshine Health's QI Department.

FEEDBACK ON PHYSICIAN SPECIFIC PERFORMANCE

As part of the quality improvement process, performance data at an individual provider or practice level is reviewed and evaluated. This may be done by the utilization management committee, credentialing committee and/or other ad hoc QIC committees. **This review of provider specific performance data may include, but is not limited to:**

- Site evaluation results including medical record audit, appointment availability, after-hours access, cultural proficiency and in-office waiting time.
- Preventive care, including well-child exams, immunizations, lead screening, prenatal care, and other age appropriate screenings for diseases or conditions. Compliance with clinical practice guidelines.
- Member complaint and grievance data.
- Utilization management data including emergency room visits/1000 and admissions/1000 reports.
- Pharmacy data including use of generics or specific drugs
- Sentinel events and/or adverse outcomes.

HEALTHCARE EFFECTIVENESS DATA INFORMATION SET (HEDIS)

HEDIS is a set of standardized performance measures developed by the National Committee for Quality Assurance (NCQA), which allows comparison across health plans. HEDIS gives purchasers and consumers the ability to distinguish between health plans based on comparative quality instead of simply cost differences.

Florida Healthy Kids Corporation holds Sunshine Health accountable for the timeliness and quality of healthcare services (acute, preventive, mental health, etc.) delivered to its Healthy Kids membership.

HEDIS consists of 20+ Effectiveness of Care type measures as well as Access to Care and Use of Services measures for which the health plan contractually reports rates to Florida Healthy Kids Corporation based on claims and/or medical record review data.

As both the state and federal governments move toward a healthcare industry that is driven by quality, HEDIS rates are becoming more and more important, not only to the health plan, but to the individual provider as well. State purchasers of healthcare can use the aggregated HEDIS rates to evaluate the effectiveness of a health plan's ability to demonstrate an improvement in access to preventive health services. Physician specific scores are being used as evidence of preventive care from primary care office practices. The HEDIS rates can serve as a basis for physician incentive programs such as 'pay for performance' and 'quality bonus funds'. These programs pay providers an additional financial incentive.

How are HEDIS rates calculated?

HEDIS rates can be calculated in two ways: administrative data or hybrid data. Administrative data consists of claim or encounter data submitted to the health plan. Measures typically calculated using administrative data include: annual Chlamydia screening, treatment of pharyngitis, treatment of URI, appropriate treatment of asthma, antidepressant medication management, access to PCP services, and utilization of acute and mental health services. Please note that these are examples only, and are not necessarily the HEDIS measures specifically monitored by the Florida Healthy Kids Corporation given the age eligibility parameters for the Healthy Kids program.

Hybrid data consists of both administrative data and a sample of medical record data. Hybrid data requires review of a random sample of member medical records to abstract data for services rendered but that were not reported to the health plan through claims/encounter data. Accurate and timely claim/encounter data reduces the necessity of medical record review. Measures typically requiring medical record review include comprehensive diabetes care, immunizations, prenatal care, and well-child care.

Who will be conducting the Medical Record Reviews (MRR) for HEDIS?

Sunshine Health will either directly review medical records or contract with a medical record review vendor, to conduct the HEDIS medical record reviews on its behalf. Medical record review audits for HEDIS are usually conducted March through May each year. At that time, you may receive a call from a medical record reviewer representative if any of your patients are selected into HEDIS samples for Sunshine Health. Your prompt cooperation with the representative is greatly needed and appreciated.

As a reminder, protected health information (PHI) that is used or disclosed for purposes of treatment, payment or healthcare operations is permitted by HIPAA Privacy Rules (45 CFR 164.506) and does not require consent or authorization from the member/patient. The Medical Record Review vendor will sign a HIPAA compliant Business Associate Agreement with Sunshine Health, which allows them to collect PHI on our behalf.

What can be done to improve my HEDIS scores?

Understand the specifications established for each HEDIS measure.

Submit claim/encounter data for each and every service rendered. All providers must bill (or report by encounter submission) for services delivered, regardless of contract status. Claim/encounter data is the most clean and efficient way to report HEDIS. If services are not billed or not billed accurately they are not included in the calculation. Accurate and timely submission of claim/encounter data will positively reduce the number of medical record reviews required for HEDIS rate calculation. Chart documentation must reflect the services provided.

If you have any questions, comments, or concerns related to the annual HEDIS project or the medical record reviews, please contact Sunshine Health QI Department at 1-844-477-8313.

MEMBER SATISFACTION SURVEY

A member satisfaction survey is included as a part of HEDIS and NCQA accreditation. It is a standardized survey administered annually to members by an NCQA certified survey vendor. The child survey provides information on their parent's or legal guardian's experience of our Healthy Kids members with the health plan services and gives a general indication of how well the health plan meets members' expectations. Global rating questions reflecting overall satisfaction include rating of personal doctor and rating of specialist seen most often. Composite scores summarize responses in key areas such as getting care quickly, getting needed care, how well doctors communicate, and shared decision-making. Responses to the survey are used in various aspects of the quality program including monitoring of practitioner access and availability.

PROVIDER SATISFACTION SURVEY

Sunshine Health conducts an annual provider satisfaction survey, which includes questions to evaluate provider satisfaction with our services such as claims, communications, utilization management, and provider services. The survey is conducted by an external vendor. Participants are randomly selected by the vendor, meeting specific requirements outlined by Sunshine Health, and the participants are kept anonymous. We encourage you to respond timely to the survey as the results of the survey are analyzed and used as a basis for forming provider related quality improvement initiatives.

FEEDBACK OF AGGREGATE RESULTS

Aggregate results of studies and guideline compliance audits are presented to the QIC. Participating physician members of the QIC provide input into action plans and serve as a liaison with physicians in the community.

Aggregate results are also published in the quarterly provider newsletter or a special provider mailing may be distributed.

At least annually, a Sunshine Health Provider Partnership Manager meets with PCPs and high volume specialists to review policies, guidelines, indicators, medical record standards, and provide feedback of audit/study results. These sessions are also an opportunity for providers to suggest revisions to existing programs, materials and recommend priorities for further initiatives. When a guideline, indicator, or standard is developed in response to a documented quality of care deficiency, Sunshine Health disseminates the materials through an in-service training program to upgrade providers' knowledge and skills. A Sunshine Health Medical Director or Pharmacist also may conduct special training and meetings to assist physicians and other providers with quality and service improvement efforts.

Waste, Abuse and Fraud

AUTHORITY AND RESPONSIBILITY

The Sunshine Health Compliance Officer has overall responsibility and authority for carrying out the provisions of the health plan's compliance program.

Sunshine Health is committed to identifying, investigating, sanctioning and prosecuting suspected fraud and abuse.

The Sunshine Health provider network 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.

WASTE, ABUSE AND FRAUD

Sunshine Health takes the detection, prevention investigation, reporting and prosecution of fraud and abuse very serious, and has a Waste, Abuse and Fraud (WAF) program that complies with state and federal laws. Sunshine Health in conjunction with its management company, Centene Corporation, successfully operates a WAF unit. Sunshine Health performs front and back end audits to ensure compliance with billing regulations. Our sophisticated code editing software performs systematic audits during the claims payment process. To better understand this system, please review the Billing and Claims chapter of this manual. The WAF unit performs prepayment and retrospective audits, which in some cases may result in prosecution and/or recoupment of previously paid monies.

Some of the most common errors seen are:

- Unbundling of codes
- Up-coding
- Add-on codes without primary CPT
- Diagnosis and/or procedure code not consistent with the member's age/gender
- Use of exclusion codes
- Excessive use of units

In order to prevent members from card sharing, Sunshine Health recommends that providers obtain a copy of a photo ID as part of the member's medical record.

If you suspect or witness a provider inappropriately billing or a member receiving inappropriate services, please call our anonymous and confidential hotline at **1-866-685-8664** or contact the health plan's Compliance Officer at **1-844-477-8313**. You may also send an email to **Compliancefl@centene.com**. Sunshine Health and/or Centene take all reports of potential WAF very seriously and investigate all reported issues.

Member Services

MEMBER SERVICES

Sunshine Health is committed to providing its Stars members with information about the health benefits that are available to them through Sunshine Health. Sunshine Health encourages members to take responsibility for their healthcare by providing basic information to assist with making decisions about their healthcare choices.

Sunshine Health has developed targeted clinical programs to address the needs of its members. Members receive education on their disease over the phone or through the mail. Staff can assist them in identifying participating providers and making appointments.

As a provider for Sunshine Health, please remember that it is your obligation to identify any member who requires translation, interpretation or sign language services. Sunshine Health will pay for these services whenever you need them to effectively communicate with a Sunshine Health member. Sunshine Health members should not be held liable for these services. To arrange for any of the above services, please call the Sunshine Health Provider Services Department at 1-844-477-8313.

MEMBER MATERIALS

Information will be provided to members by face-to-face contact and through mailings. Printed materials include:

- Newsletters
- Targeted health management information
- Envolve PeopleCare™ information
- Education on the appropriate use of an emergency room
- Member Handbook which includes:
 - o Benefit information
 - o Member rights and responsibilities

The Sunshine Health Stars Member Handbook is available in both English and Spanish and can be translated into other languages if needed. The Member Handbook is posted on Sunshine Health's website at www.sunshinehealth.com.

PROVIDER RIGHTS

Sunshine Health Providers shall be assured of the following rights:

- A Healthcare Professional, acting within the lawful scope of practice, shall not be prohibited from advising or advocating on behalf of a member who is his/her patient for the following:
 - o The member's health status, medical care or treatment options, including any alternative treatment that may be self-administered.

- o Any information the member needs in order to decide among all relevant treatment options.
- o The risks, benefits, and consequences of treatment or non-treatment.
- o The member's right to participate in decisions regarding his/her healthcare, including the right to refuse treatment, and to express preferences about future treatment decisions.
- To receive information on the Grievance and Appeal procedures.
- To have access to Sunshine Health's policies and procedures covering the authorization of services.
- To be notified of any decision by Sunshine Health to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested.
- To challenge on behalf of Sunshine Health members, the denial of coverage of or payment for, medical assistance.
- Sunshine Health provider selection policies and procedures must not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment.
- To be free from discrimination for the participation, reimbursement, or indemnification of any provider who is acting within the scope of his/her license or certification under applicable state law, solely on the basis of that license or certification.

MEMBER RIGHTS AND RESPONSIBILITIES

Members are informed of their rights and responsibilities through the Member Handbook. Sunshine Health providers are also expected to respect and honor members' rights. **The Member Rights and Responsibilities for Sunshine Health Stars members and their parent or legal guardian are:**

Rights

- To be treated with respect and in a manner that recognizes your need and right to privacy and dignity.
- To receive assistance from Sunshine Health and our contracted providers in a prompt, courteous and responsible manner.
- To receive equal and fair access to medical treatment or accommodations, regardless of your race, national origin, religion, physical handicap or the source of payment for the services.
- To be provided with information about your child's health care benefit plan and any exclusions or limitations regarding your child's coverage.
- To be provided with information about the network of physicians and other health care providers participating in your child's health care benefits plan.
- To be informed by your child's physician or other health care provider of your child's diagnosis, your child's prognosis and your child's plan of treatment in terms you understand.
- To be able to discuss all appropriate medical treatment options for your child's condition regardless of cost or benefit coverage.
- To be informed by your child's physician or other health care provider about any treatment your child may receive; to participate with physicians in making decisions about your child's health care; to have your child's health care provider request your consent for all treatment unless there is an emergency and your life/health are in serious danger. If written consent is required for procedures (such as surgery), you have the right to understand the specific procedure or treatment and associated risks and why the procedure or treatment is being recommended.

- To be advised of available patient support services, including a language or sign interpreter.
- To refuse treatment and be told of the likely consequences of your decisions.
- To express a complaint about Sunshine Health and/or its providers or the care your child has received and to receive a response in a timely manner.
- To make recommendations or complaints regarding Sunshine Health member rights and responsibilities policy.
- To file a grievance if you are not satisfied with Sunshine Health's determination regarding your complaint.

Responsibilities:

- To learn how Sunshine Health works by fully reviewing the benefits and coverage documents; please call Member Services if you have any questions in this regard.
- To ask questions until you fully understand the information you are given by Sunshine Health about your child's benefits and to know the proper use of Sunshine Health's processes.
- To always present your child's ID card when getting services.
- To guard against any unauthorized use of your child's ID card.
- To treat all Sunshine Health employees and contracted providers with the same respect and courtesy with which you would like to be treated.
- To consult with your child's PCP prior to receiving other medical care except in cases of an emergency.
- To keep all scheduled doctor's appointment or notify the provider's office when you will not be able to keep the scheduled appointment.
- To pay all co-payments, coinsurance and deductibles, and charges for non-covered services/benefits.
- To follow the doctor's advice, plans and instructions for care for your child, and consider the consequences of non-compliance.
- To establish a relationship with your child's PCP.
- To understand your child's health problems and work with your child's PCP, other treating physicians and Sunshine Health in developing shared treatment goals, as possible.
- To be honest and provide full information to your child's PCP, other treating physicians or providers, and Sunshine Health that is needed to provide care and coverage to your child.
- To freely express your opinions, concerns or complaints in a constructive manner.

MEMBER COMPLAINTS, GRIEVANCES AND APPEALS

Federal law requires managed care organizations to have internal grievance procedures under which enrollees or providers acting as their authorized representatives may challenge a denial of coverage or payment for medical necessity. These procedures must include an opportunity to file a complaint, grievance, and/or an appeal. The following describes the Sunshine Health Stars member complaint, grievance and appeals procedures:

Complaints

A parent or legal guardian of a Sunshine Health member has the right to file a complaint. A complaint is when you are unhappy with Sunshine Health or a provider. **Examples of complaints are:**

- You are unhappy with the care your child received from a provider.
- You are unhappy with the service your child is receiving from a Sunshine Health provider.
- You are unhappy with how long it takes to get an appointment.
- You are unhappy with how your child was treated.
- You are unhappy that a service is not included as a Sunshine Health benefit.
- You are unhappy with how a bill was paid.
- You are unhappy with how you were treated by Sunshine Health staff.

If you are unhappy with Sunshine Health or a provider, you have the right to file a complaint over the telephone or in writing by contacting Sunshine Health's Member Services Department. A complaint may be filed by speaking with a member service representative or in writing. **We can be reached at:**

Sunshine Health

Attn: Member Services – Member Advocate Dept. 1301 International Parkway
Suite 400

Sunrise, Florida 33323

Phone: 1-844-477-8313

Hours: 8:00 a.m.–8:00 p.m.

When you call the Member Services Department to file a complaint, the member service representative will start the complaint process and forward it to the Member Advocate Department. This department has staff who is focused on helping our members get the services they need and resolving complaints. The staff work with all of our Sunshine Health departments to help get answers for you. The Member Advocate staff has 24 hours to follow-up with you and resolve the issue. If the issue does not get resolved within 24 hours, the complaint automatically becomes a grievance.

Filing a Grievance

A grievance is a formal written complaint submitted by a parent or legal guardian of a Sunshine Health member related to:

1. Availability, coverage of, or quality of health care services including an adverse benefit determination made during the Sunshine Health Utilization Management review process;
2. Claims payment to providers or Sunshine Health decision to not pay for health care services; or
3. Concerns related to the Sunshine Health contract (explanation of coverage) for your child.

In addition, as noted above, any complaint not resolved in 24 hours automatically becomes a member grievance.

Sunshine Health will send you a confirmation letter informing you that your grievance has been received and is being reviewed. A standard grievance is normally completed within thirty days.

If your child has an urgent need for care, you can request an urgent grievance. Sunshine Health uses the Florida definition of urgent, which is when the standard 30 day timeframe of the grievance procedure would seriously jeopardize the life or health of a member or would risk the member's ability to regain maximum function. An urgent grievance can be given to Sunshine Health's Member Services department. For urgent grievances, Sunshine Health will resolve the grievance within 72 hours of receipt. Sunshine Health does not require a written request for an urgent grievance. If the grievance does not meet the definition of urgent, Sunshine Health will process it as standard, and notify you verbally and in writing of the change to standard grievance.

A grievance that is related to a denial of services is called an Appeal. An appeal deals specifically with the medical necessity for a service or treatment that is a benefit. See the information in the Filing an Appeal section below.

You have the right to file a grievance within **one year** after the event occurred. A provider may file a grievance on your behalf with your written consent.

To file a grievance you can:

- Call Member Services at 1-866-796-0530 (TDD/TTY 1-800-955-8770), or
- Write us a letter telling us why you are not happy. Be sure to include:
 - o Your child's first and last name
 - o Your child's Sunshine Health member ID number
 - o Your address and telephone number

Mail the letter to:

**Sunshine Health
Appeal and Grievance Coordinator 1301 International Parkway
Suite 400
Sunrise, FL 33323
Fax 1-866-534-5972**

If you would rather have someone speak for you, let us know. Another person can act for you. You have the right to review your grievance file at any time.

Sunshine Health will send you a letter telling you that we received your grievance within **5 days**. We will try to make a decision right away. Sometimes we can resolve it on the phone. If not, we will give you a written decision within **30 calendar days** after we get your grievance. If Sunshine Health needs extra time to resolve the grievance (or if you or your authorized representative, or provider requests additional time) we will add **14 calendar days** to the 30 day timeframe after obtaining your consent to extend the timeframe.

Filing an Appeal

If Sunshine Health receives a request to review a service that requires a prior authorization and a decision is made to not approve the service as it was requested, a parent or legal guardian of a Sunshine Health member can file an appeal. **This would include decisions to:**

- Fully or partially deny payment.
- Approve the requested health care service at a lesser level or for a period of time that was different from what was requested.
- Deny payment of the requested service but to approve payment for a different health care service.

You, your doctor, or someone that you name to help you, can ask us to change our decision. This is called an appeal. You can ask for an appeal in writing or by calling us. If you appeal by phone, you must also send in a written, signed appeal. The written appeal must be sent within 10 calendar days after we get your phone call for an appeal. If you want to appeal, you must tell us within 60 days of the date of this letter. **You can file an appeal by writing to us at:**

**Sunshine Health
Appeals and Grievances Coordinator 1301 International Parkway.
Suite 400
Sunrise, FL 33323
Phone: 1-866-796-0530
Fax: 1-866-534-5972**

We will give you an answer within 30 calendar days of you asking for an appeal.

The written appeal should include the following information:

- Your child's name.
- Your child's identification number on the Sunshine Health ID card.
- A phone number where we can reach you.
- Why you think we should change the decision.
- Medical information to support the request.

We have told your doctor of this action. We told them what he/she needs to do if they want to help you appeal the decision. You can give written notes, papers or other information important to the appeal. If you want your doctor or someone else to help you in the appeal, you must tell us this in writing.

You can ask for an "expedited appeal" if you or your doctor think that waiting up to 30 calendar days could put your child's life or health in danger. You or your doctor should tell us this when asking for an appeal. If we agree, we will make a decision within 72 hours of receiving your appeal.

If we are going to reduce, or stop a service we had approved you to receive in the past, you have the right to keep getting the service until we make our decision on your appeal if:

- We approved you to get the service from the provider.
- The time limit we approved hasn't ended.

You must ask on or before ten working days of the mailing date of this notice or the effective date of the action to continue getting the service. If you appeal the action and keep getting service, you may have to pay for the service. This is only if we decide that our first decision to deny coverage and/or payment for the service was right.

INDEPENDENT REVIEW ORGANIZATION (IRO)

If you do not agree with the Sunshine Health appeal decision, you have the right to have an independent review of the appeal decision made by Sunshine Health. Sunshine Health must pay the cost of the external review conducted by an Independent Review Organization (IRO). An IRO is not connected in any way with Sunshine Health. Sunshine Health must abide by the IRO's decision and carry out its instructions.

You can make a request for external review in writing to Sunshine Health at:

Sunshine Health (Florida Healthy Kids Program)
Appeals Department
1301 International Parkway
Sunrise, FL 33323

If assistance is needed with completing the written request, you may contact Sunshine Health at:

Phone 1-844-477-8313
TTY/TDD 1-800-955-8770
Fax 1-866-534-5972

We will send your request to the IRO. You must contact the IRO or us within 120 calendar days (4 months) of receiving the denial of appeal letter. If you do not file your request for an external independent review within 120 days, it cannot be reviewed. If you are not sure whether your appeal is eligible, or if you want more information, please contact Sunshine Health.

ASSISTANCE AND CONTACTING SUNSHINE HEALTH

Sunshine Health's Appeal and Grievance Coordinator is available to assist a member's parent or legal guardian who need help in filing a grievance or request for appeal or in completing any element in the grievance or appeal process. A member's parent or legal guardian may seek assistance or initiate a grievance or request for appeal by calling 1-866-796-0530 (or TDD/TTY 1-800-955-8770).

SPECIAL SERVICES TO ASSIST WITH MEMBERS

Sunshine Health has designed its programs and trained its staff to ensure that each member's cultural needs are considered in carrying out Sunshine Health operations. Providers should remain cognizant of the diverse Sunshine Health population. Members' needs may vary depending on their gender, ethnicity, age, beliefs, etc. We ask that you recognize these needs in serving your members. Sunshine Health is always available to assist your office in providing the best care possible to the members. There are several services that are also available to the member's parents, legal guardian and members to assist with their everyday needs. Please see the description below.

INTERPRETER/TRANSLATION SERVICES

Sunshine Health is committed to ensuring that staff and subcontractors are educated about, remain aware of, and are sensitive to the linguistic needs and cultural differences of its members. **In order to meet this need, Sunshine Health is committed to the following:**

- Making individuals available who are trained professional interpreters for Spanish and English sign language, and who will be available on site or via telephone to assist providers with discussing technical, medical or treatment information with members as needed.
- Providing Language Line services that will be available 24 hours a day, seven days a week in many languages to assist providers and members in communicating with each other when there are no other translators available for the language.
- In-person interpreter services are made available when Sunshine Health is notified in advance of the member's scheduled appointment in order to allow for a more positive encounter between the member and provider; telephonic services are available for those encounters involving urgent/emergent situations, as well as non-urgent/emergent appointments as requested.
- Providing TDD/TTY access for members who are hearing impaired through 1-800-955-8770.
- Sunshine Health nurse advice line, Envolv PeopleCare™, provides 24 hour access, seven days a week for interpretation of Spanish or the coordination of non-English/Spanish needs via the language line.
- Providing or making available member services and health education materials in alternative formats as needed to meet the needs of the members, such as audio tapes or language translation; all alternative methods must be requested by the member or designee.

Providers must call 1-844-477-8313 if interpreter services are needed. Please have the member's ID number; date/time service is requested and any other documentation that would assist in scheduling interpreter services.

Provider Services Assistance

PROVIDER SERVICES DEPARTMENT

The Provider Services Department at Sunshine Health is designed around the concept of making your experience with Sunshine Health a positive one by being your advocate within Sunshine Health. **Provider Services is responsible for providing the services listed below, which include, but are not limited to:**

- Maintenance of existing Sunshine Health Provider Manual.
- Researching of trends in claims inquiries to Sunshine Health.
- Pool settlement updates/status.

The goal of this department is to furnish you and your staff with the necessary tools to provide the highest quality of healthcare to Sunshine Health enrolled membership. **To contact the Provider Services Specialist for your area contact:**

Provider Services Operations

1-844-477-8313 (enter the #2 digit extension)

Fax 1-866-796-0528

The Provider Services toll free help line staff is available to you and your staff to answer questions, listen to your concerns, assist with members, respond to your Sunshine Health inquiries, connect you to the Sunshine Health Provider Services Specialist for your area and other services as you request.

Provider Services Representatives work to serve as your advocates to ensure that you receive necessary assistance and maintain satisfaction with Sunshine Health.

Note: Eligibility is the responsibility of the provider to pull from the Web Portal. Provider Services will not be distributing manual/paper files.

PROVIDER COMPLAINTS

Providers have the right to appeal policies/procedures and any decision made by Sunshine Health. Non claims related complaints may be filed telephonically or in writing by contacting Sunshine Health Provider Services at:

**Sunshine Health
1301 International Parkway
Suite 400
Sunrise, FL 33323
ATTN: Provider Services
1-844-477-8313**

CLAIM RESUBMISSIONS, ADJUSTMENTS AND DISPUTES

If a provider has a question or is not satisfied with the information they have received related to a claim, he or she should contact a Sunshine Health Provider Services Representative at 1-844-477-8313.

All requests for claim reconsideration or adjustment must be received within 45 calendar days from the date of notification of payment or denial. Prior processing will be upheld for reconsiderations or adjustments received outside of the 45 day timeframe, unless a qualifying circumstance is offered and appropriate documentation is provided to support the qualifying circumstance. **Qualifying circumstances include:**

- Catastrophic event that substantially interferes with normal business operations of the provider or damage or destruction of the provider's business office or records by a natural disaster.
- Pending or retroactive member eligibility. The claim must have been received within six months of the eligibility determination date.
- Mechanical or administrative delays or errors by Sunshine Health or the FHKC or their third party administrator.
- The member was eligible however the provider was unaware that the member was eligible for services at the time services were rendered.

Consideration is granted in this situation only if all of the following conditions are met:

- The provider's records document that the member refused or was physically unable to provide their member ID card or coverage information.
- The provider can substantiate that he continually pursued reimbursement from the patient until Sunshine Health eligibility was discovered.
- The provider can substantiate that a claim was filed within 180 days of discovering Sunshine Health member eligibility.
- No other paid claims filed by the provider prior to the receipt of the claim under review.

When submitting a paper claim for review or reconsideration of the claims disposition, a copy of the EOP must be submitted with the claim, or the claim must clearly be marked as **"RE-SUBMISSION"** and **include the original claim number**. Failure to boldly mark the claim as a **resubmission** and include the claim number (or include the EOP) may result in the claim being denied as a duplicate, or for exceeding the filing limit deadline.

Providers may discuss questions with Sunshine Health Provider Services Representatives regarding amount reimbursed or denial of a particular service; providers may also submit in writing, with all necessary documentation, including the EOP for consideration of additional reimbursement. Response to an approved adjustment will be provided by way of check with an accompanying EOP.

All disputed claims will be processed in compliance with the claims payment resolution procedure as described in the Sunshine Health Provider Manual.

Pharmacy

SUNSHINE HEALTH PHARMACY PROGRAM

Sunshine Health covers drugs that are included in the Sunshine Health drug formulary. Sunshine Health has many participating community retail pharmacies where a member can get his or her drugs filled. Diabetic supplies and some over the counter drugs, such as vitamins and pain relievers are covered under Sunshine Health's drug formulary. These drugs are only covered if a physician or dentist prescribes the over the counter drug.

In addition to drugs that are available at a retail pharmacy, Sunshine Health covers specialty or injectable drugs that can be provided in a physician's office or in the member's home. This does not include immunizations provided in the PCP's office.

If the member's Healthy Kids dentist prescribes a drug, Sunshine Health's formulary will be used to determine the coverage of the prescribed drug.

The Sunshine Health Healthy Kids Preferred Drug List can be found at www.sunshinehealth.com under Provider Resources.

Working with Our Pharmacy Benefit Manager (PBM)

Sunshine Health works with Envolve Pharmacy Solutions™ to process all pharmacy claims for prescribed drugs. Certain drugs may be subject to quantity, age, or gender edits or require prior authorization to be approved for payment by Sunshine Health. Please refer to the Sunshine Health formulary for medication coverage limitations and prior authorization requirements. Medications not listed on the formulary require a prior authorization prior to approval. Envolve Pharmacy Solutions™ is responsible for administering the PA process for all prescribed drugs requiring PA.

Follow these guidelines for efficient processing of your PA requests:

1. Complete the Sunshine Health/Envolve Pharmacy Solutions™ Prior Authorization Request Form.
2. Fax to Envolve Pharmacy Solutions™ at **1-866-399-0929**.
3. Once approved, Envolve Pharmacy Solutions™ notifies the prescriber by fax.
4. If the clinical information provided does not explain the request for the PA medication, Envolve Pharmacy Solutions™ responds to the prescriber by fax, informing that more information is needed.
5. For urgent or after-hours requests, a pharmacy can provide up to a 72-hour supply of most medications by calling the Envolve Pharmacy Solutions™ Help Desk at: **1-800-460-8988**.

Working with Our Specialty Pharmacy Provider

Acaria Health Specialty Pharmacy is the preferred provider of biopharmaceuticals and specialty injectables for Sunshine Health. Many high cost specialty injectables require PA to be approved for payment. Please check the Sunshine Health Stars Preferred Drug List (PDL) for the most updated list of Prior Authorizations Requirements. Follow these guidelines for the most efficient processing of your PA requests.

Non-specialty home infusion medications including TPN and IV Antibiotics can be obtained through a contracted home infusion provider. Providers can request that Acaria Health deliver the specialty drug to the office/member. If you want Acaria Health to deliver the specialty drug to the office/member:

1. Call Acaria Health at **1-855-535-1815** or fax Acaria Health at 1-855-217-0926 for PA.
2. For specialty pharmacy PA requests, providers may fax the request to 1-855-678-6976.

We Help Keep You Informed

The Sunshine Health Pharmacy Program Director, a registered pharmacist, compiles current pharmacological policy and information about important seasonal topics such as Respiratory Syncytial Virus (RSV) and influenza. The information is consistent with published guidelines and is mailed to network providers as a service. The most current version of the Sunshine Health Stars PDL and PA Request Forms can be downloaded from our website at: www.sunshinehealth.com.

The Sunshine Health Stars PDL

The Sunshine Health Stars PDL describes the circumstances under which contracted pharmacy providers will be 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 patient or others.

Pharmacy and Therapeutics Committee (P&T)

The Sunshine Health P&T continually evaluates the therapeutic classes included in the PDL. The committee is composed of the Sunshine Health medical director, pharmacy program manager and several community-based primary care physicians and specialists. The primary purpose of the committee is to assist in developing and monitoring the Sunshine Health Stars PDL and to establish programs and procedures that promote the appropriate and cost-effective use of medications. The P&T committee schedules meetings at least quarterly during the year, and coordinates therapeutic class reviews with the parent company's national P&T committee.

Unapproved Use of Preferred Medication

Medication coverage under this program is limited to non-experimental indications as approved by the FDA. Other indications may also be covered if they are accepted as safe and effective using current medical and pharmaceutical reference texts and evidence-based medicine. Reimbursement decisions for specific non-approved indications will be made by Sunshine Health. Experimental drugs, investigational drugs and drugs used for cosmetic purposes are excluded from coverage. See the benefit limitation section for additional details on drugs that are not covered or have a limitation.

Prior Authorization (PA) Process

The Sunshine Health Stars PDL includes a broad spectrum of generic and brand name drugs. Clinicians are encouraged to prescribe from the Sunshine Health Stars PDL for their patients who are members of Sunshine Health. Some preferred drugs require PA. Medications requiring PA are listed with a “PA” notation throughout the PDL, including the index. In addition, most injectable medications require PA.

The P&T committee has reviewed and approved, with input from its members and in consideration of medical evidence, the list of drugs requiring PA. This PDL attempts to provide appropriate and cost-effective drug therapy to all participants covered under the Sunshine Health pharmacy program. If a patient requires medication that does not appear on the PDL, the clinician can submit a PA request for a non-preferred medication. It is anticipated that such exceptions will be rare and that currently available PDL medications will be appropriate to treat the vast majority of medical conditions encountered by Sunshine Health providers.

A phone or fax-in process is available for PA requests:

Envolve Pharmacy Solutions™ Contacts

Prior Authorization Fax	1-866-399-0929
Prior Authorization Phone	1-866-399-0928
Clinical Hours	Monday-Friday 8:00am-8:00pm (EST)
Mailing Address	Envolve Pharmacy Solutions™ 5 RiverParkPlace East Suite 210 Fresno, CA 93720

When calling, please have patient information, including identification number, complete diagnosis, medication history and current medications readily available. Upon receipt of all necessary information, Envolve Pharmacy Solutions™ will respond by fax or phone within 24 hours except during weekends and holidays. If the request is approved, information in the online pharmacy claims processing system will be changed to allow the specific member to receive this specific drug. If the request is denied, information about the denial will be provided to the clinician. A notice of action letter will be sent to the member and requesting provider informing of the denial decision, the reason, and providing the member appeal rights.

Phone Numbers for Sunshine Health Member Services

The above phone and fax lines are dedicated to clinicians requesting PA medication items **only**. Members cannot be assisted if they call the PA toll-free number. The Sunshine Health Member Services phone number is **1-866-796-0530**.

72-Hour Emergency Supply Policy

State law allows that pharmacies dispense a 72-hour (three-day) supply of medication to a patient awaiting a PA determination. The purpose is to avoid interruption of current therapy or delay in the initiation of therapy. All participating pharmacies are authorized to provide a 72-hour supply of medication and will be reimbursed for the ingredient cost and dispensing fee of the 72-hour supply of

medication, whether or not the PA request is ultimately approved or denied. The pharmacy may call the Envolve Pharmacy Solutions™ Help Desk at 1-800- 460-8988 for a prescription override to submit the 72-hour medication supply for payment.

Specific Exclusions

The following drug categories are not part of the Sunshine Health Stars 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.
- DESI ineffective drugs as designated by CMS.
- Experimental/Investigational pharmaceuticals or products.
- Hair growth restorers and other drugs used for cosmetic purposes.
- Immunizing agents (except for influenza vaccine).
- Injectable/Oral drugs administered by the provider in the office, in an outpatient clinic or an infusion center, or in a mental health center.
- Prostheses, appliances and devices (except products for Diabetics and products used for contraception).
- Injectable drugs or infusion therapy and supplies (except those listed in the PDL).
- Nutritional supplements.
- Oral vitamins and minerals (except those listed in the PDL).
- OTC drugs (except those listed in the PDL).
- Drugs covered under Medicare Part B and/or Medicare Part D.
- Products covered under the DME benefit.

Newly Approved Products

Newly Approved drug products will not normally be placed on the preferred drug list during their first six months on the market. During this period, access to these medications will be considered through the PA review process.

Step Therapy

Medications requiring step therapy are listed with an “**ST**” notation throughout the preferred drug list. The Envolve Pharmacy Solutions™ claims system will automatically check the member profile for evidence of prior or current usage of the required agent. If there is evidence of the required agent on the member’s profile, the claim will automatically process. If not, the claims system will notify the pharmacist that a PA is required.

Policy for Injectable Drugs

Injections that are self-administered by the member and/or a family member and appear on the PDL are covered by the Sunshine Health pharmacy program. **Insulin, Glucagon Kit, Epinephrine kits, Imitrex, and medroxyprogesterone IM are covered by Sunshine Health and do not require a PA. Most other injectables require PA. Please check the Sunshine Health Stars PDL for a complete list.**

Dispensing Limits - Quantity Limit (QL) and Age Limit (AL)

Drugs may be dispensed up to a maximum 31-days' supply for each new (original) or refill. A total of 85% of the days supplied must have elapsed before the prescription can be refilled.

Age Limits

Age Based PA Requirements:

Age Based PA requirements are noted on the PDL and include the examples below.

*Cough & Cold Medications (other than guaifenesin) are limited to recipients under the Age of 21 (Healthy Kids eligibility is up to age 18).

*Rx Pediatric Multi-Vitamins with Fluoride are limited to recipients that are 13 years old and under (Healthy Kids eligibility is for ages 5 up to 18).

Mandatory Generic Substitution

Sunshine Health requires that generic substitution be made when a generic equivalent is available. All branded products that have an A-rated generic equivalent will require a Prior Authorization approval. The provision is waived for the following products due to their narrow therapeutic index: ***Aminolhylline, Amiodarone, Carbamazepine, Clozapine, Cyclosporine, Digoxin, Disopyramide, Ethosuximide, Flecainide, L-thyroxine, Lithium, Phenytoin, Procainamide, Propafenone, Theophylline, Thyroid, Valproate Sodium, Valproic Acid and Warfarin.***

DESI or IRS Drugs

Drug Efficacy Study Implementation (DESI) and Identical, Related and Similar (IRS) drugs that are classified as ineffective are not covered by the Sunshine Health Stars PDL.

Contacts for Pharmacy Appeals/Grievances

Members

In the event that a member or his/her parent/guardian disagrees with an adverse decision regarding coverage of a medication, the member may file an appeal with Sunshine Health by calling the Sunshine Health Member Services Department at 1-866-796-0530.

Physicians / Clinicians

In the event that a clinician or member disagrees with the decision regarding coverage of a medication, the clinician may request reconsideration by submitting additional information to Envolve Pharmacy Solutions™. The additional information may be provided verbally or in writing. A decision will be rendered and the clinician will be notified with a faxed response. If the request is denied, the clinician will be notified of the appeals process at that time.

An expedited appeal may be requested at any time the provider believes the adverse determination might seriously jeopardize the life or health of a member by calling Sunshine Health's Appeals & Grievance Coordinator at **1-844-477-8313**. The parent or legal guardian of a Sunshine Health member must give written approval to Sunshine Health for the provider to file an appeal or expedited appeal on their child's behalf. A response will be rendered the same day as receipt of complete information. In circumstances that require research, a same day response may not be possible. A 72-hour emergency supply of the medication will be provided to the patient until the expedited appeal review is completed.

