

WELCOME TO SUNSHINE HEALTH

Sunshine Health is a Managed Care Organization (MCO) contracted with the Florida Agency for Health Care Administration (AHCA) to serve Medicaid and other government services program members. Sunshine Health has developed the expertise to work with Medicaid members to improve their health status and quality of life. 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 (PCPs) who oversee the healthcare of Sunshine Health members.

Medicaid is the state and federal partnership that provides health coverage for selected categories of people with low incomes. Its purpose is to improve the health of people who might otherwise go without medical care for themselves and their children. Medicaid is different in every state.

Sunshine Health is a wholly owned subsidiary of Centene Corporation which provides Medicaid managed care services to members in designated counties of Florida. Centene and its wholly owned health plans have a long and successful track record offering Medicaid managed care services. For more than 20 years, Centene has provided comprehensive managed care services to the Medicaid population and currently operates health plans in Georgia, Indiana, Ohio, Massachusetts, South Carolina, Texas, Mississippi, and Wisconsin. 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

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.



PROVIDER QUICK REFERENCE GUIDE

PROVIDER SERVICES

Providers can visit the Sunshine Health website at www.sunshinehealth.com to access the following:

- Provider Manual
- Provider Forms
- Provider Directory
- Billing Manual
- Companion Guide for Electronic Transactions
- Child Health Check-Up/EPSTDT Information
- PaySpan Health for EFT's/ERA's
- Sunshine Health News
- Clinical Guidelines
- Fraud, Waste, and Abuse Training for Providers

The following information is available via the website by logging into the secure portal:

- Primary Care Provider (PCP) verification
- Member eligibility/verification
- Submit claims
- Claims inquiry/adjustment
- Request prior authorization for services

Contact Sunshine Health Provider Services Department, 8:00a.m. to 8:00p.m. EST, Mon.-Fri., at phone 1-866-796-0530, or fax 1-866-614-4955, for assistance with the following services:

- Answer questions regarding claim status
- Network participation
- Member eligibility/verification
- Request a free copy of our Provider Manual

HEDIS Measures: Sunshine Health calculates and reports HEDIS measures annually. HEDIS consists of 20+ Effectiveness of Care type measures as well as Access to Care and Use of Services measures for which the Plan contractually reports rates to the State of Florida based on claims and/or med records review data.

Measures include: Effectiveness of Care, Access, and Availability, Satisfaction with the Experience of Care, Use of Services, Cost of Care, Health Plan Descriptive Information, and Health Plan Stability.

Periodicity for Well Child visits:

- Birth exam
- Two to four days (if newborn is discharged in less than 48 hours)
- By one month
- Two months
- Four months
- Six months
- Nine months
- Twelve months
- Fifteen months
- Eighteen months
- Once per year from age two through twenty

CLAIMS SERVICES

Electronic Transactions (EDI):

EDI support for HIPAA transactions is provided by Sunshine Health's corporate office, Centene Corp. For support, please contact our EDI Dept. at 1-800-225-2573, ext. 25525 or visit our website at www.sunshinehealth.com.

The website contains our electronic Billing Manual, which offers detailed information regarding claims billing instructions, requirements for the 1500/837 Professional, and the UB04/837 facility.

Sunshine Health's Payer ID is 68069.

Claims Reconsiderations and Disputes:

All requests for claims reconsideration or adjustment must be clearly marked as such and mailed with documentation to:

Sunshine Health

PO Box 3070

Farmington, MO 63640-3823

ATTN: Adjustment/Reconsiderations/Disputes

Timely Filing Guidelines:

Initial Filing – 180 calendar days of the date of service

Coordination of Benefits (Sunshine Health as Secondary) – 90 calendar days of the primary payer's determination

Corrected/Reconsideration/Disputes – 90 calendar days from the payment/denial notification

MEDICAL MANAGEMENT

The Sunshine Health Medical Management team provides oversight for utilization management, case management, and care coordination. Authorization must be obtained prior to the delivery of certain elective and scheduled services.

Prior authorization requests timeline:

- Inpatient admissions non-emergent
 - Physician office requests for plan approval – 14 calendar days before proposed admission
- Hospital requests for plan approval – Two business days before actual date of admission
- Inpatient emergent or urgent admissions
 - Hospital notifies Plan within two business days of admission
- Newborn deliveries – Notification to Plan next business day
- Observation admission – Notification within the first 48 hours
- Out-Of-Network – Notification following stabilization of emergency care
- Non Urgent Requests – Have seven calendar days to approve/dis-approve
- Urgent Request – Have 48 hours to approve/dis-approve

Medical Management/Case Management

1-866-796-0530 – Mon. through Fri., 8 a.m. to 7 p.m. EST
1-866-796-0526 (Prior Authorization Fax)
1-877-689-1056 (Case Management Fax)

MEMBER SERVICES

To make a selection for a newborn, members should call the Member Services Department. Members may call the Plan to select and/or change their PCP assignment at any time. Members requiring translation, interpretation, or sign language services may be arranged through the Member Services Department.

Member Services Department

1-866-796-0530 - 8 a.m. to 7 p.m. EST, Mon. – Fri.
Member Services Fax 1-866-796-0523
TDD/TYY 1- 800-955-8770

VENDOR SERVICES

US Script – Pharmacy Benefit Manager

2425 W Shaw Avenue
Fresno, CA 93711
1-866-399-0928 Phone
1-866-399-0929 Fax

Specialty Pharmacy

1-866-796-0530 Phone
1-866-351-7388 Fax

Cenpatico Behavioral Health

PO Box 6900 (ATTN: Claims)
Farmington, MO 63640-3818
1-866-796-0530 Phone
www.Cenpatico.com

National Imaging Associates (NIA)

1-877-807-2363 Phone
www.RadMD.com

Opticare (routine eye care)

PO Box 7548 (ATTN: Claims)
Rocky Mount, NC 27804
1-800-334-3937 Phone
www.Opticare.com

NurseWise (24/7 Availability) 1-866-796-0530 Phone

The only entity Sunshine Health delegates grievance and appeals to is Cenpatico. All other vendors must send all complaints, grievances and appeals pursuant to the process described in the Provider Manual.

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SUNSHINE HEALTH 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 patients, our members.

SUNSHINE HEALTH SUMMARY

Sunshine Health's philosophy for Florida Medicaid members is to provide access to high quality, culturally sensitive healthcare services by combining the talents of Primary Care Providers (PCPs) and specialty providers with a highly successful, experienced managed care administrator. 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 **1-866-796-0530**.

FLORIDA MEDICAID AND THE STATEWIDE MEDICAID MANAGED CARE (SMMC) PROGRAM

Florida has offered Medicaid services since 1970. Medicaid provides health care coverage for eligible children, seniors, disabled adults and pregnant women. It is funded by both the state and federal governments. The 2011 Florida Legislature passed House Bill 7170, creating Part IV of Chapter 409, F.S. to establish the Florida Medicaid program as a statewide, integrated managed care program for all covered services including long term care services. This program is referred to as a Statewide Medicaid Managed Care (SMMC) and includes two programs: one for Managed Medical Assistance (MMA) and one for Long-Term Care (LTC).

The Florida SMMC program is governed by various rules and regulations, including the SMMC contract between Agency for Health Care Administration (AHCA) and the Managed Care Organizations (MCOs) and Florida Medicaid Handbooks. Many of these documents can be found on AHCA's website at <http://portal.flmmis.com/FLPublic/>.

IVR SYSTEM

An Interactive Voice Response (IVR) system is operational 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 status of claims.
- Available 24 hours, seven days a week.

Use the IVR System by simply calling **1- 866-796-0530**.

WEBSITE

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

- ✓ Provider Directory
- ✓ Preferred Drug List
- ✓ Frequently Used Forms
- ✓ EDI Companion Guides
- ✓ Billing Manual
- ✓ Provider Office Manual
- ✓ Submit Claims On-Line
- ✓ Managing EFT

Sunshine 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, which 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.

PROVIDER RESPONSIBILITIES



PRIMARY CARE PROVIDER (PCP)

The Primary Care Provider (PCP) is the cornerstone of Sunshine Health. The PCP serves as the “medical home” for the member. The member may change their PCP’s as frequently as they desire. 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.

Patient-Centered Medical Home (PCMH): Sunshine Health’s PMCH is built upon the joint principles of the Patient-Centered Medical Home which includes the following characteristics: a personal physician in a physician-directed, team-based medical practice; whole person orientation; coordinated and/or integrated care; quality and safety; enhanced access; and payment. Sunshine Health accepts PCMH recognition from NCQA, the Joint Commission for Accreditation of Health Organizations (JCAHO), Accreditation Association for Ambulatory Health Care (AAAHC) and URAC. Sunshine Health also evaluates PCP practices’ ability to function as a PCMH using the Sunshine Health proprietary PCMH assessment tool, which incorporates the six NCQA must-pass elements. If a practice is interested in becoming a PMCH, they can contact Provider Services at 1-866-796-0530.

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

COVERED PCP 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, including documentation of all services provided by the PCP, any specialty services, and screening for behavioral health or substance abuse conditions. The PCP shall arrange for other participating physicians to provide members with covered physician services as stipulated in their contract, and communicate with those treating providers. 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.

Covered services include:

- Professional medical services, both inpatient and outpatient, provided by the PCP, nurses, and other personnel employed by the PCP. These services include the administration of immunizations, but not the cost of biologicals.
- Periodic health assessments and routine physical examinations (performed at the discretion of the PCP, and consistent with AHCA’s, Sunshine Health’s preventive guidelines, and other nationally recognized standards recommended for the age and sex of the covered person).
- Vision screening, hearing screenings, and dental assessment (as part of CHCUP visit).
- All supplies with a payment amount of less than \$500 and covered medications used or provided during an eligible member’s office visit does not require a prior authorization.

- High cost specialty/injectable drugs, as listed on the prior-authorization list, require a prior authorization and must be obtained from Sunshine Health to ensure payment. Please call the Sunshine Health Pharmacy Department at 1-866-796-0530 to obtain more detailed information on these drugs, please refer to Page 102.
- All tests routinely performed in the PCP's office during an office visit.
- The collection of laboratory specimens.
- Voluntary family planning services such as examinations, counseling, and pregnancy testing.
- Well-child care and periodic health appraisal examinations, including all routine tests performed customarily in a PCP's office. Well-child exams performed according to the EPSDT periodicity schedule, Sunshine Health's preventive guidelines, and recommendations of the American Academy of Pediatrics (AAP), and immunizations according to the Advisory Committee on Immunization Practices (ACIP) guidelines, and in keeping with procedures outlined in this Provider Manual.
- Referral to specialty care physicians and other health providers with coordination of care, follow-up after referral
- Oversight of a member's entire drug regimen, including those prescribed by another provider, inclusive of behavioral health providers.
- PCP's supervision of home care/home infusion regimens involving ancillary health professionals provided by licensed nursing agencies.
- Any other outpatient services and routine office supplies normally within the scope of the PCP's practice.
- A treatment plan developed collaboratively with member, member's parent or legal guardian, or other member authorized person and other treating specialists, as appropriate. This includes members seen for routine care or monitoring and those who need an extended or complex course of treatment.
- Health Risk Assessments will include screening for tobacco use, providing cessation counseling, BMI, nutrition, exercise or other lifestyle risks. In addition, anticipatory guidance based on age of member – normal growth and development, seat belt use, drug or alcohol use.
- Assessments for gaps in preventive health screenings or visits along with the evidence based treatment of chronic conditions.
- Identification and referral of members who may benefit from Sunshine Health's case management, health management, or lifestyle coaching programs
- Provider shall immediately report 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). Provider warrants and represents that staff mandated to report abuse, neglect and exploitation have received appropriate training in reporting abuse, neglect and exploitation. Provider agrees to participate in any other training as mandated by regulatory authorities and/or Health Plan.

PCP AVAILABILITY

Availability 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 Sunshine Health. At least annually, we compute 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 Member Services Department analyzes member surveys and member complaint data to address AHCA and federal requirements regarding the cultural, ethnic, racial, and linguistic needs of the membership. The Quality Improvement 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 for review and recommendation and is incorporated into Sunshine Health's annual assessment of quality improvement activities. The Quality Improvement Committee 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. Such service 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 Consumer Assessment of Healthcare Provider Systems survey (CAHPS), analyzing member complaints regarding access, and reviewing telephone access.

24-HOUR ACCESS

Each PCP is responsible to maintain 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 hour 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 and scheduled and unscheduled visits.

PCP COVERAGE

The PCP shall arrange for coverage with a physician who has executed a PCP 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

Sunshine Health's appointment availability standards are:

- **Urgent Care** within one day
- **Routine Sick Patient Care** within one week
- **Post hospital discharge follow-up within one week**
- **Well Care Visit** within one month

Sunshine Health will monitor appointment and after-hours availability on an on-going basis through its Quality Improvement 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:
 - After hours telephone care within 30 minutes.
 - 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 Quality Improvement Program (QIP).

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. This includes referral to behavioral health providers. 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 member.

If the PCP is capitated, referrals from a capitated PCP to another PCP will not be authorized or covered except for the following circumstances:

- Members who are auto-assigned to another PCP in the third trimester of their pregnancy when they become eligible for services under Sunshine Health (Medicaid members who are pregnant and not in the third trimester are subject to plan review and approval).
- Members having chronic medical conditions with ongoing healthcare needs that require continuity of care transition; examples include, but are not limited to, hemophilia, HIV/AIDS, sickle cell anemia, neoplasm, and organ transplant.
- Members who have other insurance coverage in which their primary provider is different from their Sunshine Health PCP.
- Members who have been inappropriately auto-assigned, until a new PCP can be assigned.
- Members who have moved 30 miles or more from their previous residence, until a new PCP can be assigned.

No paper referral is required when a PCP is referring a member to a participating provider, as long as the service is not included on Sunshine Health Prior Authorization List. Medical services that require prior authorization by Sunshine Health can be requested via phone, fax or provider web portal. A Referral Specialist will issue the referral authorization number immediately upon approval. Referral requests for services that require Sunshine Health's prior authorization after normal business hours can be made through NurseWise, our 24/7 Nurse Line. NurseWise 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
Telephone 1-866-796-0530
Fax 1-866-796-0526
Web address- www.sunshinehealth.com

Sunshine Health has the capability to perform the ANSI X 12N 278 referral certification and authorization transaction through Centene. For more information on conducting this transaction electronically, contact:

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

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

Providers must notify Sunshine Health Case Management Department via fax submission of the Notice of Pregnancy (NOP) within 10 days of the first prenatal visit. Providers will be expected to identify the estimated date of confinement and delivery facility. Sunshine Health will order a 90-day supply of prenatal vitamins for the member to be delivered to the obstetrical provider's office by the member's next prenatal visit.

For access to out-of-network providers, the network provider must call Sunshine Health for a prior authorization for any service from an out of network or non-participating provider or facility.

Sunshine Health does not use paper referrals. Should a provider desire a standing referral, or access to a specialty care center for a life-threatening condition or certain prolonged conditions, the provider must contact Sunshine Health's Case Management Department.

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.

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).
- Most mental health and chemical dependency/substance abuse services. Please consult the Cenpatico Provider Manual for a full description of Behavioral Health programs.
- Family Planning Services and supplies from a qualified Medicaid family planning provider.

Except for emergency and family planning 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 1-866-796-0528. A PCP shall not refuse to accept new members as long as the physician has not reached their requested panel size.

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

PROVIDER TERMINATION

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

OTHER 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 AHCA provider requirements and public health initiatives.
- 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 ordering diagnostic tests. 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.
- Provider shall immediately report 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). Provider warrants and represents that staff mandated to report abuse, neglect and exploitation have received appropriate training in reporting abuse, neglect and exploitation. Provider agrees to participate in any other training as mandated by regulatory authorities and/or Health Plan.
- For hospice and nursing home providers the bed hold days will comport with Medicaid fee- for-service applicable policies and procedures.

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

PREGNANCY REQUIREMENT

Sunshine Health has benefits and programs that support our pregnant women to improve pregnancy outcomes and infant health, including, but not limited to, coordination with the Healthy Start program, immunization programs, and referral to the Special Supplemental Nutrition Program for Women, Infants, and Children, and the Children's Medical Services program for children with special health care needs. Our program for pregnant women and infants promotes early prenatal care to decrease infant mortality and low birth weight and to enhance healthy birth outcomes.

The Agency for Health Care Administration (AHCA) requires maternity providers to implement specific screenings and referrals for pregnant Medicaid women. Sunshine Health supports these requirements.

Maternal/child provider responsibilities:

Healthy Start Prenatal Risk Screening:

- Completion of the Florida's Healthy Start Prenatal Risk Screening form as part of the first prenatal visit. A copy of the completed Risk Screening form should be kept in the member's medical record and a copy provided to the member. The form is also to be submitted to the county health department within 10 business days of completion.
- If the pregnant member or infant does not score high enough to be eligible for Healthy Start case management they may still be referred when the screen is completed. Indicate on the form that the member or infant is invited to participate based on factors other than score.
- If the determination is made subsequent to the risk screening, refer the member or infant directly to the Healthy Start care coordinator based on assessment of actual or potential factors associated with high risk, such as HIV, Hepatitis B, substance abuse, or domestic violence.
- Maintain all documentation of Healthy Start screenings, assessments, findings, and referrals in the member's medical record.

Women, Infants, and Children (WIC) referrals:

- Provide a completed Florida WIC program medical referral form with the current height or length and weight (taken within 60 calendar days of the WIC appointment), a hemoglobin or hematocrit, and any identified medical/nutritional problems.
- Coordinate with the local WIC office to provide the information above from the most recent CHCUP.
- Each time a WIC referral is made, give a copy of the form to the member and keeps a copy in the member's medical record.

HIV testing and counseling:

- Give all women of childbearing age HIV counseling and offer them HIV testing. Attempt to obtain a signed objection if the pregnant woman declines an HIV test.
- Counsel all pregnant women who are infected with HIV about and offer the latest antiretroviral regimen recommended by the U.S. Department of Health & Human Services.

Hepatitis B testing and management:

- Screen all pregnant women receiving prenatal care for the Hepatitis B surface antigen (HBsAg) during the first prenatal visit. Perform a second HBsAg test between 28 and 32 weeks of pregnancy for all pregnant women who tested negative at the first prenatal visit and are considered high-risk for Hepatitis B infection. Performed this test at the same time that other routine prenatal screening is ordered. Report all HBsAg-positive women to the local county health department and to Healthy Start, regardless of their Healthy Start screening score.

Infants born to HBsAg-positive mother:

- Infants born to HBsAg-positive members receive Hepatitis B Immune Globulin (HBIG) and the Hepatitis B vaccine once they are physiologically stable, preferably within 12 hours of birth.

Complete the Hepatitis B vaccine series according to the vaccine schedule established by the Recommended Childhood Immunization Schedule for the United States.

- Test infants born to HBsAg-positive enrollees for HBsAg and Hepatitis B surface antibodies (anti-HBs) six months after the completion of the vaccine series to monitor the success or failure of the therapy.
- Report to the local county health department a positive HBsAg result in any child age 24 months or less within 24 hours of receipt of the positive test results.
- Refer infants born to members who are HBsAg-positive to Healthy Start regardless of their Healthy Start screening score.
- Report to the Perinatal Hepatitis B Prevention Coordinator at the local county health department all prenatal or postpartum members who test HBsAg-positive and report the infant and contacts to the Perinatal Hepatitis B Prevention Coordinator. Use the Practitioner Disease Report Form (DH Form 2136) for reporting. The information provided to include: name, date of birth, race, ethnicity, address, infants, contacts, laboratory test performed, date the sample was collected, the due date or estimated date of confinement, whether the enrollee received prenatal care, and immunization dates for infants and contacts.

Care during the pregnancy:

- Complete pregnancy testing and a nursing assessment with referrals to a physician, physician's assistant or advanced registered nurse practitioner for comprehensive evaluation. Refer the member for any identified services.
- Schedule return prenatal visits at least every four weeks until week 32, every two weeks until week 36, and every week thereafter until delivery, unless the member's condition requires more frequent visits.
- Contact members who fail to keep their prenatal appointments as soon as possible, and arrange for their continued prenatal care.
- Assist members in making delivery arrangements, if necessary.
- Screen for tobacco use and make available smoking cessation counseling and appropriate treatment as needed.
- Document preterm delivery risk assessments in the member's medical record by week 28.
- If identify that the member's pregnancy is high risk, obstetrical care during labor and delivery includes preparation by all attendants for symptomatic evaluation and that the member progresses through the final stages of labor and immediate postpartum care.

Nutritional Assessment and Counseling:

- Complete a nutritional assessment and providing counseling.
- Promote breast-feeding and the use of breast milk substitutes for the provision of safe and adequate nutrition for infants.
- Offer a mid-level nutrition assessment. Provide individualized diet counseling and a nutrition care plan by a public health nutritionist, a nurse or physician following the nutrition assessment.
- Document the nutrition care plan in the medical record by the person providing the counseling.

Newborn care:

- Supply the highest level of care for the newborn beginning immediately after birth, including but not be limited to, the following:
 - Instill prophylactic eye medications into each eye of the newborn.
 - When the mother is Rh negative, securing a cord blood sample for type Rh determination and direct Coombs test.
 - Weigh and measure the newborn.
 - Inspect the newborn for abnormalities and/or complications.
 - Administer one half (.5) milligram of vitamin K.
 - Complete the APGAR scoring.
- Identify the need for an immediate referral for additional care in consultation from a specialty physician, such as the Healthy Start postnatal infant screen.

- Arrange for any necessary newborn and infant hearing screenings by a licensed audiologist or an individual who has completed documented training specifically for newborn hearing screenings and who is directly or indirectly supervised by a licensed physician or a licensed audiologist.
- Continuing care of the newborn is provided through the CHCUP program component and documented in the child's medical record.

Postpartum Care for the Mother:

- Complete a postpartum examination for the member within six weeks after delivery.
- Supply voluntary family planning, including a discussion of all methods of contraception, as appropriate.

Delivering hospital responsibilities:

- Electronically file the Healthy Start Prenatal Risk Screening Instrument Certificate of Live Birth with the county health department in the county where the infant was born within five business days of the birth.
- If the birthing facility does not participating in the Department of Health (DOH) electronic birth registration system, file the birth information with the county health department within five business days of the birth, keep a copy in the member's medical record and mails a copy to the member.
- Use generally accepted and approved protocols for both low-risk and high-risk deliveries reflecting the highest standards of the medical profession, including Healthy Start and prenatal screening.

Sunshine Health Responsibility:

- Provide care coordination/case management through the gestational period of the member according to her needs. This is provided through the Start Smart for Your Baby® maternity program.
- Collaborate with the Healthy Start care coordinators to assure delivery of risk-appropriate care.
- Establish specific programs and procedures to improve pregnancy outcomes and infant health, including, but not limited to, coordination with the Healthy Start program, immunization programs, and referral to the Special Supplemental Nutrition Program for Women, Infants, and Children, and the Children's Medical Services program for children with special health care needs.
- Refer all infants, children up to age five, and pregnant, breast-feeding, and postpartum women to the local WIC office.
- Establish agreements with each local Healthy Start Coalition in the region to provide risk-appropriate care coordination/case management for pregnant women and infants.

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 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.
- Sunshine Health's hospitals should refer to their contract for complete information regarding the hospitals' obligations and reimbursement.
- Provider shall immediately report 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). Provider warrants and represents that staff mandated to report abuse, neglect, and exploitation have received appropriate training in reporting abuse, neglect and exploitation. Provider agrees to participate in any other training as mandated by regulatory authorities and/or Health Plan.

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.

PCPs and any providers delivering care to Sunshine Health members must ensure **adult** members 18 years of age and older receive information on advance directives and are informed of their right to execute advance directives. Providers **must** document such information in the permanent medical record. 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) and whether or not the member has executed an advance directive.

Sunshine Health recommends to its PCPs and physicians that:

- The first point of contact for the member in the PCP's office should ask if the member has executed an advance directive; the member's response should be documented in the medical record.
- If the member has executed an advance directive, the first point of contact should ask the member to bring a copy of the advance directive to the PCP's office and document this request in the member's medical record.
- An advance directive should be included as a part of the member's medical record, including mental health directives.
- If an advance directive exists, the physician should discuss potential medical emergencies with the member and/or designated family member/significant other (if named in the advance directive and if available) and with the referring physician, if applicable. Discussion should be documented in the medical record.
- If an advance directive has not been executed, the first point of contact within the office should ask the member if they desire more information about advance directives.
- If the member requests further information, member advance directive education/information should be provided (form available on our plan website and in the Member Handbook).

- Member Services and CONNECTIONS representatives will assist members with questions regarding advance directives; **however, no employee of Sunshine Health may serve as witness to an advance directive, or as a member's designated agent or representative.**

Sunshine Health's Quality Improvement Department will monitor compliance with this provision during medical record reviews and as scheduled thereafter.

If you have any questions regarding advance directives, contact:

Quality Improvement Department

Telephone: 1-866-796-0530

Web address- www.sunshinehealth.com

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 assist Sunshine Health in these efforts by:

- Complying with public health reporting requirements regarding communicable diseases and/or diseases which are preventable by immunization as defined by state law.
- Assisting in the notification or referral of any communicable disease outbreaks involving members to the local public health entity, as defined by state law.
- Referring 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.
- Referring 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.
- Referring members for WIC services and information sharing as appropriate.
- Assisting in the coordination and follow-up of suspected or confirmed cases of childhood lead exposure.
- Identify and report to applicable authorities any suspected abuse or neglect.
- Assisting 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/ethics 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’s Cultural Competency Plan is available on the plan’s website.

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 provider’s 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.
- Care is provided with consideration of the members’ race/ethnicity and language and its impact/influence of the members’ health or illness.
- Office staff that routinely comes in contact with members has access to and participate in cultural competency training and development.
- Office staff responsible for data collection makes reasonable attempts to collect race and language specific member information. Staff will also explain race/ethnicity categories to a member so that the member is able to identify the race/ethnicity of themselves and their children.
- Treatment plans are developed and clinical guidelines are followed with consideration of the members 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 if required by AHCA.

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 they experience 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
- 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 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 Disparities¹

- 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.
- Blacks 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.
- Racial and ethnic low-income minority children are less likely to receive childhood immunizations.

¹ AHRQ “*2003 National Healthcare Disparities Report*”

- Patient race, ethnicity, and socioeconomic status are important indicators of the effectiveness of healthcare.

The Sunshine Health 2013 Cultural Competency Plan is available through the Sunshine Health website located at www.sunshinehealth.com, or by contacting our Provider Services Department at 1-866-796-0530, who, upon request, will furnish a copy at no charge.

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 must be kept in a secure location. Sunshine Health requires providers to maintain all records for members for at least 10 years for adult patients and 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 means the complete, comprehensive member records including, but not limited to, x-rays, laboratory tests, results, examinations and notes, accessible at the site of the member's participating PCP, that document all medical services received by the member, including inpatient, ambulatory, ancillary, and emergency care, prepared in accordance with all applicable AHCA rules and regulations, and signed by the medical professional rendering the services. Medical records are audited every two years for PCP providers and results are reported to AHCA.

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) 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 on all chart pages
- Personal/biographical data is present (i.e. employer, home telephone number, spouse, next of kin, legal guardianship, 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 all members or an appropriate history is made in chart for adults
- Evidence that preventive screening and services are offered in accordance with Sunshine Health's practice guidelines
- Appropriate subjective and objective information pertinent to the member's presenting complaints is documented in the history and physical
- 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 (ER) encounters; for children and adolescents (18 years and younger) 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 or infant risk assessment for newborns. including submission of the NOP within 10 days of the initial pre-natal visit
- Signed and dated required consent forms
- 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)
- Documentation of failure to keep an appointment
- 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
- Confidentiality of member information and records protected
- Evidence that an advance directive has been offered to adults 18 years of age and older
- Pre-birth selection form

MEDICAL RECORDS RELEASE

All member medical records shall be confidential and shall not be released to another physician or person without the written authorization of the covered person or a responsible covered person's legal guardian. 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 Sunshine Health member or former Sunshine Health member to any physician not connected with Sunshine Health.

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 members. If the member or member's 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 are required to be audited to determine compliance with Sunshine Health's standards for documentation and AHCA regulations. A sample of randomly selected providers will be audited at a minimum of every two years for PCPs that serve 10 or more members. 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.

MEDICAL MANAGEMENT



OVERVIEW AND MEDICAL NECESSITY

The Sunshine Health Medical Management Department hours of operation are Monday through Friday (excluding holidays) from 8:00 a.m. to 5:00 p.m. Requests for services that require Sunshine Health's prior authorization after normal business hours can be made through NurseWise, our 24/7 Nurse Line. NurseWise may be reached through Sunshine Health's telephone number. Providers are encouraged to use the Web Portal when requesting prior authorization of medical services. For prior authorizations during business hours, the provider should contact:

Utilization Management/Case Management
1-866-796-0530
1-866-796-0526 (Prior Authorization Fax)
1-877-689-1056 (Case Management Fax)
Web address: www.sunshinehealth.com

A Referral Specialist will enter the demographic information and will then transfer the call to a Registered Nurse (RN) or a Licensed Practical Nurse (LPN) for the completion of medical necessity screening. During heavy call volumes, a licensed nurse may answer the telephone and complete the medical necessity screening.

Medically Necessary or Medical Necessity:

Services that include medical, allied or long-term care, goods or services furnished or ordered to:

- 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 patient's needs.
 - Be consistent with the generally accepted professional medical standards as determined by the Medicaid program 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.
 - Be furnished in a manner not primarily intended for the convenience of the member, the member's caretaker or the provider.
- For those services furnished in a hospital on an inpatient basis cannot, consistent with the provisions of appropriate medical care, 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 or allied goods or services does not, in itself, make such care, goods, or services Medically Necessary, a Medical Necessity, or a Covered Service/Benefit.

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

- Member's name and Medicaid ID number
- Requesting physician's name and telephone number
- Refer to provider's name, NPI number, specialty type and telephone number
- Facility name, if the request is for an inpatient admission or outpatient facility services

- Provider location if the request is for an ambulatory or office procedure
- Reason for the authorization request – primary and secondary diagnoses, planned surgical procedures, surgery date
- Relevant clinical information – past/proposed treatment plan, surgical procedure, and diagnostic 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 medical service representative will notify the caller of the specific information needed to complete the authorization process.

Sunshine Health affirms that UM 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.

Consistent with 42 CFR 438.6(h) and 422.208, delegated providers must ensure that compensation to individuals or entities that conduct utilization management activities is not structured so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any enrollee.

Failure to obtain authorization for services that require plan approval may result in payment denials.

Provider needs to notify the member regarding an approved service and provide the associated authorization number.

PRIOR AUTHORIZATION

Prior authorization requires the provider or practitioner to make a formal medical necessity determination request to the plan prior to the service being rendered. Upon receipt, the prior authorization request is screened for eligibility and benefit coverage and assessed for medical necessity and appropriateness of the health services proposed, including the setting in which the proposed care will take place.

Prior authorization is required for only those procedures and services for which the quality of care or financial impact can be favorably influenced by medical necessity or appropriateness of care review.

Sunshine Health's Medical Department reviews the Prior Authorization List regularly to determine if any services should be added or removed from the list. Such decisions are made in collaboration with the Network Management Department. Providers are notified when changes occur.

Please refer to the Prior Authorization List found on the Sunshine Health website.

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 Utilization Management Department for plan approval at least 14 calendar 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 in or between facilities (i.e., transfer from acute to rehab or transfer to a different facility).
 - Long-term care facility/nursing facility and rehabilitative services at the intermediary or sub-acute levels of care.
2. All emergent or urgent inpatient admissions: the hospital must notify the Utilization Management Department through the Sunshine Health secure, on-line portal within two business days after the date of admission. Newborn deliveries must be sent through the portal by the next business day. Clinical admission information must be provided.
 3. All Observation admissions: the hospital must notify the Utilization Management Department within the first 48 hours following an Observation admission. Clinical admission information must be provided.
 4. Services at any non-participating or out of network or 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 indicate a need for case management. Surgical or interventional procedures performed in an outpatient, ambulatory surgical settings or office setting requires prior plan authorization. Routine screening procedures such as colonoscopy or bronchoscopy, breast biopsy or procedures such as port-a-cath insertion do not require a plan prior authorization if performed at an ambulatory surgical center. For the most recent version of services requiring prior authorizations, please visit our web portal or contact Provider Services at 1-866-796-0530.

In accordance with Section 329 of the Public Health Services Act or 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

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 /Urgent 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. Sunshine Health may extend 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 Medical Management Department may be contacted:

Utilization Management
1-866-796-0530
Prior Authorization Fax 1-866-796-0526
Case Management Fax 1-877-689-1056
Web Address: www.sunshinehealth.com

Home Health & Private Duty Nursing Care

Sunshine Health covers Home Health services when deemed as medically necessary services, some of which can be effectively and efficiently provided in the place of residence of a recipient. Services include home health visits (nurse and home health aide), private duty nursing and personal care services for children, therapy services, medical supplies, and durable medical equipment. These services must be prior authorized by Sunshine Health. Home Health coverage guidelines set forth by Sunshine Health comply with provisions set forth by Medicaid's Home Health Services Coverage, Limitations Handbook. Note, limitations or exclusions imposed by Sunshine Health shall be no more stringent than those in the Medicaid Home Health Services Coverage and Limitations Handbook.

Sunshine Health will not arbitrarily deny or reduce the amount, duration or scope of a required service solely because of the enrollee's diagnosis, type of illness or condition. Sunshine Health may place appropriate limits on a service on the basis of such criteria as medical necessity, as defined by the AHCA, or for utilization control, consistent with the terms of their agreement with the State, provided the services furnished can be reasonably expected to achieve their purpose.

REFERRAL PROCESS

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. This includes referral to behavioral health providers. Those referrals that 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 member.

If the PCP is capitated, referrals from a capitated PCP to another PCP will not be authorized or covered except for the following circumstances:

- Members who are auto-assigned to another PCP in their third trimester of their pregnancy when they become eligible for services under Sunshine Health (Medicaid members who are pregnant and not in the third trimester are subject to plan review and approval).
- Members having chronic medical conditions with ongoing healthcare needs that require continuity of care transition; examples include, but are not limited to, hemophilia, HIV/AIDS, sickle cell anemia, neoplasm, and organ transplant.
- Members who have other insurance coverage in which their primary provider is different from their Sunshine Health PCP.
- Members who have been inappropriately auto-assigned, until a new PCP can be assigned.
- Members who have moved 30 miles or more from their previous residence, until a new PCP can be assigned.

No paper referral is required when a PCP is referring a member to a participating provider as long as the service is not included on Sunshine Health's Prior Authorization List. Medical services that require prior authorization by Sunshine Health can be requested via phone, fax, or provider web portal. A Referral Specialist will issue the referral authorization number immediately upon approval. Referral requests for services that require Sunshine Health's prior authorization after normal business hours can be made through NurseWise, our 24/7 Nurse Line. NurseWise 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
Telephone 1-866-796-0530
Fax 1-866-796-0526

Web address- www.sunshinehealth.com

Sunshine Health has the capability to perform the ANSI X 12N 278 referral certification and authorization transaction through Centene. For more information on conducting this transaction electronically, contact:

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

For access to out-of-network providers, the network provider must call Sunshine Health for a prior authorization for any service from an out of network or non-participating provider or facility.

Sunshine Health does not use paper referrals. Should a provider desire a standing referral, or access to a specialty care center for a life-threatening condition or certain prolonged conditions, the provider must contact Sunshine Health's Case Management Department.

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.

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)
- Most mental health and chemical dependency/substance abuse services. Please consult the Cenpatico Provider Manual for a full description of Behavioral Health programs
- Family Planning Services and supplies from a qualified Medicaid family planning provider

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

Home Health Services, Durable Medical Equipment

Sunshine Health assumes sole responsibility for the authorization and coordination for all Home Health, Home Infusion, and Durable Medical Equipment services and supplies provided in the member's home. For these services to be provided in the home, please contact Sunshine Health at 1-866-796-0530. Contact us at 1-855-463-4100 for Sunshine Health Child Welfare members. You can complete our Home Health, Home Infusion, and Durable Medical Equipment Request Form and fax to Sunshine Health at 1-866-534-5978.

Orthotics and Prosthetics

Participating providers may provide splints, orthotics and prosthetics in their office to Sunshine Health members. If the cost of the item is over \$500, the provider is required to obtain authorization through Sunshine Health. Call Sunshine Health and follow the prompts to authorizations/referrals.

Sunshine Health: 1-866-796-0530

Therapy Services:

Sunshine Health covers medically necessary evaluations and individual physical, speech-language (including augmentative and alternative communication systems), occupational, and respiratory therapy services for members under 21 years old.

Adults are covered only for medically necessary evaluations and individual physical and respiratory therapy services in an outpatient setting. For Reform members, services apply to the outpatient hospital limit.

Initial evaluations require a valid physician order. Initial evaluations do not require Sunshine Health's authorization when rendered by a Sunshine Health network provider.

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 the Sunshine Health Medical Management Department.

Utilization Management Department

Telephone 1-866-796-0530

Fax 1-877-689-1056

Web address www.sunshinehealth.com

CONCURRENT REVIEW

The Sunshine Health Medical 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.

Routine uncomplicated vaginal or C-section delivery does not require concurrent review. The hospital must notify the plan within 48 hours of delivery with complete information regarding the delivery status and condition of the newborn. Newborns who are detained after mother's discharge or newborns who require other than nursery care, must be authorized by Sunshine Health and require concurrent review.

The Sunshine Health Medical Management Department may contact the member's admitting physician's office or primary care provider's office prior to the discharge date established during the authorization process, to check on the member's progress, and to make certain the member receives medically necessary follow up services.

DISCHARGE PLANNING

Sunshine Health has a transitional care process that includes clinical and non-clinical staff whose focus is to support those members at highest risk for readmission. The process emphasizes prevention, continuity of care and coordination of services. The transitional care process was developed based on principles, established by Eric Coleman, MD, that have been shown to reduce avoidable readmissions. Key areas of focus include medication reconciliation, member and caregiver understanding of the condition and its management, early recognition of symptoms, post-discharge appointment scheduling with providers, post-discharge scheduling of tests and services (including HHC, DME and specialty medications), caregiver support, and coordination with community services.

Concurrent review staff provides discharge planning for all members in the hospital, including those at moderate and low risk for readmission. This process integrates physical health and behavioral health admissions and needs.

Discharge planning activities are expected to be initiated upon admission. The Sunshine Health Utilization and Case 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/specialists and caregivers in order to ensure that Sunshine Health members receive appropriate post hospital discharge care within seven days of their discharge.

Home health services that are provided post-hospitalization require prior authorization as do services provided to prevent a hospitalization or shorten the length of stay. For more information, refer to the section on Home Health 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. Routinely this process encompasses services performed by a provider when there was no opportunity for concurrent review. However, retrospective review is also performed on active cases where an appropriate decision cannot be made concurrently within the required timeframe due to lack of clinical information. Once all necessary information is received, a decision is made within 30 calendar days.

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 Authorization Department. These services are reasonable and 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 may last up to a maximum of 48 hours. In those instances, that a member begins their 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 of the inpatient admission. Providers should not substitute outpatient observation services 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. The Medical Director reviews all potential denials of medical necessity decision.

Providers may obtain the criteria used to make a specific decision by contacting the Medical Management Department at 1-866-796-0530. Practitioners also have the opportunity to discuss any medical or behavioral health UM denial decisions with a physician or other appropriate reviewer at the time of notification to the requesting practitioner/facility of an adverse determination. The Sunshine Health Medical Director may be contacted by calling the Sunshine Health's main toll-free phone number and asking for the Medical Director. A Case Manager may also coordinate communication between the Medical Director and requesting practitioner.

Members, a member's 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 Pkwy
4th Floor
Sunrise, FL 33323
1-866-534-5972**

SECOND OPINION

Members, a member's 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.

CONTINUITY OF CARE FOR NEW MEMBERS

Sunshine Health coordinates care for all new members enrolled into the plan in a process known as onboarding. This process ensures continuous care for members receiving an active course of treatment through their previous health plan or Medicaid fee-for-service (FFS). Sunshine Health prioritizes members for whom effective onboarding planning is especially critical or for whom disruptions could jeopardize their health

Sunshine Health provides continuation of Managed Medical Assistance (MMA) services up to 60 calendar days following the enrollment date or until the member's primary care provider (PCP) or behavioral health provider reviews the member's treatment plan. If the member is enrolled in Sunshine Health's Child Welfare plan, this timeframe is extended to 90 calendar days following the enrollment date.

Sunshine Health ensures appropriate care to members from FFS and other health plans by:

- Coordinating care with other health plans and service providers to obtain information about existing services and coordinate transition services.
- Transitioning members seamlessly into the Sunshine Health through outreach, assessments and new care plan development, and ensuring new members have a PCP.
- Authorizing and continuing services with network and out-of-network providers.

Please contact Sunshine Health Case Management Department at 1-866-796-0530

CONTINUITY OF CARE FROM A TERMINATING PROVIDER

Sunshine Health will allow members in active treatment to continue care with a terminated treating provider. Such services must be medically necessary, through completion of treatment of a condition for which the member was receiving care at the time of termination, until the member selects another treating provider, or during the next enrollment period, not to exceed six months after the termination of the provider's contract.

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

SUNSHINE HEALTH CASE MANAGEMENT SERVICES

Medical case management is a collaborative process which assesses, plans, implements, coordinates, monitors and evaluates the options and services to meet an individual's health needs, using communication and available resources to promote quality and cost-effective outcomes. Care coordination/management is a member-centered, goal-oriented, culturally relevant and logically managed process to help ensure that a member receives needed services in a supportive, effective, efficient, timely and cost-effective manner. In the appropriate setting

Sunshine Health's Case Manager supports the physician by tracking compliance with the case management plan, and facilitating communication between the PCP, member, their caregiver, managing physician, and the case management team. The Case Manager also facilitates

referrals and linkages to community based services such as local health departments and school-based clinics. The managing physician maintains responsibility for the patient's ongoing care needs. The Sunshine Health case manager will contact the PCP and/or managing physician if the member is not following the plan of care or requires additional services.

Sunshine Health will provide individual case management services for members who have physical and/or behavior high-risk conditions, high-cost, complex or catastrophic conditions. Recognizing that members often have multiple co-morbidities or co-occurring physical and behavioral health conditions as well as other special health care needs, the team employs a holistic and coordinated approach to address the member's conditions, needs and barriers to care. The Sunshine Health case manager will work with all involved providers to coordinate care, provide referral assistance and other care coordination as required. The Sunshine Health case manager may also assist with a member's transition to other care, as indicated, when Sunshine Health benefits end. Through conversations with the member and the member's caregivers, the primary case manager determines if the member and the member's caregivers require additional education managing the member's health risks, chronic condition(s) and symptoms. This includes support through Sunshine Health Healthy Behaviors program, which is comprised of:

- Health and Wellness
- Chronic Conditions Management
- Lifestyle Risk Management

CASE MANAGEMENT PROCESS

Sunshine Health's case management for high risk, Physical and behavior health complex or catastrophic conditions contain the following key elements:

- Screen and identify members who potentially meet the criteria for case management
- Assess the member's risk factors to determine the need for case management
- Notify the member and their PCP/ specialist of the member's enrollment in the Sunshine Health case management program.
- Refer and assist the member in ensuring timely access to providers
- Develop and implement a treatment plan that accommodates the specific cultural and linguistic needs of the member.
- The case manager may telephone the providers, send faxes to the providers' offices or update the member's online profile through CenTraCare.
- The case manager will share with treating providers information regarding the member such as:
 - HEDIS gaps in care for the members
 - Current care plan diagnoses, providers seen, completed labs, lab values and medications filled
 - High emergency department use, if applicable
 - Substance abuse (with a member's written consent)
- Coordinate with providers, medical services, and social/community resources to supplement care based on benefit exclusion, exhaustion or additional comprehensive needs.
- The primary case manager creates a customized care plan, which the case manager continues to monitor and revise as a member achieves pre-determined goals or a member's condition changes.
- The care plan reflects the holistic needs of the member and takes into consideration the member's physical health, behavioral health, social, environmental, financial, cognitive, spiritual, cultural and functional needs.

- The care plan identifies, monitors, measures, evaluates all of the member's needs, and determines effective actions to promote quality of care, minimize further deterioration and complications, and help maintain the member in the safest and least restrictive setting. The care plan also includes wellness and preventive services, the management of chronic conditions, measurable goals and outcomes, and information that demonstrates the goals have been met.

As the member achieves stability or independence, is established with a PCP, is adherent with medication regime and provider appointments; member will be appropriately discharged from case management.

TRANSPLANT CASE MANAGEMENT

All members considered as potential transplant candidates should contact the Sunshine Health Case Management Department for assessment and case management services. Each candidate is evaluated for coverage requirements and will be referred to the appropriate agencies and transplant centers.

LEAD CASE MANAGEMENT

Sunshine Health will provide case management services to all eligible children with blood lead levels (BLL) \geq 10 ug/dL. Services will include family education about lead poisoning, referral in obtaining lead abatement, coordination of testing of sibling of those children identified with high blood lead levels, scheduling of appointments, and transportation when needed. In addition, our CONNECTIONS program provides direct outreach to parents/guardians to educate them on blood lead poisoning.

CHRONIC AND COMPLEX CONDITIONS

Sunshine Health provides individual case management services for members who have chronic, complex, high-risk, high-cost or other catastrophic conditions. Members with special healthcare needs are included in the chronic and complex case management-care coordination program. The Sunshine Health case manager will work with all involved providers to coordinate care, provide referral assistance, and other support as required. Sunshine Health also uses disease management programs and associated practice guidelines and protocols for members with chronic conditions, including conditions such as asthma, diabetes, HIV/AIDS, congestive heart failure, and hypertension.

Members who qualify for chronic or complex case management services have an ongoing physical, behavioral or cognitive disorder, including chronic illnesses, impairments and disabilities. These limitations are expected to last at least twelve (12) months with a resulting functional limitation, reliance on compensatory mechanisms such as medications, special diet, or assistive device, and require service use or need beyond that which is normally considered routine.

The Sunshine Health case manager will coordinate care needs including behavioral health needs, assist in identifying and obtaining supportive community resources, and arrange for long-term referral services as needed. The case manager may identify (and a member may request) a specialist with whom a member with a chronic condition has an on-going relationship who may serve as the PCP and coordinate services on the member's behalf.

Members determined to need a course of treatment or regular care monitoring may have direct access to a specialist as appropriate for the member's condition and identified needs, such as through a standing referral or an approved number of visits. A member's PCP will develop a treatment plan with the member's participation and in consultation with any specialists caring for the member. The Sunshine Health Medical Director oversees these processes in accordance with state standards.

Sunshine Health encourages all PCPs and physicians to notify Sunshine Health Case Management when a member is identified that meets the criteria for a chronic or complex condition.

Fax: 1-866-796-0527

START SMART FOR YOUR BABY®

The Start Smart for Your Baby program is a medical management program designed for our pregnant members and for moms who have just had a baby. The strategic objective of Start Smart is to reduce pregnancy complications, premature delivery and infant disease. This comprehensive program covers all aspects of managing the pregnancy and newborn period. We provide education through mailings, phone and face-to-face contact and, educational podcasts on MP3 players.

Our case managers assist in educating patients about what to expect in normal as well as high-risk pregnancies, identify undetected problems that may put a patient at risk and help assure compliance with ante partum and postpartum visits.

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.

PERINATAL/HI-RISK OBSTETRICAL

Pregnancy, labor and delivery account for a large proportion of care provided to Sunshine Health members. Those at high risk for complications of pregnancy and poor neonatal outcomes are provided care coordination services through our Perinatal Program. The goals of the program are to screen all pregnant women, identify and coordinate care for pregnant women who are at high-risk for complications of pregnancy and assure that all members have access to appropriate care for diagnosis, monitoring and treatment of pregnancy. Any high-risk ancillary service must be authorized by the Sunshine Health Perinatal program nurse. Ancillary services include but are not limited to home pregnancy monitoring, home infusion therapy, provision of 17-P, education or testing, provision of DME, and more than two OB ultrasounds.

When a physician determines that a member is a candidate for 17-hydroxyprogesterone, 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. This prescription is sent to the Sunshine Health Case Manager who will check for eligibility. The CM will coordinate the ordering and delivery of the 17-P directly to the physician's office. The nurse will remain in contact with the member and the prescribing physician during the entire treatment period.

To contact our OB case manager call:

1-866-796-0530

Case Management Fax 1-877-689-1056

Sunshine Health will provide educational opportunities to inform our Members about the benefits and risks associated with behaviors that may affect the outcome of their pregnancy and facilitate transitions to home when outcomes are less than ideal. We will provide educational opportunity and support for pregnant women and their partners about appropriate care of newborns as well as identifying pediatric providers for their newborns and access to care for their newborn.

When an event occurs resulting in an early delivery and resultant admission to a Neonatal Intensive Care Unit, our Case Manager will work with the hospital neonatal providers, discharge planners, and managing pediatric provider to ensure a smooth transition to home and coordination of ongoing follow-up care as needed. When it is apparent the NICU stay will exceed

the state threshold of 15 days, the plan will coordinate ongoing care with the fee-for-service Program Coordinator.

Other case management programs will be developed based on AHCA or as determined through Sunshine Health analysis of the membership in conjunction with the Quality and Utilization Management Committees.

Providers are asked to contact a Sunshine Health Case Manager to refer a member identified in need of care coordination intervention:

Medical Management/Case Management
1-866-796-0530
Fax 1-877-689-1056

SUNSHINE HEALTH DISEASE MANAGEMENT PROGRAMS

As a part of the Sunshine Health medical management quality improvement efforts, disease management programs are offered to members. Components of the programs available 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 dental and/ or 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 and member's caregiver ability to self-manage chronic conditions.
- Coordination with Sunshine Health case manager for intensive case management program.

ASTHMA PROGRAM

The Asthma Disease Management Program targets Sunshine Health members with asthma who are over-using rescue medications, who are having repeated visits to the ER or are being admitted to the hospital with a primary diagnosis of asthma. Case managers will contact these members and provide additional education. The case manager may coordinate care with the member's PCP. The goals of this program include increasing positive clinical outcomes for the member and controlling the asthma in order to improve the quality of life for the member.

Sunshine Health's Asthma Disease Management Program utilizes evidence-based guidelines sponsored by the National Asthma Education and Prevention Program, education, care assessment, in home visits for high risk members unable to be reached by telephone, initial phone visits, physician communication, and follow-up visits as indicated by the member's ability to self-manage and remain compliant with the plan of care.

DIABETES PROGRAM

This program targets Sunshine Health members who have been diagnosed and treated for diabetes mellitus. Members are then stratified based on the severity of their illness so that interventions can be targeted to the appropriate population. Through this program, Sunshine Health members can receive additional education, case management and support from the medical management team to enhance positive clinical outcomes.

CONGESTIVE HEART FAILURE PROGRAM

Sunshine Health will include members who have a diagnosis of heart failure. The program provides telephonic outreach, education and support services to members in order to facilitate and encourage medication compliance, specially ACE and ARB inhibitors and self-care, such as daily weights, in order to minimize hospitalizations for acute heart failure.

Members may be identified for enrollment based on medical and pharmacy claim data, referral from the primary care provider, specialist physician, plan case manager or self-referral. Individual assessments are performed with a health coach and a program is developed using guidelines published by the American College of Cardiology and the American Heart Association. Members who are not interested in receiving calls or whom we are unable to reach will receive periodic relevant educational mailing along with a toll free number, which allows unlimited inbound calls to a health coach.

HYPERTENSION PROGRAM

The Hypertension Management Program provides telephonic outreach, education and support services to members in order to normalize blood pressure and minimize risk factors. Clinicians will facilitate and encourage medication education and compliance management, provide nutrition, exercise, and weight management education, and support tobacco cessation.

Members are identified for enrollment based on medical and pharmacy claim data, referral from the primary care provider, specialist physician, plan case manager, and self-referral.

DEPRESSION & PRIMARY CARE PROGRAM

The majority of people with symptoms of depression turn to primary care providers for help rather than seeking mental health services directly. For this reason, Cenpatico recognizes the important role that primary care plays in the diagnosis and treatment of depression. Over the past several decades, great strides have been made in the understanding of depression. New and effective treatment options are available in treating depression, yet the stigma continues to influence clinician and patient attitudes toward this illness and the quality of care people receive. Our program offers to connect primary care providers to tools and resources to help enhance their ability to recognize and treat depression.

Diagnostic Tool/Severity Monitoring

The PHQ-9 is the nine-item depression scale of the Patient Health Questionnaire. The PHQ-9 is based directly on the diagnostic criteria for major depressive disorder in the Diagnostic and Statistical Manual Fourth Edition (DSM-IV). In addition to a diagnostic tool, the PHQ-9 can be used to monitor treatment response.

Depression Disease Management

Cenpatico offers Choose Health program to support primary care providers in delivering patient education, monitoring of treatment response as well as provide feedback regarding patient progress. We can also offer help with providing referrals to behavioral health providers when needed.

If you have a patient that you would like to refer to our program, please call 1-866-796-0530.

Additional Resources

The IMPACT Evidenced-Based Depression Care website has developed a range of resources to help primary care clinicians recognize and manage depression at:

<http://impact-uw.org/tools/phq9.html>.

HIV/AIDS PROGRAM

Sunshine Health offers an HIV/AIDS Disease Management Program which subscribes to specific needs of HIV/AIDS affected members. By providing education, counseling and advocacy with 24 hour access to an HIV/AIDS specialized nurse, the member is empowered to be an active participant in care. This program incorporates evidence-based clinical guidelines and coordination of care with multi-disciplined medical specialties. By encouraging adherence to appropriate ongoing medical treatment and supportive resources within the community, the focus is to minimize complications and support the members' highest level of wellness.

To refer a member to any Disease Management Program call:

Sunshine Health

1-866-796-0530

Follow the prompts to Disease Management Programs.

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 its website and are mailed to practitioners as part of disease management or other quality program initiatives. The guidelines are available on request to members. Sunshine Health utilization management, member education, coverage of services, and other areas to which the guidelines apply are consistent with these guidelines. These guidelines are used for both preventive services as well as for the management of chronic diseases.

Clinical Practice guidelines (CPG) may include, but are not limited to:

- ADHD Treatment Guidelines
- Asthma Guidelines
- Diabetes Care Guidelines
- Sickle Cell Guidelines
- Sunshine Health also adopted applicable preventive health guidelines
- Preventive Health guidelines may include, but are not limited to:
 - Adult Preventive Health Guidelines
 - Antepartum Fetal Surveillance Testing Guidelines
 - Child Preventive Health Guidelines
 - Immunization Guidelines
 - Lead Toxicity Screening Guidelines
 - Guidelines for Perinatal 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 Medical Management staff may identify relevant topics for review pertinent to the Sunshine Health population. The Clinical Policy Committee (CPC) reviews all requests for coverage and makes a determination regarding any benefit changes that are indicated.

In the instance where the 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 Medical Management Department at **1-866-796-0530**.

The State will be notified in writing 30 days following any material change to the Medical Management Program.

TELEMEDICINE

Covered Telemedicine Provisions

Sunshine Health will follow the AHCA benefit coverage for telemedicine services as noted in the AHCA Medicaid Services Coverage and Limitations Handbook for behavioral health services, dental services, and practitioner services.

Non-Reimbursable Telemedicine Services

Sunshine Health will follow the AHCA guidelines on non-reimbursable telemedicine services. Sunshine Health will not reimburse for the costs or fees of any of the equipment necessary to provide services through telemedicine, including telecommunication equipment and services.

No-reimbursable services include:

- Telephone conversations
- Video cell phone interactions
- Electronic mail messages
- Facsimile transmissions
- Telecommunication with the enrollee at a location other than the site
- Store and forward visits and consultations that are transmitted after the enrollee or practitioner is no longer available

Evaluation of Practitioner Requests to Provide Telemedicine Services

When a practitioner requests to provide telemedicine services to enrollees, the practitioner must submit information on the following for Sunshine Health's consideration prior to being approved to do those services for Sunshine Health enrollees. Only providers who meet the requirements specified in the AHCA contract are eligible to provide services through telemedicine at the spoke and hub sites.

That information that the practitioner must provide to Sunshine Health includes the following:

- Information which verifies that the equipment used meets the definition of telecommunication equipment as defined in the AHCA contract and that the telemedicine operations meet the technical safeguards required by 45 CFR 164.312, where applicable.
- A list of the services planned to be provided through telemedicine, which must be limited to the specific procedures and settings allowed by AHCA.
- Attestation that the telemedicine services will be provided to enrollees only in the practitioner's office settings. The practitioner must provide Sunshine Health with the list of specific office sites in which telemedicine services will be provided.
- Attestation that the practitioner complies with HIPAA and other state and federal laws pertaining to patient privacy.
- Attestation that before telemedicine services are provided, the enrollee will be given the choice of whether to access services through a face-to-face or telemedicine encounter, and that they document the choice in the enrollee's medical/clinical record; and that should the enrollee decide to receive telemedicine services, the enrollee's medical record includes documentation that telemedicine services were provided. In addition to the attestation, the practitioner must provide their policy and procedure for medical record documentation of the choice given and the provision of the telemedicine services.

Once Sunshine Health receives the documents noted above from an interested practitioner, the information will be reviewed by Sunshine Health. If there is a question related to the information provided, a representative will contact the practitioner for the needed information.

Once a decision on the practitioner's request to provide telemedicine services has been made by Sunshine Health, the practitioner will be notified. Only practitioners approved by Sunshine Health to perform telemedicine services will be reimbursed for those services. The Sunshine Health medical record documentation audits for practitioners approved for telemedicine services will look for the applicable documentation of choice offered to enrollees and the documentation of the telemedicine services provided.

COVERED BENEFITS

A listing of Sunshine Health covered benefits may be found on the web at www.sunshinehealth.com.

ROUTINE, URGENT & EMERGENCY SERVICES



Members are encouraged to contact their PCP prior to seeking care, although it is not required in an emergency.

The following are definitions for well, **routine**, **urgent**, and **emergency services**.

Routine Well Care Visit: A routine medical visit for one of the following: CHCUP visit, family planning, routine follow-up to a previously treated condition or illness, adult physicals or any other routine visit for other than the treatment of an illness. Routine well care should be provided within one month.

Routine Sick Patient Care: Non-urgent problems that do not substantially restrict normal activity, but could develop complications if left untreated. Sick care is to be provided within one week. Examples include treatment of a cold, flu, or mild sprain or a complaint regarding a chronic disease

Urgent* - Services for conditions, which, though not life threatening, could result in serious injury or disability unless medical attention is received or do substantially restrict a Member's activity. **Urgent services** are provided within oneday. Examples include high fever, animal bites, fractures, severe pain, infectious illnesses, or behavioral health care requiring assessment within 23 hours.

Emergency* Medical Condition An emergency medical condition is defined as a medical condition manifesting itself by acute symptoms of sufficient severity, which may include severe pain or other acute symptoms, such 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 the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy or serious impairment to bodily functions, or serious dysfunction of any bodily organ or part. With respect to a pregnant woman: (1) that there is inadequate time to effect safe transfer to another Hospital prior to delivery; (2) that a transfer may pose a threat to the health and safety of the patient or fetus; (3) that there is evidence of the onset and persistence of uterine contractions or rupture of the membranes.

Emergency Services area covered inpatient and outpatient services that are as follows: (1) furnished by a provider that is qualified to furnish these services under this title; and (2) needed to evaluate or stabilize an emergency medical condition.

An emergency medical condition shall not be defined or limited based on a list of diagnoses or symptoms.

*Urgent or emergency care is not subject to prior authorization or pre-certification. Emergency Services must be provided by a qualified Provider regardless of network participation.

The PCP plays a major role in educating Sunshine Health members about appropriate and inappropriate use of hospital ERs. The PCP is responsible to follow up on members who receive emergency care from other providers.

For billing information, please refer to the General Billing Information and Guidelines section.

The attending ER physician, or the provider actually treating the member, is responsible for determining when the Member is sufficiently stabilized for transfer or discharge, and that determination is binding on Sunshine Health. However, Sunshine Health may establish arrangements with a hospital whereby Sunshine Health may send one of its own physicians with appropriate ER privileges to assume the attending physician's responsibilities to stabilize, treat, and transfer the member, provided that such arrangement does not delay the provision of emergency services.

Sunshine Health will not retroactively deny a physician claim for an emergency screening examination because the condition, which appeared to be an emergency medical condition under the prudent layperson standard, turned out to be non-emergency in nature. However, the prudent layperson test will be applied to the payment to the facility for charges. Emergency services will be covered if an authorized representative, acting on behalf of Sunshine Health, referred the member to the emergency department.

The facility should verify member eligibility as soon as possible after the member presents to the emergency department. In emergency medical conditions, the facility should use its best efforts to contact the PCP, or in the case of a pregnant woman, the member's attending provider. The facility should document all attempts to contact the PCP or the obstetrician and determinations made on appropriate care. At no time should emergency services be withheld or delayed.

When a member is admitted to the facility from the ER, either as an observation or inpatient admission, clinical data is required within two business days of the admission. For specific necessary information to submit, see the Inpatient Notification section of this manual.

ELIGIBILITY AND ENROLLMENT



ELIGIBILITY FOR SUNSHINE HEALTH

The State of Florida has the sole responsibility for determining eligibility for Medicaid for all coverage groups except for Supplemental Security Income (SSI). The Social Security Administration (SSA) determines eligibility for SSI.

Those eligible persons who are assigned to Sunshine Health currently include individuals in the following categories:

- Medicaid recipients
- Low Income Families and Children
- Sixth Omnibus Budget Reconciliation Act (SOBRA)- Pregnant women and children, including presumptive eligibility
- Supplemental Security Income (SSI) Medicaid Only
- SSI Medicare, Part B only
- SSI Medicare, Parts A and B
- Medicaid Recipients who are residents of ALFs and are not enrolled in an ALF waiver program
- Refugees
- The Meds AD population
- Individuals with Medicare coverage (e.g. dual eligible individuals) who are not enrolled in a Medicare Advantage Plan
- Title XXI MediKids

VERIFYING ENROLLMENT

Providers are responsible for verifying 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 1-866-796-0530 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, contact:

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

Until the actual date of enrollment with Sunshine Health, 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. However, Sunshine Health is responsible for those individuals who are Sunshine Health members at the time of a hospital inpatient admission and change health plans during that confinement.

NEWBORN ENROLLMENT

Upon identification of a member's pregnancy, providers should immediately notify Sunshine Health of the pregnancy and any relevant information known (i.e. due date and gender).

Sunshine Health providers shall submit a copy of the completed Florida State required DH3134 "Healthy Start Prenatal Risk Screening Instrument" form upon their knowledge of a Sunshine Health member's pregnancy. The DH3134 "Healthy Start Prenatal Risk Screening Instrument" can be found on our Provider Website or at the following URL:
<http://www.doh.state.fl.us/family/mch/hs/hstraining/appendix/b/b.pdf>.

The provider must also submit the DH Form 3134 to the County Health Department (CHD) in the county in which the prenatal screen was completed within 10 business days of completion. The provider may submit the Sunshine Health standard Notification of Pregnancy form to the plan in lieu of the DH Form 3134.

Sunshine Health must provide notification of pregnancy to DCF via the CF-ES 2039 Form to start the unborn activation process. DCF will generate a Medicaid ID number and the unborn child will be added to the Medicaid file. This information will be transmitted to the Medicaid Fiscal Agent. The Medicaid ID number will remain inactive until after the child is born and Sunshine Health notifies the state of the birth event. If the provider has already completed and submitted the CF-ES 2039 Form to the State for the assignment of the "Unborn Medicaid Number", a copy of this form should also be sent to Sunshine Health.

Newborns of Sunshine Health members will be enrolled in the same plan as the mother during the next enrollment cycle. The newborn shall continue to be enrolled in Sunshine Health unless the mother/guardian changes the enrollment.

Providers are encouraged to refer the mother to Sunshine Health to select a PCP for their newborn. A newborn enrollment packet will be mailed to all Sunshine Health expectant mothers. This packet includes information that the newborn will be auto-assigned to Sunshine Health and that she may select a PCP for her newborn prior to the birth by contacting Member Services. If the mother does not select a PCP after delivery, the mother's PCP will automatically be assigned to the newborn, unless the PCP is not accepting new members or the provider has age restrictions.

To make a PCP selection for the newborn, members should be referred to:

Member Services Department
1-866-796-0530
TDD/TTY 1-800-955-8770

All providers are also encouraged to direct the mother to her county caseworker with DCF to ensure the newborn is officially deemed eligible for the Sunshine Health program.

Eligibility for newborns whose mothers are Sunshine Health members on the date of delivery is effective on the date of birth.

Frequently, Sunshine Health receives a claim(s) for a newborn prior to the state sending the member's eligibility information. Sunshine Health is committed to researching the newborn claims that are received to ensure that a claim is NOT denied for eligibility when the newborn is a Sunshine Health member.

In addition to other procedures that apply to claims, the following guidelines are used by Sunshine Health to help ensure that newborn claims do not deny for payment:

1. When the claims department receives a claim, the newborn's eligibility is verified. If no newborn eligibility is found, the claim is pended for 30 days. The claims department will verify eligibility each day until the newborn's information is received from the state.
2. If after 30 days there is still no record of the newborn information, then the claims department will notify the Eligibility Specialist.
3. The Eligibility Specialist will contact the state to obtain the information on the newborn.
4. At that time one of the following actions will be taken:
 - If the newborn is eligible with Sunshine Health, then the Eligibility Specialist will enter the newborn information manually and instruct the claims department to process the claim
 - If the newborn is NOT eligible with Sunshine Health then the Eligibility Specialist will instruct the claims department to return the claim with a notice of newborn ineligibility

The above describes Sunshine Health general approach and is subject to modification in accordance with AHCA policies.

ENROLLMENT/COMMUNITY OUTREACH GUIDELINES FOR SUNSHINE HEALTH PROVIDERS

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

A Sunshine Health Outreach representative will give an overview of the community outreach plan to all network physicians and their staff and present them with the AHCA Policy and Procedure Guidelines on General Outreach and Enrollment. This will define what a provider may or may not do in regards to reaching out to our members. Sunshine Health will also use approved communication tools to educate providers on plan-specific information such as claims processing and systems technologies.

Provider communication tools will 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
- 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, flyers, and print advertisement.
- Providers may distribute information about non-health plan specific health care 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 agencies choice counselor/enrollment broker.
- Providers cannot orally or in writing compare benefits or provider network among health plans other than to confirm whether they participate in a health plan network.
- Providers cannot furnish lists of their Medicaid 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



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 not be limited to:

A member is disruptive, unruly, threatening, or uncooperative to the extent that the member seriously impairs the provider's ability to provide services to the member or to other members and 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 Pkwy
4th Floor
Sunrise, FL 33323
1-866-796-0530

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 members 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.

VALUE ADDED BENEFITS FOR SUNSHINE HEALTH CARE MEMBERS

Sunshine Health has developed a package of Value Added Services for its members that includes benefits in addition to the State Covered Services. The Value Added Services were designed to improve members' well-being, encourage responsible and prudent use of healthcare benefits and enhance the cost effectiveness of the Florida Medicaid Program. For information on value added benefits, please visit www.sunshinehealth.com.

NURSEWISE®

Our members have many questions about their health, their primary care provider and access to emergency care. Our health plan offers a nurse line service to encourage members to talk with their physician and to promote education and preventive care.

NurseWise is our 24-hour nurse line for members. The RNs provide basic health education, nurse triage and answer questions about urgent or emergency access, all day long. The staff often answers questions about pregnancy and newborn care. In addition, members with chronic problems, like asthma or diabetes, are referred to case management for education and encouragement to improve their health.

Members may use NurseWise to request information about providers and services available in your community after the health plan is closed. Providers can use it to verify eligibility any time of the day. The NurseWise 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 of products to perform triage services for adults. 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 member's access to an RN every day. If you have any additional questions, please call Provider Services at **1-866-796-0530**.

CHILD HEALTH CHECK-UP (CHCUP)



SUNSHINE HEALTH CHILD HEALTH CHECK-UP (CHCUP) SERVICES AND STANDARDS

CHCUP is a program of comprehensive preventive health services available to Sunshine Health recipients through the month of their 21st birthday. The program is designed to maintain health by providing early intervention to discover and treat health problems. CHCUP is a preventive program that combines diagnostic screening and medically necessary follow-up care for dental, vision and hearing examinations for eligible members.

CHCUP services include:

- Outreach and informing
- Screening in accordance with the AHCA periodicity schedule
- Tracking compliance with CHCUP requirements
- Diagnostic and treatment services

Standards for providing CHCUP services are described and are included in the state MCO Policies and Procedures Manual.

PCPs are required to perform CHCUP medical 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 CHCUP eligible member. Initial well-child exams are to be completed within 90 days of the initial effective date of membership and within 24 hours of birth for all newborns. 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 are as follows:

- *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 and/or dental 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. In infants, the history and subjective findings of the ability to regard and reach for objects, the ability to demonstrate an appropriate social smile, and to have age appropriate interaction with the examiner is sufficient. At ages four 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.
- *Dental Screening* – A general assessment of the dental condition (teeth and/or gums) is obtained on all children. As indicated and beginning at age two years old a referral should be made to a dentist.
- *Hearing Screening* – A hearing test is required appropriate to the child's age and educational level. For the child under age four, hearing is determined by whatever method is normally used by a provider, including, but not limited to, a hearing kit. For the child over age four, an audiometer, if available is recommended. If needed an appropriate referral should be made to a specialist. It is

recommended that high-risk neonates be evaluated with objective measures, such as brain stem evoked response testing, prior to discharge from the hospital nursery.

- *Other Necessary Healthcare* – States must provide other necessary healthcare, diagnosis services, treatment, and other measure described in section 1905(a) of the Act to correct or ameliorate defects, and physical and mental illnesses and conditions discovered by the screening services.

Periodic Screening CHCUP beneficiaries are eligible to receive comprehensive preventive health services through the month of their 21st birthday. The following is a general guide for the ranges in which screenings should occur (refer also to **Attachment American Academy of Pediatrics Periodicity Schedule**):

- Birth exam (identified from hospital claim and not billable as a CHCUP screening).
- Two to four days if newborn is discharged in less than 48 hours
- By one month
- Two months
- Four months
- Six months
- Nine months
- Twelve months
- Fifteen months
- Eighteen months
- Once per year from age two through twenty

Note: The codes for reporting screening services for new and established patients are as follows:

- 99381 - New Patient under one year
- 99382 - New Patient (ages 1-4 years)
- 99383 - New Patient (ages 5-11 years)
- 99384 - New Patient (ages 12-17)
- 99385 - New Patient (ages 18-39 years)
- 99391 - Established patient under one year
- 99392 - Established patient (ages 1-4 years)
- 99393 - Established patient (ages 5-11 years)
- 99394 - Established patient (ages 12-17 years)
- 99395 - Established patient (ages 18-39 years)
- 99431 - Newborn care (history and examination)
- 99432 - Normal newborn care

Screenings for children 17 years and under should be billed with diagnosis code V20.2 and for children 18-21 V70.0. Providers can bill with other diagnosis codes other than ones listed here for CHCUP.

Preventive health is a major principal on which managed care organizations are based, *measured and held accountable*. Sunshine Health supports its contracted providers to encourage their Sunshine Health patients to participate in the State of Florida's preventive care program, CHCUP. Sunshine Health will send reminders of the need for a well-child examination to all CHCUP eligible members. For newborns, parents/guardians will receive a letter explaining the CHCUP schedule through two years olds. For the child's second birthday, a CHCUP reminder postcard will be sent advising of the two suggested exams before the child turns three. For ages three through 20, reminders will be sent annually based on the month of the birth. Providers must demonstrate compliance with the CHCUP periodicity schedule and screening requirements (including blood lead screening) for at least 80% of their eligible members, in accordance with the methodology prescribed by the Centers for Medicare and Medicaid Services.

IMMUNIZATIONS

Children must be immunized during medical checkups according to the CHCUP Routine Immunization Schedule by age and immunizing agent.

Since immunizations are a required component of CHCUP screening services 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.

Immunization of children should be provided according to the guidelines recommended by the AHCA, 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, and Florida State Law.

PCPs must participate with the Vaccine for Children Program (VFC). If a provider does not routinely administer immunizations as part of his/her practice, they should refer the child to the county health department but must maintain a current record of the child's immunization status.

BLOOD LEAD SCREENING

Sunshine Health CHCUP guidelines include Blood Lead Level Screenings for children from the ages of nine months through 72 months. A Lead Screening Questionnaire should be completed at the time of each routine office visit for children in this age group.

All Medicaid children are considered at increased risk for having elevated blood lead levels (BLLs). **A blood lead test must be used when screening Medicaid-eligible children.** An elevated BLL is considered anything ≥ 10 ug/dl. A blood lead test result equal to or greater than 10 ug/dl obtained by capillary specimen (finger stick) must be confirmed using a venous blood sample. According to CMS policy, all Medicaid children require a screening blood lead test at 12 and 24 months of age. Children between the ages of 12 months and 72 months of age must receive a screening blood lead test if they have not been previously screened for lead poisoning.

DOMESTIC VIOLENCE

Sunshine Health members' may include individuals at risk for becoming victims of domestic violence. Thus, it is especially important that providers are vigilant in identifying these members. Member Services can help members identify resources to protect them from further 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 provider's 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 our Provider Services Department that the following information is current in our files:

- **Provider Name** (as noted on his/her current W-9 form)
- **Provider nine (9) digit Medicaid Number**
- **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.

Providers must submit, all original claims (first time claims), corrected 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. Sunshine Health has the ability to receive coordination of benefit (COB or Secondary) claims electronically.

All requests for reconsideration or adjustment to paid claims must be received within 90 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.

ON-LINE 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)

Beginning July 1, 2008, Sunshine Health will require all 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

Sunshine Health accepts paper claims from providers and require all paper submitters to use standard CMS 1500 and CMS 1450 (UB04) paper formats.

For Sunshine Health 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

- **Do** use the correct PO Box number.
- **Do** submit all claims in a 9" x 12", or larger envelope.
- **Do** type all fields completely and correctly.
- **Do** use black or blue ink only.
- **Do** submit on a proper form . . . CMS 1500 or UB 04.

Don'ts

- **Don't** submit handwritten claim forms.
- **Don't** use red ink on claim forms.
- **Don't** circle any data on claim forms.
- **Don't** add extraneous information to any claim form field.
- **Don't** use highlighter on any claim form field.
- **Don't** submit photocopied claim forms.
- **Don't** submit carbon copied claim forms.
- **Don't** 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 submit 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” 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, CMS 1450 (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 90 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 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.

Sunshine Health is authorized to take whatever steps are necessary to ensure that the provider is recognized by the state Medicaid program, including its choice counseling/enrollment broker contractor(s) as a participating provider of Sunshine Health and that the provider’s submission of encounter data is accepted by the Florida MMIS and/or the state’s encounter data warehouse.

For all contracts with reimbursement for services based on AHCA’s Medicaid fee-for-service (FFS) rates, please note the following:

Any reference to the “Medicaid FFS 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 FFS 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 on the date (“Fee Change Effective Date”) that is the later of: (i) the first day of the month following thirty (30) days after publication by AHCA of such fee schedule updates, or (ii) 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 six months of the eligibility determination date.
- Mechanical or administrative delays or errors by Sunshine Health or AHCA.
- 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 Medicaid card or information.
- The provider can substantiate that he continually pursued reimbursement from the patient until Medicaid eligibility was discovered.
- The provider can substantiate that a claim was filed within 180 days of discovering Medicaid Plan 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-9 codes.
- Submit all claims/encounters with the proper provider number.
- Submit all claims/encounters with the member's complete Medicaid number.
- 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.
- Verify other insurance information entered on claim.

CODE AUDITING AND EDITING

Sunshine Health utilizes code-auditing software for automated claims coding verification and to ensure that Sunshine Health is processing claims in compliance with general industry standards.

The code auditing software takes into consideration the conventions set forth in the healthcare insurance industry, such as Center for Medicare and Medicaid Services (CMS) policies, current health insurance and specialty society guidelines, and the American Medical Association's CPT Assistant Newsletter.

Using a comprehensive set of rules, the code auditing software provides consistent and objective claims review by:

- Accurately applying coding criteria for the clinical areas of medicine, surgery, laboratory, pathology, radiology and anesthesiology as outlined by the American Medical Association's (AMA) CPT-4 manual.
- Evaluating the CPT-4 and HCPCS codes submitted by detecting, correcting and documenting coding inaccuracies including, but not limited to, unbundling, upcoding, fragmentation, duplicate coding, invalid codes, and mutually exclusive procedures.
- Incorporating Historical Claims Auditing (HCA) functionality which links multiple claims found in a member's claims history to current claims to ensure consistent review across all dates of service.

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

Duplicate services – submission 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	<i>Description</i>	Status
72010	Radiologic exam, spine, entire, survey study, anteroposterior & lateral	Allow
72010	Radiologic exam, spine, entire, survey study, anteroposterior & lateral	Disallow

Explanation:

- 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 0-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 (0-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 & coordination of care w/ other providers or agencies are provided consistent w/ nature of problem(s) & patient's &/or family's needs. Problem(s) are low/moderate severity. Physicians spend 15 min face-to-face w/ patient &/or family.	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 & coordination of care w/ other providers or agencies are provided consistent w/ nature of problem(s) & patient's &/or family's needs. Problem(s) are low/moderate severity. Physicians spend 15 min face-to-face w/ patient &/or family.	Disallow

Explanation:

- Procedure 11000 (0-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) & patient's/family's needs. Presenting problem(s) are low severity. Physicians spend 30 min face-to-face with patient/family.	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:

<i>Code</i>	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, total	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:

HEDIS Measures & Applicable CPT Category II codes:**Cholesterol Management for Patients with Cardiovascular Conditions**

CPT Category II codes: 3048F, 3049F, 3050F (codes to identify LDL-C Screening)

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)

Care for Older Adults (for Medicare Special Need Plans only)

CPT Category II codes: 1157F or 1158F (codes to identify advance care planning); 1159F (code to identify medication list) *and* 1160F (code to identify medication review); 1170F (code to identify functional status assessment); 1125F, 1126F, 0521F (codes to identify pain screening)

Medication Reconciliation Post-Discharge (for Medicare Special Need Plans only)

CPT Category II code: 1111F (code to identify medication reconciliation)

CODE EDITING ASSISTANT

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 individual product lines.

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-9 codes. Submit institutional claims with valid Revenue Codes *and* CPT-4 or HCPCS (when applicable), ICD-9 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-9 diagnosis codes, to the ultimate specificity, for *all* claims. This means that ICD-9 codes must be carried out to the fourth or fifth digit when indicated by the coding requirements in the ICD-9 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 1) of the ICD-9 coding manual in addition to the Alphabetic List (Volume 2) 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-9 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.

CLAIM 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 adjusted claims, requests for reconsideration and disputed claims will be finalized to a paid or denied status 30 calendar days of receipt. Reconsideration and disputed 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. Mentions electronic submission but refers below to 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:
 - Date of service
 - Diagnosis
 - Place of service
 - Procedural coding (appropriate CPT-4, ICD-9 codes)
 - Charge information and units
- Servicing provider's name, address and Medicaid Number
- Provider's federal tax identification number
- All mandatory fields must be complete and accurate

Submit claims for hospital based inpatient and outpatient services as well as swing bed services on a UB 04.

THIRD PARTY LIABILITY

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

Medicaid is always the payer of last resort. Sunshine Health providers shall make reasonable efforts to determine the legal liability of third parties to pay for services furnished to Sunshine Health members. If the provider is unsuccessful in obtaining necessary cooperation from a member to identify potential third party resources, the provider shall inform Sunshine Health that efforts have been unsuccessful. Sunshine Health will make every effort to work with the provider to determine liability coverage.

If third party liability coverage is determined after services are rendered, Sunshine Health will coordinate with the provider to pay any claims that may have been denied for payment due to third party liability.

Completing a CMS 1500 Form

All medical claims are to be submitted on the CMS 1500.

The CMS 1500 claim form is required for:

- 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
43 – 50	Not in Use

51	Inpatient Psychiatric Facility
52	Psychiatric Facility Partial Hospitalization
53	Community Mental Health Center
54	Immediate Care Facility/Mentally Retarded
55	Residential Substance Abuse Treatment Facility
56	Psychiatric Residential Treatment Center
57 - 60	Not in Use
61	Comprehensive Inpatient Rehabilitation Facility
62	Comprehensive Outpatient Rehabilitation Facility
63, 64	Not in Use
65	End Stage Renal Disease Treatment Facility
66 – 70	Not in Use
71	State or Local Public Health Clinic
72	Rural Health Clinic
73 – 80	Not in Use
81	Independent Laboratory
82 - 98	Not in Use
99	Other Unlisted Facility

COMPLETING A CMS-1450 (UB 04) CLAIM FORM

A CMS-1450 (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 CMS-1450 (UB 04) 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 CMS-1450 (UB 04):

- 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 covered through Medicaid. Providers can bill a member for services that are not covered by Sunshine Health or Medicaid fee-for-service (FFS). Carved out services outlined earlier in this manual should be billed to the State Medicaid FFS Program.

If copayments are waived as an expanded benefit, the providers must not charge enrollees copayments for covered services; and,

If copayments are not waived as an expanded benefit, a notice that the amount paid to the providers by AHCA shall be the Medicaid fee schedule amount less any applicable copayments.

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 the service being rendered, the provider has obtained and kept a written **Member Acknowledgement Statement** signed by the client that states:

*"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 AHCA as being reasonable and medically necessary for my care. I understand that Sunshine Health through its contract with the AHCA 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 State Controlled Substance certificate (if applicable).
- Copy of current Drug Enforcement Administration (DEA) registration Certificate.
- Copy of W-9.
- Copy of Educational Commission for Foreign Medical Graduates (ECFMG) certificate, if applicable.
- Copy of cultural competency training certificate, if applicable.
- Copy of current unrestricted Medical License to practice in the state of Florida.
- Current copy of specialty/board certification certificate, if applicable.
- 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.
- Copy of current Patient Care Compensation Fund (if applicable).
- Copy of Clinical Laboratory Improvement Amendments (CLIA) (if applicable).
- Copy of enumeration letter issued by National Plan and Provider Enumeration System (NPPES), depicting the providers' unique National Provider Identifier (NPI).

Sunshine Health will conduct a background check with the Florida Department of Law Enforcement for all providers not currently enrolled in the Medicaid FFS Program.

Sunshine Health will verify the following information submitted for Credentialing and/or Recredentialing:

- State license through appropriate licensing 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, OIG) OIG/LEIE database as well as FACIS for the sanctions.

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

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

FAILURE 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 recredentialing if new office locations exist or change in office locations has occurred. This review is conducted for all primary care providers, pediatricians, OB/GYN's, and high-volume behavioral health providers. A satisfactory review ($\geq 80\%$) 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 recredentialing 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, they have 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 14 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.

A provider has the right to be informed of the status of their application upon request to the Credentialing Department.

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 14 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 60 days from the receipt of the additional documentation. The applicant will be sent a written response to his/her request within two weeks of the final decision.

Quality Improvement Program



1-866-796-0530/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. To that end, Sunshine Health will provide for the delivery of quality care with the primary goal of improving the health status of its members. Where the member's condition is not amenable to improvement, Sunshine Health will implement measures to prevent any further decline in condition or deterioration of health status or provide for comfort measures as appropriate and requested by the member. This 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.

Sunshine Health will also disseminate bulletins as needed for changes to the Provider Manual.

PROGRAM STRUCTURE

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

The *Quality Improvement Committee (QIC)* is a senior management committee with physician representation that is directly accountable to the BOD. The purpose of the QIC is to provide oversight and direction in assessing the appropriateness of care and service delivered 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 QIC has delegated clinical quality review to the Utilization Management Committee (UMC).

The *Utilization Management Committee (UMC)* is a physician-driven sub-committee of the QIC, whose primary function is to perform oversight of clinical care and medical services delivered to Sunshine Health members, review clinical quality activities of sub-committees and make recommendations to the QIC as required to improve clinical quality.

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 (QIP) GOALS AND OBJECTIVES

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

QI **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 services will meet industry-accepted standards of performance.
- Fragmentation and/or duplications of services will be minimized through integration of quality improvement activities 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 Immunizations, Prenatal Care, Diabetes, Asthma, Early Detection of Chronic Kidney Disease, and Early Periodic Screening, Diagnosis, and Treatment (EPSDT) Guidelines. Sunshine Health will measure compliance with clinical practice guidelines until 90% or more of relevant network providers are consistently in compliance.
- Compliance with all applicable regulatory requirements and accreditation standards will be maintained.

Sunshine Health's QI 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 over time.
- 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:
 - Support the quality improvement program, including data analysis and reporting.
 - 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 (QI) PROGRAM SCOPE

The scope of the Quality Improvement (QI) Program is comprehensive and addresses both the quality of clinical care and the quality of service provided to Sunshine Health's members. Sunshine Health's Quality Improvement Program incorporates all demographic groups, care settings, and services in Quality Improvement activities, including preventive care, primary care, specialty care, acute care, short-term care, long-term care (depending upon the Sunshine Health's products), ancillary services, and Sunshine Health operations. To that end, Sunshine Health's Quality Improvement Program 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 recredentialing)
- Behavioral healthcare within AHCA benefits
- Delegated entity oversight
- Continuity and coordination of care
- Utilization Management, including under and over utilization
- Compliance with member confidentiality laws and regulation
- Employee and provider cultural competency
- Provider appointment availability
- Provider and Plan after-hours telephone accessibility
- Member satisfaction
- Provider satisfaction
- Member Grievance System
- Provider Complaint System
- Member enrollment and disenrollment
- PCP changes
- Department performance and service
- Patient safety
- Pharmacy
- Marketing practices

INTERACTION WITH FUNCTIONAL AREAS

The QI Department maintains strong working relationships with key functional areas within the health plan such as Health Economics, Provider Network Services, Member Services and Connections, Utilization Management, Regulatory Compliance, the Provider Complaint Coordinator, and the Appeals and Grievance Coordinator. Quality is integrated throughout Plan, and represents the strong commitment to quality of care and services for members.

- *Health Economics* 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.
- *Member Services, Connections* and QI staffs collaborate in relation to Member Satisfaction survey activities, including performance improvement projects. The QI and Member Services/Connections departments work collaboratively to maintain performance data related to CHCUP 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.
- *Utilization Management* provides utilization management, case management and disease focused services to enrolled members. UM staff identify and refer quality concerns to the QI

department for investigation; the UM staff recommend benefits enhancements and participate in QI activities and projects.

- *Regulatory Compliance* and the QI Department work together so Sunshine Health's new initiatives comply with State contract and accreditation requirements for NCQA.
- *The Appeal and Grievance Coordinator* and the QI department work closely so that: any grievance related to a quality of care issue is promptly investigated; grievances and second-level reviews of grievances and administrative 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, OB/GYN representation on key quality committees such as, but not limited to, the QIC, Credentialing Committee, P&T Committee, Utilization Management Committee, Peer Review Committee, and select ad-hoc committees.

PERFORMANCE IMPROVEMENT PROCESS

Sunshine Health's QI Council reviews and adopts an annual QI Program and QI Work Plan based on managed care Medicaid appropriate industry standards. 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 Chief Medical Officer along with the Senior Vice President of Medical Management (Sr. VPMMA), or designee in conjunction with the QI Department, 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 or the service. Other initiatives will 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 Plan to monitor improvement over time.

Plan utilizes a 10-step methodology recommended by *Health Care System for Managed Care: A Guide for States* to implement its quality improvement initiatives. However, there may be opportunities for improvement identified in which a modified version of this process may be used.

The development and selection of clinical performance improvement projects is delegated to the Quality Improvement Committee and the Utilization Management Committee due to its clinical representation. The QIC is delegated the development and selection of non-clinical performance improvement projects due to its representation of key functional areas within the organization affecting services. The QIC continues to monitor progress of clinical PIPs as well via regular reporting via UMC. The Sunshine Health QI Program allows for continuous performance of quality improvement activities through analysis, evaluation and improvement in the delivery of healthcare provided to all members, and has established mechanisms to track issues over time.

Annually, Sunshine Health develops a Quality Improvement (QAPI) 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 QI Committee 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 QI committees and sub-committees, and Sunshine Health Board of Directors to monitor progress. The Work Plan is modified and enhanced throughout the year with approval from the state and QIC. Modifications are reported to the Board of Directors and appropriate QI committees.

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

FEEDBACK ON PHYSICIAN SPECIFIC PERFORMANCE

As part of the quality improvement process, performance data on each provider is reviewed and evaluated. This may be done by the Credentialing Committee and/or other committees involved in the quality improvement program. 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, cervical cancer screening, breast cancer screening, and screening for detection of chronic diseases such as diabetes and kidney disease.
- Prenatal care.
- Member Complaint and grievance data.
- Utilization management data including referrals/1000 and bed days/1000 reports.
- Sentinel events and/or adverse outcomes.
- Compliance with clinical practice guidelines.

HEALTH EFFECTIVENESS 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. HEDIS reporting is a required part of the AHCA contract. AHCA holds Sunshine Health accountable for the timeliness and quality of healthcare services (acute, preventive, mental health, etc.) delivered to its diverse 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 the State of Florida 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 use the aggregated HEDIS rates to evaluate the effectiveness of a Health Insurance Company's ability to demonstrate an improvement in Preventive Health outreach to its members. Physician specific scores are being used as evidence of preventive care from primary care office practices. The rates then serve as a basis for physician incentive programs such as 'pay for performance' and 'quality bonus funds'. These programs pay providers an increased premium based on scoring of such quality indicators used in HEDIS.

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 mammogram, annual Chlamydia screening, annual Pap test, treatment of pharyngitis, treatment of URI, appropriate treatment of asthma, cholesterol management, antidepressant medication management, access to PCP services, and utilization of acute and mental health services.

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, control of high-blood pressure, immunizations, prenatal care, and well-child care.

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

Sunshine Health staff will collect medical records needed for HEDIS reporting. Medical record review audits for HEDIS are usually conducted March through May each year. At that time, you may receive a call from Quality Improvement staff if any of your patients are selected into HEDIS samples for Sunshine Health. Your prompt cooperation with the staff is greatly needed and appreciated. Records may be collected at your office or you may fax them to the secure QI fax: 1-866-796-0528.

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. HEDIS Quick Reference Guides are located on the Sunshine Health website under "For Providers."

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 **1-866-796-0530**.

CONSUMER ASSESSMENT OF HEALTHCARE PROVIDER SYSTEMS (CAHPS) SURVEY

This is a member satisfaction survey that 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 adult CAHPS survey provides information on the experiences of Medicaid members with the MCO services and gives a general indication of how well the MCO 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. The child CAHPS survey looks at the same global and composite areas but provides information on parents' experience with Sunshine Health services. Member responses to the CAHPS 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. An external vendor conducts the survey. 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 QI Committee. 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 Provider Partnership Manager meets with primary care providers 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 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. The Sunshine Health Medical Director and Pharmacist conduct special training and meetings to assist physicians and other providers with quality and service improvement efforts.

WASTE, ABUSE, AND FRAUD (WAF) SYSTEM

Sunshine Health is committed to the prevention, detection, correction, reporting and prosecution of fraud, waste or abuse. Sunshine Health in conjunction with its management company, Centene Corporation, successfully operates a Special Investigations Unit (SIU). The Special Investigations Unit performs front and back-end audits to ensure compliance with billing regulations, and our sophisticated code editing software performs systematic audits during the claims payment process. 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 by contacting the Compliance Officer at **1-866-796-0530** or by email to Compliancefl@centene.com. To report suspected fraud, waste or abuse in the Medicaid/Long Term Care/Florida Healthy Kids programs, please use one of the following avenues:

AHCA Consumer Complaint Hotline: 1-888-419-3456
Florida Attorney General's Office: 1-866-966-7226
The Florida Medicaid Program Integrity Office: 1-850-412-4600

Complaint Form at: https://apps.ahca.myflorida.com/inspectorgeneral/fraud_complaintform.aspx

Department of Financial Services (DFS) – Division of Insurance Fraud Complaint Form at: <https://apps8.fldfs.com/first/> or DFS website at <http://www.myfloridacfo.com/division/fraud/> then click on report insurance fraud.

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

- Federal and State False Claims Act
- Qui Tam Provision (Whistleblower)
- Anti-Kickback Statute
- Physician Self-Referral Law (Stark Law)
- HIPAA
- Social Security Act
- US Criminal Codes

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

FWA Training is available via our company website – we have a training program providers can download in PDF format. We also include training for Fraud, Waste, and Abuse in our Provider Orientation packets.

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

If you or your employees have not taken the Compliance and/or FWA Training, please log onto Sunshine Health's website at www.sunshinehealth.com to complete the training. Please contact Provider Services for additional instructions as needed. It is your responsibility and part of your contractual obligation to

comply with all state and federal program requirements for your continued participation with Sunshine Health.

AUTHORITY AND RESPONSIBILITY

Sunshine Health's Compliance Officer has the overall responsibility and authority for carrying out the provisions of the compliance program, especially the measures of prevention, detection, reduction, correction and reporting of fraud, waste, abuse and any other non-compliance related issues.

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

PROVIDER MARKETING ACTIVITIES

Sunshine Health will ensure, through provider education, outreach and monitoring that its providers are aware of and comply with the following:

- Providers are permitted to make available Sunshine Health marketing materials as long as the provider and/or the facility distributes or makes available marketing materials for all Managed Care Plans with which the provider participates.
- AHCA does not expect providers to proactively contact all Managed Care Plans; rather, if a provider agrees to make available and/or distribute Managed Care Plan marketing materials it should do so knowing it must accept future requests from other Managed Care Plans with which it participates.
- Providers may to display posters or other materials in common areas such as the provider's waiting room.
- Long-term care facilities are permitted to provide materials in admission packets announcing all Managed Care Plan contractual relationships.
- Providers may engage in discussions with recipients should a recipient seek advice. However, providers must remain neutral when assisting with enrollment decisions.

Sunshine Health will ensure, through provider education, outreach and monitoring that its providers are aware of and comply with the following:

Providers may not:

- Offer marketing/appointment forms.
- Make phone calls or direct, urge or attempt to persuade recipients to enroll in the Managed Care Plan based on financial or any other interests of the provider.
- Mail marketing materials on behalf of Sunshine Health.
- Offer anything of value to induce recipients to select them as their provider.
- Offer inducements to persuade recipients to enroll in Sunshine Health.
- Conduct health screening as a marketing activity.
- Accept compensation directly or indirectly from Sunshine Health for marketing activities.
- Distribute marketing materials within an exam room setting.

- Furnish Sunshine Health lists of their Medicaid patients or the membership of any Managed Care Plan.

Providers may:

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

MEMBER SERVICES



MEMBER SERVICES

Sunshine Health is committed to providing its members with information about the health benefits that are available to them through the Sunshine Health program. 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 programs to address the needs of its members. Members may attend classes, receive specific disease management bulletins and treatment updates, appointment reminder cards, and informational mailings.

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 are not to be held liable for these services. To arrange for any of the above services, please call the Sunshine Health Provider Services Department at **1- 866-796-0530**.

CONNECTIONS PROGRAM

Sunshine Health recognizes the special needs of the population it serves. In response to these special needs, the CONNECTIONS program has been developed to address the challenges in member outreach, member education, and in member's understanding of the managed care health system.

CONNECTIONS is an educational and outreach program that brings our members a special personal-touch service. The program is designed to promote preventive health practices and connect members to quality healthcare and community social services. By assigning CONNECTIONS representatives to individual members, CONNECTIONS creates a special link between members and Sunshine Health providers.

CONNECTIONS representatives will:

- Contact new members by telephone to welcome them to Sunshine Health.
- Introduce members to Sunshine Health managed care and assist them in understanding their available options for preventive healthcare in the Sunshine Health network and how to access services appropriately.
- Conduct home visits and monthly member orientation sessions for basic member education about Sunshine Health and services available through the Sunshine Health network.
- Participate in community activities centered on health education.
- Council members on accessing appropriate levels of care and non-compliance issues.
- Assist members in making appointments.
- Advise members of their rights and responsibilities.

CONNECTIONS serve as a link between the member, PCP and Sunshine Health. This is encouraged through face-to-face activities such as new Sunshine Health mom visits and member orientation sessions.

Watch for activities that CONNECTIONS may be hosting in the Sunshine Health provider mailings. Participating Sunshine Health providers can contact the Medical Management Department at 1-866-796-0530 to request that a home visit be completed when a Sunshine Health member is found to be non-

compliant, (for example missing medical appointments) with recommended medical treatment or has other identified issues or high risk factors (for example frequent ER visits for routine medical care) that negatively impact the member's health status. Sunshine Health members who require additional coaching to learn how to access the system appropriately can be referred by the Sunshine Health PCP to have a visit from the CONNECTIONS representative.

HEALTHY BEHAVIORS PROGRAMS

The Healthy Behaviors program offers enrollees financial and other incentives to encourage healthy behaviors and manage conditions. Enrollees may earn up to \$125 cash per year upon successful completion of the various activities. The rewards are issued in the form of a CentAccount debit card, which may be used to purchase health-related items, utilities, public transportation, childcare and food but may not be used to purchase fast food, alcohol, or cigarettes. As a provider, you may also instruct members to contact the Customer Service Department at Sunshine Health at 1-866-796-0530.

First Program: Health and Wellness Healthy Behaviors, rewards any member who completes certain health and wellness exams and screenings, including annual well visits, dental and vision exams, flu shots, and age-specific cancer screenings.

Second Program: Condition Management Healthy Behaviors, focuses on the management of pregnancy, diabetes, hypertension, asthma, heart failure and substance abuse. Members must complete certain screenings, visit their treating provider, fill prescribed medications and have several discussions about their condition with a health coach. Members with substance abuse also must attend six AA/NA meetings over a six-month period.

Third program: Lifestyle Risk Healthy Behaviors, rewards members with certain chronic conditions if they complete any of four lifestyle risk activities, including tobacco cessation, weight management, exercise, and stress management.

MEMBER MATERIALS

Members will receive various pieces of information from Sunshine Health through mailings and through face-to-face contact. The member handbook is printed in English and Spanish and can be requested in other languages identified by the state. These materials include:

- Quarterly Newsletters
- Targeted Health Management Brochures
- Provider Directory
- NurseWise information
- ER Information
- Member Handbook which includes:
 - Benefit information, including pharmacy network information and how to get transportation
 - Member rights and responsibilities

Providers interested in receiving any of these materials may contact:

Member Services Department

1-866-796-0530

Fax 1-866-714-7998

TDD/TYY 1- 800-955-8770

www.sunshinehealth.com

PROVIDERS BILL OF 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:
 - The member's health status, medical care, or treatment options, including any alternative treatment that may be self-administered.
 - Any information the member needs in order to decide among all relevant treatment options.
 - The risks, benefits, and consequences of treatment or non-treatment.
 - 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 & RESPONSIBILITIES

Members are informed of their rights and responsibilities through the Member Handbook. Sunshine Health providers are also expected to respect and honor member's rights.

Sunshine Health members have the following rights and responsibilities:

- To be treated with respect and with due consideration for his/her dignity and the right to privacy and non-discrimination as required by law.
- To receive information about Sunshine Health providers and member rights and responsibilities.
- To participate with their providers and practitioners in making decisions regarding their healthcare. This includes the right to refuse treatment.
- To exercise these rights without adversely affecting the way Sunshine Health and its providers treat the members.
- To receive the following materials:
 - Enrollment notices;
 - Information materials;
 - Instructional materials; and
 - Available treatment options and alternatives, in a manner and format that may be easily understood.
- To receive family planning services from any participating Medicaid doctor without prior authorization.
- To get information about your rights and responsibilities, as well as the Sunshine Health providers and services.

- To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation, as specified in the Federal regulations on the use of restraints and seclusion.
- To receive healthcare services that are accessible, are comparable in amount, duration and scope to those provided under Medicaid FFS. And to receive healthcare services that are sufficient in amount, duration and scope to reasonably be expected to achieve the purpose for which the services are furnished (also 42 CFR 438.206 & 438.210).
- To request and receive a copy of your medical record (also 45 CFR 164.524).
- To request that your medical record be corrected (also 45 CFR 164.526).
- To receive notice of any significant changes in the Benefits Package at least 30 days before the intended effective date of the change.
- To a candid discussion of appropriate or medically necessary treatment options for your conditions, regardless of cost or benefit coverage.
- To receive assistance from both Florida Medicaid and Sunshine Health in understanding the requirements and benefits of the health plan.
- To get a second opinion from a qualified healthcare professional.
- To receive notice if Sunshine Health will not provide services due to moral or religious reasons within 30 days before the service.
- To receive services in a culturally competent manner, including members with limited English ability, and diverse cultural and ethnic backgrounds.
- As a potential member, to receive information about the basic features of managed care; which populations may or may not enroll in the program and Sunshine Health's responsibilities for coordination of care in a timely manner in order to make an informed choice.
- To receive information about Sunshine Health, its benefits, services, and practitioners.
- To receive information on the following:
 - Benefits covered;
 - Procedures for obtaining benefits, including any authorization requirements;
 - Cost sharing requirements;
 - Service area;
 - Names, locations, telephone numbers and non-English languages spoken by current Sunshine Health providers, including at a minimum, PCPs, specialists, and hospitals;
 - Any restrictions on member's freedom of choice among network providers;
 - Providers not accepting new patients; and
 - Benefits not offered by Sunshine Health but available to members and how to obtain those benefits, including how transportation is provided.
- To privacy of healthcare needs and information as required by federal law (Standards for Privacy of Individually Identifiable Health Information).
- To choose a PCP and to change to another PCP at anytime
- To receive Sunshine Health's policy on referrals for specialty care and other benefits not provided by the member's PCP.
- To receive timely access to care, including referrals to specialists when medically necessary without barriers.
- To get care from a provider not in Sunshine Health's network if your doctor says the care is medically needed and is not available from one of our providers.
- To allow or refuse their personal information be sent to another party for other uses unless the release of information is required by law (also 45 CFR 164.524).
- To receive services that are appropriate and are not denied or reduced solely because of diagnosis, type of illness, or medical condition.
- To receive information on the Grievance, Appeal, and Medicaid Fair Hearing procedures.

- To voice grievances or file appeals about Sunshine Health decisions that affect their privacy, benefits or the care provided.
- To file for a Medicaid Fair Hearing
- To expect their medical records and care be kept confidential as required by law.
- To make an advance directive, such as a living will.
- To choose a person to represent them for the use of their information by Sunshine Health if they are unable to.
- To receive translation services free of charge for all non-English languages.
- To be notified that oral interpretation is available and how to access those services.
- To receive a complete description of disenrollment rights at least annually.
- To receive detailed information on emergency and after-hours coverage, to include, but not limited to:
 - What constitutes an emergency medical condition, emergency services, and post-stabilization services.
 - That emergency services do not require prior authorization.
 - The process and procedures for obtaining emergency services.
 - The locations of any emergency settings and other locations at which providers and hospitals furnish emergency services and post-stabilization services covered under the contract.
 - Member's right to use any hospital or other setting for emergency care.
 - Post-stabilization care services rules in accordance with Federal guidelines.
- To make recommendations regarding Sunshine Health's member rights and responsibilities policy.
- To inform Sunshine Health of the loss or theft of their Member ID card.
- To present their Member ID card when using healthcare services.
- To be familiar with Sunshine Health procedures to the best of their ability.
- To call or contact Sunshine Health to obtain information and have questions clarified.
- To provide information (to the extent possible) that Sunshine Health and its practitioners and providers need in order to provide care.
- To follow the prescribed treatment (plans and instructions) for care that has been agreed upon with your practitioners/providers.
- To inform your provider on reasons you cannot follow the prescribed treatment of care recommended by your provider.
- To understand your health problems and participate in developing mutually agreed-upon treatment goals to the degree possible.
- To keep your medical appointments and follow-up appointments.
- To access preventive care services.
- To follow the policies and procedures of Sunshine Health and the State Medicaid program.
- To be honest with providers and treat them with respect and kindness.
- To get regular medical care from their PCP before seeing a specialist.
- To follow the steps of the appeal process.
- To notify Sunshine Health, DCF, and your providers of any changes that may affect your membership, healthcare needs or access to benefits. Some examples may include:
 - If you have a baby.
 - If your address changes.
 - If your telephone number changes.

- If you or one of your children are covered by another health plan.
- If you have a special medical concern.
- If your family size changes.
- To keep all your scheduled appointments; be on time for those appointments, and cancel 24 hours in advance if you cannot keep an appointment.

MEMBER GRIEVANCES

MEMBER COMPLAINTS

Federal law requires Medicaid managed care organizations to have internal grievance procedures under which Medicaid enrollees or providers acting as their authorized representatives may challenge a denial of coverage or payment for medical assistance. These procedures must include an opportunity to file a complaint, grievance, and/or an appeal to seek a Medicaid Fair hearing through DCF.

IMPORTANT DEFINITIONS FOR MEMBER GRIEVANCES

The following are some definitions related to the member grievance process:

A “**complaint**” is the lowest level of problem resolution and provides Sunshine Health an opportunity to resolve a problem without its becoming a formal grievance. Complaints must be resolved by close of business the day following receipt or be moved into the grievance system within 24 hours.

A “**grievance**” is an expression of dissatisfaction about any matter other than an “action.” For example, a member would file a grievance if the member has a problem with issues such as:

- The quality of your care
- Waiting times for appointments
- Waiting time to be seen while in a doctor’s office
- The way your doctor or their staff behave

An “**action**” is the denial or limit by Sunshine Health of services requested by the member or their provider.

- This can include the level of service, example: outpatient vs. inpatient hospital care.
- It can also include a reduction, suspension or termination of a service that was already authorized for the member.
- It can mean the denial of all or part of the payment for a service or failure to provide the service in a timely manner.
- It can also mean Sunshine Health failure to act on a grievance or appeal the member requested within 90 days of receiving the request.

An “**appeal**” is a request for a review of an action.

For example:

- If we refuse to cover or pay for services you think we should cover, the member may file an appeal.
- If one of our contracted providers refuses to give the member a service the member thinks should be covered, the member may file an appeal.
- If the member thinks we are stopping their coverage of a service **too soon**, the member may file an appeal.
- With the member’s permission, a provider may also file an appeal for the member.

Sunshine Health is required to keep track of all complaints, appeals, and grievances in order to report data to the State on a quarterly and annual basis. This information is used to improve our service to our members.

FILING A GRIEVANCE WITH SUNSHINE HEALTH

If a member is dissatisfied with Sunshine Health for any reason, other than an action, (as noted above) the member may file a grievance. This may be done orally by calling Member Services 1-866-796-0530, or in writing. If the member chooses to notify us by phone, they will also need to put their grievance in writing within ten (10) calendar days and they must sign it. We can help them with this. As a member's physician, you can file a grievance on behalf of your member if the member gives you written approval to do this. The member cannot be disenrolled or penalized in any way if they file a grievance.

Sunshine Health will send the member a letter acknowledging their grievance, unless they have requested an "expedited" appeal. Sunshine Health must resolve the member grievance within 90 calendar days from receipt.

The member may file a grievance any time up to one (1) year following the date of the incident. The member or the member's healthcare provider may request an extension if necessary and if this is in their best interest. An extension can be made for up to fourteen (14) days. We are available to assist the member Monday through Friday, 8:00 a.m. to 5:00 p.m. Effective as of 3/1/14 our Member Services hours will be extended from 8:00 a.m. - 8:00 p.m. EST.

If a member would like to contact us in writing, please address your letter to:

**Sunshine Health Appeals/Grievances Coordinator
1301 International Pkwy
4th Floor
Sunrise, FL 33323**

Sunshine Health is required to send the member a written notice about the resolution of the grievance. We must do this within 90 calendar days of the resolution. This notice will tell the member the results and the date of the resolution. If our resolution is not in the member's favor, based on the written notice that the member receives, they have the right to file a Medicaid Fair Hearing.

Be sure to contact our Member Services Department if the member has questions, needs any help or have additional information to submit about their grievance. The member may call Member Services at 1-866-796-0530. Members who have a behavioral health complaint or grievance may call Member Services at 1-866-896-0530 and select the behavioral health option.

MEDICAID FAIR HEARING PROCESS

The member has the right to ask for a Medicaid Fair Hearing at any time within 90 days of the date on Sunshine Health's notice of the resolution of their grievance. The member may do this in addition to, and at the same time as, pursuing resolution through Sunshine Health's grievance and appeals process.

To request a Medicaid Fair Hearing, contact:

**Office of Appeals Hearings
1317 Winewood Blvd.
Bldg. 5 – Room 255
Tallahassee, FL 32399-0700**

The member or someone they appoint to represent them, or a provider (with their written consent) may request a Medicaid Fair Hearing on their behalf. The parties to a Medicaid Fair Hearing include the member, their representative or a representative of a deceased member and Sunshine Health.

If the member chooses to have a Medicaid Fair Hearing, they give up their right to a review by the State's Beneficiary Assistance Program (BAP).

CONTINUATION OF BENEFITS

The member's benefits will continue while the Medicaid Fair Hearing is pending, if:

1. They file their request for a Medicaid Fair Hearing in a timely manner **on/or** before the latter of:
 - a) Ten (10) business days after the notice of adverse action is mailed.
 - b) Ten (10) business days after the intended effective date of action.
2. The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment;
3. The services must have been ordered by an authorized provider;
4. The authorization period has not expired; and/or
5. The member requests an extension of benefits.

If Sunshine Health continues the member's benefits during this time, we will until one of the following occurs:

1. They withdraw their request for Medicaid Fair Hearing
2. Ten (10) business days pass from an oral request or fifteen (15) business days pass after Sunshine Health sends the member notice of resolution of the appeal against the member, unless the member has requested Medicaid Fair Hearing within those ten (10) business days and has requested continuation of benefits.
3. A Medicaid Fair Hearing decision adverse to the member is made.
4. The authorization expires or authorized service limits are met.

If the final resolution of the Medicaid Fair Hearing is in the member's favor, Sunshine Health will pay for the disputed services as required. If the final resolution of the Medicaid Fair Hearing is not in the member's favor, they may be liable for all costs accrued while the Medicaid Fair Hearing was pending. Sunshine Health may recover the cost of the services furnished while the Medicaid Fair Hearing was pending.

If the services were not provided during the time, the Medicaid Fair Hearing was pending and Sunshine Health's decision is reversed, Sunshine Health will authorize and pay for those services.

APPEAL PROCESS

The member may file an appeal of a decision by within thirty (30) calendar days of receipt of Sunshine Health's notice to them about our action.

An appeal can be filed orally or in writing. Our Member Services staff can assist the member with this in any way. Oral appeals must be followed by a written, signed appeal within ten (10) calendar days of the oral filing. Sunshine Health will send the member a notice to remind them that they must file a written appeal within ten (10) business days of receiving their oral request for appeal. If the member needs help completing their written appeal, please call Member Services at 1-866-796-0530. Translators and interpreters will help them, if they need help, with no charge to the member.

Sunshine Health's timeframe to resolve a member's appeal begins on the date that we receive their oral request. A provider may file an appeal on the member's behalf, with their written consent.

Sunshine Health will resolve the member's appeal within forty-five (45) calendar days from the date Sunshine Health received their initial request, unless they have requested an "expedited" appeal. This timeframe can be extended up to fourteen (14) calendar days if the member requests it or Sunshine Health finds there is a need for additional information, and the delay is in the member's best interest. Sunshine Health will notify the member in writing within five (5) business days if we need an extension. Sunshine Health will notify the member within two (2) weeks of the resolution.

If the resolution to the member's appeal is in their favor, Sunshine Health will provide the services as quickly as their condition requires.

EXPEDITED APPEAL PROCESS

The member may ask for an “expedited or urgent” appeal if taking the time for a standard resolution could seriously jeopardize your life, health or ability to attain, maintain or regain maximum function.

The member may file an “expedited” appeal orally or in writing. Their doctor may file one on their behalf, with the member’s written consent. You do not need to follow-up this request in writing.

If the member or their physician files an “expedited” appeal, Sunshine Health will:

1. Inform the member of the limited time available to present your evidence and allegation of fact or law, in person or in writing;
2. Resolve each expedited appeal and give the member notice as quickly as their condition requires, but within 72 hours after Sunshine Health receives their appeal;
3. Provide member with a written notice of the resolution; and
4. Try to provide member with oral notice of the resolution.

If Sunshine Health’s denies the member request for an “expedited” appeal, Sunshine Health will:

1. Transfer the member’s appeal to the standard timeframe of no longer than forty-five (45) calendar days from when Sunshine Health receives the request for an expedited appeal.
2. Grant a fourteen (14) day extension if in the member’s best interest.
3. Provide oral notice to the member by close of business on the day of disposition.
4. Provide the member with written notice of the denial within two (2) calendar days.

APPEALING TO THE BENEFICIARY ASSISTANCE PROGRAM (BAP)

If a member has completed Sunshine Health’s grievance and appeals process, and they remain dissatisfied, they may file an appeal with the BAP. The notice of resolution letter from Sunshine Health will tell the member how to start a review by BAP. It will also include BAP’s address and telephone number. This agency can also be contacted at any time during the appeal or grievance process. To do so, you must request a hearing within 365 calendar days or one year. The BAP will only hear their case if it involves the availability of health care services, the coverage of benefits, or a benefit action/denial made by us, claim payment, handling, or reimbursement for benefits. If the member takes their concern to a Medicaid Fair Hearing, they *may not* also request a BAP review.

Submit appeals to:

**Agency for Health Care Administration (AHCA)
Beneficiary Assistance Program
Building 1, MN #26
2727 Mahan Drive
Tallahassee, Florida 32308
(850) 412-4502**

(888) 419-3456 (toll free) EXHAUSTION OF THE GRIEVANCE PROCESS

If you still have questions or concerns about the quality of medical care you receive, call AHCA’s Consumer Hot Line at 1-888-419-3456.

MEDICAID STATE FAIR HEARING

An enrollee may seek a Medicaid Fair Hearing without having first exhausted the Health Plans grievance and appeal process. If the member is dissatisfied with the decision of the grievance, or appeal within 90 days of receipt of the decision of the grievance, they may request a Medicaid Fair Hearing by writing:

**The Office of Public Assistance Appeal Hearings
1317 Winewood Boulevard, Building 5, Room 255
Tallahassee, Florida 32399-0700**

If the member requests a Medicaid State Fair Hearing and wants their benefits to continue, the request must be filed within ten (10) days of receipt of the decision or within ten (10) business days after the intended effective date of the action, whichever is later. If the decision of the Fair Hearing is in favor of the health plan, the member may be responsible for the cost of the continued benefit.

BENEFICIARY ASSISTANCE PROGRAM (BAP)

Within one year of the grievance decision, the member may request a review with the BAP Program by contacting AHCA at:

**Agency for Health Care Administration (AHCA)
BENEFICIARY ASSISTANCE PROGRAM (BAP)
Building 1, MS #26
2727 Mahan Drive, Tallahassee, Florida 32308
1-888-419-3456
EXPEDITED RESOLUTION OF APPEALS**

If a decision on an appeal is required immediately due to the member's health needs, which cannot wait with the standard resolution time, an expedited appeal may be requested. Sunshine Health's decision on the expedited resolution will be provided within 72 hours after receiving the appeal request. The appeal request can be made orally or in writing.

If the Sunshine Health denies a request for expedited resolution of an appeal, the appeal will immediately be transferred to standard resolution of appeal timeframe, subject to an authorized extension of up to fourteen (14) calendar days. Sunshine Health will contact the member by telephone by close of business on the day of disposition and follow-up within two calendar days with written notice.

CONTINUATION OF BENEFITS

Sunshine Health members may continue receiving services or items until a decision is made about his/her grievance, appeal or fair hearing process if the member was receiving ongoing services that were suspended, reduced, or terminated.

Sunshine Health must continue the member's benefits if:

- The member or the provider files the appeal within ten (10) business days after the Notice of Action is mailed or within ten (10) business days after the intended effective date of the action; whichever is later.
- The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment.
- The services were ordered by an authorized provider.
- The member requests an extension of benefits.

ASSISTANCE AND CONTACTING SUNSHINE HEALTH

Sunshine Health's Appeal and Grievance Coordinator is available to assist members who need help in filing a grievance or request for appeal or in completing any element in the grievance or appeal process. Members 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 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:

- Having individuals available who are trained professional interpreters for Spanish and American 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 140 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 medical advice line, NurseWise, 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 Member Services at 1-866-796-0530 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.

TRANSPORTATION SERVICES

In addition to benefits outlined in this Provider Office Manual, Sunshine Health will provide non-emergency transportation services to members. This service is for the purpose of receiving medical and dental care when appointment has been scheduled. Medicaid non-emergency transportation services are provided through TMS Transportation at 1-866-790-8817. Members are required to make transportation appointments 48 hours in advance.

PROVIDER SERVICES ASSISTANCE



PROVIDER SERVICES DEPARTMENT

The Provider Services Department at Sunshine Health will include Provider Relations staff who will be available to respond quickly and efficiently to all provider inquiries. This collaborative effort is designed around the concept of making your experience with Sunshine Health a positive one. By calling Provider Services at 1-866-796-0530, providers will be able to receive real time assistance for all issues or requests, including but not limited to:

- Credentialing/Network Status
- Claims Inquiries
- Request for adding physicians to an existing group

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.

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, and will connect you to a Sunshine Health Provider Relations Specialist should further escalation need to occur.

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

The Provider Services Department is available Monday through Friday from 8:00 AM to 8:00 PM and can be reached by contacting:

Provider Services Department
1-866-796-0530
Fax 1-866-796-0528

PROVIDER COMPLAINTS

Providers have the right to appeal policies/procedures and any decision made by Sunshine Health, including complaints on claims payments. A complaint may be filed telephonically or in writing by contacting Sunshine Health Provider Services at:

Sunshine Health
1301 International Pkwy, 4th Floor
Sunrise, FL 33323
ATTN: Provider Services
1-866-796-0530

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, they should contact a Sunshine Health Provider Services Representative at 1-866-796-0530.

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 six months of the eligibility determination date. Mechanical or administrative delays or errors by Sunshine Health or the Agency for Health Care Administration (AHCA). 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 Medicaid card or information.
- The provider can substantiate that he continually pursued reimbursement from the patient until Medicaid eligibility was discovered.
- The provider can substantiate that a claim was filed within 180 days of discovering Medicaid Plan 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. 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 the Sunshine Health Provider Manual.

PHARMACY



SUNSHINE HEALTH PHARMACY PROGRAM

Sunshine Health covers prescription drugs and certain over-the-counter (OTC) drugs when ordered by a Sunshine Health doctor. Some medications require prior authorization or have limitations on age, dosage, and/or maximum quantities.

Working with Our Pharmacy Benefit Manager (PBM)

Sunshine Health works with **US Script** to process all pharmacy claims for prescribed drugs. Certain drugs require prior authorization to be approved for payment by Sunshine Health. These include:

- All medications not listed on the Sunshine Health Preferred Drug List (PDL).
- Some Sunshine Health preferred drugs (require prior authorization on the PDL).

US Script is responsible for administering the prior authorizations process for all prescribed drugs requiring prior authorization. All medications not listed on the Sunshine Health PDL and some Sunshine Health preferred drugs require prior authorization to be approved for payment by Sunshine Health.

Follow these guidelines for efficient processing of your prior authorization requests:

- 1) Complete the Sunshine Health/US Script form: *Request for prior authorization*.
- 2) Fax to US Script at: **1-866-399-0929**.
- 3) Once approved, US Script notifies the prescriber by fax.
- 4) If the clinical information provided does not explain the request for prior authorization medication, US Script responds to the prescriber by fax, offering PDL alternatives.
- 5) For urgent or after-hours requests, a pharmacy can provide up to a 72-hour supply of most medications by calling the US Script Pharmacy Help Desk at: **1-866-399-0928**.

Working with Our Specialty Pharmacy Provider

Acaria is the provider of biopharmaceuticals and specialty injectables for Sunshine Health. Most specialty injectables, billed for more than \$250, require prior authorization to be approved for payment. Our Pharmacy Program Director and Medical Director oversee the clinical review. Follow these guidelines for the most efficient processing of your biopharmaceuticals and specialty injectables prior authorization requests.

Providers can request that our specialty vendor deliver the specialty drug to the office/member. If you want the specified drugs to be delivered to the office/member:

- 1) Call Sunshine Health at **1-866-796-0530** or fax the enrollment form to 1-866-351-7388 for prior authorization.
- 2) If approved, our specialty drug vendor will contact the provider or member for delivery confirmation.

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 PDL and prior authorization request forms and can be downloaded from our website at: www.sunshinehealth.com.

The Sunshine Health PDL

The Sunshine Health 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, or
- Relieve the physician/clinician or pharmacist of any obligation to the patient or others.

Pharmacy and Therapeutics (P&T) Committee

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 providers and specialists. The primary purpose of the committee is to assist in developing and monitoring the Sunshine Health 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.**

Prior Authorization Process

The Sunshine Health PDL includes a broad spectrum of generic and brand name drugs. Clinicians are encouraged to prescribe from the Sunshine Health PDL for their patients who are members of Sunshine Health. Some preferred drugs require prior authorization. Medications requiring prior authorization are listed with a "prior authorization" notation throughout the PDL, including the index. In addition, **all injectable medications (except Insulin, Glucagon Kit, Epi-pens, Imitrex, and medroxyprogesterone IM) require prior authorization.**

The P & T Committee has reviewed and approved, with input from its members and in consideration of medical evidence, the list of drugs requiring prior authorization. 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 prior authorization 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 prior authorization requests:

<u>US Script Contacts</u>	Prior Authorization Fax	1-866-399-0929
	Prior Authorization Phone	1-866-399-0928
	Clinical Hours	Mon. – Frid. 11:00 a.m.- 8:00 p.m. (EST)
	Mailing Address	US Script 2425 W Shaw Avenue Fresno, CA 93711

When calling, please have patient information, including Medicaid number, complete diagnosis, medication history and current medications readily available. Upon receipt of all necessary information, US Script will respond by fax or phone within 24 hours except during weekends and holidays. **If the request is approved**, information in the on-line 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.

Clinicians are requested to utilize the PDL when prescribing medication for those patients covered by the Sunshine Health pharmacy program. If a pharmacist receives a prescription for a drug that requires a prior authorization request, the pharmacist should attempt to contact the clinician to request a change to a product included in the Sunshine Health PDL.

Phone Numbers for Sunshine Health Member Services

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

72-Hour Emergency Supply Policy

State and Federal law require that a pharmacy dispense a 72-hour (three day) supply of medication to any patient awaiting a prior authorization determination. The purpose is to avoid interruption of current therapy or delay in the initiation of therapy. All participating pharmacies are 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 prior authorization request is ultimately approved or denied. **The pharmacy must call the US Script Pharmacy 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 PDL and **are not covered by the 72-hour emergency supply policy**:

- Anorectics: Drugs used for weight loss (unless prescribed for an indication other than obesity)
- Anti-Hemophilia Products (Billed as FFS to Florida Medicaid)
- Cough and Cold Medications for members ages 21 and over
- DESI ineffective drugs as designated by CMS
- Drugs used to treat infertility
- Experimental/Investigational pharmaceuticals or products
- Erectile dysfunction products prescribed to treat impotence
- Hair growth restorers and other drugs used for cosmetic purposes
- Immunizing agents (except for influenza vaccine)
- Injectable/Oral drugs administered by the provider in the office, in an outpatient clinic or and 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

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 (ST)

Medications requiring step therapy are listed with a "ST" notation throughout the preferred drug list. The US Script 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 prior authorization 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, Epi-pen, Ana-Kit, Imitrex, and medroxyprogesterone IM are covered by Sunshine Health and do not require prior authorization. All other injectables require prior authorization.**

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

Drugs may be dispensed up to a maximum 34-day supply for each new (original) or refill. A total of (85%) of the days supplied must have elapsed before the prescription can be refilled.

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 be reimbursed at the MAC price. The provision is waived for the following products due to their narrow therapeutic index: *Aminophylline, Amiodarone, Carbamazepine, Clozapine, Cyclosporine, Digoxin, Disopyramide, Ethosuximide, Flecainide, L-thyroxine, Lithium, Phenytoin, Procainamide, Propafenone, Theophylline, Thyroid, Valproate Sodium, Valproic Acid, and Warfarin.*

Over-The-Counter (OTC) Items may be a covered benefit for some members

The Sunshine Health PDL covers a few OTC medications. All covered OTC's appear in the PDL. **All OTC medications must be written on a valid prescription**, by a licensed physician/clinician, in order to be reimbursed. Just take the prescription to the pharmacy to have it filled.

Drug Efficacy Study Implementation (DESI) or Identical, Related, and Similar (IRS) Drugs

DESI and IRS drugs that are classified as ineffective are not covered by the Sunshine Health PDL. **Contacts for Pharmacy Appeals/Grievances**

Members

In the event that a member disagrees with the decision regarding coverage of a medication, the member may file an appeal/grievance with Sunshine Health by calling the Sunshine Health Member Services at **1-866-796-0530**.

Physicians / Clinicians

In the event that a clinician or member disagrees with the decision regarding coverage of medication, the clinician may request reconsideration by submitting additional information to US Script. 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 **1-866-796-0530**. 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.

CHILD WELFARE

Sunshine Health's Child Welfare Program

(This section describes those areas that are unique to the Sunshine Health's Child Welfare Program)

Description of the Child Welfare Program

Sunshine Health Child Welfare serves children and youth enrolled in Medicaid who have an open case in the Florida Safe Families Network (FSFN), the federally approved Child Welfare system in Florida which identifies children receiving Child Welfare Services. The Agency for Health Care Administration (AHCA) has contracted with Sunshine Health as the single managed care plan for Florida to serve this vulnerable population. Sunshine Health provides management of all physical, behavioral, dental, vision, and pharmacy services for children in the Child Welfare system. Sunshine Health Child Welfare serves all 11 ACHA Regions and the 20 Community Based Care (CBC) Regions across the state. CBCs are a comprehensive redesign of Florida's Child Welfare system. It combines the outsourcing of foster care and related services to competent service agencies with an increased local community ownership of service delivery and design.

One of the unique aspects of Sunshine Health's Child Welfare Program is the partnership between Sunshine Health, Cenpatico (Sunshine Health's behavioral health vendor) and CBC - Integrated Health, LLC (CBC-IH). CBC-IH is the entity representing the local area CBC's across the state. Sunshine Health is funding CBC coordinator's to be placed in all participating CBC locations to support the integrated model. These coordinators will serve as conduits of information between the Medicaid and Child Welfare system.

Sunshine Health's Child Welfare Program has been structured to build integrated programs that are member focused and address the needs of the child welfare population. The streamlined process of integrated physical and behavioral health services in concert with the Child Welfare service delivery plan will improve the access to services and quality of care. To support the providers in managing the care for these children, Sunshine Health and Cenpatico work together to assure that provider input is received, understood and shared among Child Welfare decision-makers and that joint efforts in treatment and service planning are ongoing, all with the goal of improving both physical and behavioral health outcomes, increasing stability and ultimately, improved permanency outcomes for children/youth.

Continuity of Care for Newly Enrolled Child Welfare Members

Sunshine Health coordinates care for all new members enrolled in the plan. This process ensures continuous care for members receiving an active course of treatment through their previous health plan or Medicaid fee-for-service (FFS). Sunshine Health prioritizes members for whom effective continuity of care is especially critical or for whom disruptions could jeopardize their health.

Sunshine Health provides continuation of Managed Medical Assistance (MMA) services up to 90 calendar days following the enrollment date or until the member's PCP or behavioral health provider reviews the member's treatment plan. Whenever new members are in the midst of an ongoing treatment and services were prior authorized by another managed care plan or Medicaid FFS, Sunshine Health continues to approve and pay for that course of treatment. Sunshine Health may need to collect clinical information and enter an authorization in order for the current treating provider to receive payment for that ongoing course of treatment.

Sunshine Health ensures appropriate care to members from Medicaid FFS and other health plans by:

- Coordinating care with other health plans and service providers to obtain information about existing services.
- Identifying members with previously scheduled appointments or who are receiving ongoing care.
- Authorizing continuity of care services with network and out-of-network providers.
- Coordinating and approving previously authorized services.
- Identifying new members who may need case management support, assisting members to obtain appropriate services and identifying the need for non-covered services.
- Ensuring new members have a PCP.
- Assisting new members in obtaining medical/case records from previous providers within 30 days of enrollment in Sunshine Health in compliance with HIPAA privacy and security rules consistent with the confidentiality requirements in 45 CFR parts 160 and 164, which specifically describes the requirements regarding the privacy of individually identifiable health information.

Medication Management for Child Welfare Members

Sunshine Health covers the medications for the Child Welfare members. For the first year of the Child Welfare Program, Sunshine Health will follow AHCA's preferred drug list (PDL). Any prescription written for a psychotropic medication for a member under the age of 13 must be accompanied by the express written and informed consent of the member's parent or legal guardian. Psychotropic medications include: antipsychotics, antidepressants, anti-anxiety medications, and mood stabilizers. Anticonvulsants and attention-deficit/hyperactivity disorder (ADHD) medications (stimulants and non-stimulants) are not included. The physician ordering the medication must document the consent in the member's medical record and provide the pharmacy with a signed attestation of the consent with the prescription. Sample attestation forms can be obtained at the following link:

http://www.fdhc.state.fl.us/Medicaid/Prescribed_Drug/pdf/110818_Consent_Form_interactive.pdf.

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

Management and Coordination of Physical Health and Behavioral Health Services

Sunshine Health, Cenpatico, and CBC-IH work together to assure quality behavioral health services are provided to all members in Sunshine Health's Child Welfare Program. We support whole-person health care, which also supports the caregivers, because medical and behavioral health conditions are often not independent of one another, therefore the treatment of both must be coordinated. Sunshine Health manages and reimburses for the medical, drug, dental, and vision services. Cenpatico manages and reimburses claims for covered behavioral health and substance use disorder benefits for the Child Welfare members.

This coordination includes joint operational and clinical processes which are focused on coordination with the various individual CBC entities, supporting the continuum of care, and providing case management support. Physical health conditions can and often do, exacerbate mental health conditions or can trigger mental health issues, such as depression resulting from asthma or diabetes, coupled with trauma and removal from the home. Mental health conditions can and often do impact physical health conditions. Children and youth in the child welfare population often have higher utilization of psychotropic medications and an over diagnosis of mental health issues versus interventions for behavioral issues resulting from abuse, neglect, and trauma. The treatment and medication regimens for physical and mental health conditions can interact negatively. For example, many psychotropic medications can cause weight gain, which can exacerbate metabolic syndrome or diabetes. Even differential diagnosis can be complicated if the assessment fails to consider potential physical causes for apparent mental conditions, such as psychosis-like symptoms triggered by high liver enzymes in members with liver disease.

Sunshine Health encourages PCPs to consult with the Child Welfare members' behavioral health/substance use disorder providers. The PCP has extensive knowledge about the member's

medical condition, mental status, psychosocial functioning, and family situation. Sunshine Health encourages our practitioners to communicate this information to behavioral health/substance use disorder providers when making the referral or during the course of treatment, with member consent, when required. Behavioral health practitioners/providers are asked to refer members with known or suspected untreated physical health problems or disorders to their PCP for examination and treatment.

Examples of key areas where communication among the member's PCP and behavioral health providers can inform treatment decisions include:

- Prescription medication, especially when the medication has potential side effects, such as weight gain, that could complicate medical conditions, such as diabetes.
- The member is known to abuse over-the-counter, prescription or illegal substances in a manner that can adversely affect medical or behavioral health treatment.
- The member has lab work which is applicable to their medical and behavioral health treatment.
- The member is receiving treatment for a behavioral health diagnosis that can be misdiagnosed as a physical disorder (panic symptoms can be confused with cardiac symptoms).

Practitioners may use all available communications means to coordinate treatment for members in their care. All communication attempts and coordination activities must be clearly documented in the member's medical record.

Cenpatico requires that providers report specific clinical information to the member's PCP in order to preserve the continuity of the treatment process. With appropriate written consent from the member, it is the providers responsibility to keep the member's PCP abreast of the member's treatment status and progress in a consistent and reliable manner. Such consent shall meet the requirements set forth in 42 CFR 2.00 et seq., when applicable. If the member requests this information not be given to their PCP, the provider must document this refusal in the member's treatment record, and if possible, the reason why. Cenpatico has asked their providers to include the following information in their report to the PCP:

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

Caution must be exercised in conveying information regarding substance use disorders, which is protected under separate federal law.

To access behavioral health benefits through Cenpatico, contact the Sunshine Health ProviderServices line at at 1-866-796-0530 and select the behavioral health option.

Coordination of Care

Sunshine Health's coordination of care process is designed to ensure the coordination and continuity of care during the movement between providers and settings. During transitions, children/youth with complex needs are at risk for poorer outcomes due to potential medication errors and other errors of communication among the involved providers and between providers and patients/caregivers.

Continuity of healthcare means different things to different types of caregivers, and can be of several types:

- Continuity of information. Information on prior events is used to give care that is appropriate to the patient's current circumstance.

- Continuity of personal relationships. Recognizing that an ongoing relationship between patients and providers is the foundation that connects care over time and bridges discontinuous events.
- Continuity of clinical management.

Sunshine Health's care managers participate in discharge planning when a Child Welfare member is admitted to a facility. They will assist the members and their caregivers in obtaining any of the ordered service and coordinate appointments with the PCP or other treating practitioners. Should a child be admitted for a behavioral health diagnosis, Cenpatico's clinical staff will provide the same support to the member and their caregivers. The Sunshine Health and Cenpatico clinical staff hold integrated care team meetings to help develop strong care plans for the members who may need additional case management support or to facilitate communication among the member's medical and behavioral health providers.

Case Management

Sunshine Health's care coordination process provides individualized and customized care plans that focus on organizing, securing, integrating and modifying the resources necessary to maximize and support the member's wellness and autonomy. This care coordination process is managed by clinical and non-clinical support staff. The care coordination process emphasizes prevention, continuity of care and coordination of services. Case managers and other support staff help identify and assess a member's risk factors and gaps in care. They also may help children who are medically complex or members who have a variety of health-related needs, including referrals and scheduling assistance, inpatient discharge planning and post-discharge care, disease management and coordination with providers, medical services, and social/community resources.

The primary case manager creates a customized care plan, which the case manager continues to monitor and revise as a member achieves pre-determined goals or a member's condition changes. The care plan reflects the holistic needs of the member and takes into consideration the member's physical health, behavioral health, social, environmental, financial, cognitive, spiritual, cultural and functional needs. The care plan identifies, monitors, measures and evaluates all of the member's needs and determines effective actions to promote quality of care, minimize further deterioration and complications, and help maintain the member in the safest and least restrictive setting. The care plan also includes wellness and preventive services, the management of chronic conditions, measurable goals and outcomes, and information that demonstrates the goals have been met.

To ensure the care plan effectively addresses a member's comprehensive needs, the case manager may solicit the input of the Sunshine Health multidisciplinary integrated care team (ICT). Recognizing that members often have multiple co-morbidities or co-occurring physical and behavioral health conditions as well as other special health care needs, the team employs a holistic and coordinated approach to address the member's conditions, needs and barriers to care.

Throughout the care coordination process, the primary case manager maintains regular communication with the member's PCP and/or treating providers to assist the provider in making treatment decisions, coordinating services and identifying appropriate community-based services to supplement the member's care. As members become stabilized, the primary case manager identifies them for health management programs related to their particular condition or lifestyle risk, such as tobacco cessation, exercise, weight management, and stress management.

Through scheduled outreach based on the member's risk level, the primary case manager regularly updates the member's care plan and reassesses the member's risk as the member's condition changes and goals are achieved, with the ultimate goal of improving or, at the very minimum, stabilizing the member's health.

You may refer a member for case management support at any time. Please call 1-866-796-0530 and select the case management prompt.

Training

Sunshine Health and Cenpatico work together to develop training programs, educate and assist physical health and behavioral health providers on the unique needs of the Child Welfare members and in the appropriate exchange of medical information to support coordination of care. Additional trainings are provided, upon request, to all providers and their staff regarding the requirements of their contract and special needs of the children/youth enrolled in Sunshine Health Child Welfare. Sunshine Health and Cenpatico will offer a variety of clinical training opportunities to providers that support their ability to provide quality services to members. Children who experienced child abuse, neglect, and trauma have various, compounding challenges that require unique approaches. For example, Cenpatico has developed a Trauma Informed Care training program to orient providers to current national best practices. Trainings for providers will be offered at various times throughout the year and may be offered live or webinar format.

If you have any questions regarding Sunshine Health, contact the Provider Services Department at 1-866-796-0530 or by fax 1-866-796-0528. You can also visit our website at www.sunshinehealth.com.

In order to use our secure Provider Portal, you must register at www.sunshinehealth.com/Providerlogin/. When registering for the Provider Portal, check the Sunshine Health Provider Web Portal for needed assistance or contact information.

Sunshine Health's Provider Responsibilities

Primary Care Provider/Behavioral Health Integration and Communication

PCPs must screen members for any behavioral condition, and may treat members within the appropriate scope of their practice and may refer members for treatment to a network behavioral health Provider.

In the Sunshine Health program, PCP's and behavioral health Providers are required to send each other initial and interim summary reports of a members' physical and behavioral health status. Reports between PCP and behavioral health Providers may be required more frequently if clinically indicated, directed by the Sunshine Health Service Management Team, or court-ordered. Reports must include information required for judicial review of medical care under Florida law. These reports can be provided directly between Providers or via the Sunshine Health Provider Web Portal. Providers may fax reports to the Sunshine Health Medical Management Department at 1-866-796-0526. Coordination with the Department of Family and Protective Services. Sunshine Health works with the Department of Children and Families (DCF) to ensure that the at-risk population, both children in-custody and not in custody of DCF, receive needed services. Children who are served by DCF may transition in and to various areas of the state rapidly.

During the transition period for a child moving between custodians and beyond, Providers must:

- Assist in scheduling medical or behavioral appointments as needed or earlier as requested by DCF.
- Provide periodic written updates on treatment status of members to DCF as required by DCF.
- Provide medical records to DCF upon request.
- Participate, when requested by DCF, in planning to establish permanent homes for members.
- Testify in court for child protection litigation as required by DCF.
- Comply with DCF policy regarding medical consent and release of confidential information.
- Refer suspected cases of abuse or neglect to DCF.

- Participate in Sunshine Health's training activities regarding DCF coordination.

For assistance with members and DCF, Providers should call Sunshine Health's Provider Services Department at 1-866-796-0530. To report concerns of abuse, neglect or exploitation of children, the elderly or people with disabilities, contact the Florida Abuse/Neglect Hotline at 1-800-962-2873 or TDD 1-800-453-5145 on the website at <http://www.myflfamilies.com/service-programs/abuse-hotline>.

Sunshine Health's Foster Care Program Eligibility

The following groups are eligible to participate in the Sunshine Health Foster Care program:

- Children and young adults in DCF conservatorship
- Members age 18-22 who voluntarily agree to continue in a foster care placement
- Young adults who have exited care and are participating in the foster care youth transitional Medicaid program
- (MTFCY) age 18-21

Former Foster Care in Higher Education (FFCHE) Foster Care Youth are also eligible to receive Sunshine Health benefits through the month of their 23rd birthday. FFCHE coverage will be provided to an individual who:

- Was in foster care on their 18th birthday
- Is at least 21 or 22 years of age
- Is enrolled in an institution of higher education in Florida
- Is not receiving adequate health coverage
- Meets all other eligibility rules for citizenship, resources, and income

Please note that newborns born to FFCHE members are not Sunshine Health eligible. Newborns will not automatically be enrolled in Medicaid. FFCHE members must be encouraged to apply for Medicaid benefits for the newborn. To locate a local Medicaid office, please contact 4-1-1. For specific questions on the FFCHE program and eligibility requirements, please refer them to DCF during normal office hours at 1-866-762-2237 or TTY 1-800-955-8771.

Excluded Individuals

Members excluded from the Sunshine Health program are children who are:

- In the Florida Youth Commission
- In the Florida Juvenile Probation System
- From other states places in Florida
- In Medicaid-paid facilities such as nursing homes, state-supported living centers, or Intermediate Care Facilities for the Mentally Retarded (ICF-MR)
- Dual eligible clients (Medicaid/Medicare)
- Placed outside of Florida
- In Hospice

Clients in a Waiver Program will be enrolled in Sunshine Health but receive waiver services from the Waiver Program. These Waiver Programs include:

- Consolidated Waiver Program (CWP)
- Community Living Assistance and Support Services (CLASS)
- Home and Community-based Services (HCS)
- Deaf-Blind Multiple Disabilities (DBMD)
- Medically Dependent Children Program (MDCP)
- Florida Home Living

Sunshine Health Newborn Enrollment

If a woman is a Sunshine Health Member at the time of delivery, the newborn is not automatically a Sunshine Health member from the date of birth. Please contact your local

Medicaid office to determine legibility as the mother must apply for Medicaid benefits. Newborns should receive a Medicaid ID number within 30 days of birth. Claims should be billed under the newborn's ID number, followed by the letter "A". For multiple births use the letter "B" or "C" as needed. For assistance regarding pharmacy services and newborns, contact the Sunshine Health's Member Services Department at 1-866-796-0530.

Court Ordered Services

Providers are encouraged to contact Sunshine Health's and/or Cenpatico's (our delegated behavioral health vendor) utilization management departments when they have been requested to provide court-ordered services. The Sunshine Health or Cenpatico clinical staff will obtain a copy of the court order from either the Provider or DCF and review the request. If the service(s) require a prior authorization the utilization management process will be followed. If there is lack of clarity if the court-ordered services is a covered benefit, Sunshine Health and/or Cenpatico, will communicate with the local CBC to resolve the issue of responsibility. Please fax court orders to Sunshine Health's Medical Management Department at 1-866-714-7998.

Contraceptive Services

Any child in DCF paid Sunshine Health program may request and receive any contraceptive service except sterilization without the consent of the child's parents, caregivers, or managing conservator at their local Florida County Health Department.

Sunshine Health Value Added Services

Sunshine Health Sunshine Health members have access to services in addition to basic Medicaid benefits and services. This includes:

- Additional transportation services via bus, van or cab when Medical Transportation Services (MTP) services are not readily available.
- Small "care grants" to members to pay for wrap-around services identified and included in the Health Care Service Plan.

This benefit can be authorized by calling the Sunshine Health Member Services Department at 1-866-796-0530.

Exceptions to Medical Consent Policy

For children under age 18 years who are under the managing conservatorship of DCF, there are exceptions to the Medical Consent Policy. This includes:

- Withholding or withdrawing life sustaining treatment
- Abortion
- Organ donation/anatomical gifts
- Admission to mental health facility
- Early Childhood Intervention (ECI) or Independent School District (ISD)
- Drug Research program
- Electroconvulsive Therapy (ECT)
- Aversive Conditioning

Routine, Urgent, and Emergent Services Residential Placement for Children

DCF often requires medical and/or behavioral health assessments for children in foster care in order to determine an appropriate residential placement for the child. Sunshine Health is contractually required to assist DCF with scheduling appointments for these assessments within 72 hours of request, depending on the severity of the child's needs. Providers must assist Sunshine Health by prioritizing the scheduling of these appointments so that required timeframes are met. Providers must also coordinate with Sunshine Health to provide the results of the assessments, including diagnosis and recommendations, to DCF within two business days.

Department of Children and Families (DCF) and Protective Services Reporting

Any Sunshine Health or Cenpatico provider is responsible for appropriate referrals to the DCF for suspected or confirmed cases of abuse.

To report concerns of abuse, neglect or exploitation of children or people with disabilities contact the Florida Abuse/Neglect hotline at 1-800-962-2873 (TDD 1-800-453-5145) or

<http://www.myffamilies.com/service-programs/abuse-hotline>

Court Ordered Commitment of Members

A Member who has been ordered to receive treatment under the provisions of Florida State Health and Safety Code must receive the services ordered by that court of competent jurisdiction. Any modification or termination of services must be presented to the court with jurisdiction over the matter for determination. Cenpatico cannot deny, reduce or controvert the medical necessity of inpatient psychiatric services provided pursuant to a Court Ordered Commitment for members. The member can only appeal the commitment through the court system. To ensure services are not inadvertently denied, Providers must contact Cenpatico and provide telephonic or written clinical information as well as a copy of the court order. Cenpatico may be reached by contacting Sunshine Health Provider Services at 1-866-796-0530 and selecting the behavioral health option.