

SUNSHINE STATE HEALTH PLAN, INC.
POLICY AND PROCEDURE

DEPARTMENT: Provider Services (Member & Provider Services Dept.)	DOCUMENT NAME: Provider Services and Complaints
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APPROVED DATE:	RETIRED:
EFFECTIVE DATE: 08/01/2013	REVIEWED/REVISED:
PRODUCT TYPE: LTC	REFERENCE NUMBER: LT.PRVR.03

SCOPE:

Centene Claims Department, Corporate and Sunshine State Health Plan (Sunshine Health) Provider Relations, and Medical Management Departments.

PURPOSE:

To provide an overview of Provider Services and instructions for processing provider complaints.

POLICY:

Sunshine Health shall establish and maintain a formal Provider relations function to timely and adequately respond to inquiries, questions and concerns from network Providers. Sunshine Health shall implement policies addressing the compliance of Providers with the requirements of this Contract, institute a mechanism for Provider dispute resolution and execute a formal system of terminating Providers from Sunshine Health's network.

The Managed Care Plan has sufficient facilities, service locations and personnel to provide the covered services as required in the Contract.

Sunshine Health shall establish a provider complaint system that permits a provider to dispute Sunshine Health's policies, procedures, or any aspect of a Health Plan's administrative functions, including proposed Actions and claims billing disputes, and service authorizations. The Managed Care Plan's process for provider complaints concerning claims issues shall be in accordance with s. 641.3155, F.S. Disputes between the Managed Care Plan and a provider may be resolved as described in s. 408.7057. See Attachment D-II, Section IX for information regarding complaints as part of the enrollee grievance process. .

Sunshine Health shall submit its Provider complaint system policies and procedures to the Agency for written approval.

Sunshine Health shall include its Provider complaint system policies and procedures in its Provider handbook as described above.

Sunshine Health shall also distribute the Provider complaint system policies and procedures, including claims issues, to out of network providers upon.

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request. Sunshine Health may distribute a summary of these policies and procedures, if the summary includes information about how the provider may access the full policies and procedures on Sunshine Health's Web site. This summary shall also detail how the provider can request a hard-copy from Sunshine Health at no charge to the provider.

The Managed Care Plan shall provide sufficient information to all providers in order to operate in full compliance with this contract and all applicable federal and state laws and regulations.

The Managed Care Plan shall monitor provider compliance with Contract requirements and take corrective action when needed to ensure compliance.

Notwithstanding the provisions in this subsection, a terminated provider may refuse to continue to provide care to an enrollee who is abusive or noncompliant.

For continued care under this subsection, the Managed Care Plan and the terminated provider shall continue to abide by the same terms and conditions as existed in the terminated contract.

The requirements in the Contract regarding continuity of care do not apply to providers who have been terminated from the managed care plan for cause.

Sunshine Health shall ensure that claims are processed and comply with the federal and State requirements set forth in 42 CFR 447.45 and 447.46 and Chapter 641, F.S., whichever is more stringent.

PROCEDURE:

1. Informal Claim Adjustments/Claim Complaints:

A Provider may submit an Informal Claim Adjustment or complaint verbally/telephonically or in writing. An **Informal Claim Adjustment/complaint** is a verbal or written expression by a Provider which indicates dissatisfaction or dispute with Sunshine Health's, claim adjudication to include the amount reimbursed or regarding denial of a particular service.

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The Provider Services Representative (PSR) determines if the request is an informal claims adjustment/claim complaint or provider complaint. If it is a complaint the PSR will refer the call (transfer) and/or routing of case to the Provider Complaints Coordinator (PCC).

- A. Requests for informal claim payment adjustments/complaint must be received by Sunshine Health within 45 calendar days of the date of receipt of the EOP.
- B. If the request qualifies as an **informal claim adjustment**, the representative proceeds to resolve the issue with the provider and documents the outcome of the call in CRM. If the call is resolved on first contact, the CRM case will be logged as resolved.
- C. If the call is not resolved on first contact, CRM will remain open and the case to the Claims Department for resolution as an adjustment.
 - The PCC will work with the Claims Department where staff with technical claims expertise resolve the issue and maintain tracking of the request through the CRM.
 - The provider will receive, within 3 business days, of Sunshine State Health Plan's receipt of the complaint a written confirmation from the PCC.
 - The PCC monitors timeliness of resolution of request for complaints
 - Requests for adjustments must be received by Sunshine Health within 45 calendar days of the date of receipt of the EOP.

2. Provider Complaints:

A Provider may file a **Provider complaint** regarding Sunshine Health's policies, procedures, or any aspect of Sunshine State Health Plan's administrative functions other than administrative review matters. Including the process by which Sunshine State Health Plan handles Notice of Proposed Actions and EOPs in addition to dissatisfaction with the resolution of the Provider's informal claims adjustment/claim complaint.

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- Sunshine Health has dedicated staff for providers to contact via telephone, electronic mail, regular mail or in person, to ask questions, file a provider complaint and resolve problems.
- A Provider Complaints Coordinator is a dedicated staff person specifically designated to receive and process provider complaints.
- Sunshine Health allows providers forty-five (45) calendar days to file a written complaint for issues that are not about claims.
- The Provider Complaints Coordinator (PCC) reviews the complaint to ensure that it has been filed within the required 45 calendar days. If the complaint is not timely, then the PCC sends written notice to the provider that the complaint is not filed timely.
- Within three (3) business days of receipt of a timely filed complaint, the Provider Complaints Coordinator (PCC) will notify the provider (verbally or in writing) that the complaint has been received and the expected date of resolution.
- The PCC will create a Complaint Case in CRM and capture the appropriate AHCA Complaint type to ensure accurate reporting.
- The PCC works with the Claims Department, Provider Relations, or other appropriate staff (with PCC's tracking and monitoring) to investigate each provider complaint using applicable statutory, regulatory, and State Contractual provisions, collecting all pertinent facts from all parties and applying Sunshine State Health Plan's written policies and procedures.
- The PCC will document findings and actions taken during the investigation in the CRM Complaint Case.
- If providers call the provider call center regarding the status of their request, PSR's electronically access the status through CRM and respond to the provider's inquiry, usually on the same call, or refers the provider (transfer call) to the PCC to discuss the complaint.

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- The PCC will document why a complaint is unresolved after fifteen (15) calendar days of receipt in CRM and provide written notice of the status to the provider every fifteen (15) calendar days thereafter.
- The PCC will ensure that Sunshine Health executives with the authority to require corrective action are involved in the provider complaint process.
- The PCC will engage the Claims Manager and or Provider Relations Manager, who have the authority to require corrective action, via electronic mail with potential barriers that may prevent timely resolution of a complaint. Additional parties, such as Compliance or Quality Improvement, may be engaged depending on the type or severity of the complaint.
- Upon resolution, the PCC will document the resolution in CRM, send written notification to the provider, select the appropriate AHCA disposition type and close the Complaint case in CRM.
- Sunshine Health shall resolve all complaints within ninety (90) calendar days of receipt and provide written notice of the disposition and the basis of the resolution to the provider within three (3) business days of resolution.
- Sunshine Health shall ensure that claims are processed and comply with the federal and State requirements set forth in 42 CFR 447.45 and 447.46 and Chapter 641, F.S., whichever is more stringent.
- Sunshine Health shall resolve all complaints within ninety (90) calendar days of receipt and provide written notice of the disposition and the basis of the resolution to the provider within three (3) business days of resolution;

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- Sunshine Health shall establish and maintain a formal Provider relations function to timely and adequately respond to inquiries, questions and concerns from network Providers. Sunshine Health shall implement policies addressing the compliance of Providers with the requirements of this Contract, institute a mechanism for Provider dispute resolution and execute a formal system of terminating Providers from Sunshine Health's network.
- Provider complaint coordinator, in conjunction with the Claims Department and Medical Management Department will process provider complaints in accordance with all applicable State and Federal regulations, and Provider contracts.
- Providers are allowed 45 calendar days from the date of receipt of the Explanation of Payment (EOP) to file a complaint regarding claims.
- Sunshine Health may delegate certain limited functions to provider subcontractors in connection with the Policy and Procedure.
- Sunshine Health will ensure that executives with the authority to require corrective action are involved in the provider complaint process.
- Sunshine health will report provider complaints monthly to the Agency by the fifteenth (15th) calendar day of the month following the report month as specified in Attachment D-II II, Section XII, Reporting Requirements. The managed care plan submits the report using the Provider Complaint Log template in accordance with the Report Guide.

3. Coordination of Provider Complaint Resolution by PCC

- A. The PCC tracks and monitors timeliness of resolution of **Provider Complaints** and identifies in advance potential barriers to their timely and complete resolution.

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- B. The PCC serves as the central Sunshine State Health Plan coordinating point for provider complaints. The PCC collaborates on a daily basis with PSR's, Appeals and Grievance Coordinators (AGC's) and dedicated, specialized Sunshine State Health Plan's Claims Department staff and clinical staff (in the Medical Management, Quality Improvement Departments) to ensure thorough and prompt communication with providers and resolution of provider complaints.
- C. The PCC provides complaint reports to the (AGC) and Performance Improvement Team (PIT) which includes Sunshine State Health Plan executives with the authority to monitor and require corrective action plans of providers when appropriate.

4. Administrative Review

Appeals of UM decisions follow the process as outlined in policy FL.UM.08

5. Limited Delegation by SUNSHINE HEALTH

- A. Sunshine State Health Plan delegates authority to provider subcontractors only through written delegation agreements.
- B. To the extent that Sunshine State Health Plan delegates claims payment, utilization management or network management functions to provider subcontractors, Sunshine State Health Plan may delegate authority for the delegatee to receive and determine informal claim payment adjustments, claim appeals, and requests for administrative review and provider appeals.
- C. Delegates must follow the same timelines, accountabilities, and processes set forth in this Policy and Procedure (however delegatee's may designate other position titles for their staff so long as the individual's qualifications and responsibilities are at least equivalent to those set forth in this Policy and Procedure.
- D. All information regarding this policy is described in the Sunshine State Health Plan provider manual which all providers receive upon contracting with Sunshine State Health Plan.

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REFERENCES:

FL. UM. 08

FL. AHCA LTC Contract

ATTACHMENTS

DEFINITIONS:

Administrative Review - a request for reconsideration or exception to a plan policy or contract requirement (e.g. eligibility or benefits) or a request requiring clinical review of a previously adjudicated claim, requesting either that a Claims Department or system denial decision be overturned, or that additional payments occur because of extenuating/complicated circumstances.

Adjustment - a request for reconsideration of a manual or systematically processed claim, in which a provider request either a denial decision be overturned or that additional payments occur of a claim that in the eyes of the company was processed correctly;

OR

Any written claim resubmission request from a provider which states the request is an “appeal.”

Appeals and Grievance Coordinator (AGC) - The SUNSHINE HEALTH staff person who assists members in filing and other matters relating to grievances and requests for administrative review, and who monitors and coordinates the processing of member grievances and requests for administrative review that are filed by a member, member’s authorized representative, or a provider on behalf of a member and with the member’s written consent.

Claim Review - a request for reconsideration or exception to a plan policy or contract requirement (e.g. eligibility or benefits) or a request requiring clinical review of a previously adjudicated claim, requesting either that a Claims Department or system denial decision be overturned, or that additional payments occur because of extenuating/complicated circumstances.

EOP - An Explanation of Payment (EOP) that denies in whole or in part payment of a claim constitutes a notice of Proposed Action regarding claim

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payment, for purposes of filing a request for administrative review on behalf of a member, with written member consent.

Informal Claims Adjustment - a request for reconsideration of a manually or system processed claim, in which a provider requests either a denial decision be overturned or that additional payments occur of a claim that in the yes of the company was processed correctly;

OR

Any written claim resubmission request from a provider which states the request is an “appeal.”

Provider Complaint Coordinator – The Sunshine State Health Plan staff person who monitors and coordinates processing of providers’ informal requests for claims payment adjustments, claims appeals and provider appeals (but not requests for administrative review filed by a provider on behalf of a member and with the member’s written consent; the latter are monitored and coordinated by the Appeals and Grievance Coordinator).

REVISION LOG

REVISION	DATE

POLICY AND PROCEDURE APPROVAL

The electronic approval retained in Compliance 360, Centene’s P&P management software, is considered equivalent to a physical signature.

Vice President Operations: _____

Vice President Compliance: _____