



EZCARE

PROVIDER MANUAL

EZCARE

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Chapter 1: Main Contact Information & Provider Resources

Hours of Operation

Corporate Office: Monday through Friday 8:00 AM to 5:00 PM

Member Services Department: Monday – Friday 8:00 AM to 7:00 PM

Provider Relations Department: Monday – Friday 8:30 AM to 5:30PM

All other departments: Monday – Friday 8:30 AM to 5:30 PM

Website: WWW.EZCAREMHPFL.COM

Mailing Address

Corporate Office: Medica Health Plans of Florida, Inc.
4000 Ponce De Leon Blvd. Suite 650
Coral Gables, FL 33146

Correspondence: Medica Health Plans of Florida, Inc.
4000 Ponce De Leon Blvd. Suite 650
Coral Gables, FL 33146

Provider Appeals & Grievances: Medica Health Plans of Florida, Inc.
Provider Appeals & Dispute Department
PO Box Address 14-5330
Coral Gables, FL 33114-5330

Claims: Medica Health Plans of Florida, Inc.
Claims Department
PO Box Address 14-5330
Coral Gables, FL 33114-5330

For the following Covered Services, please call the numbers and submit claims directly to the providers below.

| | |
|--|-----------------------------|
| Dental Services - DentaQuest of Florida, Inc | 1-877-468-5581 |
| Mental Health - COMPCARE | 1-877-224-0971 |
| Transportation Services | 1- 888-542-6635 BROWARD |
| | 1-866-726-1457 MIAMI - DADE |

Behavioral Health Claims: Comprehensive Behavioral Care , Inc. (CompCare)
3405 W. Dr. Martin Luther King Jr. Blvd., Suite 101
Tampa, FL 33607

Dental Claims: DentaQuest - Claims
12121 North Corporate Parkway
Mequon, WI 53092

Transportation **Miami – Dade County: Logisticare 1-866-726-1457**
Broward County: Medical Transportation Services 1-888-542-6635

Pharmacy: Express Scripts, Inc.
P O Box 66583
St. Louis, MO 63166

Key Contacts

| DEPARTMENT | TELEPHONE NUMBER | FAX NUMBER |
|---|--|----------------------------------|
| Claim Disputes and Appeals | (305) 460 0650 (800) 348 5548 | |
| MHP FL Member Services: | (305) 421 1228 (877) 690 7783 TTY: (305) 421 1251 OR (800) 517 6923 | (305) 476 0616 (800) 517 6924 |
| MHP FL Eligibility & Benefits: | (305)421 1220 OR (954) 986 0266 OR (866) 273 9444 | (877) 769 4999 |
| Medicaid Office Eligibility Verification 24 hours a day / 7 days a week | (800) 925-1955 | |
| MHP FL Medical Management: Miami Dade County & Broward County | (305) 421 1220 (954) 986 0266 Or (866) 273 9444 | (877) 769 4999 |
| Transportation | Broward: 1 888 542 6635 Miami Dade: 1866 726 1457 | |
| Comprehensive Behavioral Care, Inc. Customer Service Department Claims, Pre- Certification and general inquires | (877) 224 0971 www.compcare.com (877) 224 0972 (877) 224 0971 (877) 224 0971 | |

| | | |
|--|-------------------------|--|
| Agency for Health Care Administration | (850) 921- 5458 | |
| Subscriber Assistance Program / Beneficiary Assistance Program Building 1, MS #26 2727 Mahan Drive Tallahassee, Florida 32308 | (850) 412 - 4502 | |

Provider Resources on the Internet

| | |
|--|---|
| MEDICA HEALTH PLANS OF FLORIDA, INC. | www.ezcaremhpf.com |
| ALL FLORIDA GOVERNMENT & AGENCIES | |
| Agency for Health Care Administration (AHCA) | http://ahca.myflorida.com |
| Children's Medical Services | http://www.cms-kids.com |
| Department of Children and Families (DCF) | www.state.fl.us/cf_web |
| Medicaid Information at DCF | www.dcf.state.fl.us/ess |
| Department of Elder Affairs (DOEA) | http://elderaffairs.state.fl.us |
| Department of Health (DOH) | www.doh.state.fl.us |
| Florida Administrative Code (FAC) | http://fac.dos.state.fl.us |
| Florida Health Statistics | www.floridahealthstat.com |
| Florida KidCare | www.floridakidcare.org |
| Florida Statutes | www.leg.state.fl.us |
| MEDICAID FISCAL AGENT | |
| HP Enterprise Services | http://mymedicaid-florida.com |
| Provider Handbooks | Go to Provider Support, then Handbooks |
| Fee Schedules | Go to Provider Support, then Fees |
| Administrative Forms | Go to Provider Support, then Medicaid Forms |
| FEDERAL GOVERNMENT | |
| Code of Federal Regulations | http://origin.www.gpoaccess.gov/cfr |
| Department of Health and Human Services | |
| CMS (Centers for Medicare and Medicaid Services) | www.cms.hhs.gov |
| Medicare | www.medicare.gov |
| Social Security Administration (SSA) | www.ssa.gov |
| U.S. Government Official Web Portal | www.firstgov.gov |

Note: All updates and revisions to the E Z Care Provider Handbook are available on the website @ www.ezcaremhpf.com . Providers are encouraged to regularly check the website for updates. A copy of this Provider Handbook may be downloaded from the Health Plan's website at www.ezcaremhpf.com. To request a hardcopy from the Health Plan at no charge to the provider, provider may call the Health Plan directly at (305) 460 0650 or (800) 348 5548 and request a copy.

Definitions

The following terms as used in this Provider Handbook shall be construed and/or interpreted as follows, unless the MHP – FI Provider Agreement otherwise expressly requires a different construction and/or interpretation.

Abandoned Call — A call in which the caller elects an option and is either not permitted access to that option or disconnects from the system.

Abuse — Provider practices that are inconsistent with generally accepted business or medical practices and that result in an unnecessary cost to the MHP – FI or the Medicaid Program or in reimbursement for goods or services that are not medically necessary or that fail to meet professionally recognized standards for health care; or recipient practices that result in unnecessary cost to MHP – FL or the Medicaid program.

Action — The denial or limited authorization of a requested service, including the type or level of service, pursuant to 42 CFR 438.400(b). The reduction, suspension or termination of a previously authorized service. The denial, in whole or in part, of payment for a service. The failure to provide services in a timely manner, as defined by the State. The failure of the MHP - FL to act within ninety (90) days from the date the Health Plan receives a Grievance, or 45 days from the date the Health Plan receives an Appeal.

Advance Directive — A written instruction, such as a living will or durable power of attorney for health care, recognized under State law (whether statutory or as recognized by the courts of the State), relating to the provision of health care when the individual is incapacitated.

Advanced Registered Nurse Practitioner (ARNP) — A licensed advanced registered nurse practitioner who works in collaboration with a physician according to protocol, to provide diagnostic and clinical interventions. An ARNP must be authorized to provide these services by Chapter 464, F.S., and protocols filed with the Board of Medicine.

Agency — State of Florida, Agency for Health Care Administration.

Agent - A term that refers to certain independent contractors with the state that perform administrative functions, including but not limited to: fiscal agent activities; outreach, eligibility and enrollment activities; systems and technical support. The term as used herein does not create a principal-agent relationship.

Ancillary Provider — A Provider of ancillary medical services who has contracted with MHP – FL to provide ancillary medical services to the E Z Care Enrollees.

Appeal — A request for review of an Action, pursuant to 42 CFR 438.400(b).

Authoritative Host - A system that contains the master or “authoritative” data for a particular data type, e.g. enrollee, provider, health plan, etc. The authoritative host may feed data from its master files to other systems in real time or in batch mode. Data in an authoritative host is expected to be up to date and reliable.

Automatic Assignment (or Auto-Assign) — The Enrollment of an eligible Medicaid Recipient, for whom Enrollment is mandatory, in a Health Plan chosen by AHCA or its Agent, and/or the assignment of a new Enrollee to a PCP chosen by the Health Plan.

Baker Act — The Florida Mental Health Act, pursuant to Sections.394.451-394.4789, F.S.

Behavioral Health Services — Services listed in the Community Mental Health Services Coverage & Limitations Handbook and the Targeted Case Management Coverage & Limitations Handbook as specified in this AHCA in Section VI.A Behavioral Health Care, General Provisions.

Behavioral Health Care Case Manager — An individual who provides mental health care Case Management services directly to or on behalf of an Enrollee on an individual basis in accordance with 65E-15, F.A.C., and the Medicaid Targeted Case Management Handbook.

Behavioral Health Care Provider — A licensed mental health professional, such as a "Clinical Psychologist," or registered nurse qualified due to training or competency in mental health care, who is responsible for the provision of mental health care to patients, or a physician licensed under Chapters 458 or 459, F.S., who is under contract to provide Behavioral Health Services to Enrollees.

Benefit Maximum – (Reform only) - The point when the cost of covered services received by a non-pregnant enrollee, age 21 or older, reaches \$550,000 in a contract year, based on Medicaid fee-for-service payment levels. Care coordination services and emergency services and care must continue to be offered by the health plan, but the cost of additional services, excluding emergency services and care, will not be covered by the Medicaid program for the remainder of the contract year in which the benefit maximum is met. In addition, the health plan shall provide benefit reporting in accordance with Section XII, V.

Benefits — A schedule of health care services to be delivered to Enrollees covered by E Z Care as set forth in Chapter 3 of the E Z Care Provider Handbook.

Blocked Call — A call that cannot be connected immediately because no circuit is available at the time the call arrives or the telephone system is programmed to block calls from entering the queue when the queue backs up behind a defined threshold.

Business Days — Traditional workdays, which are Monday, Tuesday, Wednesday, Thursday, and Friday.

Calendar Days — All seven (7) days of the week. Unless otherwise specified, the term “days” in this Provider Handbook refers to calendar days.

Capitation Rate — The per member per month amount, including any adjustments, that is paid by MHP – FL to a capitated provider under contract with MHP - FL for each Medicaid recipient enrolled under E Z Care for the provision of Medicaid services during the payment period.

Capitated Health Plan – A Health Maintenance Organization (HMO), Provider Service Network or other health plan that is paid a per member/ per month fee to cover the cost of providing health care to its enrollees.

Care Coordination/Case Management — A process which assesses, plans, implements, coordinates, monitors and evaluates the options and services required to meet an Enrollee's health needs using communication and all available resources to promote quality cost-effective outcomes. Proper Case Management occurs across a continuum of care, addressing the ongoing individual needs of an Enrollee rather than being restricted to a single practice setting. For purposes of this Provider Handbook Care Coordination and Case Management are the same.

Catastrophic Component Threshold – (Capitated Reform plans only) - The point at which the cost of covered services, based on Medicaid fee-for-service payment levels, reaches \$50,000 for an enrollee in a contract year. For a health plan that accepts the comprehensive capitation rate only, the Agency begins reimbursing the health plan for the cost of covered services received by the enrollee for the remainder of the contract year. This reimbursement is based on a percentage of Medicaid fee-for-service payment levels.

Cause — Special reasons that allow Mandatory Enrollees to change their Health Plan option outside their Open Enrollment period; May also be referred to as “Good Cause.”

Centers for Medicare & Medicaid Services (CMS) — The agency within the United States Department of Health & Human Services that provides administration and funding for Medicare under Title XVIII,

Medicaid under Title XIX, and the State Children's Health Insurance Program under Title XXI of the Social Security Act.

Certification — The process of determining that a facility, equipment or an individual meets the requirements of federal or State law, or whether Medicaid payments are appropriate or shall be made in certain situations.

Child Health Check-Up Program (CHCUP) — A set of comprehensive and preventative health examinations provided on a periodic basis that are aimed at identifying and correcting medical conditions in Children/Adolescents.

Children/Adolescents — Enrollees under the age of 21. For purposes of the provision of Behavioral Health Services, excluding inpatient psychiatric services, adults are persons age 18 and older, and children/adolescents are persons under age 18, as defined by the Department of Children and Families

Children & Families, Department of (DCF) — The state agency responsible for overseeing programs involving behavioral health, childcare, family safety, domestic violence, economic self-sufficiency, refugee services, homelessness, and programs that identify and protect abused and neglected children and adults.

Choice Counselor/Enrollment Broker — The State's contracted or designated entity that performs functions related to outreach, education, counseling, enrollment, and disenrollment of potential enrollees into a Health Plan.

Choice Counseling Specialists — Certified individuals authorized by an Agency-approved process who provide one-on-one information to Medicaid Recipients, to assist the Medicaid Recipients in choosing the Health Plan that best meets their health care needs and those of their family.

Claim – (1) A bill for services, (2) a line item of service, or (3) all services for one recipient within a bill, pursuant to 42 CFR 447.45, in a format prescribed by the Agency through its Medicaid provider handbooks.

Clean Claim – A claim that can be processed without obtaining additional information from the provider of the service or from a third party. It does not include a claim from a provider who is under investigation for fraud or abuse, or a claim under review for medical necessity, pursuant to 42 CFR 447.45

Cold Call Marketing — Any unsolicited personal contact with a Medicaid recipient by the health plan, its staff, its volunteers or its vendors with the purpose of influencing the Medicaid recipient to enroll in the plan or either to not enroll in, or disenroll from, another health plan.

Commission for the Transportation Disadvantaged (CTD) — An independent commission housed administratively within the Florida Department of Transportation. The CTD's mission is to ensure the availability of efficient, cost-effective, and quality transportation services for transportation disadvantaged persons.

Community Living Support Plan – A written document prepared by a behavioral health resident of an assisted living facility with a limited mental health license and the resident's behavioral health case manager in consultation with the administrator of the facility or the administrator's designee. A copy must be provided to the administrator. The plan must include information about the supports, services, and special needs that enable the resident to live in the assisted living facility and a method by which facility staff can recognize and respond to the signs and symptoms particular to that resident that indicate the need for professional services.

Community Outreach – The provision of health or nutritional information or information for the benefit and education of, or assistance to, a community in regard to health-related matters or public awareness that promotes healthy lifestyles. Community outreach also includes the provision of information about health care services, preventive techniques and other health care projects and the provision of

information related to health, welfare and social services or social assistance programs offered by the State of Florida or local communities.

Community Outreach Materials – Materials regarding health or nutritional information or information for the benefit and education of, or assistance to, a community on health-related matters or public awareness that promotes healthy lifestyles. Such materials are meant specifically for the community at large and may also include information about health care services, preventive techniques and other health care projects and the provision of information related to health, welfare, and social services or social assistance programs offered by the State of Florida or local communities. Community outreach materials are limited to brochures, fact sheets, billboards, posters, and ad copy for radio, television, print or the Internet.

Community Outreach Representative – A person who provides health information, information that promotes healthy lifestyles, information that provides guidance about social assistance programs, and information that provides culturally and linguistically appropriate health or nutritional education. Such representatives must be appropriately trained, certified and/or licensed, including but not limited to, social workers, nutritionists, physical therapists and other health care professionals.

Complaint – Any oral or written expression of dissatisfaction by an enrollee submitted to the health Plan or to a state agency and resolved by close of business the following business day. Possible subjects for complaints include, but are not limited to, the quality of care, the quality of services provided, aspects of interpersonal relationships such as rudeness of a provider or Health Plan employee, failure to respect the enrollee's rights, Health Plan administration, claims practices or provision of services that relates to the quality of care rendered by a provider pursuant to the health plan's contract. A complaint is an informal component of the grievance system.

Comprehensive Component – (Capitated Reform plans in counties where no HMOs are present and Reform FFS PSNs only) - The amount of financial risk assumed by a Health Plan to provide covered service up to \$50,000 per enrollee based on Medicaid fee-for-service payment levels.

Continuous Quality Improvement — A management philosophy that mandates continually pursuing efforts to improve the quality of products and services produced by an organization.

Contract — The agreement between the Health Plan and the Agency to provide Medicaid services to Enrollees, comprised of the Contract, any addenda, appendices, attachments, or amendments thereto.

Contract Period – The term of the contract between the Health Plan and the Agency.

Contract Year – Each September 1 through August 31 within the Contract Period.

Contracting Officer — The Secretary of the Agency or his/her delegate.

County Health Department (CHD) — CHDs are organizations administered by the Department of Health for the purpose of providing health services as defined in Chapter 154, F.S., which include the promotion of the public's health, the control and eradication of preventable diseases, and the provision of primary health care for special populations.

Coverage & Limitations Handbook (Handbook) — A Florida Medicaid document that provides information to a Medicaid Provider regarding Enrollee eligibility, claims submission and processing, Provider participation, covered care, goods and services, limitations, procedure codes and fees, and other matters related to participation in the Medicaid program.

Covered Services — Those services provided by the Health Plan in accordance with the contract between the Health Plan and the Agency to provide Medicaid services to Enrollees, comprised of the Contract, any addenda, appendices, attachments, or amendments thereto.

Crisis Support — Services for persons initially perceived to need emergency mental health services, but upon assessment, do not meet the criteria for such emergency care. These are acute care services that are available twenty-four (24) hours a day, seven (7) days a week, for intervention. Examples include: mobile crisis, crisis/emergency screening, crisis hot-line and emergency walk-in.

Direct Service Behavioral Health Care Provider — An individual qualified by training or experience to provide direct behavioral health services under the supervision of MHP – FL medical director.

Disease Management – A system of coordinated health care intervention and communication for populations with conditions in which patient self-care efforts are significant. Disease Management supports the physician or practitioner/patient relationship and plan of care; emphasized prevention of exacerbations and complications utilizing evidence-based practice guidelines and patient empowerment strategies, and evaluates clinical, humanistic and economic outcomes on an ongoing basis with the goal of improving overall health.

Disenrollment — The Agency-approved discontinuance of an Enrollee's Enrollment in a Health Plan.

Downward Substitution of Care — The use of less restrictive, lower cost services than otherwise might have been provided, that are considered clinically acceptable and necessary to meet specified objectives outlined in an Enrollee's plan of treatment, provided as an alternative to higher cost services. For services related to mental health, Downward Substitution of Care may include care provided by private practice psychologists and social workers, psycho-social rehabilitation, Medicaid community mental health services or Medicaid mental health targeted Case Management, and other services considered clinically appropriate, more cost-effective and less restrictive.

Durable Medical Equipment (DME) — Medical equipment that can withstand repeated use, is customarily used to serve a medical purpose, is generally not useful in the absence of illness or injury and is appropriate for use in the Enrollee's home.

Emergency Behavioral Health Services — Those services required to meet the needs of an individual who is experiencing an acute crisis, resulting from a mental illness, which is a level of severity that would meet the requirements for an involuntary examination as specified in Section 394.463, Florida Statutes, and in the absence of a suitable alternative or psychiatric medication, would require hospitalization.

Emergency Medical Condition — (a) 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 that the absence of immediate medical attention could reasonably be expected to result in any of the following: (1) Serious jeopardy to the health of a patient, including a pregnant woman or fetus; (2) Serious impairment to bodily functions; (3) Serious dysfunction of any bodily organ or part. (b) 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, in accordance with Section 395.002, F.S.

Emergency Services and Care — Medical screening, examination and evaluation by a physician or, to the extent permitted by applicable laws, by other appropriate personnel under the supervision of a physician, to determine whether an Emergency Medical Condition exists. If an Emergency Medical Condition exists, Emergency Services and Care includes the care or treatment that is necessary to relieve or eliminate the Emergency Medical Condition within the service capability of the facility.

Emergency Transportation – The provision of Emergency Transportation Services in accordance with 409.908(13)(d)(4), F.S.

Encounter Data – A record of covered services provided to Enrollees of a MHP - FL. An Encounter is an interaction between a patient and provider (health plan, rendering physician, pharmacy, lab, etc.) who delivers services or is professionally responsible for services delivered to a patient.

Enhanced Benefit — (Reform only) - An activity or behavior identified by the state as beneficial to the health of an individual and designated to earn a credit in the Enhanced Benefit Program.

Enhanced Benefit Account — (Reform only) - The individual account resulting from an enrollee's earning rewards for healthy behaviors under the Enhanced Benefit Program.

Enhanced Benefit Program — (Reform only) – Also known as Enhanced Benefits Reward\$, a program offered through Medicaid Reform that rewards enrollees for healthy behaviors.

Enrollee — A Medicaid Recipient currently enrolled in MHP - FL.

Enrollment — The process by which an eligible Medicaid Recipient becomes an Enrollee in a Health Plan.

Expedited Appeal Process — The process by which the Appeal of an Action is accelerated because the standard time-frame for resolution of the Appeal could seriously jeopardize the Enrollee's life, health or ability to obtain, maintain or regain maximum function.

External Quality Review (EQR) — The analysis and evaluation by an **EQRO** of aggregated information on quality, timeliness, and access to the health care services that are furnished to Medicaid recipients by a Health Plan.

External Quality Review Organization (EQRO) — An organization that meets the competence and independence requirements set forth in federal regulations 42 CFR 438.354, and performs EQR, other related activities as set forth in federal regulations or both.

Federal Fiscal Year – The United States government's fiscal year starts October 1 and ends on September 30.

Federally Qualified Health Center (FQHC) — An entity that is receiving a grant under section 330 of the Public Health Service Act, as amended, and Section 1905(1)(2)(B) of the Social Security Act. FQHCs provide primary health care and related diagnostic services and may provide dental, optometric, podiatry, chiropractic and mental health services.

Fee-for-Service (FFS) — A method of making payment by which the Agency sets prices for defined medical or allied care, goods or services.

Fiscal Agent — Any corporation or other legal entity that enters into a contract with the Agency to receive, process and adjudicate claims under the Medicaid program.

Fiscal Year — The State of Florida's Fiscal Year starts July 1 and ends on June 30.

Florida Medicaid Management Information System (FMMIS) — The information system used to process Florida Medicaid claims and payments to Health Plans, and to produce management information and reports relating to the Florida Medicaid program. This system is used to maintain Medicaid eligibility data and provider enrollment data.

Florida Mental Health Act — Includes the Baker Act that covers admissions for persons who are considered to have an emergency mental health condition (a threat to themselves or others), as specified in ss.394.451-394.4789, F.S.

Fraud — An intentional deception or misrepresentation made by a person with the knowledge that the deception results in unauthorized benefit to herself or himself or another person. The term includes any act that constitutes fraud under applicable federal or state law.

Full-Time Equivalent Position (FTE) — The equivalent of one (1) full-time employee who works 40 hours per week.

Good Cause — See Cause.

Grievance — An expression of dissatisfaction about any matter other than an Action. Possible subjects for grievances include, but are not limited to, the quality of care, the quality of services provided and aspects of interpersonal relationships such as rudeness of a Provider or employee or failure to respect the Enrollee's rights.

Grievance Procedure — The procedure for addressing Enrollees' grievances.

Grievance System — The system for reviewing and resolving enrollee complaints, grievances and appeals. Components must include a complaint process, a grievance process, an appeal process, access to an applicable review outside the Health Plan (Subscriber Assistance Program or Beneficiary Assistance Program), and access to a Medicaid Fair Hearing through the Department of Children and Families..

Health Assessment — A complete health evaluation combining health history, physical assessment and the monitoring of physical and psychological growth and development.

Health Care Professional — A physician or any of the following: podiatrist, optometrist, chiropractor, psychologist, dentist, Physician Assistant, physical or occupational therapist, therapist assistant, speech-language pathologist, audiologist, Registered or practical Nurse (including nurse practitioner, clinical nurse specialist, certified Registered Nurse anesthetist and certified nurse midwife), a licensed certified social worker, registered respiratory therapist and certified respiratory therapy technician.

Health Maintenance Organization (HMO) — An organization or entity licensed in accordance with Section 641 of the Florida Statutes or in accordance with the Florida Medicaid State plan definition of an HMO.

Health Plan — An entity that integrates financing and management with the delivery of health care services to an enrolled population. It employs or contracts with an organized system of providers, which delivers services, and frequently shares financial risk. The term includes health plans contracted with the Agency to provide Medicaid services under the Florida Medicaid Reform program as well as 1915(b) managed care waiver (non-Reform) areas, and includes health maintenance organizations authorized under Chapter 641, F.S., exclusive provider organizations as defined in Chapter 627, F.S., health insurers authorized under Chapter 624, F.S., and provider service networks as defined in s. 409.912, F.S., including the specialty plan for children with chronic conditions as authorized under Section 409.91211(3)(bb) and (12), F.S

HEDIS – Healthcare Effectiveness Data and Information Set developed and published by the National Committee for Quality Assurance. HEDIS includes technical specifications for the calculation of performance measures.

Hospital — A facility licensed in accordance with the provisions of Chapter 395, Florida Statutes, or the applicable laws of the state in which the service is furnished.

Hospital Services Agreement — The agreement between the MHP - FL and a Hospital to provide medical services to the Health Plan's Enrollees.

Individuals with Special Health Care Needs — Adults and Children/Adolescents, who face physical, mental or environmental challenges daily that place at risk their health and ability to fully function in society. Factors include individuals with mental retardation or related conditions; individuals with serious chronic illnesses, such as human immunodeficiency virus (HIV), schizophrenia or degenerative neurological disorders; individuals with disabilities resulting from many years of chronic illness such as arthritis, emphysema or diabetes; and Children/Adolescents and adults with certain environmental risk factors such as homelessness or family problems that lead to the need for placement in foster care.

Information — (a) Structured Data: Data that adhere to specific properties and Validation criteria that are stored as fields in database records. Structured queries can be created and run against structured data, where specific data can be used as criteria for querying a larger data set; (b) Document: Information that does not meet the definition of structured data includes text, files, spreadsheets, electronic messages and images of forms and pictures.

Information System(s) — A combination of computing hardware and software that is used in: (a) the capture, storage, manipulation, movement, control, display, interchange and/or transmission of information, i.e. structured data (which may include digitized audio and video) and documents; and/or (b) the processing of such information for the purposes of enabling and/or facilitating a business process or related transaction.

Insolvency — A financial condition that exists when an entity is unable to pay its debts as they become due in the usual course of business, or when the liabilities of the entity exceeds its assets.

Licensed — A facility, equipment, or an individual that has formally met state, county, and local requirements, and has been granted a license by a local, state or federal government entity.

Licensed Practitioner of the Healing Arts — A psychiatric nurse, Registered Nurse, advanced registered nurse practitioner, Physician Assistant, clinical social worker, mental health counselor, marriage and family therapist, or psychologist.

List of Excluded Individuals and Entities (LEIE) — A database maintained by the Department of Health & Human Services, Office of the Inspector General. The LEIE provides information to the public, health care providers, patients and others relating to parties excluded from participation in Medicare, Medicaid and all other federal health care programs.

Managed Behavioral Health Organization (MBHO) — A behavioral health-care delivery system managing quality, utilization and cost of services. Additionally, an MBHO measures performance in the area of mental disorders.

Mandatory Assignment — The process the Agency uses to assign Potential Enrollees to a Health Plan. The Agency automatically assigns those Mandatory Potential Enrollees who did not voluntarily choose a Health Plan.

Mandatory Enrollee — The categories of eligible Medicaid recipients who must be enrolled in a Health Plan or MediPass or, if subject to Reform, must be enrolled only in a Health Plan.

Mandatory Potential Enrollee — A Medicaid recipient who is required to enroll in a Health Plan or MediPass but has not yet made a choice.

Market Area — The geographic area in which the Health Plan is authorized to market and/or conduct pre-enrollment activities.

Medicaid — The medical assistance program authorized by Title XIX of the Social Security Act, 42 U.S.C. §1396 et seq., and regulations there under, as administered in the State of Florida by the Agency under 409.901 et seq., F.S.

Medicaid Fair Hearing – An administrative hearing conducted by the Department of Children and Families to review an action taken by a Health Plan that limits, denies, or stops a requested service.

Medicaid Program Integrity (MPI) – The unit of the Agency responsible for preventing and identifying fraud and abuse in the Medicaid program

Medicaid Recipient— Any individual whom DCF, or the Social Security Administration on behalf of the DCF, determines is eligible, pursuant to federal and State law, to receive medical or allied care, goods or services for which the Agency may make payments under the Medicaid program, and who is enrolled in the Medicaid program.

Medicaid Reform— The program resulting from Chapter 409.912 11, F.S.

Medical Foster Care Services — Services provided to enable medically-complex children under the age of 21, whose parents cannot care for them in their own home, to live and receive care in foster homes rather than in hospitals or other institutional settings. Medical foster care services are authorized by Title XIX of the Social Security Act and s. 409.903, F.S., and Chapter 59G, FAC

Medical Record— Documents corresponding to medical or allied care, goods or services furnished in any place of business. The records may be on paper, magnetic material, film or other media. In order to qualify as a basis for reimbursement, the records must be dated, legible and signed or otherwise attested to, as appropriate to the media and meet the requirements of 42 CFR 456.111 and 42 CFR 456.211.

Medically Necessary or Medical Necessity— Services that include medical or allied care, goods or services furnished or ordered to:

1. Meet the following conditions:

- a. Be necessary to protect life, to prevent significant illness or significant disability or to alleviate severe pain;
- b. 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;
- c. Be consistent with the generally accepted professional medical standards as determined by the Medicaid program, and not be experimental or investigational;
- d. Be reflective of the level of service that can be furnished safely and for which no equally effective and more conservative or less costly treatment is available statewide; and
- e. Be furnished in a manner not primarily intended for the convenience of the Enrollee, the Enrollee's caretaker or the provider.

2. Medically Necessary or Medical Necessity 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.

3. 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.

Medicare— The medical assistance program authorized by Title XVIII of the Social Security Act.

Medicare Advantage Special Needs Plan - A Medicare plan defined by Section 1859(b)(6) of the Social Security Act and 42 CFR Section 422.2 that exclusively enrolls or enrolls a disproportionate percentage of special needs individuals as set forth in 42 CFR Section 422.4(a)(1)(iv).

Meds AD — Those recipients up to 88% of FPL with assets up to \$5,000 for an individual and \$6,000 for a couple without Medicare and those with Medicare that are not receiving institutional care, hospice care, or home and community based services.

National Provider Identifier (NPI) – An identification number assigned through the National Plan and Provider Enumerator System of the federal Department of Health and Human Services. NPIs can be obtained online at <https://nppes.cms.hhs.gov>

Neglect — A failure or omission to provide care, supervision, and services necessary to maintain enrollee's physical and mental health, including but not limited to, food, nutrition, supervision and medical services that are essential for the well-being of the enrollee. Neglect might be a single incident or repeated conduct that results in, or could reasonably be expected to result in, serious physical or psychological injury, or a substantial risk of death.

Newborn — A live child born to an Enrollee, who is a member of the Health Plan.

Non-Covered Service — A service that is not a Covered Service/Benefit of the Medicaid State Plan or of MHP - FL.

Nursing Facility — An institutional care facility that furnishes medical or allied inpatient care and services to individuals needing such services. See Chapters 395 and 400, F.S.

Open Enrollment — The sixty (60) day period before the end of an Enrollee's Enrollment year, during which an Enrollee may choose to change Health Plans for the following Enrollment year.

Outpatient — A patient of an organized medical facility, or distinct part of that facility, who is expected by the facility to receive, and who does receive, professional services for less than a twenty-four (24) hour period, regardless of the hours of admission, whether or not a bed is used and/or whether or not the patient remains in the facility past midnight.

Overpayment — Includes any amount that is not authorized to be paid by the Medicaid program or MHP – FL whether paid as a result of inaccurate or improper cost reporting, improper claiming, unacceptable practices, fraud, abuse, or mistake.

Participating Specialist — A physician, licensed to practice medicine in the State of Florida, who contracts with MHP - FL to provide specialized medical services to MHP - FL Enrollees.

Peer Review — An evaluation of the professional practices of a provider by the provider's peers in order to assess the necessity, appropriateness and quality of care furnished as such care is compared to that customarily furnished by the provider's peers and to recognized health care standards.

Pharmacy Benefits Administrator — An entity contracted by MHP - FL accepting pharmacy prescription claims for enrollees in the plan, assuring these claims conform to coverage policy and determining the allowed payment.

Physician's Assistant — A person who is a graduate of an approved program or its equivalent or meets standards approved by the Board of Medicine and is certified to perform medical services delegated by the supervising physician in accordance with Chapter 458, F.S.

Physicians' Current Procedural Terminology (CPT) — A systematic listing and coding of procedures and services published annually by the American Medical Association.

Plan Factor – (Reform only) - A budget-neutral calculation using a Health Plan's available historical enrollee diagnosis data grouped by a health-based risk assessment model. A health plan's plan factor is developed from the aggregated individual risk scores of the health plan's prior month's enrollment. The plan factor modifies a health plan's monthly capitation payment to reflect the health status of its enrollees

Portable X-Ray Equipment — X-ray equipment transported to a setting other than a hospital, Clinic or office of a physician or other Licensed Practitioner of the Healing Arts.

Post-Stabilization Care Services — Covered Services related to an Emergency Medical Condition that are provided after an Enrollee is stabilized in order to maintain the condition, or to improve or resolve the Enrollee's condition pursuant to 42 CFR 422.113.

Potential Enrollee — Pursuant to 42 CFR 438. 10(a), an eligible Medicaid Recipient who is subject to Mandatory Assignment or may voluntarily elect to enroll in a given Health Plan, but is not yet an Enrollee of a specific Health Plan.

Pre-Enrollment — The provision of marketing materials to a Medicaid recipient.

Preferred Drug List – A listing of prescription products selected by a pharmaceutical and therapeutics committee as cost effective choices for clinician consideration when prescribing for Medicaid recipients.

Prepaid Health Plan — A Health Plan reimbursed on a prepaid basis. (see Health Plan)

Primary Care — Comprehensive, coordinated and readily-accessible medical care including: health promotion and maintenance; treatment of illness and injury; early detection of disease; and referral to specialists when appropriate.

Primary Care Case Management — The provision or arrangement of Enrollees' primary care and the referral of Enrollees for other necessary medical services on a 24-hour basis.

Primary Care Provider (PCP) — A participating and contracted physician practicing as a general or family practitioner, internist, pediatrician, obstetrician, gynecologist, advanced registered nurse practitioners, physician assistants or other specialty approved by MHP – FL and the Agency, who furnishes Primary Care and patient management services to an Enrollee. See sections 641.19, 641.31 and 641.51, Florida Statutes.

Prior Authorization — The act of authorizing specific services before they are rendered.

Protocols — Written guidelines or documentation outlining steps to be followed for handling a particular situation, resolving a problem or implementing a plan of medical, nursing, psychosocial, developmental and educational services.

Provider — A person or entity that is eligible to provide Medicaid services.

Provider Contract — An agreement between the MHP - FL and a health care Provider.

Quality — The degree to which a Health Plan increases the likelihood of desired health outcomes of its Enrollees through its structural and operational characteristics and through the provision of health services that are consistent with current professional knowledge.

Quality Enhancements — Certain health-related, community-based services that MHP - FL must offer and coordinate access to for its Enrollees, such as children's programs, domestic violence classes, pregnancy prevention, smoking cessation, or substance abuse programs.

Quality Improvement Plan (QI Plan) — A written document that describes the Health Plan's Quality Improvement Program (QIP), processes, and current strategy for improving the health care outcomes of its Enrollees.

Quality Improvement Program (QIP) — The process of assuring the delivery of health care is appropriate, timely, accessible, available and Medically Necessary.

Registered Nurse (RN) — An individual who is licensed to practice professional nursing in accordance with Chapter 464, F.S.

Remediation – The act or process of correcting a fault or deficiency

Request for Benefit Information (RBI) — The form completed by a Potential Enrollee with the assistance of a Health Plan representative and submitted by the Health Plan to the Choice Counselor/Enrollment Broker to initiate the receipt of information for the Enrollment process. Also known as Pre-Enrollment Application.

Residential Services — As applied to DJJ, refers to the out-of-home placement for use in a level 4, 6, 8 or 10 facility as a result of a delinquency disposition order. Also referred to as a Residential Commitment Program.

Risk Adjustment (also Risk-Adjusted) - (Reform only) - A process to adjust capitation rates to reflect the health conditions relative to the health status of the enrolled population. This process includes but is not limited to, risk assessment models, demographics, or population grouping.

Risk Assessment — The process of collecting information from a person about hereditary, lifestyle and environmental factors to determine specific diseases or conditions for which the person is at risk.

Rural — An area with a population density of less than 100 individuals per square mile, or an area defined by the most recent United State Census as rural, i.e. lacking a metropolitan statistical area (MSA).

Rural Health Clinic (RHC) — A clinic that is located in an area that has a health-care provider shortage. An RHC provides primary health care and related diagnostic services and may provide optometric, podiatry, chiropractic and mental health services. An RHC employs, contracts or obtains volunteer services from licensed health care practitioners to provide services.

Sales Activities — Actions performed by an agent of any Health Plan, including the acceptance of Pre-Enrollment Application Requests for Benefit Information, for the purpose of Enrollment of Potential Enrollees.

Screen or Screening — Assessment of an Enrollee's physical or mental condition to determine evidence or indications of problems and need for further evaluation or services.

Service Area — The designated geographical area within which the MHP – FL is authorized by the AHCA Contract to furnish Covered Services to Enrollees.

Service Authorization — The Health Plan's approval for services to be rendered. The process of authorization must at least include a Health Plan Enrollee's or a Provider's request for the provision of a service.

Service Location — Any location at which an Enrollee obtains any health care service provided by MHP - FL under the terms of the AHCA Contract.

Sick Care — Non-urgent problems that do not substantially restrict normal activity, but could develop complications if left untreated (e.g., chronic disease).

Special Supplemental Nutrition Program for Women, Infants & Children (WIC) — Program administered by the Department of Health that provides nutritional counseling; nutritional education; breast-feeding promotion and nutritious foods to pregnant, postpartum and breast-feeding women, infants and children up to the age of five (5) who are determined to be at nutritional risk and who have a low to moderate income. An individual who is eligible for Medicaid is automatically income

eligible for WIC benefits. Additionally, WIC income eligibility is automatically provided to an Enrollee's family that includes a pregnant woman or infant certified eligible to receive Medicaid.

Specialty Plan – A Health Plan designed for a specific population and whose Enrollees are primarily composed of Medicaid Recipients, Children with Chronic Conditions or for Medicaid Recipients who have been diagnosed with the human immunodeficiency virus or acquired immunodeficiency syndrome (HIV/AIDS). A Health Plan must be licensed under Chapter 641, Florida Statutes, in order to offer a Specialty Plan for the population with HIV/AIDS.

State — State of Florida.

Subcontract — An agreement entered into by the health plan for provision of administrative services on its behalf related to this contract.

Subcontractor — Any person or entity with which MHP - FL has contracted or delegated some of its functions, services or responsibilities for providing services under the AHCA Contract.

Subscriber Assistance Program – (HMOs only) - The state panel authorized under s. 408.7056, F.S. that hears appeals from HMO enrollees whose complaints have not been resolved through the Health Plan's grievance and appeal process.

Surface Mail — Mail delivery via land, sea, or air, rather than via electronic transmission.

Surplus — Net worth, i.e., total assets minus total liabilities.

Temporary Assistance to Needy Families (TANF) — Public financial assistance provided to low-income families through the Department of Children and Families

Transportation — An appropriate means of conveyance furnished to an Enrollee to obtain Medicaid authorized/covered services.

Unborn Activation — The process by which an unborn child, who has been assigned a Medicaid ID number is made Medicaid eligible upon birth.

Urban — An area with a population density of greater than 100 individuals per square mile or an area defined by the most recent United State Census as urban, i.e. as having a metropolitan statistical area (MSA).

Urgent Behavioral Health Care — Those situations that require immediate attention and assessment within twenty-three (23) hours even though the Enrollee is not in immediate danger to himself/herself or others and is able to cooperate in treatment.

Urgent Care — Services for conditions, which, though not life-threatening, could result in serious injury or disability unless medical attention is received (e.g., high fever, animal bites, fractures, severe pain, etc.) or do substantially restrict an Enrollee's activity (e.g., infectious illnesses, flu, respiratory ailments, etc.).

Validation — The review of information, data, and procedures to determine the extent to which they are accurate, reliable, free from bias and in accord with standards for data collection and analysis.

Vendor — An entity submitting a proposal to become a Health Plan contractor.

Violation — A determination by the Agency that a Health Plan failed to act as specified in this Contract or applicable statutes, rules or regulations governing Medicaid Health Plans. Each day that an ongoing violation continues shall be considered, for the purposes of this Contract, to be a separate

Violation. In addition, each instance of failing to furnish necessary and/or required medical services or items to Enrollees shall be considered, for purposes of this Contract, to be a separate Violation. As well, each day that a Health Plan fails to furnish necessary and/or required medical services or items to Enrollees shall be considered, for purposes of this Contract, to be a separate Violation.

Voluntary Enrollee — A Medicaid recipient who is not mandated to enroll in a health plan, but chooses to do so.

Voluntary Potential Enrollee — A Medicaid recipient who is not mandated to enroll in a health plan, has expressed a desire to do so, but is not yet enrolled in a plan.

Well Care Visit — A routine medical visit for one (1) 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.

Acronyms:

ACCESS – Automated Community Connection to Economic Self-Sufficiency, the Department of Children and Families public assistance service delivery system.

ADL - Activities of Daily Living

ALF - Assisted Living Facility

APD - Agency for People with Disabilities

ARNP - Advanced Registered Nurse Practitioner

BBA - Balanced Budget Act of 1997

BMHC - Bureau of Managed Health Care

CAP - Corrective Action Plan

CARES - Comprehensive Assessment & Review for Long-Term Care Services

CDC - Centers for Disease Control and Prevention

CFARS - Children's Functional Assessment Rating Scales

CHD - County Health Department

CMS - Centers for Medicare & Medicaid Services

CFR - Code of Federal Regulations (cites may be searched online at [ww.gpoaccess.gov/cfr/retrieve.gtml](http://www.gpoaccess.gov/cfr/retrieve.gtml))

CHCUP - Child Health Check-Up Program

CPT - Physicians' Current Procedural Terminology

CTD - Commission for the Transportation Disadvantaged

CWPMHP - Child Welfare Prepaid Mental Health Plan

DCF - Department of Children & Families

DFS - Department of Financial Services

DHHS - United States Department of Health & Human Services

DOH - Department of Health

DJJ - Department of Juvenile Justice

DEA - Drug Enforcement Administration

DME - Durable Medical Equipment

EDI - Electronic Data Interchange

ET - Eastern Time

EH - Emotionally Handicapped

EPSDT - Early and Periodic Screening, Diagnosis & Treatment Program

EQR - External Quality Review

EQRO - External Quality Review Organization

EST - Eastern Standard Time

FAC - Florida Administrative Code

FARS - Functional Assessment Rating Scales

FFS - Fee-for-Service

FQHC - Federally Qualified Health Center

F.S. - Florida Statutes

FSFN - Florida Safe Families Network (formerly HomeSafeNet)

FTE - Full-Time Equivalent Position

HEDIS - Healthcare Effectiveness Data and Information Set

HIPAA - Health Insurance Portability & Accountability Act

HMO - Health Maintenance Organization

HSA - Health Savings Account

HSD - Bureau of Health Systems Development

IBNR - Incurred But Not Reported

LEIE - List of Excluded Individuals & Entities

MBHO - Managed Behavioral Health Organization

MFCU - Medicaid Fraud Control Unit, Office of the Attorney General

MPI - Medicaid Program Integrity Bureau, Office of the AHCA Inspector General

NMHPA - Newborns and Mothers Health Protection Act

NCQA - National Committee for Quality Assurance

NPI - National Provider Identifier

ODBC - Open Database Connectivity

PA - Physician's Assistant

PCCB - Per Capita Capitation Benchmark

PCP - Primary Care Physician

PPEC - Prescribed Pediatric Extended Care

PDL - Preferred Drug List

PIP - Performance Improvement Plan

PMHP - Prepaid Mental Health Plan

PSN - Provider Service Network

QE - Quality Enhancement

QI - Quality Improvement

RFP - Request for Proposal

RHC - Rural Health Clinic

SAMH - Substance Abuse & Mental Health Office of the Florida Department of Children & Families

SED - Severely Emotionally Disturbed

SFTP - Secure File Transfer Protocol

SIPP - Statewide Inpatient Psychiatric Program

SNIP - Strategic National Implementation Process

SOBRA - Sixth Omnibus Budget Reconciliation Act

SQL - Structured Query Language

SSI - Supplemental Security Income

TANF - Temporary Assistance for Needy Families

TGCS - Therapeutic Group Care Services

UM - Utilization Management

WEDI - Workgroup for Electronic Data Interchange

WIC - Special Supplemental Nutrition Program for Women, Infants & Children

Chapter 2: Medica Health Plans of Florida, Inc.

Medica Health Plans of Florida, Inc. (MHPFL) is a Florida for Profit Corporation licensed and certified in the state of Florida through the Florida Department of Financial Services and the Agency for Healthcare Administration to operate as a duly licensed Health Maintenance Organization in accordance with Chapter 641, Parts I and III of the Florida Statutes.

Medica Health Plans of Florida, Inc. is a Health Plan which integrates financing and management with the delivery of Medicaid benefits and services to categories of eligible Medicaid recipients as determined by the State of Florida and in accordance with the Florida Medicaid Reform Program resulting from s. 409.91211, F.S. and Non - Reform program under Medicaid as authorized in s, 409.912, F.S. and as defined in the Agency's 1915(b) managed care waiver in designated service areas within the state of Florida. **Unique to reform is that the plan may vary the coverage level and offer more or less coverage to adults than currently covered by Medicaid for the following services: prescribed drugs; hospital outpatient services (excluding emergency care); durable medical equipment and supplies; home health services; chiropractic; podiatric; physical and respiratory, vision, dental and hearing. Any limits imposed by the Health Plan that are more restrictive than fee-for-service coverage do not apply to pregnant women or children.**

Medica Health Plans of Florida shall provide all medically necessary services up to the State Plan limit in accordance with the Medicaid Handbook requirements for pregnant women, children/adolescents, and enrollees with a HIV/AIDS diagnoses as identified by the Agency.

The state approves all benefit packages to ensure that they are sufficient to meet the needs of the enrolled population.

As an integrated Health Plan, providers participating with E Z CARE agree to furnish a specific set of health care benefits consistent with this Provider Handbook and all current Florida Medicaid Handbooks ("Handbooks") as noticed in the Florida Administrative Weekly (FAW) or incorporated by reference in rules and regulations governing the provision of covered services and as promulgated in the Florida Administrative Code to eligible Medicaid recipients enrolled with E Z CARE. MHPFL retains fiscal and administrative responsibilities for the health care services and benefits furnished to members.

In addition to the required benefits and services, the Health Plan may offer expanded benefits and services to enrollees but it may not deny or reduce the amount, duration, or scope of the required covered benefit or service.

Medica Health Plans of Florida, Inc.

Provider Network

The success of Medica Health Plans of Florida, Inc. in providing or arranging for the provision of quality health care services for its members depends on a strong relationship with its Provider Network of contracted Primary Care Physicians (PCP), medical specialists, hospitals, skilled nursing facilities, home health agencies, ambulatory clinics and many other providers and suppliers that make up its comprehensive network of participating health care providers. The Medical Management staff works directly and closely with the Medica Health Plans of Florida Provider Network on utilization management, Quality Improvement and quality improvement activities. These activities may include performing on-site and concurrent reviews; discharge planning, and retrospective medical chart reviews; evaluating providers' participation with our quality assessment and improvement activities; evaluating providers' compliance with Medica Health Plans of Florida' clinical care guidelines, etc. Medica Health Plans of Florida' practice guidelines and utilization management guidelines are adopted from recognized medical societies as well as from standards of care in the medical community and are based on:

- The consideration of the needs of the enrolled population.
- In consultation with Network Providers and,
- Periodic reviews and revisions by pertinent Medica Health Plans of Florida Committees.

Medica Health Plans of Florida, Inc. will not prohibit or otherwise restrict a Network Provider acting within the scope of his/her lawful scope of practice, from advising, or advocating on behalf of, an individual who is a patient and member enrolled under Medica Health Plans of Florida. However, this general rule may not require Medica Health Plans of Florida to cover, furnish, or pay for a particular medical service or procedure.

Contracted providers and suppliers have the operational and technical support of the Departments of Network Development and Provider Relations. Network Development's primary responsibility is to ensure that contracts are established and maintained with providers and suppliers of health care and health care related services to enable the delivery of the benefit package(s). Network Development is also responsible for managing and reporting changes in your status such as:

- Address
- Phone number
- Hours
- Covering physicians
- Addition/deletion of physicians in your practice
- Restricting or opening your patient panel (*a 90-day written advance notice may apply*)
- Corrective actions taken by regulatory authorities
- Credentials
- Professional liability insurance
- Tax ID Number
- Board Certification
- Licensure

Please mail or fax your written notification to:

**Medica Health Plans of Florida, Inc.
 Network Development Department
 4000 Ponce De Leon Blvd., Suite 650
 Coral Gables, FL 33146
 Fax: (305) 460 0613**

The Department of Provider Relations provides Medica Health Plans of Florida's Provider Network, and their office staff, training on policies and procedures affecting their participation with Medica Health Plans of Florida and monitors the Network Providers' compliance with operational standards and practices. Additionally the department lends support in addressing the providers' concerns and issues relating to their participation with Medica Health Plans of Florida including assistance in matters of:

- Questions about procedures or policies
- Forms or literature you may need
- Arrange an orientation for the physicians and/or staff members in your office
- Changes in network activities
- Providing assistance in the resolution of provider claim disputes and claims appeals process
- Any Complaint Provider may have regarding MHP - FL and any facets of it's program

- 1) The Department of Provider Relations will be the designated area within Medica Health Plans of Florida, Inc. to which provider related issues, concerns, complaints as well as suggestions and questions/inquiries are directed, documented and concluded. In all instances Provider Relations representatives have the authority to review and investigate the provider complaints using statutory, regulatory, and contractual and provider contract provisions, collecting all pertinent facts from all parties and applying the Health Plan's written policies and procedures.
- 2) A Provider Relations representative will work directly with the provider to resolve the matter.
- 3) As part of the Provider Complaint System, providers will be instructed that they may file a written complaint within (45) calendar days from the date of the unsatisfactory occurrence.
- 4) If the matter in dispute cannot be resolved through informal or formal discussions between the provider and Medica Health Plans of Florida, an arbitration proceeding may be filed as stipulated in the provider's Provider Participation Agreement. Arbitration proceedings under Medica Health Plans of Florida' agreement will be conducted in Miami Dade County. Arbitration will be conducted pursuant to the rules and regulations of the American Health Lawyers Association Alternative Dispute Resolution Service Rules of Procedures for Arbitration ("AHLA Arbitration Service")
- 5) The Department of Provider Relations will ensure that the Health Plan provides a written notice communicating the outcome of the review to the provider.

Provider Complaints must be directed to the following address within 45 days from the unsatisfactory occurrence:

**Medica Health Plans of Florida, Inc.
Department of Provider Relations
4000 Ponce De Leon Blvd., Suite 650
Coral Gables, FI 33146**

Both departments assist participating providers with any questions or concerns pertaining to their participation with Medica Health Plans of Florida.

If a contract between Medica Health Plans of Florida and a treating provider is terminated for any reason other than for cause, each party shall allow members for whom treatment was active to continue coverage and care when 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 open enrollment period offered by Medica Health Plans of Florida, whichever is longer, but not longer than 6 months after termination of the contract. Each party to the terminated contract shall allow a member who has initiated a course of prenatal care, regardless of the trimester in which care was initiated, to continue care and coverage until the completion of postpartum care.

Data Collection

Health Maintenance Organizations are required to maintain a health information system that collects, analyzes and integrates all data necessary to compile, evaluate and report certain statistical data related to costs, utilization, quality, grievances and other matters as AHCA may require from time to time. As a Medica Health Plans of Florida, Inc. contracted provider, you are required to submit all data necessary for Medica Health Plans of Florida to fulfill these obligations, within the required time frames. During the course of performing these functions, Network Providers may use or disclose Protected Health Information ("PHI") subject to the terms and conditions stipulated in their Medica

Health Plans of Florida Provider Agreement and Business Associate Amendment provided that such use or disclosure does not violate the HIPAA Privacy Regulations, GLB or other federal or state privacy laws applicable to Medica Health Plans of Florida, Inc. You are required to certify in writing at the time of submission to Medica Health Plans of Florida that all data including, but not limited to, encounter data and other information that AHCA may specify is truthful, reliable and complete.

The Member and Medica Health Plans of Florida, Inc.

Upon enrollment, a Medica Health Plans of Florida member agrees to receive all of his/her health services from or through their Primary Care Physician (PCP) in order for health services to be covered. A Primary Care Physician ('PCP') is a duly licensed physician licensed under Chapter 458, 459, 460 or 461 of the Florida Statutes. The Primary Care Physician is responsible for providing, prescribing and directing all care and treatment of the Member, to Medica Health Plans of Florida network of participating physicians and providers. A female member may select as her primary care physician an obstetrician/gynecologist who has agreed to serve as a PCP in Medica Health Plans of Florida network of participating physicians.

Except for emergency services and care the member must receive all health care services through Medica Health Plans of Florida's Provider Network. Routine or elective medical services not ordered, coordinated, or provided by or under the direction of the member's Primary Care Physician (PCP) are not covered services and Medica Health Plans of Florida, Inc. will not pay for such services. Each Member must choose, or have chosen on their behalf, a Primary Care Physician.

Members of Medica Health Plans of Florida, Inc. will be treated with dignity and respect and will have their right to privacy regardless of race, physical or mental disability, ethnicity, gender, sexual orientation, creed, age, religion or national origin, cultural or educational background, economic or health status, English proficiency, reading skills or source of payment.

As a member of Medica Health Plans of Florida, Inc. members have a right to:

- Be treated with courtesy and with due consideration for his or her dignity and privacy.
- A prompt and reasonable response to questions and requests from MHP and its network of contracted providers.
- Know their healthcare providers, and responsible parties in the delivery of health care to include:
- The provider's office address and telephone numbers, except private or "back line" numbers.
- The specialty and subspecialty authorized by the plan to participate by provider while contracted with the plan;
- Hospital affiliations (restrictions, sanctions, status or any other information provided by the hospital is to remain confidential). The name of the boards(s) certifying the provider, with respective issuance and expiration dates; and the names of medical schools, internships, residences, and fellowship programs attended by the provider, with respective attendance dates.
- Information on the providers credentialing process.
- Information about the absence of provider malpractice insurance coverage.
- A language interpreter service available upon request.

- Know what patient support services are available.
- Know what their patient responsibilities are.
- To be furnished health care services in accordance with federal and state regulations.
- To receive information on available treatment options and alternatives, presented in a manner appropriate to the enrollee's condition and ability to understand.
- To participate in decision regarding his or her health care, including the right to refuse treatment.
- Upon his/her request, receive full information and necessary counseling on the availability of known financial resources for their care.
- To receive information regarding ownership of the health plan.
- To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.
- To request and receive a copy of his or her medical records, and request that they be amended or corrected.
- Offer suggestions to the health plan about policies regarding grievances procedures and external appeals process.
- Upon his/her request, receive a reasonable estimate of charges for medical care.
- Access medical treatment or accommodations, regardless of race, national origin, religion, handicap, or source of payment.
- Treatment for any medical condition that may deteriorate from failure to obtain medical treatment.
- Know if the medical treatment is for the purposes of experimental research and to give their consent or refusal to participate in the experimental research.
- Express complaints, grievances and appeals through the grievance and appeals procedures established by MHP - FL.
- Select a Primary Care Physician of their choice from MHPFL's Network of Providers.
- Access to a second medical opinion, if requested, by either a contracted physician or non-contract physician in the organization's service area.
- Upon request, change primary or specialty physicians.
- To use advance directives.
- Be free to exercise his or her rights, and that the exercise of those rights does not adversely affect the way the health plan and its providers or the State agency treat the enrollee.

As members of Medica Health Plans of Florida, Inc. members have a responsibility to:

- Provide his/her health care provider, to the best of their ability, accurate and complete information about present complaints, past illnesses, hospitalizations, medications and other matters concerning your health.
- Follow the treatment plan recommended by the health care provider.
- Keep medical appointments and when unable to, notify the health care provider or facility.
- Be responsible for their actions when refusing treatment or not following the health care provider's instructions.
- Assure that financial obligations of their health care are fulfilled as promptly as possible including co-payments, deductibles, co-insurance amounts, non-covered services and benefits.
- Follow health care facility rules and regulations affecting patient care and conduct.
- Learn about Medica Health Plans of Florida, Inc. and their health care coverage through Medica Health Plans of Florida member education material and the Evidence of Coverage.
- Learn and adhere to the proper use of Medica Health Plans of Florida' services and procedures for accessing medical treatment.
- Consult their Primary Care Physician and obtain his or her direction prior to receiving medical care unless it is a medical emergency
- Advise Medica Health Plans of Florida if they are leaving Medica Health Plans of Florida's service area.

Chapter 3: Covered Services

Covered Services are medically necessary services as specified in the Contract with the State of Florida Agency for Health Care Administration in accordance with the Florida Medicaid Reform Program resulting from s. 409.91211, F.S. and Non - Reform program under Medicaid as authorized in s, 409.912, F.S. and as defined in the Agency's 1915(b) managed care waiver in designated service areas within the state of Florida. Such services include medical or allied care, goods or services furnished or ordered to:

1. Meet the following conditions as specified in Chapter 59G-1 General Medicaid under 59G -1.010 (166) of the Florida Administrative Code:
 - e. Be necessary to protect life, to prevent significant illness or significant disability or to alleviate severe pain;
 - f. 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;
 - g. Be consistent with the generally accepted professional medical standards as determined by the Medicaid program, and not be experimental or investigational;
 - h. Be reflective of the level of service that can be furnished safely and for which no equally effective and more conservative or less costly treatment is available statewide; and
 - e. Be furnished in a manner not primarily intended for the convenience of the Enrollee, the Enrollee's caretaker or the provider.
2. Medically Necessary or Medical Necessity 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.
3. 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.

Through the provision of covered services to enrollees the Health Plan must comply with all current Florida Medicaid handbooks (handbooks) as noticed in the Florida Administrative Weekly (FAW), or incorporated by reference in rules relating to the provision of services except where the provisions of the contract alter the requirements set forth in the handbooks. In addition, the health plan must comply with the limitations and exclusions in the handbooks, unless otherwise specified by the contract. In no instance may the limitations or exclusions imposed by the Health Plan be more stringent than those specified in the handbooks. The health plan may not arbitrarily deny or reduce the amount, duration or scope of a required service solely because of the diagnosis, type of illness, or condition. The Health Plan may exceed these limits by offering expanded services.

For more detailed information regarding the Health Plan's covered services and limitations please refer to www.ezcarehpf.com and <http://ahaca.myflorida.com/Medicaid/flmedicaid.shtml>.

COVERED SERVICES INCLUDE:

- **Advanced Registered Nurse Practitioner (ARNP) Services:**
Services rendered by licensed, participating advanced registered nurse practitioner (ARNPs). The services must be rendered in collaboration with a physician.
- **Child Health Check-Up Services:**

These services include: health and development history, unclothed physical assessment or examination, nutritional assessment, routine immunization update, laboratory tests (including lead screening), vision screening, hearing screening, dental screening, health education, and development assessment. Referral and follow-up for further diagnosis and treatment as indicated as a result of the screening process.

Child Health Check-Up consists of a comprehensive, preventive health screening that is performed on a periodic basis on children 20 years of age or younger.

The Child Health Check-Up schedule is as follows:

- Birth;
- 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; and
- Once per year from age 2 through 20.*

Note: Additional screening examinations may be provided on referral, if medically necessary, from a health care, developmental, or education professional or on request of a parent, guardian or the recipient. A dental referral is provided for recipients beginning at age three, or earlier if indicated. Subsequent examinations by a dentist are recommended every six months or as prescribed by a dentist or other authorized provider. Vision and hearing screenings are provided according to an established periodicity schedule.

Note: See the Florida Medicaid Child Health Check-Up Coverage and Limitations Handbook for information on Child Health Check-Up screenings and optional forms. The handbook is available on the Medicaid Handbook and Resource Library CD-ROM and the Medicaid fiscal agent's website at <http://floridamedicaid.acs-inc.com>. Click on Provider Support and then click on Handbooks.

- **Chiropractic Services:**

Chiropractic services include a new patient visit, manipulation of the spine, and spinal x-rays. The new patient visit consists of a screening and any required manipulation of the spine.

- **Durable Medical Equipment and Medical Supplies:**

Medically necessary DME and medical supplies provided by participating providers. Medical necessity for DME or supplies must be documented by a prescription, a statement of medical necessity, a plan of care, or a hospital discharge plan. The documentation must be signed and dated by the attending physician and include specific information on the item needed, the duration of need, and the recipient's diagnosis.

Examples of medically necessary covered DME and supplies include, but are not limited to:

1. Ambulatory equipment (canes, crutches, walkers);
2. Augmentative and assistive communication devices;
3. Blood glucose meters and strips;
4. Commodes;
5. Diabetic supplies;
6. Enteral nutrition supplements when prior authorized;
7. Heparin Lock Flush Syringes;

8. Hospital type beds and accessories;
9. Insulin syringes;
10. Orthotics and prosthetics;
11. Ostomy and urological supplies;
12. Oxygen and oxygen-related equipment;
13. Peak flow meters;
14. Spacers;
15. Suction pumps;
16. Urine Ketone Test Strips; and
17. Wheelchairs.

- **Emergency Services:**

Emergency medical care provided in an Emergency Room 24 hours a day, 7 days a week for conditions manifesting themselves 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 that the absence of immediate medical attention could reasonably be expected to result in any of the following: (1) Serious jeopardy to the health of a patient, including a pregnant woman or fetus; (2) Serious impairment to bodily functions; (3) Serious dysfunction of any bodily organ or part. (b) 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, in accordance with Section 395.002, F.S. . Members do not need approval from MHP - FL or from their PCP to go to the emergency room if they are having a medical situation. Post Stabilization services are covered without prior authorization. These are services that are medically necessary after an emergency medical condition have been stabilized.

- **Family Planning Services:**

Family planning services including information, referral education, counseling, diagnostic procedures and contraceptive drugs and supplies are covered for eligible enrollees of childbearing age who desire family planning services and supplies. The services covered are for the purpose of spacing children or preventing pregnancies. Family planning services are available in County Health Departments.

Family planning services are not covered for a minor (under age 18) unless the minor:

- Has his or her parent's or legal guardian's consent;
- Is married;
- Is a parent;
- Is pregnant; or
- Will suffer from probable health hazards if such services are not provided as determined by the physician, based on sexual activity or other medical reasons.

The provider must document the reason for providing family planning services specific to family planning to the minor in the recipient's medical record.

- **Diabetes Supplies and Education**

Coverage for medically appropriate and necessary equipment, supplies, and services used to treat diabetes, including outpatient self-management training and educational services if these services are deemed necessary.

- **Dialysis:**

Covered services include in-center hemodialysis, in-center administration of the injectable medication Erythropoietin (EPOgen or EPO), and home peritoneal dialysis. The dialysis treatment includes routine laboratory tests, dialysis-related supplies and ancillary and parenteral items.

- **Hearing Services**

Hearing services rendered by participating hearing aid specialists.

Hearing services include:

- Cochlear implant services;
- Diagnostic testing;
- Hearing aids;
- Hearing aid evaluations;
- Hearing aid fitting and dispensing;
- Hearing aid repairs and accessories; and
- Newborn hearing screening.

- **Home Health Care Services:**

Home health services rendered by participating home health agencies which may include:

- Home visit services provided by a registered nurse or a licensed practical nurse;
- Home visits provided by a qualified home health aide;
- Private duty nursing;
- Personal care services;
- Therapy (occupational and physical therapy and speech-language pathology) services; and
- Medical supplies, appliances and durable medical equipment.

- **Hospital Services – Inpatient:**

All items and services needed to give appropriate care during a stay at a participating hospital including room and board, nursing care medical supplies, and all diagnostic and therapeutic services. The Plan covers a maximum of 45 inpatient days per calendar year. (Includes only non-emergency care at hospitals when prior authorization is obtained by the participating hospital).

- **Hospital Services – Outpatient:**

Outpatient hospital services include those services that are preventive, diagnostic, therapeutic or palliative care and service items that are provided to an outpatient including medical supplies, nursing care, therapeutic services and drugs. The services must be provided under the direction of a licensed physician or dentist.

- **Immunizations:**

Vaccines for Recipients Birth Through 18 Years:

For eligible recipients from birth through 18 years of age, vaccines and combination vaccines providing protection against the following diseases are available free to the VFC-enrolled provider through the VFC program and are covered services. **Note:** The most current schedule is available on the Internet at www.cdc.gov/nip. (*Click on publications.*) Providers may also obtain the current schedule from their County Health Departments.

The CDC's National Immunization Information Hotline is 1-800-232-2522 and in Spanish is 1-800-232-0233.

Diphtheria, Tetanus and Pertussis (DTaP)

Haemophilus Influenzae Type b (HIB)

Hepatitis B (pediatric and adult)

Meningococcal Conjugate (MCV4)

Pneumococcal (PCV 7)

Polio (IPV)

Measles, Mumps, and Rubella (MMR)

Tetanus and Diphtheria (Td) (Adult)

Influenza

Varicella

Human Papillomavirus (HPV)

Rotavirus

The following vaccines are available by request or for high-risk areas only through the VFC program:

Hepatitis A

Diphtheria and Tetanus (DT) (Pediatric)

Pneumococcal Polysaccharide (PPV)

Meningococcal Polysaccharide (MPSV4)

Vaccines for Recipients 19 Through 20 Years

For eligible recipients ages 19 through 20 years, vaccines and combination vaccines providing protection against the following diseases are reimbursable :

Hepatitis A

Hepatitis B

Human Papillomavirus (HPV)

Influenza

Measles, Mumps, and Rubella (MMR)

Meningococcal Conjugate (MCV 4)

Meningococcal Polysaccharide (MPSV4)

Pneumococcal Polysaccharide (PPV)

Tetanus and Diphtheria (Td)

Varicella

- **Licensed Midwife Services:**

Obstetrical care services rendered by participating licensed midwives during the antepartum and postpartum phases of pregnancy and home deliveries.

Services include Initial comprehensive and prenatal examinations; Labor management for recipients who transfer to a hospital; Newborn assessment; Post delivery examinations; Post delivery recovery; Related pregnancy services; and Vaginal delivery.

- **Pregnancy Related Services (Maternity Care)**

Maternity services include the following: nursing assessment and counseling, Florida's Healthy Start Prenatal Risk Screening, nutrition assessment, delivery and, in adherence with the Newborns and Mothers Health Protection Act (NMHPA), post partum care for mothers and their newborns, Florida's Healthy Start Infant (Postnatal) Screening, and follow-up care.

- **Mental Health Services:**

Services that are medically necessary and are rendered or recommended by a physician, psychiatrist, or licensed mental health professional and are included in an individualized treatment plan. Treatment planning includes working with the Enrollee, their natural support system, and all involved treating Providers to develop an individualized plan for addressing identified clinical needs. A Behavioral Health Care Provider must complete a face-to-face interview with the Enrollee during the development of the plan.

The Individualized Treatment Plan shall:

1. Be recovery-oriented and promote resiliency;
 2. Be enrollee-directed;
 3. Accurately reflect the presenting problems of the enrollee;
 4. Be based on the strengths of the enrollee, family, and other natural support systems;
 5. Provide outcome-oriented objectives for the enrollee;
 6. Include an outcome-oriented schedule of services that will be provided to meet the enrollee's needs;
 7. Include the coordination of services not covered by the plan such as school- based services, vocational rehabilitation, housing supports, Medicaid fee-for service substance abuse treatment, and physical health care.
- **Mental Health Targeted Case Management:**

Case Management Program designed to assist enrollees with serious emotional disturbances and adults with a severe mental illness in gaining access to needed medical, social, educational, and other services subject to the Medicaid Mental Health Targeted Case Management Coverage and Limitations Handbook.
 - **Physician Services:**

Physician services include services rendered by a licensed physician, psychiatrist, advanced registered nurse practitioner, physician assistant, podiatrist, chiropractor, ambulatory surgical center, rural health clinic, federally qualified health center, birthing center, and county health department clinic. Physician services can be rendered in the physician's office, the patient's home, a hospital, a nursing facility or other approved places of service as necessary to treat a particular injury, illness, or disease.
 - **Podiatry Services:**

Podiatry services rendered by participating podiatrists. The services can be provided in the podiatrist's office, inpatient hospital, outpatient/emergency department of a hospital, ambulatory surgical center, nursing facility, intermediate care facility for the developmentally disabled (ICF/DD), boarding home, recipient's home, or other custodial facility.
 - **Prescribed Drugs:**

When dispensed at participating pharmacies most legend drugs including injectable drugs, and specific non-legend drugs are covered. Most drugs included on the Medicaid Preferred Drug List (PDL) are available without prior authorization (PA). Drugs not on the PDL require PA including

step therapy using PDL products and some drugs with clinical protocol requirements require PA to insure the clinical protocol is met. <http://floridamedicaid.acs-inc.com>

Prescriptions for psychotropic medication prescribed for an enrollee under the age of thirteen (13) must be accompanied by the express written and informed consent of the enrollee's parent or legal guardian. Psychotropic (Psychotherapeutic) medications include antipsychotics, antidepressants, anti-anxiety medications, and mood stabilizers.

- **Primary Care Case Management Services:**

Includes all services and procedures rendered by a Participating Primary Care Provider when required for preventive, diagnostic, therapeutic or to treat a particular injury, illness or disease. Excludes experimental procedures and cosmetic surgery.

- **Therapy Services: Occupational; Physical; Respiratory & Speech**

Are covered for Members under 21 years of age as medically necessary and in compliance with Medicaid Coverage and Limitations Handbook. Adults, 21 years and older are covered for outpatient physical and respiratory therapy.

- **Transplant Services:**

Bone marrow transplantation is covered for the treatment of certain types of cancers and aplastic anemias; solid organ transplantation is covered for failure of the organ due to a variety of illnesses.

Determinations for medically accepted transplant procedures are established within the guidelines of the Agency for Health Care Administration Organ Transplant Advisory Council, the Bone Marrow Transplant Advisory Panel, and Medicaid medical consultants.

| SUMMARY OF RESPONSIBILITY | | | | |
|--------------------------------------|--------------------------------|-------------------------------------|--------------------------------|-------------------------------------|
| | REFORM | | NON-REFORM | |
| | Adult (21 and Over) | Pediatric (20 and Under) | Adult (21 and Over) | Pediatric (20 and Under) |
| Evaluation | Health Plan | Health Plan | Health Plan | Health Plan |
| Bone Marrow | Health Plan | Health Plan | Health Plan | Health Plan |
| Cornea | Health Plan | Health Plan | Health Plan | Health Plan |
| Heart | Health Plan* | Health Plan* | Medicaid** | Medicaid** |
| Intestinal/ Multivisceral | Health Plan | Health Plan | Health Plan | Health Plan |
| Kidney | Health Plan | Health Plan | Health Plan | Health Plan |
| Liver | Health Plan* | Health Plan* | Medicaid** | Medicaid** |

| | | | | |
|--|--------------|--------------|--|--|
| Lung | Health Plan* | Health Plan* | Medicaid** | Medicaid** |
| Pancreas | Health Plan | Health Plan | Health Plan | Health Plan |
| Pre- and Post-Transplant Care, including Transplants <u>Not Covered by Medicaid</u> | Health Plan | Health Plan | Health Plan (except heart, lung, or liver) | Health Plan (except heart, lung, or liver) |
| Other Transplants <u>Not Covered by Medicaid</u> | Not Covered | Not Covered | Not Covered | Not Covered |

*For candidate for a heart or lung transplant, or with a Model End Stage Liver Disease (MELD) score of 11-25 for a liver transplant, the health plan must submit a copy of the UNOS form to BMHC with a request to disenroll the member from the Health Plan. The recipient cannot re-enroll with the Health Plan until at least one year post transplant. This re-enrollment is not automatic.

**Transplant services specified with two asterisks, as well as pre- and post-transplant follow-up care, are covered through fee-for-service Medicaid and not by the Health Plan.

- **Translation Services / Cultural Competency**

Enrollees and providers may receive interpreter services at no cost when accessing covered benefits. The service is arranged through the Member Service Department by enrollees and through the Medical Management Department when requested by a provider providing service to an eligible enrollee. Providers, MHPFL Employees, and systems will effectively provide services to people of all cultures, races, ethnic backgrounds, and religions in a manner that recognizes values, affirms, and respects the worth of the individual Enrollees and protects and preserves the dignity of each enrollee. For a free download of the Cultural Competency Plan summary describing how the Health Plan will ensure that services are provided in a culturally competent manner to all enrollees, including those with limited English proficiency, please refer to our website at www.ezcaremhpf.com. Sign language service is provided for the hearing impaired when needed as well as access to TTY/TDD lines. Additionally, all enrollee written material is available for enrollees in their primary language.

- **Transportation**

Non-Emergency Medical Transportation (NEMT) services defined as medically- necessary transportation for any enrollee and personal care attendant or escort, if required, who have no other means of transportation available to any covered and compensable service for the purpose of receiving treatment, medical evaluation, or therapy. NEMT services do not include ambulance transportation.

In Miami Dade County, members need to call State's Transportation Coordinator to schedule a transportation services.

In Broward County Medica Health Plans of Florida Health Plan arrange services through Medical Transportation Services. Members must call 1-888-542-6635 directly to coordinate transportation services.

Quality Enhancement Programs:

In addition, MHP – FL covers the provision of the following quality and benefit enhancements:

Smoking Cessation - Regularly scheduled smoking-cessation programs must be conducted by the plan as an option for all plan members. Members must also have access to smoking-cessation counseling. MHP – FL must provide Primary Care Physicians with the Quick Reference Guide for Smoking Cessation Specialists, published by the U.S. Department of Health and Human Services;

Substance Abuse - Primary Care Physicians screenings of enrollees for signs of substance abuse as part of prevention evaluation. Targeted enrollees must be asked to attend community or plan-sponsored substance abuse programs.

Domestic Violence - Primary Care Physicians screenings of enrollees for signs of domestic violence and must provide referral services to applicable, domestic-violence-prevention community agencies;

Pregnancy Prevention – Conduct pregnancy-prevention programs directly or coordinate efforts aimed at involving members in existing community pregnancy-prevention programs.

Prenatal/Postpartum Pregnancy Programs - Regular home visits conducted by a home health nurse or aide, counseling and educational materials to pregnant members and postpartum members who are not in compliance with the Health Plan's prenatal and postpartum programs. Programs will be coordinated with Healthy Start Care Coordinators to prevent duplication of services; and

Children's Programs - Conduct regular general wellness programs targeted specifically toward plan members from birth to the age of five directly or coordinate efforts aimed at involving members in existing community children's wellness programs. Programs must promote increased utilization of prevention and early intervention services for at-risk families with children in the target population.

| E Z Care Schedule of Benefits | | | | |
|--|--------------------------|----------|-----------------------|----------|
| Medica Health Plans of Florida, Inc. Covered Services Chart | Non-Reform | | Reform | |
| <i>Covered Benefits highlighted and designated with (R) requires PCP Referral and Prior Authorization from the Health Plan.</i> | Miami Dade County | | Broward County | |
| Ambulance Services | X | | X | |
| Ambulatory Surgical Centers (ASC) | X | <i>R</i> | X | <i>R</i> |
| Birth Center Services | X | | X | |
| Child Health Check-Up Services | X | | X | |
| Chiropractic Services | X | <i>R</i> | X | <i>R</i> |
| Community Behavioral Health Services | X | <i>R</i> | X | <i>R</i> |
| County Health Department Services (CHD) | X | | X | |
| Dental Services* | X | | X | |
| Durable Medical Equipment and Medical Supplies | X | <i>R</i> | X | <i>R</i> |
| Dialysis Services | X | <i>R</i> | X | <i>R</i> |
| Emergency Room Services | X | | X | |
| Family Planning Services / Maternity | X | | X | |
| Federally Qualified Health Center (FQHC) Services | X | | X | |
| Freestanding Dialysis Centers | X | <i>R</i> | X | <i>R</i> |

| E Z Care Schedule of Benefits | | | | |
|--|-------------------|----------|---------------|----------|
| Medica Health Plans of Florida, Inc. Covered Services Chart | Non-Reform | | Reform | |
| Hearing Services | X | <i>R</i> | X | <i>R</i> |
| Home Health Care Services | X | <i>R</i> | X | <i>R</i> |
| Hospital Services – Inpatient (Behavioral Health and Physical Health) | X | <i>R</i> | X | <i>R</i> |
| Hospital Services – Outpatient | X | <i>R</i> | X | <i>R</i> |
| Immunizations | X | | X | |
| Independent Laboratory Services (When ordered by a Participating Provider and rendered by Quest Laboratory) | X | | X | |
| Licensed Midwife Services | X | | X | |
| Over the Counter (OTC) Pharmacy (Maximum \$25 per household / per month) | X | | X | |
| Primary Care Physician /ARNP/ PA Services | X | | X | |
| Physician Specialists | X | <i>R</i> | X | <i>R</i> |
| Podiatry Services | X | <i>R</i> | X | <i>R</i> |
| Portable X-ray Services | X | <i>R</i> | X | <i>R</i> |
| Prescribed Drugs (When ordered by a Participating Provider and supplied by a licensed Health Plan participating pharmacy) | X | | X | |
| Primary Care Case Management Services | X | | X | |
| Rural Health Clinic Services | X | | X | |
| Targeted Case Management | X | | X | |
| Therapy Services: Occupational | X | <i>R</i> | X | <i>R</i> |
| Therapy Services: Physical | X | <i>R</i> | X | <i>R</i> |
| Therapy Services: Respiratory | X | <i>R</i> | X | <i>R</i> |
| Therapy Services: Speech | X | <i>R</i> | X | <i>R</i> |
| Transplant Services | X | | X | |
| Transportation Services* | | | X | |
| Vision Services | X | | X | |

* For non-Reform populations, Medicaid State Plan dental services and transportation services (notated in the table with an asterisk) are considered optional services. If an “X” is listed in the non-Reform column, MHPFL provides limited dental services or transportation services in Miami Dade County.

Expanded Services

The health plan agrees to provide the following expanded benefits to reform and non-reform enrollees as specified below in accordance with contract provisions.

- (a) Over the counter drug benefit per month, per household
- (b) Dental services include the arrangement and provision of Medicaid State Plan dental services to the adult and child populations as follows in **Broward County**.

- **Dental Services:**

Dental services rendered by licensed, participating dentists for all eligible Medicaid enrollees 20 years of age or younger to include:

1. Dentures, complete and partial;
2. Diagnostic examinations;
3. Endodontics/Periodontal treatment;
4. Oral surgery;
5. Orthodontic treatment;
6. Periodontal services;
7. Preventive services;
8. Radiographs necessary to make a diagnosis
9. Restorations.
10. CHCUP dental screening (including a direct referral to a dentist for Enrollees beginning at three (3) years of age or earlier as indicated)

For the application of sealants on permanent first and second molars once per three years, per tooth.

For orthodontics, Medicaid services are limited to treatment of severely handicapping malocclusions or correction of a dental condition deterring physical development.

For adult dental services when rendered by a participating provider, acute emergency dental procedures to alleviate pain or infection, dentures and denture-related procedures are provided to enrollees age 21 and older. Evaluations for adults are limited to determining the need for dentures or for acute emergency services. Emergency services are limited to an emergency problem focused evaluation, necessary x-rays to make a diagnosis, extraction, and incision and drainage of an abscess.

Adult dental services include:

1. Complete removable partial dentures;
2. Comprehensive oral evaluation;
3. Denture-related procedures;
4. Incision and drainage of an abscess;
5. Necessary radiographs to make a diagnosis;
6. Problem-focused oral evaluation; and
7. Extractions and surgical procedures essential to the preparation of the mouth for dentures.

In no instance may the limitations or exclusions imposed by the health plan be more stringent than those specified in the Medicaid Dental Services Coverage, Limitations & Reimbursement Handbook

In Dade County, dental services for Adults & Children are limited to 1 exam, 1 x-ray, and 1 cleaning

(c) Circumcision for boys up to 1 year old

Direct Access Services

Medica Health Plans of Florida, Inc. members may access the health services listed below directly from participating providers. No referral is required from the PCP or prior authorization from the Health Plan. Participating specialty providers should keep the primary care physician informed of the clinical progress of the patient, including test results within 7 days following his or her encounter with the member.

If other services or benefits are obtained without prior authorization, *other than* Emergency Services and Care and the direct access services hereby described, the member will be responsible for the cost of

such services. The following outlines the situations when members may self-refer. **All other services must be prior authorized by the Health Plan.**

1) Access to Dermatologists

Members shall have access to contracted Dermatologists for office visits, minor procedures, and testing with a Dermatologist under contract with Medica Health Plans of Florida, without a referral or other authorization before receiving services.

Covered services are subject to the limitations, exclusions, and provisions of the Member Agreement. This is in accordance with Chapter 627.6472 (16) and 641.31(33) of the Florida Statutes.

2) Access to Chiropractors and Podiatrists

Members shall have access to a contracted practitioner licensed under Chapters 460 and 461 (Chiropractors or Podiatrists) for the purpose of providing Covered Services under Chapters 460 and 461 without the need for a referral from the Primary Care Physician. Covered Services are subject to the limitations, exclusions, and provisions of the plan benefit.

3) Well-Woman Examination

A female member shall have access to a contracted obstetrician / gynecologist for one annual visit and for medically necessary follow up care detected at that visit. Covered services are subject to the limitations, exclusions and provisions of the plan benefit and in accordance with Chapter 641.51(11) of the Florida Statutes.

a) A baseline mammogram for any woman who is 35 years of age or older, but younger than 40 years of age.

(b) A mammogram every 2 years for any woman who is 40 years of age or older, but younger than 50 years of age, or more frequently based on the patient's physician's recommendations.

(c) A mammogram every year for any woman who is 50 years of age or older.

(d) One or more mammograms a year, based upon a physician's recommendation for any woman who is at risk for breast cancer because of a personal or family history of breast cancer, because of having a history of biopsy-proven benign breast disease, because of having a mother, sister, or daughter who has had breast cancer, or because a woman has not given birth before the age of thirty.

4) Sexually Transmitted Diseases / Communicable Diseases

Members shall have access to the diagnosis and treatment of sexually transmitted diseases and other communicable diseases such as tuberculosis and human immunodeficiency rendered by county health departments without the need for a referral from the PCP.

5) Immunizations

Members shall have direct access to immunizations provided by county health departments without the need for a referral from the PCP.

6) Family Planning Services

Family planning services regardless of whether the provider is a plan provider; planning and referral, education and counseling, initial examination, diagnostic procedures and routine laboratory studies, contraceptive drugs and supplies, and follow-up care in accordance with the Medicaid Physicians Services Coverage and Limitations Handbook.

Advance Directives

The following guidelines delineate Medica Health Plans of Florida's position with respect to Florida

Law and rules relative to advance directives. These guidelines shall not condition treatment nor admission upon whether or not the individual has executed or waived an advance directive.

Medica Health Plans of Florida Inc. respects the right of every competent adult to make decisions concerning his or her own health, including the right to choose or refuse medical treatment. Medica Health Plans of Florida will not condition the provision of care or otherwise discriminate against an individual based on whether or not the individual has executed an advance directive. Medica Health Plans of Florida requires that its participating providers maintain a copy of an advance directive as part of the medical record if the member has provided it. The medical record should also note if the member has not executed an Advance Directive. Medica Health Plans of Florida does not require for a member to have an advance directive and the member may cancel an advance directive at any time.

In the event of a conflict between Medica Health Plans of Florida's policies and procedures or a provider's policies and procedures and the individual's advance directive, the following provisions shall be made:

1. A health care provider or facility that refuses to comply with a patient's advance directive, or the treatment decision of his or her surrogate, shall make reasonable efforts to transfer the patient to another health care provider or facility that will comply with the directive or treatment decision. Florida Law does not require a health care provider or facility to commit any act which is contrary to the provider's or facility's moral or ethical beliefs, if the patient:

Is not in an emergency condition; and Has received written information upon admission informing the patient of the policies of the health care provider or facility regarding such moral or ethical beliefs.

2. A health care provider or facility that is unwilling to carry out the wishes of the patient or the treatment decision of his or her surrogate because of moral or ethical beliefs must within 7 days either:

Transfer the patient to another health care provider or facility. The health care provider or facility shall pay the costs for transporting the patient to another health care provider or facility; or

If the patient has not been transferred, carry out the wishes of the patient or the patient's surrogate, unless the patient's family, the health care facility, or the attending physician, or any other interested person who may reasonably be expected to be directly affected by the surrogate or proxy's decision concerning any health care decision believes:

- A. The surrogate or proxy's decision is not in accord with the patient's known desires or the provisions of Chapter 765, F.S.;
- B. The advance directive is ambiguous, or the patient has changed his or her mind after execution of the advance directive;
- C. The surrogate or proxy was improperly designated or appointed, or the designation of the surrogate is no longer effective or has been revoked;
- D. The surrogate or proxy has failed to discharge duties, or incapacity or illness renders the surrogate or proxy incapable of discharging duties;
- E. The surrogate or proxy has abused powers; or
- F. The patient has sufficient capacity to make his or her own health care decisions.

The patient's family, the health care facility, or the attending physician, or any other interested person who may reasonably be expected to be directly affected by the surrogate or proxy's decision concerning any health care decision may seek expedited judicial intervention pursuant to rule 5.900 of the Florida Probate Rules, if any of the issues described above are applicable.

Any practitioner or facility transferring the patient to another practitioner or facility shall contact the Department of Medical Management and notify of such transfer prior to transferring the patient. The Department of Medical Management shall coordinate future services with contracted providers that are willing to execute the wishes of the patient or his/her surrogate.

Chapter 4: Eligibility & Enrollment

Who can enroll in E Z CARE ?

Florida law mandates that Medicaid recipients must enroll with a managed care provider unless they have Medicare or other third party coverage, reside in a long term care facility, are enrolled in hospice, or are enrolled in a Medicaid program with limited benefits. Eligible recipients are given 30 days from the date that Medicaid eligibility begins to select a managed care option. If recipients do not select an option within 30 days, they are automatically assigned to a managed care plan.

Recipients who enroll with a managed care plan are enrolled for a 12-month period beginning on the date of enrollment. They have 90 days, from the date of enrollment, to try the plan and request a change. After the initial 90 days, they must remain with their plan for the next nine months. Only plan changes for “good cause” will be allowed during these nine months. Each 12 months thereafter, recipients will receive notification of their open enrollment period, which is when they may change plans for the following year.

The following populations differentiate a broad set of categories that consist of multiple Medicaid eligibility classes. Certain exceptions may apply within these categories and will be determined by the Agency for Health Care Administration (AHCA). Only Medicaid recipients who are included in these population groupings and reside in the health plan’s service area are eligible to enroll and receive covered benefits and services through E Z CARE .

The categories of eligible recipients that must enroll in a health plan and those authorized to be enrolled in a health plan are: Low Income Families and Children; Sixth Omnibus Budget Reconciliation Act (SOBRA) Children; Supplemental Security Income (SSI) Medicaid Only, Refugees, and the Meds AD population unless they otherwise meet a requirement of a voluntary or excluded population. Title XXI MediKids are eligible for enrollment in the plan in accordance with section 409.8132, F.S. Except as otherwise, Title XXI MediKids eligible participants are entitled to the same conditions and services as currently eligible Title XIX Medicaid beneficiaries. Women enrolled in the plan that change eligibility categories to the SOBRA eligibility category due to the pregnancy will remain eligible for enrollment in the plan.

The three (3) basic groups eligible for Medicaid are:

a) SSI (Supplemental Security Income) recipients as determined by Social Security:

To be eligible for SSI, an individual must be age 65 or older or if 64 years of age or younger, be totally and permanently disabled, and meet the SSI income and asset limits. SSI recipients are automatically entitled to Medicaid with full benefits

b) Children & Families with full Medicaid benefits:

- Temporary Assistance for Needy Families (TANF): Low income families including single parent families and families with a disabled or unemployed parent.
- Medicaid Expansion Designated by Sixth Omnibus Budget Reconciliation Act – SOBRA (MEDS): Including children 18 years of age or younger and pregnant women
- Public Medical Assistance (PMA): includes children in intact families and children born after September 30, 1983, not living with relatives;
- Foster Care, Adoption Subsidy and Emergency Shelter include dependent children in the care and control of the state and children with special medical needs whose adoption was supported by the state or a private adoption agency; and

- Mary Brogan Breast and Cervical Cancer Program include women who are screened and diagnosed with breast or cervical cancer through the Florida Breast and Cervical Cancer Early Detection Program administered by the Department of Health. Women entitled through this program must have income at or below 200% of the federal poverty level.

1. Voluntary Populations

The following categories describe recipients who may voluntarily enroll in a health plan but are not required to do so:

- Foster care children/adolescents, including children/adolescents receiving medical foster care services or receiving adoption assistance;
- Individuals diagnosed with developmental disabilities, as defined by the Agency, including those in the Developmental Disabilities Waiver;
- Children with chronic conditions who are eligible to participate in the Children's Medical Services Program or a specialty plan for children with chronic conditions but not enrolled in the program;
- Individuals with Medicare coverage (dual eligible individuals with either Medicare Part B coverage or Medicare Parts A and B coverage) who are not enrolled in a Medicare Advantage Plan, except those enrolled in a Medicare Advantage Special Needs Plan and not otherwise ineligible under the terms of this contract;
- Children and adolescents who have an open case for services in the Department of Children and Families' Florida Safe Families Network (FSFN) database system (formerly HomeSafenet) unless they otherwise meet a requirement of a mandatory population or an excluded population;
- Women enrolled in the plan who change eligibility categories to the SOBRA category due to their pregnancy will remain eligible for enrollment in the plan or may disenroll;
- Individuals who are residents in ALFs and are not enrolled in an Assisted Living for the Elderly (ALE) waiver program and are not otherwise in a mandatory population; and
- For Reform populations, individuals enrolled in Project AIDS Care (PAC) waiver unless they otherwise meet a requirement of a mandatory or excluded population; and
- Individuals enrolled in the Channeling Waiver, Aged and Disabled Adult Waiver, Adult Cystic Fibrosis Waiver, Adult Day Health Care Waiver, Alzheimer's Disease Waiver, Traumatic Brain and Spinal Cord Injury Waiver, Familial Dysautonomia Waiver, Family and Supported Living Waiver, or Model Waiver.

2. Mandatory Populations

- The categories of eligible recipients authorized to be enrolled in the plan are:
 - Low Income Families and Children;
 - Sixth Omnibus Budget Reconciliation Act (SOBRA) Children;
 - Supplemental Security Income (SSI) Medicaid Only,
 - Refugees;
 - Title XXI MediKids, in accordance with s. 409.8132, F.S., and

- (6) Medicaid Eligibility Designated by SOBRA/Aged and Disabled population (Meds AD) unless they otherwise meet a requirement of a voluntary or excluded population.
- b. Except as otherwise specified in this contract, Title XXI MediKids-eligible participants are entitled to the same conditions and services as currently eligible Title XIX Medicaid recipients.

Enrollment in E Z CARE

Enrollment in **E Z CARE** may be elective as chosen by the Medicaid recipient or the recipient may be auto - assigned by the Agency for Health Care Administration (AHCA). Whether the recipient has elected or has been auto - assigned to **E Z CARE**, enrollment will be effective at 12:01 a.m. on the first (1st) Calendar Day of the month following the recipient's selection or Auto- Assignment on or between the first (1st) Calendar Day of the month and the Penultimate Saturday of the month.

Provided the enrollee maintains continued eligibility, Mandatory Enrollees will have a Lock-In period of twelve (12) months. After an initial ninety (90) day change period, Mandatory Enrollees will only be able to disenroll from **E Z CARE** for Cause.

AHCA or its Agent will automatically re-enroll an enrollee into E Z CARE if he or she has a temporary loss of eligibility, defined for this purpose as less than 180 Calendar Days. In this instance, the Lock-In period will continue as though there had been no interruption in eligibility, keeping the original twelve (12) month period.

Disenrollment from E Z CARE

An Enrollee may submit to the Agency or its Agent a request to disenroll from MHPFL without cause during the ninety (90) calendar day change period following the date of the Enrollee's initial Enrollment with MHPFL, or the date the Agency or its Agent sends the Enrollee notice of the Enrollment, whichever is later. An Enrollee may request disenrollment without cause every twelve (12) months thereafter.

- MHPFL shall ensure that it does not restrict the Enrollee's right to disenroll voluntarily in any way.
- MHPFL or its agents/representatives shall not provide or assist in the completion of a disenrollment request or assist the Agency's Choice Counselor/Enrollment Broker in the disenrollment process.
- MHPFL shall ensure that Enrollees that are disenrolled and wish to file an appeal have the opportunity to do so. All Enrollees shall be afforded the right to file an appeal, except for the following disenrollment reasons:
 1. Moving out of the Service Area;
 2. Loss of Medicaid eligibility;
 3. Enrollee death.

The effective date of an approved disenrollment shall be the last calendar day of the month in which disenrollment was made effective by the Agency or its Agent, but in no case shall disenrollment be later than the first (1st) calendar day of the second (2nd) month following the month in which the Enrollee or MHPFL files the disenrollment request. If the Agency or its Agent fails to make a disenrollment determination within this timeframe, the disenrollment is considered approved.

➤ **Voluntary Disenrollment (Cause for Disenrollment):**

A **Mandatory Enrollee** may request disenrollment from MHPFL for cause at any time. Such request shall be submitted to the Agency or its Agent. The following reasons constitute **Cause for Disenrollment** from MHPFL:

1. The Enrollee moves out of the county, or the Enrollee's address is incorrect and the Enrollee does not live in the county.
2. The Provider is no longer with MHPFL.
3. The Enrollee is excluded from enrollment.
4. A substantiated marketing violation occurred.
5. The Enrollee is prevented from participating in the development of his/her treatment plan.
6. The Enrollee has an active relationship with a provider who is not on MHPFL's panel, but is on the panel of another Health Plan.
7. The Enrollee is enrolled in the wrong Health Plan as determined by the Agency.
8. MHPFL no longer participates in the county.
9. The State has imposed intermediate sanctions upon MHPFL, as specified in 42 CFR 438.702(a)(3).
10. The Enrollee needs related services to be performed concurrently, but not all related services are available within MHPFL's network; or, the Enrollee's PCP has determined that receiving the services separately would subject the Enrollee to unnecessary risk.
11. MHPFL does not, because of moral or religious objections, cover the service the Enrollee seeks.
12. The Enrollee missed his/her Open Enrollment due to a temporary loss of eligibility, defined as 180 days or less.
13. Other reasons per 42 CFR 438.56(d)(2), including, but not limited to, poor quality of care; lack of access to services covered under the Contract; inordinate or inappropriate changes of PCPs; service access impairments due to significant changes in the geographic location of services; lack of access to Providers experienced in dealing with the Enrollee's health care needs; or fraudulent Enrollment.

➤ **Voluntary Enrollees** may disenroll from MHPFL at any time.

➤ **Involuntary Disenrollment:**

1. MHPFL will maintain the proper written documentation that supports any request for involuntary disenrollment. The following are acceptable reasons for which MHPFL shall submit Involuntary Disenrollment requests to the Agency or its Choice Counselor/Enrollment Broker, as specified by the Agency:
 - Enrollee has moved out of the Service Area;
 - Enrollee death;
 - Determination that the Enrollee is ineligible for Enrollment based on the criteria specified in the Contract in Section III.A.3, Excluded Populations, and
 - Fraudulent use of the Enrollee ID card.



2. MHPFL will promptly submit such disenrollment requests to the Agency or its Choice Counselor/Enrollment Broker, as specified by the Agency. In no event shall MHPFL submit the disenrollment request at such a date as would cause the disenrollment to be effective later than forty-five (45) calendar days after MHPFL's receipt of the reason for involuntary disenrollment.
3. MHPFL may submit an involuntary disenrollment request to the Agency or its Choice Counselor/Enrollment Broker, as specified by the Agency, after providing to the Enrollee at least one (1) verbal warning and at least one (1) written warning of the full implications of his or her failure of actions:
 - For an Enrollee who continues not to comply with a recommended plan of health care. Such requests must be submitted at least sixty (60) calendar days prior to the requested effective date.
 - For an Enrollee whose behavior is disruptive, unruly, abusive or uncooperative to the extent that his or her Enrollment in MHPFL seriously impairs the organization's ability to furnish services to either the Enrollee or other Enrollees. This Section does not apply to Enrollees with mental health diagnoses if the Enrollee's behavior is attributable to the mental illness.
4. The Agency may approve such requests provided that MHPFL documents that attempts were made to educate the Enrollee regarding his/her rights and responsibilities, assistance which would enable the Enrollee to comply was offered through case management, and it has been determined that the Enrollee's behavior is not related to the Enrollee's medical or behavioral condition. All requests will be reviewed on a case-by-case basis and subject to the sole discretion of the Agency. Any request not approved is final and not subject to dispute or appeal.
5. MHPFL shall not request disenrollment of an Enrollee due to:
 - Health diagnosis;
 - Adverse changes in an Enrollee's health status;
 - Utilization of medical services;
 - Diminished mental capacity;
 - Pre-existing medical condition;
 - Uncooperative or disruptive behavior resulting from the Enrollee's special needs (with the exception of C.3.f.(2) above);
 - Attempt to exercise rights under the Health Plan's Grievance System; or Request of one (1) PCP to have an Enrollee assigned to a different Provider out of the Health Plan.

Membership ID Card

The Membership ID Cards Medica Health Plans of Florida issues to members are for identification purposes only. Members should carry the card with them at all times and should present the card every time they receive health services. Possession of a Membership ID Card confers no right to services or benefits. To be entitled to services or benefits, the member must be an individual whom DCF, or the Social Security Administration on behalf of the DCF, determines is eligible, pursuant to federal and State law, to receive medical or allied care, goods or services and who is enrolled in the Medicaid program and MHP – FL. Any person receiving services or benefits, for which they are not entitled, will be responsible for all costs of such services or benefits.

Sample ID Card:

(FRONT)

| | | |
|---|------------|----------------|
|  MEDICA HEALTH PLANS OF FLORIDA Inc. | | EZ CARE |
| Member Name: | Plan Code | |
| Member ID: | Account #: | |
| Group# | | |
| PCP Name: | PCP ID#: | |
| PCP Phone #: | | |
| RxBIN: | RxPCN: | |
| RxGrp: | | |
|  | | |
| THIS CARD IS FOR IDENTIFICATION ONLY AND DOES NOT GUARANTEE COVERAGE. | | |

(BACK)

| | |
|--|---|
| <u>Member Information</u> | |
| Member Services: | (305) 421-1228 or (877) 690-7783 |
| Member Services TTY: | (305) 421-1251 or (800) 517-6923 |
| For the following Covered Services, please call the numbers and submit claims directly to the providers below. | |
| Atlantic Dental | 1-800-964 - 7811 |
| Mental Health - COMPCARE | 1-877-224-0971 |
| Transportation Services | 1- 888 - 542-6635 Broward |
| | 1- 866-726 -1457 Miami -Dade |
| Rx Coverage: ANY PARTICIPATING MEDICAID PHARMACY | |
| <u>Provider Information:</u> | |
| Prior Authorization and Eligibility: (305) 421-1220 or (866) 273-9444 | |
| <u>Claims Information:</u> | |
| Medica Health Plans of FL, Inc. PO Box 14-5330, Coral Gables, FL 33114-5330 | |
| Visit us at: www.ezcarehpf.com | |

Chapter 5: Primary Care Physicians & Specialty Care

Primary Care Physician (PCP)

The Health Plan believes in a strong Primary Care Physician (PCP) and patient relationship based on trust and respect. One of Medica Health Plans of Florida's goals is to reinforce this concept and emphasize the importance of it. The role of the primary care physician as a care giver and coordinator is essential to the overall management of the enrollee's health care.

A listing of all participating PCPs is available to enrollees in the **E Z CARE** Provider Directory as well as hospitals and other healthcare providers who have agreed contractually to render covered benefits and services in accordance with this Provider Handbook and with the Florida Medicaid Coverage and limitations Handbooks and the Florida State Plan. (REFERENCE www.ezcaremhpf.com and <http://floridamedicaid.acs-inc.com>, then click on Provider Handbooks). The Health Plan 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 the Health Plan and that the provider's submission of encounter data is accepted by the Florida MMIS and/or state's encounter data warehouse.

Health care providers that contract with **the Health Plan** are referred to as participating providers. For certain types of medical procedures, Physician Assistants, Nurse Practitioners, and or/or Nurse Midwives or other individuals who are not licensed physicians may provide services.

In addition, Primary Care Physicians (PCP) are responsible, but not limited to, actively participating in delivering or coordinating the overall health care of E Z CARE members. In carrying out that responsibility the PCP is accountable for the following coordination of care components:

- Serves as the provider and care manager (commonly referred to as the "gatekeeper") of the member's health care. As the focal person of contact, the PCP functions as a resource and consultant for all health care services provided to an Enrollee.
- Treat all medical problems within your level of expertise and coordinate and manage all covered medical services.
- Keep a complete medical record for each individual member. Individual records should contain all relevant information about medical and other services performed by all providers. This includes a complete current medical history with notations for allergies, medications, diagnostic work-ups, treatments, and follow-up. All records should be well organized and legible.
- Each member should have access to all information in his/her medical records.
- Comply with the Medica Health Plans of Florida Referral Authorization Request Process **before** sending a **E Z CARE** member to another provider.
- Promoting health care maintenance for the treatment of illness and injury early detection of disease
- Practicing preventive pediatric and adult health care consistent with the requirements of the Child Health Check Up Program (CHCUP) and periodic health evaluations for adults

- Family Planning Services
- Issuing Referrals to specialists within the E Z CARE Provider Network when applicable and medically appropriate
- Agree to accept new patients during the term of your contract with MHPFL **E Z CARE** consistent with at least (1) FTE per 1,500 enrollees.
- Be accessible (24) hours per day, seven days a week and keep an after-hours answering service that is accessible using the daytime telephone number. After hours calls must be answered within (30) minutes of the initial contact.
- Have a flexible appointment schedule to respond to the severity of patients' illnesses as follows:

| | |
|-----------------------------------|-----------------------------|
| Urgent Care: | within one (1) day |
| Routine Sick Patient Care: | within one (1) week |
| Well Care Visit: | within one (1) month |

- Agree to arrange for coverage of primary care services during absences due to vacation, illness or other situations through a Medicaid eligible PCP.
- Submit Referral Requests for prior authorization to MHPFL Medical Management Department approval.
- Notify MHPFL Department of Network Development of any provider information changes, i.e. address, malpractice insurance, new provider being added to group.
- Following termination, PCP shall agree to allow members in active treatment to continue their care when such care is medically necessary and until the member elects another treating PCP or during the next open enrollment period for a period not to (6) months after the termination of the contract.
- Perform Child Health Check-Up Program (CHCUP) when medically indicated for children 20 years of age and younger which consists of a comprehensive health and developmental history, including assessment of past medical history, developmental history and behavioral health status; comprehensive unclothed physical examination; developmental assessment; nutritional assessment; appropriate immunizations according to the appropriate Recommended Childhood Immunization Schedule for the United States; laboratory testing (including blood I lead testing); health education (including anticipatory guidance); dental screening (including a direct referral to a dentist for Enrollees beginning at three (3) years of age or earlier as indicated); vision screening, including objective testing as required; hearing screening, including objective testing as required; diagnosis and treatment; and referral and follow-up as appropriate.
- Participate in the Vaccines for Children Program (VFC) as administered by the Department of Health, Bureau of Immunizations and ensure an adequate supply of vaccines at all times. **Note:** The most current immunization periodicity schedule is available on the Internet at www.cdc.gov/nip. **(Click on publications.)** Providers may also obtain the current schedule from their County Health Departments. The CDC's National Immunization Information Hotline is 1-800- 232-2522 and in Spanish is 1- 800-232-0233.
- Collect and submit Encounter Data for enrollees to include service level encounter data for all covered services in the format and in the time frames required by MHP – FL.
- Notify the health plan of an enrollee's pregnancy, whether identified through medical history, examination, testing, claims, or otherwise

Additional PCP Responsibilities:

- Lead Poisoning Screening is required for children at ages twelve (12) and twenty-four (24) months and in addition, children between ages twenty-four (24) months and seventy-two (72) months if there is no previous record of a previous test.
- HIV counseling and offer HIV testing to all women of childbearing age. Pregnancy Test for all women of childbearing if indicated, and refer all pregnant women to OB-GYN specialist.
- Report all HBsAG-positive (pre-natal or post-partum) women to the local CHD and to Healthy Start regardless of their Healthy Start Score with DH Form 2136.
- Maintain in member's chart all documentation of Healthy Start screening, assessment, findings and referrals and ensure quick access.
- Complete WIC Program Medical referral program for all eligible pregnant women or children and subsequent WIC certification with current height and weight taken within the last 60 calendar days, Hemoglobin or Hematocrit, any identified medical/nutritional problems. WIC Eligibility Requirements and DH Form 3075.
- Provider will attempt to contact all new Medicaid patients 21 years of age or older to perform an Adult Health Screening if a screening is due.
- Issue referral for routine screening mammography as recommended by the American Cancer Society for all females age 35 and older.
- Provider shall provide family planning services for the purpose of enabling members to make comprehensive and informed decisions about family size and/or spacing of births. Provider shall provide the following services: planning and referral, education and counseling, initial examination, diagnostic procedures and routine laboratory studies, contraceptive drugs and supplies, and follow-up care in accordance with the Medicaid Physicians Services Coverage and Limitations Handbook.

OB-GYN Provider Duties and Responsibilities:

- If the provider knows the recipient is pregnant and Medicaid eligible and that her unborn child does not have a Medicaid ID number, the provider may have the newborn assigned a number by sending a **CF-ES 2039, Medical Assistance Referral Form**, to the Department of Children and Families district office to request that a Medicaid-eligible newborn be added to the eligibility file on an expedited basis. The forms are available from the district Department of Children and Families office. Provider should also send a copy of the form to MHP – FL Medical Management Department.
- Complete Florida Healthy Start Risk Screening Instrument- **DH Form 3134**. Refer member for services regardless of score based on factors other than score if done at time of screening, or if such determination is made subsequent to risk screening. Refer member 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 violence.
- Complete WIC Program Medical referral program for all eligible pregnant women and subsequent WIC certification with current height and weight taken within the last 60 calendar days, Hemoglobin or Hematocrit, any identified medical/nutritional problems. **WIC Eligibility Requirements and DH Form 3075**

- Offer all pregnant members HIV counseling and HIV testing at initial prenatal care visit and again at twenty-eight and thirty-two weeks and obtain a signed objection if a pregnant woman declines an HIV test.
- Counsel all pregnant women who are infected with HIV and offer the latest antiretroviral regimen as recommended by the U.S. Department of Health and Human Services.
- Ensure that all pregnant women are tested for Hepatitis B surface antigen (HBsAg) during first pre-natal visit and a second HBsAg test is performed between twenty-eight and thirty two weeks of pregnancy for members who tested negative at first visit and are considered high-risk for Hepatitis B infection.
- Report all HBsAG-positive (pre-natal or post-partum) women to the local CHD and to Healthy Start regardless of their Healthy Start Score with **DH Form 2136**.
- Providers (**OB GYN** and attending Pediatrician) have to ensure that infants born to HBsAG positive women receive Hepatitis B Immune Globulin (HBIG) and the Hepatitis B vaccine once physiologically stable, preferably within twelve (12) hours of birth and shall complete the Hepatitis B Maxine series according to the recommended vaccine schedule established by the Recommended Childhood Immunization Schedule for the United States.
- Schedule return prenatal visits at least every four (4) weeks until the thirty-second (32nd) week, every two (2) weeks until the thirty-sixth (36th) week, and every week thereafter until delivery. Post partum examination within six (6) weeks after delivery. Refer non-compliant members to Medical Management Department for follow-up by the OB Case Manager.
- Screen all pregnant members for tobacco use.
- Refer Enrollees for smoking cessation counseling and appropriate treatment as needed by contacting MHP – FL Medical Management Department. For **Quick Reference Guide** to assist in identifying tobacco users and supporting and delivering effective Smoking Cessation interventions.
- Supply nutritional assessment and counseling to all pregnant Enrollees.
- Refer all enrollees with positive HIV or Hepatitis B values to MHP – FL Medical management Department

Pediatrician Provider Duties and Responsibilities:

- Complete Florida's Healthy Start Infant (Postnatal) Risk Screening Instrument (**DH Form 3135**) and submit completed Form with certificate of live birth to CHD of county in which the infant was born within ten (10) business days of completion. Provider is to retain one copy in member's Medical Record and provide a copy to the member.
- Test infants born to HBsAg positive mothers for HBsAG and Hepatitis B surface antibodies (anti-HBs) six (6) months after the completion of the vaccine series to monitor the success or failure of the therapy.
- Report to local CHD a positive HBsAg result in any child aged twenty-four (24) months or less within twenty-four (24) hours of receipt of the positive test result. **Form DH 2136**.
- Infants born to HBsAg-positive women have to be referred to Healthy Start (**DH Form 3135**) regardless of their Healthy Start screening score as well as to the Perinatal Hepatitis B Prevention Coordinator at the local CHD.

- Because any necessary Newborn and infant hearing screenings have to be referred to licensed audiologists with documented newborn hearing screening training under direct or indirect supervision by licensed physician or licensed audiologist., refer Newborn Audiology examinations to participating provider.
- Complete WIC Program Medical referral program for all eligible children and subsequent WIC qualification with current height and weight taken within the last 60 calendar days, Hemoglobin or Hematocrit, any identified medical/nutritional problems. **WIC Eligibility Requirements and DH Form 3075**
- Lead Poisoning Screening is required for children at ages twelve (12 and twenty-four (24) months and in addition, children between ages twenty-four (24) months and seventy-two (72) months if there is no previous record of a previous test. Refer any member with abnormal levels of lead to **MHP – FL Medical Management Department.**
- Notify the health plan of an enrollee's pregnancy, whether identified through medical history, examination, testing, claims, or otherwise

Chapter 6: Quality Improvement (QI)

The Quality Improvement Program (QI) has been developed consistent with all regulatory requirements of the Agency for Health Care Administration (AHCA), the Centers for Medicaid and Medicare Services (CMS) and the accreditation organization. It has been created to ultimately have a definitive process that ensures Medica Health Plans of Florida's provision or the arrangement for the provision of optimum quality health care through processes, structures and data management systems.

Medica Health Plans of Florida's Medical Director, as the Program's chairperson, is charged with the responsibility of the overall function of the Quality Improvement Program and is accountable for the Quality Improvement, credentialing, risk management and utilization management functions for Medica Health Plans of Florida; Other management staff and Network providers of Medica Health Plans of Florida, Inc. are active participants in the QA program as well. They are an essential component in assessing the health care and services provided to members and in recommending improvement initiatives as needed. Participants in the QA Program will assist in identifying, planning, evaluating and monitoring processes and outcomes related to member care and services. The Quality Improvement Committee (QIC) and subcommittees, consisting of the Appeals/Grievance Committee, Peer Review, Compliance, P & T and credentialing are responsible for the implementation and operations of the Quality Improvement Program.

The QA program monitors, trends, evaluates all components of Medica Health Plans of Florida Inc. health care delivery system and the full range of its services. The scope of the QA program includes but is not limited to:

- ❖ Evaluation of clinical performance. (Peer Review)
- ❖ Review of medication usage.
- ❖ Evaluation as to appropriate use of tests and studies and other health services.
- ❖ Evaluation of subscriber grievances.
- ❖ Evaluation of outcomes of care using evidence based clinical practice guidelines to evaluate patient care patterns and clinical performance for health services provided by means of medical record reviews.
- ❖ Written procedures for taking appropriate corrective action whenever, as determined under the Quality Improvement Program, inappropriate or substandard services have been provided or omitted.
- ❖ All findings, conclusions, recommendations, actions taken are documented and reported to the Board of Directors.
- ❖ Monitoring outcomes of Performance Measures, i.e. HEDIS and AHCA-defined measures against benchmarks; initiating performance action plans as needed.
- ❖ Monitoring compliance with the health plan's Cultural Competency Plan.
- ❖ Monitoring and evaluation of the quality of service which includes the availability of services (access to providers, appointment procedures), the accessibility of services (telephone systems, Member Services, Medical Management) and the acceptability by the member of these services.
- ❖ Establishing a system using measurable criteria to identify, prioritize and implement improvements to the quality of care and services.
- ❖ Monitoring and assessing acute, chronic and preventative health care utilization patterns for the identification of quality improvement projects.

- ❖ Complying with Medica Health Plans of Florida's Credentials/Retention program and facility/Subcontractor Credentials/Retention program to determine that all providers meet standards established by Medica Health Plans of Florida, Inc.
- ❖ Monitoring member satisfaction with the administration of Medica Health Plans of Florida's health care benefits and network of contracted Providers
- ❖ Evaluation of adverse incidents (risk management) to improve outcomes by implementing process improvement/prevention initiatives.

Credentialing

Medica Health Plans of Florida, Inc. has a credentialing and recredentialing program in place that complies with all applicable laws of the State of Florida as well as Federal laws. In addition, the credentialing and recredentialing program of Medica Health Plans of Florida, Inc. is designed to meet or exceed the stringent requirements established by selected accreditation agencies.

All providers of health care applying to contract with Medica Health Plans of Florida, Inc. are required to complete Medica Health Plans of Florida's credentialing process prior to rendering services to members. The credentialing process is a process designed to evaluate the quality, education, training and certifications of health care providers. Applicants not meeting the credentialing and recredentialing standards set by Medica Health Plans of Florida, Inc. are not accepted to participate as contracted providers. All providers approved for participation are closely monitored using Quality Improvement mechanisms and are recredentialed usually every three years. Providers failing to meet credentialing and/or other quality standards, including professional conduct, during their participation term may be subject to a reduction, suspension, or termination of practice privileges and/or other form of disciplinary action believed to be in the best interest of the health plan's membership. By law, Medica Health Plans of Florida, Inc. is required to report to the National Practitioner Data Bank (NPDB), and/or to the Health Integrity and Protection Data Bank (HIPDB), and/or to the appropriate State Licensing Agency the names and any other relevant information required by law regarding (a) practitioners declined participation or terminated for reasons related to professional competence or conduct; (b) practitioners whose clinical privileges are adversely affected for a period longer than 30 days if the adverse action is based on the practitioner's professional competence or conduct; and (c) practitioners who surrender clinical privileges (i) while under investigation for reasons related to professional competence or conduct, or (ii) in return for no investigation being conducted. Other laws may also require Medica Health Care Plans of Florida to submit reports to State and Federal agencies specific to a particular health care provider.

In order to be participants of Medica Health Plans of Florida, Inc. and continue active participation, all practitioners must meet the following credentialing standards:

- ❖ Complete, sign and date a credentialing application, and usually within three years after initial credentialing approval, complete sign and date a recredentialing application.
- ❖ Maintain an active license to practice in the State of Florida in the area of services to be provided lacking restrictions, limitations, conditions or other disciplinary activity warranting denial of participation.
- ❖ If contracting as a specialty provider, be certified by a specialty board acceptable to the health plan, or have completed a residency program approved by the Accreditation Council for Graduate Medical Education (ACGME) or by the American Osteopathic Association (AOA), followed (if applicable) by any required additional training (e.g., a fellowship program) in the area of services to be provided.
- ❖ If applying as a primary care physician under the disciplines of family medicine, internal medicine, pediatrics, or obstetrics and gynecology, be certified by a specialty board acceptable to the health plan, or have completed a residency training program approved by the Accreditation Council for

Graduate Medical Education (ACGME) or by the American Osteopathic Association (AOA) in the areas of family medicine, internal medicine, pediatrics or obstetrics and gynecology.

- ❖ If applying as a General Practitioner Primary Care Physician (except pediatrics) or General Practitioner Home Health Physician be (1) a graduate of a medical school recognized by the Foundation for Advancement of International Medical Education and Research (FAIMER), or by the Liaison Committee on Medical Education (LCME), or by the American Osteopathic Association's Commission on Osteopathic College Accreditation (AOA-COCA); and (2) meet all other criteria for participation adopted by Medica Health Plans of Florida for General Practitioners, including additional certifications, hospital staff privileges, experience and current competency.
- ❖ Practitioners who are not MDs or DOs must meet all education, certification and training requirements imposed by the State of Florida for licensure in the practitioner's discipline.
- ❖ Maintain a DEA or CDS certificate, if applicable.
- ❖ If servicing Medicaid recipients, maintain an active Florida Medicaid provider number and meet the requirements established by Section 435.03, F.S.
- ❖ If servicing Medicaid recipients, maintain an active Florida Medicaid provider number.
- ❖ Practice his/her profession in a manner which is not substantially oriented toward clinically unsound, experimental or unproven or otherwise inappropriate modalities of treatment.
- ❖ Consent to participate in Medica Health Plans of Florida's utilization review and quality improvement programs.
- ❖ Allow practice-site evaluations, as applicable.
- ❖ Demonstrate capability of providing health care services to the enrollees.
- ❖ Lack history of denial or cancellation of professional liability insurance warranting denial of participation.
- ❖ Maintain professional liability insurance in the amounts acceptable to the health plan, or be in compliance with the financial responsibility requirements established by the State of Florida.
- ❖ Lack restrictions, limitations, conditions, dismissal or other disciplinary activity imposed by any state, federal, or other government agency, association, hospital, payer (including Medicare and Medicaid) or any other entity warranting denial for participation.
- ❖ Remain free of sanctions imposed by CMS or AHCA during the participation term with the health plan warranting participation denial.
- ❖ Consent to comply with Medica Health Plans of Florida's policies and procedures.
- ❖ Have an established or plan to establish an office meeting the plan's quality criteria and service needs within an area serviced by the plan, if applicable.
- ❖ Maintain on-call coverage arrangements.
- ❖ Establish a network or maintain an observed pattern of referrals primarily to participating providers.
- ❖ Provide services primarily of the type covered by the health plan benefit contracts and/or of the type for which the health plan is providing or arranging administrative and/or managed care services.

- ❖ Meet any other criteria adopted by Medica Health Plans of Florida at the time the application is processed or during the participation term.

Organizations contracting to provide health care services to members of Medica Health Plans of Florida, Inc. are also required to be credentialed prior to providing services to any member. Organizations are also recertified usually every three years. In order to be participants of Medica Health Plans of Florida, Inc. and continue active participation, all organizations must meet the following credentialing standards:

- ❖ Maintain current license(s) and/or certification(s) required by State, Federal and local governments for the operation of the facility lacking restrictions, limitations, conditions or other disciplinary activity warranting denial of participation.
- ❖ Complete, sign and date a credentialing application and usually within three years after initial credentialing complete sign and date a recertification application.
- ❖ Be in good standing with state and federal regulatory bodies.
- ❖ If rendering services to Medicaid recipients, maintain active participation in the Florida Medicaid Program and meet the requirements established by Section 435.03, F.S.
- ❖ Consent to participate in the plan's utilization review and quality improvement programs.
- ❖ Lack history of denial or cancellation of professional liability insurance warranting denial of participation.
- ❖ Have active accreditation issued by a major accrediting organization acceptable to Medica Health Plans of Florida, Inc. or pass an on-site inspection conducted by Medica Health Plans of Florida, Inc.
- ❖ Maintain professional liability insurance and commercial general liability insurance in the amounts acceptable to the plan.
- ❖ Meet any other criteria adopted by Medica Health Plans of Florida at the time the application is processed and during the participation term.
- ❖ Lack restrictions, limitations, conditions, or other disciplinary activity imposed by any state, federal, or other government agency, association, hospital, payer (including Medicare and Medicaid) or any other entity warranting denial for participation.
- ❖ Remain free of sanctions imposed by CMS or AHCA during the participation term with the health plan warranting participation denial.
- ❖ Consent to comply with Medica Health Plans of Florida's policies and procedures.
- ❖ Allow practice-site evaluations, as applicable.
- ❖ Demonstrate capability of providing health care services to the enrollees.
- ❖ Maintain ownership, leadership and a workforce of individuals and/or entities that remain free of sanctions from State and Federal agencies (including CMS and AHCA) warranting participation denial.
- ❖ Maintain a professional staff fully qualified and licensed to provide services to the plan's membership meeting the utmost quality and service.

Medical Records

Confidentiality and accuracy of a subscriber's medical record must be maintained at all times. The privacy of any information that identifies a particular member must be safeguarded. Information from or copies of a subscriber's medical record may only be released to authorized individuals. Physicians and other healthcare providers must ensure that unauthorized individuals cannot gain access to or alter a subscriber's medical record. Original medical records may only be released in accordance with state laws, court orders or subpoenas, and timely access by members to the information that pertains to them must be ensured. Additionally, physicians, other health care providers and Medica Health Plans of Florida, Inc. must abide by all federal and state laws regarding confidentiality and disclosure of mental health records, medical records and other health and member information. Upon request of a member or the member's legal representative, health care providers are required to furnish, in a timely manner, without delays for legal review, copies of all reports and records relating to examination or treatment, including x rays, and insurance information. Psychiatric, psychological or psychotherapeutic records may be provided in a report in lieu of copies of records.

However upon the patient's written request, complete copies of the patient's psychiatric records shall be provided directly to a subsequent treating psychiatrist. The furnishing of such report or copies shall not be conditioned upon payment of a fee for services rendered.

Participating providers shall maintain a medical records system which are consistent with professional standards and which permits prompt retrieval of information and provides legible and timely information accurately documented and readily available to appropriate or authorized health care practitioners.

Flow sheet templates for diabetes and preventative health care have been provided (Section VII) where physicians can note dates and results of office exams, lab work, immunizations and health care education/counseling. The uniform practice guidelines can assist the physicians in managing timely health care services, allowing for better outcomes.

Medical Record Audit

Medical Record Audits may be conducted by Medica Health Plans of Florida at the time of the provider's application to participate with Medica Health Plans of Florida, and periodically thereafter.

Providers of healthcare contracting with Medica Health Plans of Florida are expected to follow and meet applicable medical record standards adopted by Medica Health Plans of Florida and in accordance with the accreditation organization's standards.

Medical Record Standards

The following medical record processes and record elements are considered essential:

STANDARDS

1. Medical records must be located away from public access
2. The office must have a procedure to ensure staff follows confidentiality rules.

Guide:

- The office ensures that all staff is aware of patient confidentiality rules.
- Staff signs a confidentiality agreement upon hiring.

- The office has a designated person in charge of medical records, collecting, processing, maintenance, protection against tampering, loss or destruction, storage retrieval, distribution and retention/retirement of records.

3. The medical record system is consistent with professional standards and permits prompt retrieval of information and provides legible and timely information accurately documented and readily available to appropriate or authorized health care practitioners.

Guide:

- Whether electronic or hardcopy, the medical record must allow for the prompt retrieval of information.
- Medical records (hardcopy or electronic) must be stored in a systematic order (e.g., alphabetized and filed in a secured space).
- There should be a backup procedure for records stored electronically (note password protection and levels of security for reading and/or updating record).
- There is a policy & procedure for the release of medical records.
- There is a policy & procedure regarding retention of active records and retirement of active records.

4. Patient charts must have identifying information.

Guide:

- Patient charts must have the name of the patient, member identification number, date of birth, sex, and responsible party, if applicable.

5. The medical record is complete and organized.

Guide:

- The medical record must be complete – all required documentation present and filed timely.
- All documents in the chart should be secured.
- The physical condition of the chart should be clean.

6. Consistency in medical recordkeeping is present.

Guide:

- The office must follow a consistent organization pattern for all medical records.

7. Personal/biographical data must include address, marital status, primary language spoken, employer, home and work phone numbers and responsible party, if applicable.

Guide:

- The information must be current.
- The information must be legible and complete.
- There is a system in place for updating information on a regular basis.

8. Entries in the medical record must be signed **and dated** by the author.

Guide:

- All entries relative to patient care are consistently signed or initialed by the author and dated. The author must include his/her professional credentials with his/her signature/initials (e.g., MD, DO, RN, etc).

9. The record must be legible to two readers other than the author.

Guide:

- The auditor and another person can read entries in the medical record.

10. A problem list is present in the medical record showing significant illnesses and medical conditions.

Guide:

- The list must be consistent with current and past problems, updated as new problems arise.
- Dates of onset and resolution must be present.

11. The record must contain a listing of current medications.

Guide:

- A listing, showing current medications taken by the patient must be present.

12. Allergies and adverse reactions to medications must be prominently noted in the record. It is explicitly stated if the patient has no allergies or adverse reactions.

Guide:

- This information should be instantly available, either on front of the chart, on the problem list, or on every patient encounter form and updated as needed when allergies are suspected.
- The information must be prominently noted.
- Each encounter should address allergies and adverse reactions and updated whenever new allergies are identified.

13. Past medical history should include a detailed medical, surgical and social history. Accidents must also be documented. History for children and adolescents should also include prenatal care and birth information.

Guide:

- There should be a specific office form, completed by the patient or parent, to assist the physician in gaining complete information about the patient.
- The history should contain a detailed medical, surgical and social history, current medications and allergies and incorporated in the record.
- Ideally, there should be an "Initial Encounter Form" in place, completed by the physician detailing clarification of information given by the patient.

14. For patients 14 years and over there is documentation about the current use of alcohol, tobacco and other substances.

Guide:

- The physician should assess and document patient's use of alcohol, tobacco, and other substance abuse on initial assessment.
- If not documented by the physician, information should be found on the completed patient history form.
- Information should be updated on all well checkups and on every encounter if substance abuse is the cause or a contributing factor to current physical complaints.

15. The history and physical documents appropriate subjective and objective information for the presenting complaints.

Guide:

- The beginning of the progress note should have a statement regarding why the patient is there, including onset and duration of problem and what treatments have been tried.
- Objective data should include vital signs and a complete examination of affected/related systems and mental health status, as well as negative findings
- The physician should document all physical findings.

- Include screening appropriate to patient's age.
- Pediatrics: H&P includes developmental assessments, nutritional status, breast feeding if applicable and scheduled well visit child check-ups (CHCUP), including newborns.

16. Clinical research entries are clearly documented as to diagnosis and to intervention.

Guide:

- Documentation addressing “**clinical research**” treatment for a specific condition needs to be prominently noted.

17. Laboratory, diagnostic procedures, consultations and referrals are ordered, as appropriate, based on diagnosis and recorded adequately and timely.

Guide:

- Appropriate labs, including screenings and other diagnostic studies are done.
- Periodic labs for specific diseases and medication monitoring are performed appropriately.
- Routine laboratory tests and exams are ordered according to age-sex specific guidelines (i.e., part of an annual exam or preventive screening).
- Follow-up of abnormal labs and diagnostic test are ordered as necessary.
- Pediatrics: lead screening [12m, 5y and high risk]; eye and ear screenings [through age 17y]; WIC referrals as needed.
- Record the patient's involvement in a community program when appropriate.

18. Working diagnoses are consistent with findings and chief complaint.

Guide:

- The physician should do an adequate exam and documentation to clearly indicate compliance, findings and his/her impression.
- Appropriate supporting laboratory data and other testing should be ordered.
- Diagnostic tests should sufficiently support or rule out diagnosis.

19. Treatment plans are consistent with diagnoses and approved clinical practice guidelines.

Guide:

- A treatment plan is essential for the implementation of a course of therapy/treatment to assure appropriate care for acute, chronic and preventive care.
- Treatment plans should be updated at every encounter.
- Treatment plans should contain a plan for the diagnosis, care, therapies administered and prescribed, disposition, recommendations, instructions and follow-up of each noted condition should be reviewed against approved national care guidelines.
- Confirm Florida's Health Start Prenatal Risk Screening; pregnant patient as part of first prenatal visit.

20. Unresolved problems from previous visits are addressed in subsequent visits.

Guide:

- Physician follows up with previous problems by documenting that those problems have been re-addressed or resolved.
- There is evidence in the chart that the physician is aware that there are ongoing, unresolved problems.

Guide:

- A copy of the consultant's findings and recommendations, including plan of treatment and follow-up needs, are included in the medical record.
- The report is signed or initialed by the referring physician when it is reviewed.
- There is documentation if the member did not go to the consultant.

22. Summaries of health records of other physicians, hospitals, surgical centers, and/or SNFs are part of the record.

Guide

- The medical record will contain summaries or health records when other physicians, hospitals, surgical centers and/or SNFs when applicable.

23. Continued care summaries are documented when transfer occurs to another Practitioner, when applicable.

Guide:

- The record should include a summary of the member's record when there is transfer to another practitioner to continue care.
- Confirm the office's policy regarding medical record summaries for transferred members.

24. Consultation, lab and imaging reports are initialed by the physician signifying review. **Pediatrics:** Lead Screening. **OB/GYN:** Pregnancy test; HIV, HBsAG & Syphilis at at first pre-natal visit.

Guide:

- All lab work and radiology reports have been initialed by the physician, preferably with a date of review included.

25. Outcome of services is appropriate

Guide:

- Documentation supports result(s) of treatment plan(s).

26. The disposition of the case, recommendations and instructions to the patient and the outcome of services must be documented. Risks of surgery/treatment, alternative treatment and instructions to the patient and the outcomes of services must be documented appropriately. There is evidence that the patient assisted in care and treatment decisions.

Guide:

- The record must contain documentation regarding the disposition of the case and any recommendations and instructions given to the patient, including risks of recommended surgery/treatment. The record must also reflect the outcome of the services.
- Evidence that the patient assisted in care and treatment decisions.

27. Records transferred from other providers (e.g., PCPs, consultants, specialists, ER visits, hospitalizations) are contained in the medical record within 30days of service.

Guide:

- Records are present, date of receipt recorded and filed in an orderly fashion.
- A signed medical release form should be present.

28. Consultation and abnormal lab and imaging study results have an explicit notation in the record of follow-up plans.

Guide:

- Consultations and abnormal lab results should have specific note, either in the progress notes or on lab/imaging study of plan for follow-up. Ideally, this should be noted between encounters in progress notes.
- If office staff documented abnormalities, physician must initial plan.

29. Significant and/or recurrent diagnostic and therapeutic problems are followed-up in a timely manner to eliminate or reduce risk to patient.

Guide:

- The physician should order appropriate diagnostics in a timely manner according to the patient's individual problems.
- The physician should monitor the patient on a regular and appropriate basis for identified problems.

30. An immunization record is present for all children. Adults whose age or health status requires flu or pneumovax, hepatitis B and rubella have immunization status noted.

Guide:

- Current, up-to-date immunization record is present for children, adolescents and adults, based on age and required number on immunizations.
- Adult immunization record of pneumovax (if known), flu vaccine annually for appropriate immune compromised patients, hepatitis B for high risk, rubella for women of child bearing age, and tetanus vaccine within the past 10 years; or a record of exemption or refusal of immunization is present with signature from patient or parent.

31. Preventive screening and counseling is offered and recorded in accordance with the health plan's clinical practice guidelines and Quality Enhancement Programs.

Guide:

- The physician should document and date all preventive screening and counseling done or offered to patient, including well checkups for all ages.
- The physician should do appropriate screenings in a timely manner, according to age/gender appropriate expectations.
- Document compliance with Quality Enhancement Programs, as applicable

32. All services provided by the providers and education provided is recorded regarding diet, exercise, safe sex, domestic violence , substance abuse, tobacco cessation and stress management, when applicable.

Guide:

- When applicable, the record will document education to promote the following holistic approaches to health care:
 - ✓ Healthy eating
 - ✓ Physical fitness
 - ✓ Healthy sex, to include contraception, and disease prevention
 - ✓ Domestic violence counseling and referral
 - ✓ Smoking cessation education and referral
 - ✓ Substance abuse education and referral
 - ✓ Stress management and relaxation

33. There is evidence that the member was provided with information regarding advanced directives.

Guide:

- For all patients over age 18, the record must contain documentation of the existence of an advance directive. If the patient has not executed an advance directive, the record must reflect that the patient does not have an advance directive. If the record reflects that the patient has an advance directive, the advance directive must be part of the individual's medical record.

34. Missed and cancelled appointment are followed-up appropriately

Guide:

- The physician, Office Manager and/or Physician Assistant should record and date in the progress notes acknowledgement(s) of missed appointments and to show proactive steps to contact the member to reschedule the appointment.

35. Significant timely telephone advice is documented.

Guide:

- The physician should record and date telephone advice to patient or designated family member detailing the conversation in the progress notes.

Access to Care

Medica Health Plans of Florida, Inc. operates in a defined geographic service area. It is within the service area that Medica Health Plans of Florida offers comprehensive health care benefits for eligible members. Medica Health Plans of Florida must maintain a network of contracted physicians and other health care professionals and providers to meet access standards within the designated service area. Medica Health Plans of Florida, Inc. must ensure that all covered services are available and accessible through a network of contracted physicians and various other health care professionals and providers, and that all medically necessary services are available 24 hours a day, seven days a week.

Availability of health care providers during normal business hours through an established appointment system and, at a minimum, telephone contact/triage services by health care professionals outside of business hours is required. There must be a provision that patients with appointments have a professional evaluation within one hour of scheduled appointment time. If a delay is unavoidable, the patient shall be informed and provided an alternative. In the event that members must be seen outside of normal business hours, there must be provisions for referring the patients in an expeditious fashion to a health care/emergency facility within reasonable time and distance. Therefore, provision of "after hours" service, particularly for urgent care, is essential if inappropriate utilization of emergency room services is to be avoided. Therefore, the standard that all medically necessary services be available 24 hours a day, seven days a week aims to ensure that:

- The operating hours of provider sites allow for the provision of care to members during normal business hours.
- There is access to care after normal working hours (5 p.m. to 9 a.m.) for those urgent medical events that require attention after hours.
- The hours of operation do not discriminate against Medica Health Plans of Florida, Inc. members relative to other patients.

To accomplish this, Medica Health Plans of Florida, Inc. has established accessibility standards. The accessibility standards for the provision of ambulatory health care services for contracted Primary Care Physician offices and contracted specialists are as follows:

- Emergency: Immediately
- Urgent Care Services: Within 24 hrs.
- Routine Symptomatic cases: Within 2 weeks
- Routine Non - Symptomatic: As soon as possible

Medica Health Plans of Florida, Inc. monitors compliance with these standards on an ongoing basis, and takes appropriate corrective actions as necessary.

Medica Health Plans of Florida, Inc. also ensures that the hours of operation of contracted providers do not discriminate against Medica Health Plans of Florida members, and that services are provided in a culturally competent manner to all enrollees, including those with limited English proficiency or reading skills, diverse cultural and ethnic backgrounds, and physical or mental disabilities.

Chapter 7: Medical Management

The Medical Management Department, (MMD) oversees the medical and administrative requirements of the Health Plan's benefits to ensure equitable access to quality health care and services across the provider network. The Medical Director is responsible for the implementation of the Utilization Management Plan. The (MMD) performs Prospective, Retrospective Utilization Reviews and conducts Population Management Programs. The expertise of the professional health care staff is available to assist with all aspects of the Utilization Management Program.

Medica Health Plans of Florida adopts preventive and non-preventive clinical practice guidelines to assist providers in making decisions about the provision of appropriate health care services for preventive, non-preventive, acute and chronic medical conditions. The clinical practice guidelines adopted by Medica Health Plans of Florida are based on valid and reliable clinical evidence from recognized organizations such as the U.S. Preventative Services Task Force, the American Cancer Society, American Diabetes Association, American College of Physicians, and InterQual ® Level of Care Criteria.

Providers may refer to our clinical care guidelines on our website at www.ezcaremhpf.com.

Case Management

Case management activities assist in the identification of member needs for medical and nonmedical services. A care team assesses, coordinates services with PCPs, develops care plans, and educates, monitors and follows up targeted members considered high risk based on medical and/or mental illnesses. Patients believed to be in need of case management services can be referred to the Director of Medical Management.

Disease Management (DM)

The organization provides DM Programs to members, who have chronic medical conditions such as asthma, HIV/AIDS, diabetes, CHF and hypertension. A team approach is utilized that involves the member's Primary Care Physician, a Care Management Coordinator and a Social Worker. These individuals act as member advocates and will strategize to develop initiatives to best manage the medical condition, to promote member accountability and improve the member's quality of life and functional status.

Members are provided feedback about their progress in meeting goals; primary care physicians are also kept informed on the condition and progress of individual members.

Prior Authorization

With the exception of emergency care and services and some direct access services Medica Health Plans of Florida, Inc. requires that the Department of Medical Management authorize all other outpatient and inpatient health care services prior to such services being rendered.

PCP REFERRALS

All referrals requiring an authorization need to be submitted by the subscriber's PCP directly to Medica Health Plans of Florida' Medical Management Department utilizing the **PCP Referral Form**. The PCP Referral Form is to be utilized by the PCP in all instances in which the member is directed and referred for outpatient care.

The PCP may submit the Referral Form via fax or choose to mail it the same day he/she issues it. **Only** a PCP

may make initial referrals to either contracted network providers, or non-contracted providers when medically appropriate following the appropriate protocols as such:

- Referral Forms are to be completed to the extent required. If the Referral Form is not completed to the extent required, it will be returned to the PCP for completion and re-submission.
- On a **daily basis** Medical Management will review the PCP referrals received for medical appropriateness. If the PCP Referral meets all the pertinent criteria for approval, the Referral will be entered into our computer systems to obtain an **authorization**. The **authorization number** will be clearly noted on the PCP Referral form and the authorized referral will be faxed on a **daily basis** to the pertinent specialty care provider.
- If the referral authorization is denied, the PCP, the treating provider and the member will be formally notified of the denial and the reason for the denial via US mail. Notifications of denial will provide detailed information pertinent to appeals and / or requests for reconsideration.
- All outpatient and inpatient specialty care services, rendered **without prior authorization** will not be covered and claims that may be submitted by the specialty care provider will be denied. Once the specialty provider renders service a consultation report or discharge summary should be sent back to the PCP within 7 days following their encounter with the subscriber.

Inpatient Care Services

With the exception of emergency care and services, inpatient care services require prior authorization. It is the responsibility of the in patient facility to coordinate and obtain prior authorization before services are rendered.

Unauthorized admissions or admissions for which Medica Health Plans of Florida has received late notification, including roll over admissions following emergency care and services, will be denied for coverage.

Unauthorized admissions will be communicated to the PCP once Medica Health Plans of Florida learns of the admission. Such circumstance may be the result of an admission following the member requiring emergency care services or urgent care services in or out of the service area.

Medica Health Plans of Florida will also communicate to the PCP transfers which may occur from the hospital to a Skilled Nursing Facility or to an Inpatient Rehabilitation Facility utilizing the **Department of Children & Family Form CF-MED 3008**.

Concurrent Review

Concurrent review is the process by which the Department of Medical Management and the Department of Hospital Services evaluates the appropriateness and continuity of ongoing care and services being provided to Medica Health Plans of Florida members. Concurrent reviews are conducted by care management coordinators for inpatient services. Generally concurrent review for hospital inpatient care is performed every one to three days from the date of admission through the date of discharge. Concurrent reviews for skilled nursing facilities and rehabilitation are conducted periodically.

The progress notes of concurrent reviews conducted on hospital inpatient care are communicated daily via fax to the PCP for their records and reference (Exhibit B).

The progress notes of concurrent reviews conducted on skilled nursing facilities and rehabilitation are communicated periodically via fax to the PCP for their records and reference (Exhibit B).

Complex and Serious Medical Conditions

Medica Health Plans of Florida, Inc. is required to have in place policies and procedures to identify members with complex or serious medical conditions and to assess, diagnose and monitor those conditions on an ongoing basis. A serious and complex condition is one that is persistent and substantially disabling or life-threatening that requires treatments and services across a variety of domains of care to ensure the best possible outcomes for each unique patient or member. Possible categories of conditions that might be considered serious and complex include, but are not limited to, life threatening conditions, conditions that cause serious disability without necessarily being life threatening, conditions associated with severe consequences, conditions affecting multiple organ systems, conditions requiring coordination of care and management by multiple specialties, and conditions requiring treatments that carry a risk of serious complications. Disease Management Programs are available for HIV, asthma, diabetes, CHF and hypertension.

A treatment plan must be established and implemented that is appropriate to the condition, and allows for an adequate number of authorized direct access visits to specialists to accommodate the treatment plan. The treatment plan must be time-specific and be updated periodically by the Primary Care Physician (PCP) and the Department of Medical Management. Medica Health Plans of Florida Case Managers will work closely with the PCP to identify members with complex or serious medical conditions and to develop appropriate treatment plans and monitor them on an ongoing basis.

Throughout the entire care management strategy for members with serious and complex medical conditions, three principles should be evident. First, the care management strategy should reflect a commitment to continuity and coordination of care. This entails monitoring continuity and coordination activities, analyzing data to identify opportunities for improvement, and taking actions to bring about improvements, as indicated. Second, the care process should include multidisciplinary perspectives and treatments, as appropriate. The care of members with serious and complex medical conditions may require the assessment and treatment expertise of primary care providers; medical and surgical specialists; nurses and nurse specialists; social workers; pharmacists; occupational, speech, and physical therapists; rehabilitation specialists; behavioral and mental health professionals; and community-based services providers and resources. Access to treatment expertise from these various disciplines should be available as needed. Third, patients and their family members should be involved at every step so that the care process incorporates the patient's expectations and preferences and documents the patient's role in achieving treatment goals.

Coordination of services is an essential component of the member's treatment plan.

A health care professional, who may either be the primary care provider, a team of providers, or Medica Health Plans of Florida's Care Management Coordinator and/or Social Worker should have primary responsibility for evaluating the member's needs, recommending and arranging the services required by the enrollee, and facilitating communication and information exchange among the different providers treating the patient/member.

Second Medical Opinions

Requests for second medical opinions are granted to members in any instance in which the member disputes the Health Plan's or the physician's opinion of the reasonableness or necessity of surgical procedures or is subject to a serious injury or illness. The second opinion, if requested, is to be provided by a physician chosen by the member who may select:

- A. A participating physician with the Health Plan; or
- B. A non participating physician located in the same geographical service area of the Health Plan.

For second medical opinions provided by participating physicians, the Health Plan shall pay the amount of all charges, but such charges shall not exceed fees established by contract for covered services. The organization shall pay 60% of the total amount of all charges that are usual, reasonable and customary in the community for second medical opinions performed by non participating physicians and the member shall be responsible for 40% of such amount.

MHP – FL does require that any tests deemed necessary by a non participating as a result of a second medical opinion be conducted by participating providers of the Health Plan.

The participating provider's professional judgment concerning the treatment of a member derived after a second medical opinion shall govern as to the treatment obligations of MHP – FL. Treatment not authorized by MHP – FL shall be at the sole expense of the member.

MHP – FL may deny a member reimbursement rights granted under the second medical opinion protocol in the event the member seeks in excess of three such referrals per year if such referrals are determined by the Health Plan to be evidence that the member has unreasonably over utilized the second opinion benefit.

Chapter 8: Risk Management

Medica Health Plans of Florida has developed and implemented an incident reporting system which identifies quality issues and minimizes risk of injury/incidents to enrollees. The development and implementation of an incident reporting system is based upon the affirmative action duty of all health care providers and all agents and employees of Medica Health Plans of Florida, Inc to report injuries and incidents. All incidents are to be reported to the Risk Manager or Designee within 24 hours of identification of the incident, to allow for submission to AHCA within the required 3 business days.

All incident reports will be reviewed and investigated by the Risk Manager or Designee. This analysis will include the analysis of enrollee grievances which relate to patient care and quality of medical services. The Risk Manager or Designee will work with the appropriate Medica Health Plans of Florida committees to develop recommendations for appropriate corrective actions and/or prevention education. All findings, conclusions, resolutions, corrective actions and follow ups will be reported to the Quality Improvement and Improvement Committee and AHCA will be sent reports as required per Florida Statutes and Administrative rules.

WHAT IS An AHCA MEDICA REPORTABLE INCIDENT?

The following actions/incidents shall be reported to the Risk Manager on an Incident Report:

1. "Adverse or untoward incident" based upon AHCA definition, is an event over which the healthcare personnel could exercise control and:
 - a. Is associated in whole or in part with medical intervention as described below rather than the condition for which such intervention occurred, and
 - b. Is not consistent with or expected to be a consequence of such medical intervention, or
 - c. Occurs as a result of medical intervention for which the patient has not given his informed consent, or
 - d. Occurs as the result of any other action or lack thereof on the part of the facility or personnel of the facility; or
 - e. Results in a surgical procedure being performed on the wrong patient, or;
 - f. Results in a surgical procedure unrelated to the patient's diagnosis or medical needs being performed on any patient including the surgical repair of injuries or damage resulting from the planned surgical procedures, wrong site or wrong procedure surgeries, and procedures to remove foreign objects remaining from surgical procedures; and
- a. **Causes injury as defined:**
 1. Outcomes when caused by an adverse incident; or
 2. Death; or
 3. Brain damage; or
 4. Spinal damage; or
 5. Permanent disfigurement; or
 6. Fracture or dislocation of bones or joints; or
 7. Any condition requiring definitive or specialized medical attention which is not consistent with the routine management of the patient's case or patient's preexisting physical condition; or
 8. Any condition requiring surgical intervention to correct or control; or
 9. Any condition resulting in transfer of the patient, within or outside the facility, to a unit providing a more acute level of care; or
 10. Any condition that extends the patient's length of stay; or

11. Any condition that results in a limitation of neurological, physical, or sensory function, which continues after discharge from the facility.

b. Medica Incidents to be reported

1. Falls or physical compromise
2. Sexual Misconduct/Sexual Harassment
3. Safety Concerns
4. Theft
5. Unprofessional behavior
6. Violence, or threat of violence
7. Property Damage, threat of property damage
8. Death or life altering event
9. Any threat of legal proceeding by member, provider, patient, associate/employee, visitor, agency or other individual.

What is an Incident Report?

This is the **objective** record that is established at the time of awareness of an actual or potential incident/occurrence and records **ONLY** the facts available at the time. Personal opinions or subjective information **is not** to be included in the Incident Report.

The Incident Report provides for specific documentation and is forwarded to the Risk Manager within 24 hours for evaluation, completion, investigation and determination of applicable corrective action plans. Serious Incidents must be reported by phone. The Incident Report is **NOT** copied and is **NOT** placed in the Medical Record or Employee Record. The Incident Report is confidential.

Fraud and Abuse

Medica Health Plans of Florida, Inc has implemented a Fraud and Abuse Program designed to prevent, detect and report activities that seem or are proven to be inconsistent with the standard delivery or receipt of health care services. Medica Health Plans of Florida, Inc is required by law to conduct a full investigation of instances where fraud and abuse activities are suspected. Medica Health Plans of Florida, Inc will report to State and Federal agencies suspected fraud and abuse and cooperate with these agencies during the investigation process.

In the managed care industry fraud is generally defined as an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself/herself or to some other person. It includes any act that constitutes fraud under applicable Federal or State law. Abuse is defined as the practice of a provider that is inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the health care program, or result in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. State and Federal funds (i.e., Medicare and Medicaid funds) paid to a health plan, then used to provide services to patients and reimburse subcontractors (i.e. physicians, hospitals, etc) are still State and Federal funds from a fraud and abuse perspective. Because of the increasing amount of fraud and abuse in the health care industry, prosecutors and judges are punishing those who commit fraud and abuse to the full extent of the law, including substantial monetary penalties and incarceration.

The following are examples of some fraud and abuse activities commonly discovered in the health care field. These examples are provided as a general guide only. Those who break the law seem to arrange very thoughtful schemes and not be described below. If you suspect fraud and abuse activities you should report it, even if not included here. Medica Health Plans of Florida, Inc has established a

Compliance Hotline to handle allegations of fraud and abuse and other matters inconsistent with the law. The telephone number for the Compliance Hotline is (305) 460-0648. The Compliance Hotline is confidential and the reporting individual may remain anonymous. By law, any person who reports violations of fraud and abuse are protected and retaliation against the individual making the report is prohibited.

Examples and description of common fraud and abuse activities:

Balance billing: The contracting provider bills the patient directly for the total amount of the bill or for the amount of the charge that the provider has agreed to write off after the health plan has paid.

Kickbacks for referrals: An individual gets paid (with money or other compensation) for referring patients to a particular health care provider.

Inflating the bills for services and/or goods provided: The contracting provider bills the health plan at full fee-for-service rates even though a lower rate was negotiated in the managed care contract.

Double-billing: This occurs when the provider receives more than one payment for the same service and keeps the money.

Improper Coding (up-coding and unbundling): By using the wrong billing code or unbundling the codes included in a larger, more inclusive set of codes, the contracting provider is able to be reimbursed at a higher rate than if the correct billing codes were used and the services were billed together.

Billing for services never rendered: The provider bills for services not provided.

Reporting phantom patient visits and improper cost reporting: Providers submit inflated reports of patient traffic and treatment costs in order to induce payers to increase future per-patient capitation fees.

Falsification of health care provider credentials: Falsification of health care provider credentials can put patients at risk because they may be receiving care from an unqualified, unlicensed, or a debarred provider and may result in the improper payment for the services of a provider who does not meet the required professional qualifications.

Arranging for services with related parties: Arranging for services with related parties, such as subsidiaries or other entities where funds benefit the referring provider (directly or indirectly) may provide an opportunity for diversion of funds without the provision of services, or payment of exorbitant amounts for legitimate services. Antitrust violations are also included in this category and can result from efforts to reduce or eliminate competition through the use of illegal tying agreements (written or not). Without competition, higher rates and price fixing can occur.

Patient fraud and abuse: Beneficiaries may abuse the system through inappropriate utilization of services, such as selling medication prescribed to them. Other forms of fraud may include lending an enrollment card to an ineligible person in order for that person to receive health care services to which he or she is not entitled.

Reports of suspected or confirmed fraud and abuse activities may also be filed with the Office of Inspector General at the Agency for Health Care Administration. If you prefer to file a report of fraud and abuse directly with the Agency for Health Care Administration, please contact the Agency's Hotline at 1 (888) 419 3456.

Chapter 9: Claims Overview

Medica Health Plans of Florida network providers are paid pursuant to the contractual terms stipulated in their Agreements. Some providers may be paid on a capitated basis, while others may receive their compensation based on a fee for service basis. Please refer to your provider contract to determine which method of payment applies to you. If you have agreed to be paid on a fee-for-service basis, the contract will specify what fee schedule your payment will be based upon. If you have agreed to be paid on a capitated basis, your contract will specify the methodology used to calculate your monthly payment.

Capitation payment(s) will be made monthly. A list of members assigned to you as of a point in time will accompany your monthly payment.

Claim payment will be made in accordance with the current level of reimbursement at the time of service pursuant to the terms and conditions applicable to your Participation Agreement.

The mailing address for claims submission is:

Medica Health Plans of Florida, Inc.
PO Box Address 14-5330
Coral Gables, FL 33114-5330
Att: Claims Dept.

You may submit paper claims or you may elect to submit claims electronically. If you elect to submit paper claims, only those claim forms indicated below will be accepted by Medica Health Plans of Florida, Inc. The prescribed forms for claims are the following:

UB - 04 Claim Form.

The following providers, when billing on a paper claim form must bill on a UB- 04 claim form to receive reimbursement from MHP - FL:

- Freestanding Dialysis Centers
- Hospitals
- Hospital-Based Skilled Nursing Facilities
- Hospices
- Intermediate Care Facilities for the Developmentally Disabled (ICF/DD)
- Nursing Facilities
- State Mental Hospitals
- Rural Swing Bed Providers
- Statewide Inpatient Psychiatric Program (SIPP) Waiver providers

CMS-1500 Health Insurance Claim Form.

(For use by physicians and other suppliers to request payment for medical services.)

The following providers, when billing on a paper claim form, must bill on a CMS-1500 claim form to receive reimbursement from MHP - FL:

- Advanced Registered Nurse Practitioners
- Ambulance, Land and Air
- Ambulatory Surgical Centers
- Assistive Care Providers
- Audiologists

- Birthing Centers
- Child Health Check-Up Providers
- Children at Risk Targeted Case Management
- Children's Health Services Targeted Case Management
- Chiropractors
- Community Mental Health Services Providers
- County Health Departments
- County Health Department Certified Match
- Dentists
- Durable Medical Equipment
- Early Intervention Services
- Federally Qualified Health Centers
- Hearing Aid Specialists
- Home and Community-Based Waiver Services
- Home Health
- Independent Laboratories
- Licensed Midwives
- Medicaid Certified School Match
- Medical Foster Care
- Mental Health Targeted Case Management
- Opticians
- Optometrists
- Physicians
- Physician Assistants
- Podiatrists
- Portable X-ray
- Prescribed Pediatric Extended Care
- Registered Nurse First Assistants
- Rural Health Clinics
- Therapists
- Visual Services
- Wheelchair and Stretcher Vans
- Any other provider whose service specific Coverage and Limitations Handbook requires the CMS-1500claim form.

Providers may order claim forms by completing and submitting a claims order form to the Medicaid fiscal agent. The order form is available on the Medicaid fiscal agent's Web Portal at <http://mymedicaid-florida.com>. Click on Provider Support, and then on Forms. Providers may also obtain forms by calling the Provider Contact Center at 800-289-7799 and selecting Option 7.

Completing the Claim Form

When billing for services, please bill your normal charges, complete all fields to the extent required and clearly include the following information on the form:

- ❖ The Member/ participant's full name, address and Social Security.
- ❖ The Member's ID # and group number, if any.
- ❖ Information on other insurance or coverage applicable to Medica Health Plans of Florida, Inc. plan participant.
- ❖ The name, signature, rendering address, billing address, tax ID, MPIN, telephone number of physician/provider performing the service.

- ❖ NPI number must be used in all standard transactions, whether you're submitting claims electronically or in paper form. All HIPAA covered healthcare providers, whether they are individuals or organizations must use the NPI number to identify themselves in all HIPAA standard transactions.
- ❖ Appropriate diagnostic and procedure/service codes.
- ❖ ICD-9- CM (to the highest level of specificity).
- ❖ CPT-4 procedure codes with appropriate modifiers.
- ❖ HCPC with appropriate modifiers.
- ❖ Revenue Codes (Facility Room & Board and Non Room &Board).
- ❖ Number of service units rendered.
- ❖ Referring physician's name.
- ❖ Date of service(s).
- ❖ Authorization number (if applicable).
- ❖ NDC for prescription drug therapy.
- ❖ Job-related, auto or other accident information when available.

Claims missing any of the above required information cannot be processed. Physicians and providers submitting claims without the required information will be notified the claim cannot be processed and advised what additional information is needed to enable adjudication. Claims submitted with inaccurate coding will be denied. A Medica Health Plans of Florida, Inc. plan participant may not be billed for services for which a claim submission has been returned to the physician or provider for lack of information, or denied due to inaccurate coding.

Complete the claim forms using the service-specific Coverage and Limitations Handbook as a reference. Follow the instructions found in these handbooks for completing the CMS-1500 and UB- 04 claim forms for Medicaid reimbursement. Some fields are not self explanatory or have multiple uses, so if you are uncertain as to how to complete an item on the claim form, please refer to these handbooks for the most comprehensive and correct instructions. Incorrect entries can result in denied claims.

Note: The Florida Medicaid Coverage and Limitations Handbooks are available on the Medicaid fiscal agent's Web Portal at <http://mymedicaid-Florida.com>. Click on Provider Support, and then on Provider Handbooks. The handbooks are incorporated by reference in the Medicaid Services Rule Chapter, 59G-4, F.A.C.

Electronic Submission

Electronic claims submission offers physicians and other providers faster and more efficient payment, less paperwork and lower mailing costs. Electronic claims are accepted for CMS 1500 and all UB-94 billings.

Value-added enhancements to electronic data interchange at Medica Health Plans of Florida, Inc. may include claim status, eligibility inquiry, viewing remittance advices and reviewing reports in general. Please find us on the web at WWW.EZCAREMHPFL.COM.

Preferred Connection

Medica Health Plans of Florida, Inc. has developed a provider portal in order to provide quality interfaces and electronic submission. The portal will enable providers to process claims, determine eligibility and coverage, authorizations/referrals and provider reimbursement. In addition, MHP – FL has a national contract with EMDEON Gateway Services for electronic submissions that providers may access through their clearing house relationships.

Getting Connected

Providers must obtain an enrollment package from the EDI Department. Medica Health Plans of Florida, Inc. supports FTP and HTTPS interfaces for the transmittal and receipt of X12 transactions.

For Assistance

If you would like more information about submitting claims electronically, please contact the Department of Provider Relations listed in the “How to Reach Us” section.

When to File a Claim

When Medica Health Plans of Florida, Inc. is the primary carrier, typically claims with required information must be submitted within 6 months following the date that services are rendered or the date of discharge or as required by law. Please refer to your provider agreement.

Typically, Medica Health Plans of Florida, Inc. is under no obligation to pay for claims received more than 6 months after the date services are rendered or the date of discharge, or as required by law. Please refer to your provider agreement. Medica Health Plans of Florida, Inc. members cannot be billed for claims denied due to late submission.

The filing limit for reconsideration is 60 days, or as required by law or your provider agreement.

Clean Claims

A clean claim containing all the necessary information and authorization required will be processed within: (1) twenty (20) days of receipt if submitted electronically and/or (2) forty (40) days of receipt if submitted non-electronically. A Remittance Advice will accompany the payment.

All claims for payment or overpayment, whether electronic or nonelectronic:

(a) Are considered received on the date the claim is received by the Medica Health Plans of Florida at its designated claims-receipt location or the date a claim for overpayment is received by the provider at its designated location.

(b) Must be mailed or electronically transferred to Medica Health Plans of Florida within 6 months after the following have occurred:

1. Discharge for inpatient services or the date of service for outpatient services; and
2. The provider has been furnished with the correct name and address of Medica Health Plans of Florida, Inc.

Providers must not duplicate a claim previously submitted unless it is determined that the original claim was not received or is otherwise lost.

For all electronically submitted claims, Medica Health Plans of Florida will within 24 hours after the beginning of the next business day after receipt of the claim, provide electronic acknowledgment of the receipt of the claim to the electronic source submitting the claim.

For all non electronically submitted claims, Medica Health Plans of Florida will provide acknowledgment of receipt of the claim within 15 days after receipt of the claim to the provider or designee or provide a provider or designee within 15 days after receipt with electronic access to the status of a submitted claim.

If Medica Health Plans of Florida determines that it has made an overpayment to a provider for services rendered to a member, Medica Health Plans of Florida will make a claim for such overpayment to the provider's designated location. When Medica Health Plans of Florida makes a claim for overpayment to a provider it will give the provider a written or electronic statement specifying the basis for the retroactive denial or payment adjustment. Claims for overpayment will be submitted to a provider within 30 months after the Medica Health Plans of Florida's payment of the claim. A provider must pay, deny, or contest the claim for overpayment within 40 days after the receipt of the claim. All contested claims for overpayment must be paid or denied within 120 days after receipt of the claim. Failure to pay or deny overpayment and claim within 140 days after receipt creates an uncontestable obligation to pay the claim. A provider that denies or contests a claim for overpayment or any portion of a claim shall notify Medica Health Plans of Florida, in writing, within 35 days after the provider receives the claim that the claim for overpayment is contested or denied. The notice that the claim for overpayment is denied or contested must identify the contested portion of the claim and the specific reason for contesting or denying the claim and, if contested, must include a request for additional information. If the Medica Health Plans of Florida submits additional information, then we will, within 35 days after receipt of the request, mail or electronically transfer the information to the provider. The provider shall pay or deny the claim for overpayment within 45 days after receipt of the information. The notice is considered made on the date the notice is mailed or electronically transferred by the provider.

Payment of an overpayment claim is considered made on the date the payment was mailed or electronically transferred. An overdue payment of a claim bears simple interest at the rate of 12 percent per year. Interest on an overdue payment for a claim for an overpayment payment begins to accrue when the claim should have been paid, denied, or contested.

Where to Send Claims

The appropriate claim office address is listed on the back of the Medica Health Plans of Florida's member's ID card. If the Medica Health Plans of Florida, Inc. member does not have an ID card readily available, simply contact Provider Services at the number found in the "How to Reach Us" section to obtain this information or submit your claim to the following address:

**Medica Health Plans of Florida, Inc.
PO Box Address 14-5330
Coral Gables, FL 33114-5330
Att: Claims Dept.**

Correspondence

Any correspondence concerning claims should include the claim number listed on the Provider Remittance Advice (or a copy of the Provider Remittance Advice). Also, please include the Medica Health Plans of Florida, Inc. plan participant's name, the subscriber's name all of which appear on the ID card.

Encounter Submission and Collection

Medica Health Plans of Florida, Inc. requires its contracted plan providers to complete and submit encounter data within 30 days of the date of service. Medica Health Plans of Florida participating providers must submit member encounter data to Medica Health Plans of Florida, Inc. using the approved Encounter Form (CMS 1500). Hospitals and other facilities should use the UB-04 Form. The encounter data enables Medica Health Plans of Florida, Inc. to:

- Track utilization.
- Analyze patient care patterns.
- Adhere to state and federal HMO regulation requirements.
- Provide a source for Quality Improvement studies.

The encounter forms must be submitted on the CMS 1500 or UB-04 form to the address listed below or electronically to Medica Health Plans of Florida, Inc. at www.mhpf.com

Medica Health Plans of Florida, Inc.
PO Box Address 14-5330
Coral Gables, FL 33114-5330
Att: Claims Dept.

The forms must be completed to the extent required, including all elements that would be required to process a regular clean claim. Incorrect or incomplete encounters (CMS1500 or UB-04) will be returned to the pertinent provider for correction.

Coding Criteria

Medica Health Plans of Florida, Inc. standard is to accept valid revenue codes, current CPT, ICD-9-CM and HCPCS codes and modifiers. This is the accepted methodology for coding all contracts and claim submissions.

Level III local HCPCS codes should only be used on claims for Medicare and Medicaid recipients. Level III local HCPCS codes are those codes within the range from W0000 to Z0000.

Provider Claim Disputes / Resolving Claims Disputes

As part of their initial provider in – service, the Department of Provider Relations shall instruct participating providers on the MHP – FL claims resolution process.

As used in this procedure, the term "claim" for a non - institutional provider means a paper or electronic billing instrument submitted to the health maintenance organization's designated location that consists of the HCFA 1500 data set, or its successor, that has all mandatory entries for a physician licensed under chapter 458, chapter 459, chapter 460, chapter 461, or chapter 463, or psychologists licensed under chapter 490 or any appropriate billing instrument that has all mandatory entries for any other non - institutional provider. For institutional providers, "claim" means a paper or electronic billing instrument submitted to the health maintenance organization's designated location that consists of the UB-92 data set or its successor with entries stated as mandatory by the National Uniform Billing Committee.

As used in this procedure, "Health care provider" or "provider" means a state-licensed or state-authorized facility, a facility principally supported by a local government or by funds from a charitable organization that holds a current exemption from federal income tax under s. 501(c)(3) of the Internal Revenue Code, a licensed practitioner, a county health department established under part I of chapter 154, a prescribed pediatric extended care center defined in s. [400.902](#), a federally supported primary care program such as a migrant health center or a community health center authorized under s. 329 or s. 330 of the United States Public Health Services Act that delivers health care services to individuals, or a community facility that receives funds from the state under the Community Alcohol, Drug Abuse, and Mental Health Services Act and provides mental health services to individuals.

As used in this procedure, "Agency" means the Agency for Health Care Administration.

Providers presenting disputes pertaining to claims shall be instructed to present the claim dispute in a matter consistent with the dispute and appeals rights afforded them through the Health Plan's Claims Dispute Resolution Process. All claims disputes and appeals shall be directed to the Appeals & Dispute Unit.

If the claim in dispute cannot be resolved through communication between the provider and Medica

Health Plans of Florida, an arbitration proceeding may be filed as stipulated in the Provider Participation Agreement. Arbitration proceedings under the MHP – FI agreement with the provider shall be conducted in Miami Dade County. Arbitration will be conducted pursuant to the rules and regulations of the American Health Lawyers Association Alternative Dispute Resolution Service Rules of Procedures for Arbitration ("AHLA Arbitration Service").

Providers may contest claim decisions on matters regarding:

- Denied Claims.
- Provider payment methodology.
- Contract/benefit plan limitations.
- Overpayments or underpayments of claims.
- Interest Payment Disputes

Claim contestations must be submitted within sixty (60) days from the date stated on the Provider Remittance Advice or your provider agreement. The contestation process is initiated by providing a written request to the claim office. This request should include the following information which can be obtained from the Provider Remittance Advice:

- Vendor Number
- Provider Name of the provider presenting the dispute
- Tax ID Number and NPI Number of the provider presenting the dispute
- Patient name and relationship to subscriber.
- MHP FL Claim number being contested.
- Issue or reason for contestation.
- Any pertinent clinical or administrative information that would be of assistance in reviewing your claim dispute.

All Claim Disputes & Appeals must be submitted to the following address:

Medica Health Plans of Florida, Inc
Provider Appeals & Dispute Department
P O Box 14 – 1368
Coral Gables, FI 33114 - 1368

The Provider Appeals & Dispute Department will review the contestation of a claim. During the review process additional information may be requested and the provider has thirty five (35) calendar days in which to submit the required information. A written response to the contestation will be provided upon completion of the review. That response will include the review findings, an explanation of the

denial/issue and, if the initial determination is upheld, instructions on additional recourse options, if any exist. Medica Health Plans of Florida's dispute resolution process related to a denied claim not under active review by a mediator, arbitrator, or third-party dispute entity shall be finalized within 60 days after the receipt of the provider's request for review or appeal.

A provider or any representative of a provider, regardless of whether the provider is under contract with Medica Health Plans of Florida, may not collect or attempt to collect money from, maintain any action at law against, or report to a credit agency a member for payment of covered services for which Medica Health Plans of Florida contested or denied the provider's claim. This prohibition applies during the pendency of any claim for payment made by the provider to Medica Health Plans of Florida for payment of the services or Medica Health Plans of Florida's internal dispute resolution process to determine whether Medica Health Plans of Florida is liable for the services. For a claim, this pendency applies from the date the claim or a portion of the claim is denied to the date of the completion of Medica Health Plans of Florida's internal dispute resolution process, not to exceed 60 days. This does not prohibit collection by the provider of any applicable copayments, coinsurance, or deductible amounts due the provider.

Claim disputes that are not resolved satisfactorily between Medica Health Plans of Florida participating and non participating providers may be presented to Maximus, Inc. Maximus, Inc. is the resolution organization under contract with the Agency for Health Administration (ACHA) which assists ACHA in administering The Statewide Provider and Health Plan Claim Dispute Resolution Program which was established by the 2000 Florida Legislature to provide assistance to contracted and non - contracted providers and managed care organizations for resolution of claim disputes that are not resolved by the provider and the managed care organization. Maximus, Inc. operates a toll free hot line 1 (800) 356 8151 to provide information to interested parties.

A provider or any representative of a provider, regardless of whether the provider is under contract with MHP – FL, may not collect or attempt to collect money from, maintain any action at law against, or report to a credit agency a subscriber of an organization for payment of services for which the organization is liable, if the provider in good faith knows or should know that the organization is liable. This prohibition applies during the pendency of any claim for payment made by the provider to the organization for payment of the services and any legal proceedings or dispute resolution process to determine whether the organization is liable for the services if the provider is informed that such proceedings are taking place. It is presumed that a provider does not know and should not know that an organization is liable unless:

- (a) The provider is informed by MHP - FL that it accepts liability;
 - (b) A court of competent jurisdiction determines that MHP - FL is liable;
 - (c) The office or agency makes a final determination that the organization is required to pay for such services subsequent to a recommendation made by the Subscriber Assistance Panel pursuant to s. 408.7056; or
 - (d) The agency issues a final order that MHP - FL is required to pay for such services subsequent to a recommendation made by a resolution organization pursuant to s. 408.7057.
- (5) MHP – FL may report any suspected violation of this section by a health care practitioner to the Department of Health and by a facility to the agency, which may take such action as authorized by law.

Chapter 10: Member Appeals, Grievances and Medicaid Fair Hearing

Definitions:

Grievance: Something considered to give just cause for complaint or protest; a complaint of unfair treatment. Possible subjects for grievance include but are not limited to, the quality of care, the quality of services provided and aspects of interpersonal relationships such as rudeness of a Provider or employee or failure to respect the Member's rights.

Appeal: are requests for review of an action.

Action: The denial or limited authorization of a requested service, including the type or level of service; the reduction, suspension or termination of a previously authorized service; the denial, in whole or in part, of payment for a service; the failure to provide service in a timely manner, as defined by the State; the failure of the Health Plan to act within ninety (90) days from the date the Health Plan receives a Grievance, or 45 days from the date the Health Plan receives an Appeal. For a resident of a rural area with only one (1) managed care entity, the denial of an Member's request to exercise his or her right to obtain services outside the network.

Independent Reviewer: An internal person of the organization or external individual who was not involved in the case and denial decision. If the case and denial decision was based on a medical condition/decision, the external reviewer can be a contracted provider who was not involved in the case and denial decision and work or be part of the practice/organization that rendered the service(s).

The Grievance and Appeals Department has a process in place to ensure proper, timely handling in the processing of Grievances and Appeals. Upon receipt of request from member or his / her designee whether via telephone or correspondence the coordinator that receives the complaint documents and tracks the complaint in the system, if Grievance or Appeal is received in writing, documents received are stamped with date and time the Grievance or Appeal documents were received.

1. Appeals / Grievances are composed of two stages:
 - a. The Informal process is designed to handle issues, inquiries and complaints quickly, objectively, and in a non-adversarial manner. The intent is to resolve the member's issue at the time of the first call when possible.
 - b. The Formal process is an additional objective review of issued after the member has utilized the informal process. These appeals / grievances are presented in writing. Appeals requests that are initially filled verbally must be received in writing within 30 days.
2. Expedited Appeals. Those cases that require urgent resolution (72- hours) will be handled on a case-by-case basis by the Grievance / QI Department and Medical Director. Examples of cases that may be defined as urgent include emergency management or potential quality incident. The Grievance / QI Department will collect and forward all relevant information to the Medical Director for immediate review. The decision will be communicated by telephone and in writing.

Grievance Process

The Grievance Committee for MHPFL consists of company representation (Provider Relations, Member Service, Operations, Risk Management, Case Management, QI, UM, Medical Director, etc.) and medical professionals (PCPs or Specialist as appropriate).

The voting members of the Grievance Committee for this review request must not be involved in the case previously, not be a member of the Board of Directors, not be involved in the review or investigation of the case previously, or not have a direct financial interest in the case or in the outcome of the review. Members of the Grievance Committee that were involved in the case previously may however present information about the case for review by the panel.

MHPFL will have physician involvement in reviewing grievances related to adequacy of care/services. Physician involvement in the grievance process is not limited to the Member's PCP, but includes at least one other physician. The person initiating the complaint may appear in person to meet with a representative at their convenience. The case will be reviewed by a healthcare professional with clinical expertise in cases in which the denial was based on lack of medical necessity, a grievance resulting from the denial or processing an appeal as expedited, and a grievance or appeal that involves clinical issues.

If Member has a complaint or is dissatisfied with any services that MHPFL provided or on how Member was treated by a provider or a representative of MHPFL a grievance can be filed in writing or verbally through MHPFL Member Services Department 24 hours a day, 7 days a week. If in writing, Member's letter must include the following information: Member's name, member's ID number, Member's contact information (telephone number and address), and the reason for the grievance.

If a Member or Member's Provider (whether a participating or non-participating provider), acting on Member's behalf, with Member's written consent wants to file a grievance verbally, they need to call the Member Services Department. Member Services telephone number is provided on the back of the Member's ID Card, Member Handbook and Provider Directory. A representative of Medica Health Plans of Florida, Inc. will assist in documenting the conversation so that we may begin processing the grievance. Information is logged/tracked in MHPFL's system. Member may also send a letter stating what was told to the Member Services Representative. MHPFL will start processing the Member's verbal grievance the same day it is filed.

A Member may file a Grievance at any time during a one-year period from the date of occurrence. MHPFL will acknowledge receipt of Member's Grievance and will resolve his/her Grievance within the State-established time frames not to exceed the 90 Calendar Days, from the day we received the initial Grievance request, be it oral or in writing.

MHPFL may extend the Grievance resolution timeframe by up to 14 Calendar Days if the Member requests an extension, or MHPFL documents that there is a need for additional information and the delay in the Member's best interest.

MHPFL must notify the Member, in writing, within 90 Calendar Days (in the event that a 14-day extension was not requested) of the resolution of the Grievance. The Notice of disposition shall include the results and date of the resolution of the Grievance, and for decisions not in the Member's favor, the notice of disposition shall include, patients right to request a Medicaid Fair Hearing if applicable.

In the event that a Member is still dissatisfied with MHPFL decision once the Grievance Committee has completed their review of the grievance, the Member is given the right to request a Medicaid Fair Hearing. If Member decides to request a hearing, Member may continue to receive coverage for benefits until a decision is made at the hearing. If Member decides to requests a Medicaid Fair Hearing and wants to continue receiving benefits covered by MHPFL until hearing decision is made, Member must file request within 10 days from the date Medica Health Plans of Florida, Inc. sent decision letter or within 15 days if Member sends MHPFL request by U.S. Mail. However, if the Medicaid Fair Hearing decides that MHPFL'S decision was right, then Member may have to pay for the cost of the continued benefit. The Member or Member's Provider may request a Medicaid Fair Hearing within 90 days from the date MHPFL issued letter. To file a Grievance with the Medicaid Fair Hearing, Member/Provider needs to write to:

**Department of Child and Family Services
Office of Public Assistance Appeals Hearings
1317 Winewood Boulevard, Building 5, Room 203
Tallahassee, Florida 32399-0700**

If Member elects not to request a Medicaid Fair Hearing as discussed above however is dissatisfied with MHPFL decision on the resolution of their Grievance and has exhausted MHPFL Grievance process, Member has the right to appeal to the AHCA Subscriber Assistance Program (SAP). The SAP will not consider a Grievance taken to a Medicaid Fair Hearing. Member must request a review by the SAP within one (1) year after the receipt of MHPFL final decision letter being issued to Member. To file Grievance with the SAP, Member must write to:

**Agency for Healthcare Administration
Subscriber Assistance Program (SAP)
Building 1, MS #26
2727 Mahan Drive
Tallahassee, Florida 32308**

Letter must include the following information: Plan name (Medica Health Plans of Florida, Inc.) member's name, member ID#, member's contact information, and the reason for filing the Grievance.

The contact phone numbers for the BAP are: (850) 412 - 4502 or (888) 419-3456 (toll free).

Appeals Process

The Member or provider will also be advised of his or her right to appeal if the Member is not satisfied with the final decision reached by MHPFL. Member or provider (acting on Member's behalf, with Member's written consent) will have 30 days to file an appeal from the date of the action. MHPFL will acknowledge that the appeal as been received. MHPFL will resolve the appeal in 45 days (if 14 Calendar Days extension is not requested). MHPFL will let the Member know within 5 Business Days if they need more time to resolve his or her appeal and issue a written notice explaining reason for the delay. Member would need to agree to let MHPFL take the additional days if necessary.

Member or Member's provider may file an Appeal either orally or in writing, however when the Appeal is filed orally, the Member or Provider must submit a written, signed Appeal within 30 Calendar Days from the day MHPFL received the initial oral Appeal request. Whether request was received orally or in writing MHPFL is not to exceed 45 Calendar Days from the day initial request was received.

In the event that the resolution is in favor of the Member, MHPFL will need to provide services as quickly as the Member's health condition requires. MHPFL must provide the Member or Provider with a reasonable opportunity to present to evidence and allegations of fact or law, in person and/or in writing. MHPFL will also allow the Member and/or Member's representative the opportunity before and during the Appeal process, to examine the Member's case file, including all Medical Records and any other documents and consider the Member, the Member's representative or the representative of a deceased Member's estate as parties to the Appeal. The Appeal procedure must be the same for all Members.

MHPFL is to provide the Member and or Member's provider a notice of resolution of the Appeal, to include the results and date of the resolution within 2 business days after the decision was made. For decisions not wholly in the Member's favor, the notice needs to include:

Member's right to request a Medicaid Fair Hearing, Information on how to request the Medicaid Fair Hearing to include the address to DCF.

Member has the right to continue receiving Benefits pending a Medicaid Fair Hearing, information on how to request the continuation of Benefits and notice that if MHPFL's decision is upheld in the Medicaid Fair Hearing the Member may be responsible for the cost of continued Benefits.

MHPFL will provide DCF with a copy of the written notice of disposition upon request; and ensure that no punitive action is taken against a provider who files an Appeal on behalf of a Member or supports a Member's Appeal.

If MHPFL continues or reinstates the Member's Benefits while the Appeal is pending, MHPFL must continue providing the Benefits until 1 of the following occurs:

- (a). the member withdraws the appeal;
- (b). 10 Business Days pass from the date of MHPFL's notice of resolution of the Appeal if the resolution is unfavorable to the Member and if the Member has not requested a Medicaid Fair Hearing with continuation of Benefits until a Medicaid Fair Hearing decision is reached.
- (c). The Medicaid Fair Hearing panel's decision is unfavorable to the Member; or

(d). the authorization to provide services expires, or the Member meets the authorized service limits.

If the Final Resolution of the Appeal is unfavorable to the Member, MHPFL may recover the costs of the services furnished from the Member while the Appeal was pending.

If MHPFL did not furnish the services while the Appeal was pending and the Appeal panel reverses MHPFL's decision to deny, limit or delay services, MHPFL must authorize or provide the Benefits disputed as quickly as the Member's health condition requires.

If the services were furnished while the Appeal was pending and the Appeal Panel reverses MHPFL's decision to deny, limit or delay services, MHPFL's must approve payment for disputed benefits.

Expedited Appeals

In the event that MHPFL makes a decision that is not to the Members satisfaction he/she has the right to file an appeal, if Member feels that the time for a standard appeal could be a danger to his/her life or health or may cause he/she to be injured, the Member or his/her Provider may ask for an expedited review and obtain the answer within 72 hours, if the expedited appeal request is granted.

MHPFL upon receipt of Member's request for an expedited Appeal will determine if Appeal requires an expedited review. If request for expedited Appeal review is denied, MHPFL will transfer the Appeal to the standard time frame of no longer than 45 Calendar Days from the date MHPFL received the request for Appeal (with a possible 14 day extension). MHPFL will make all reasonable efforts to provide immediate oral notification of MHPFL's denial for expedited resolution of Appeal and will provide written notice of the denial of the expedited Appeal within 2 Calendar Days. The Member or Member's provider will not be able to file with The Subscriber Assistance Program (SAP) until having completed the Appeals process with MHPFL. Once the Member receives the final decision letter from MHPFL he/she must submit Appeal to the SAP within 1 year of receipt of the final decision letter.

The Grievance Department Coordinator completes the initial review of correspondence to ensure the following has been included:

1. Confirms the member's eligibility and benefits.
2. If the complaint is related to a provider, confirms that the provider is a participating provider.
3. Documentation consists of:
 - a. Date of receipt
 - b. Category of concern, (i.e., access, billing / claims issues, excluded benefits, or formulary issues, etc.)
 - c. Documented comments.
 - d. Letter acknowledging receipt of the complaint.
 - e. Date medical records are requested.
 - f. Date resolution is sent to the person initiating the complaint.

If a member or provider cannot be contacted via telephone, a letter will be sent requesting clarification or additional information.

MHPFL shall provide a Member with written or electronic notification of any unfavorable benefit determination. The notification shall describe and be written in a manner considered to be understood by the Member and contain the following:

- 1. The specific reason(s) for the Unfavorable Benefit Determination.**
2. Reference to the specific policy provisions in which the determination is based.
3. A description of any additional material or information necessary for the Member to perfect the claim and an explanation of why such material or information is necessary.
4. A description of the review procedures of MHPFL and the time limits applicable to such procedures.
5. If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the Unfavorable Benefit Determination, either the specific rule, guideline, protocol, or other similar criterion or a Statement that such rule, guideline, protocol or other similar criterion was relied upon in making the Unfavorable Benefit Determination and that a copy shall be provided free of charge to the Member upon request.
6. If the Unfavorable Benefit Determination is based on whether the treatment or service is Experimental and/or Investigational or not Medically Necessary, either an explanation of the scientific or clinical judgment for the

determination, applying the terms of the policy to the Member's medical circumstances, or a Statement that such explanation shall be provided free of charge upon request.

MHPFL's appeal procedures shall include the following substantive procedures and safeguards:

1. Member may submit written comments, documents, records, and other information relating to the claim.
2. Upon request and free of charge, the Member shall have reasonable access to and copies of any relevant documents.
3. The appeal shall take into account all comments, documents, records, and other information the Member submitted relating to the claim, without regard to whether such information was submitted or considered in the initial unfavorable benefit determination.
4. The appeal shall be conducted by an appropriate named fiduciary of MHPFL who is neither the individual who made the initial unfavorable benefit determination nor the subordinate of such individual. Such person shall not postpone the initial unfavorable benefit determination.
5. In deciding an appeal of any unfavorable benefit determination that is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is experimental and/or investigational or not medically necessary, the appropriate named fiduciary shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment.
6. The appeal shall provide for the identification of medical or vocational experts whose advice was obtained on behalf of MHPFL in connection with a Member's unfavorable benefit determination, without regard to whether the advice was relied upon in making the unfavorable benefit determination.
7. The Appeal shall comply with the process addressed in this policy/procedure and Individual Reviewer involved or engaged for purposes of a consultation/review for an Unfavorable Benefit Determination (Denial Decision), shall be an individual who is neither involved, and/or consulted with the initial Unfavorable Benefit Determination or case (that is subject of this Appeal), or related, work or part the office/practice subordinate of any individual (member/provider).
8. In the case of an Urgent Care Claim, there shall be an expedited review process pursuant to which:
 - a. a request for an expedited appeal of an unfavorable benefit determination may be submitted orally or in writing by the Member; and
 - b. All necessary information, including MHPFL's benefit determination on review, shall be transmitted between MHPFL and the Member, or the provider acting on behalf of the member, by telephone, facsimile, or other available similarly expeditious methods.

1. **Exhibit A: Primary Care Referral Form:** A proprietary form developed by Medica Health Plans of Florida, Inc. (MHPFL) for the use by participating Primary Care Physicians (PCP) **only** to refer Health Plan members to participating and non participating providers for covered medical services.
2. **Exhibit B: Notice of Denial:**
3. **Exhibit C: Concurrent Review Form:** A proprietary form developed by Medica Health Plans of Florida, Inc. (MHPFL) for the use by the MHPFL Departments of Medical Management and Hospital Services to communicate to the PCP the progress notes of concurrent reviews conducted on member admissions to hospitals, skilled nursing facilities and rehabilitation facilities.



PCP REFERRAL FORM

| | |
|---|---|
| <p>MEMBER INFORMATION</p> <p>Member Name: _____ Subscriber #: _____ Address: _____ Telephone #: _____ D.O.B: _____</p> | <p>PROVIDER INFORMATION</p> <p>Provider: _____ Address: _____ Telephone: _____ Appointment Date: _____ Time: _____</p> |
|---|---|

| | |
|--|---|
| <p>PCP INFORMATION</p> <p>PCP Name: _____ Address: _____ Telephone #: _____ Referral Date: _____ PCP Signature: _____</p> <p><i>PCP Referrals Forms are for use by PCPs Only. Only properly authorized & signed PCP Referral Forms will be processed.</i></p> | <p>INPATIENT OR OUTPATIENT PROCEDURES FACILITY INFORMATION</p> <p style="font-size: 1.2em;">Outpatient Facility ↑ Hospital ↑</p> <p>Name: _____ Address: _____ Telephone: _____ Appointment Date: _____ Time: _____</p> |
|--|---|

Is referral related to an accident: † Yes †No If yes, what type: _____

CLINICAL INFORMATION

† SERVICE DENIAL – MEMBER REQUESTED A SERVICE THAT IS NOT MEDICALLY NECESSARY OR IS NOT A COVERED BENEFIT. SPECIFY SERVICE DENIED.

FAX THE FORM TO THE MEDICAL MANAGEMENT DEPARTMENT Dade (305) 448-4439 / Br. (954) 986-0766

Diagnosis or Symptom: _____

Referral for:

_____ Diagnostic Testing _____

_____ Surgery / Procedure _____

_____ HHC, _____ DME _____

_____ OTHER: _____

THIS REFERRAL DOES NOT GUARANTEE PAYMENT, MEMBER ELIGIBILITY, AND/OR BENEFITS. SPECIALIST MUST PROVIDE CONSULTATION REPORT TO PRIMARY CARE PHYSICIAN WITHIN 7 DAYS OF VISIT. PLEASE CALL FOR AN AUTHORIZATION NUMBER PRIOR TO THE PATIENT'S APPOINTMENT. IF THE PATIENT CANCELS OR CHANGES APPOINTMENT, NOTIFY US AS SOON AS POSSIBLE AT (305) 421-1220

Authorization Confirmation will be forwarded electronically via facsimile to the member's PCP and to the specialty provider authorized to render covered medical services. Retain a copy of the authorization confirmation for reference in the patient's medical record.

Exhibit B



4000 Ponce de Leon Blvd., Suite 650 • Coral Gables, FL 33146

NOTICE OF DENIAL

| | |
|------------------|-----------------------|
| Date: | PCP Name: |
| Member's name: | Member ID Number: |
| Member' Address: | Group Number: |
| | Plan: MEDICAID |

We have denied coverage of the following medical services or items that you or your physician requested:

We denied this request because:

If you don't agree with this decision, you can file an Appeal in writing within 30 calendar days after the date of the notice. If you require assistance with your Appeal, please contact Member Services Department at (305) 460-0675 (for calls within Miami-Dade County) or at (800) 719-9531 (for calls from outside Miami-Dade County). If you have a hearing or speech impairment, please call us our TTY/TDD at (305) 421-1251 (for calls within Miami-Dade County) or at (800) 517-6923 (for calls from outside Miami-Dade County). **Attached is important information about your Appeal Notification.**

For any other question(s) and assistance, please call Member Services Department at the number listed above.

Sincerely,

[Dr.'s Name}

IMPORTANT INFORMATION ABOUT YOUR APPEAL NOTIFICATION

What if I Don't Agree With This Decision?

You have the right to appeal. To exercise it, file your appeal in writing within 30 calendar days after the date of this notice. We can give you more time if you have a good reason for missing the deadline.

Who May File An Appeal?

You or someone you name to act for you (your **authorized representative**) may file an appeal. You can name a relative, friend, advocate, attorney, doctor, or someone else to act for you. Others already may be authorized under State law to act for you.

You can call us at (305) 460-0675 (for calls within Miami-Dade County) or at (800) 719-9531 (for calls from outside Miami-Dade County) to learn how to name your authorized representative. If you have a hearing or speech impairment, please call us at TTY/TDD at (305) 421-1251 (for calls within Miami-Dade County) or at (800) 517-6923 (for calls from outside Miami-Dade County).

If you want someone to act for you, you and your authorized representative must sign, date, and send us a statement naming that person to act for you.

For more information about your appeal notification, call us or check your Member Handbook.

There Are Two Kinds of Appeals You Can File:

Standard (30 days) - You can ask for a standard appeal. We must give you a decision no later than 30 days after we get your appeal. (We may extend this time by up to 14 days if you request an extension, or if we need additional information and the extension benefits you.)

Expedited/ Fast (72 hour review) - You can ask for a fast appeal if you or your doctor believe that your health could be seriously harmed by waiting too long for a decision. We must decide on a fast appeal no later than 72 hours after we get your appeal. If your request for Expedited review is denied we will transfer the request to the standard 30-day time frame (we may extend this time by up to 14 days if you request an extension, or if we need additional information and the extension benefits you.)

- **If any doctor** asks for a fast appeal for you, or support you in asking for one, and the doctor indicates that waiting for 30 days could seriously harm your health, **we will automatically give you a fast appeal.**
- If you ask for a fast appeal without support from a doctor, we will decide if your health requires a fast appeal. If we do not give you a fast appeal, we will decide your appeal within 30 days.

What Do I Include With My Appeal?

You should include: your name, address, Member ID number, reasons for appealing, and any evidence you wish to attach. You may send in supporting medical records, doctors' letters, or other information that explains why we should provide the service. Call your doctor if you need this information to help you with your appeal. You may send in this information or present this information in person if you wish.

How do I File An Appeal?

For a Standard Appeal: You or your authorized representative should mail or deliver your written appeal to the address below:

Medica Health Plans of Florida, Inc.
Attention: Appeals & Grievances Coordinator
4000 Ponce de Leon Blvd., Suite 650
Coral Gables, FL 33146

For a Fast Appeal: You or your authorized representative should contact us by telephone or fax:

Tel: (800) 719-9531

Fax: (800) 517-6924

TTY/TTD: (800) 517-6923

Note: MHP-FL will not take punitive action against a provider who files an Appeal on behalf of a Member or supports a Member's Appeal.

What Happens Next? If you appeal, we will review our decision. After we review our decision, if any of the services you requested are still denied, you are entitled to request a Medicaid Fair Hearing. You have the right to request and continue receiving Benefits pending a Medicaid Fair Hearing; however, if decision remains denied, you may have to pay the cost. If you elect not to request a Medicaid Fair Hearing; however, you are dissatisfied with our decision and have exhausted the appeals process, you have the right to appeal to the AHCA Beneficiary Assistance Program (BAP) within 365 days after receipt of our final decision letter being issued to you.

If you need further assistance, please contact MHP-FL's Member Services Department at the numbers listed below and they will be able to assist you.

Member Services Contact Information:

:

Toll Free: (800) 719-9531

TTY/TTD: (800) 517-6924

Other Resources To Help You:

- **Agency for Health Care Administration**
Beneficiary Assistance Program (BAP)
2727 Mahan Drive, Mail Stop 26
Tallahassee, Florida 32308

The contact phone numbers for the BAP are: (850) 921-5458 or (888) 419-3456 (toll free).

- **Department of Child and Family Services**
Office of Public Assistance Appeals Hearings
1317 Winewood Boulevard, Building 5, Room 203
Tallahassee, Florida 32399-0700

Exhibit C



| Hospital | Rm #. | Adm. Date | D/C. Date |
|-------------------------|--------------|----------------------|-----------|
| Days Authorized: _____ | | Variance Days: _____ | |
| Authorization # : _____ | | Member Name: _____ | |
| Member # : _____ | | DOB: _____ | |
| PCP _____ | Phone: _____ | Fax: _____ | |
| Attending: _____ | Phone: _____ | Fax: _____ | |

Review Type: Onsite Telephonic
Arrived Via: Rescue Ambulance Self Elective sent from PCP's office Other Rollover 23hr
Bed Type: Dates RR Tele CCU ICU

Admitting Diagnosis: _____, _____, _____

Discharge Dx: _____ Or/ Proc. (s) Date: _____

Consultants: _____

Past Medical History: _____

Admission Review Concurrent Review Meets Criteria Medical Director Referral Risk member Referral

QI Issue: _____

Diagnostic Tests or Procedures: _____

Laboratory Results: _____

IV Meds/S.Q. _____

P/O Meds: _____

| |
|--|
| Disposition/ D/C: <input type="checkbox"/> Home <input type="checkbox"/> Rehab/SNF Facility Name: _____ <input type="checkbox"/> Hospice _____ |
| HHC _____ |
| <input type="checkbox"/> ESRD/Dialysis Coordination <input type="checkbox"/> Coumadin Monitoring <input type="checkbox"/> Home Again Program <input type="checkbox"/> Expired Date: _____ |
| <input type="checkbox"/> CHF Program <input type="checkbox"/> High Risk CM Program <input checked="" type="checkbox"/> Code 15; High Risk Manager Referral Date: _____ |
| <input checked="" type="checkbox"/> SNP <input type="checkbox"/> Multiple Dx <input type="checkbox"/> Frail/Disabled <input type="checkbox"/> Hospice/ End of Life State; Referral Date: _____ |

CARE MANAGER _____ DATE OF REVIEW _____

Hospital Concurrent Review

Patient Name: _____ Facility: _____

Concurrent Review Date: _____

Meets Criteria Medical Director Referral Risk Member Referral QI Issue

Care Manager signature: _____

Concurrent Review Date:

Meets Criteria Medical Director Referral Risk Member Referral QI Issue

Care Manager Signature: _____

Concurrent Review Date:

Meets Criteria Medical Director Referral Risk Member Referral QI Issue

Care Manager signature: _____

Concurrent Review Date:

Meets Criteria Medical Director Referral Risk Member Referral QI Issue

Care Manager signature: _____
Hospital Concurrent Review

Patient Name: _____ Facility: _____

Concurrent Review Date: _____

Meets Criteria Medical Director Referral Risk Member Referral QI Issue

Care Manager signature: _____

Concurrent Review Date:

Meets Criteria Medical Director Referral Risk Member Referral QI Issue

Care Manager Signature: _____

Concurrent Review Date:

Meets Criteria Medical Director Referral Risk Member Referral QI Issue

Care Manager signature: _____

Concurrent Review Date:

Meets Criteria Medical Director Referral Risk Member Referral QI Issue

Care Manager signature: _____

Hospital Concurrent Review

Patient Name: _____ Facility: _____

Concurrent Review Date: _____

Meets Criteria Medical Director Referral Risk Member Referral QI Issue

Care Manager signature: _____

Concurrent Review Date:

Meets Criteria Medical Director Referral Risk Member Referral QI Issue

Care Manager Signature: _____

Concurrent Review Date:

Meets Criteria Medical Director Referral Risk Member Referral QI Issue

Care Manager signature: _____

Concurrent Review Date:

Meets Criteria Medical Director Referral Risk Member Referral QI Issue

Care Manager signature: _____
Hospital Concurrent Review

Patient Name ID#
Facility

Concurrent Review Date:

Meets Criteria Medical Director Referral Risk Member Referral QI Issue

Case Manager Signature: _____

Concurrent Review Date:

Meets Criteria Medical Director Referral Risk Member Referral QI Issue

Care Manager signature: _____

Concurrent Review Date:

Meets Criteria Medical Director Referral Risk Member Referral QI Issue

Care Manager signature: _____

Concurrent Review Date:

Meets Criteria Medical Director Referral Risk Member Referral QI Issue

Care Manager signature: _____