



# PROVIDER HANDBOOK

PHYSICIANS & DENTISTS

2013



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# 2013 CMS PROVIDER HANDBOOK • PHYSICIANS & DENTISTS

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**SECTION I - INTRODUCTION**

<b>Purpose</b>	This handbook was developed to provide CMS physicians and dentists an overview of Children’s Medical Services programs, provider participation criteria and requirements.
<b>Statutory Authority</b>	<p>Children’s Medical Services (CMS): Chapter 391, Florida Statutes (F.S.)</p> <ul style="list-style-type: none"><li>➤ Florida KidCare: Chapters 391.026 and 409.813-409.814, F.S.</li><li>➤ Titles V, XIX, and XXI, Social Security Act</li></ul> <p>Child Protection Team (CPT) Program: Chapter 39.303, F.S.</p> <p>Regional Perinatal Intensive Care Centers (RPICC): Chapter 383.15-21, F.S.</p> <p>Early Steps (ES): IDEA, Part C, 34 CFR Part 303</p>
<b>CMS Program Overview</b>	<p>Children’s Medical Services provides a comprehensive continuum of medical and supporting services to enrolled clients. The continuum of care includes prevention and early intervention services, primary care, medical and therapeutic specialty care. Services are provided through an integrated statewide system that includes local, regional, and tertiary care facilities and providers.</p> <p>Primary care is the well-child and acute care component of the Children’s Medical Services Network. CMS uses a private practice model that ensures 24-hour access to primary care physicians and linkages into secondary and tertiary care providers.</p> <p>The CMS system of care also includes a wide range of specialty services and long-term care services for medically complex or medically fragile children and high-risk pregnant women.</p>

## SECTION II – GENERAL PROVISIONS

**Children’s Medical Services is a comprehensive, managed system of care for children under age 21 with special healthcare needs. CMS includes Early Steps (Florida’s early intervention system under the Individuals with Disabilities Education Act (IDEA), Part C), the Florida Newborn Screening Program, Florida’s Medical Foster Care Program, CMS Regional Perinatal Intensive Care Centers Program, and many other specialty programs for children with medical, behavioral, and developmental needs.**

### Access to Care

Participating CMS physicians and dentists agree to provide or arrange to provide all necessary covered services including emergency services to CMS enrolled children referred to the provider. The physician/dentist will render covered services to CMS enrolled children in an efficient and professional manner, which at a minimum shall be in accordance with the same standards and time availability as offered to non-CMS children. **Primary Care Physicians** must have the ability to render a clinical decision 24 hours, 7 days a week.

Participating CMS physicians and dentists agree to provide covered services to all assigned or referred CMS children. The physician/dentist will neither differentiate nor discriminate in the treatment or quality of medical services delivered to CMS children on the basis of race, color, national origin, religion, disability or gender. Physicians/dentists will ensure services are family centered, inclusive, culturally competent, and include family members as an integral part of service planning, implementation and on-going assessment.

Physicians/dentists may not refuse to provide a covered service to assigned CMS children, as long as the services are within the providers’ capabilities and resources.

### **Timely Treatment Service Standards**

Participating physicians and dentists must agree to provide care in accordance within the following established access standards:

- ***Routine Well-Child Care*** - in which there is no significant medical problem or concern (e.g., child health services per the AAP periodicity schedule and immunizations) must be provided within four weeks of the request for services by the child or the parent/guardian.
- ***Routine Symptomatic Care*** - in which there is a medical concern, but for which there is no urgent or emergency condition, is to be provided within two weeks.
- ***Urgent Care*** - medical care for health problems 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) or do substantially restrict the enrollee’s activity (e.g., infectious illnesses, flu, respiratory ailments, etc.), must be provided within 24 hours.

- **Emergency Care** - those inpatient, outpatient and physician/dental services which are needed immediately because of an injury or unforeseen medical condition and are considered necessary to prevent permanent damage to the enrollee's health, in accordance with the prudent layperson's standard, must be provided immediately.

## Authorizations and Referrals

Referral services for CMS Network enrolled children are prior authorized by the child's primary care physician.

In the event that a physician/dentist is unable or unqualified to provide a covered service to an assigned CMS child, the physician or dentist shall refer only to other CMS participating physicians/dentists unless the required covered service is unavailable through an approved CMS provider.

### **Emergency Care**

Emergency care is to be provided to the child without prior authorization. The physician will notify CMS of all emergency referrals the next business day following the admission.

The physician shall admit CMS children requiring hospitalization or ancillary services only to CMS approved hospitals and facilities unless the necessary services are not available from a participating hospital or facility.

When admitting a CMS child to an out of network physician, hospital or facility, the physician will obtain prior authorization as outlined below, except in the case of an emergency.

### **Out-of-network Services**

- In-state services not available within the CMS Network must be prior approved by the local CMS Medical Director.
- Out-of-state services must be prior approved by the CMS Deputy Secretary of Health.

Approved CMS physicians providing primary care services for CMS Medicaid children must provide and authorize all services identified in the MediPass provider contract.

If the physician/dentist provides services to a CMS child who is enrolled in the Medicaid program, the physician will be bound by laws and regulations administered by the Florida Agency for Health Care Administration (AHCA).

## Reimbursement

Services will be compensated based on the client's funding source.

### **Medicaid Clients**

All Medicaid covered services are to be billed to Medicaid or Medicaid managed care entity in which the child is enrolled. Medical services not

covered by Medicaid may be provided with the approval of the local CMS Medical Director, if the services are determined to be medically necessary. Documentation of medical necessity will be required.

There are no co-payments or deductibles in this program.

### **Title XXI CMS Network Enrollees (Florida KidCare)**

The Title XXI CMS Network benefit package is consistent with the Medicaid state plan benefit package, excluding waiver services.

Claims for services provided to Title XXI CMS Network enrollees are submitted to CMS-KIDS/MED3000, the Children's Medical Services third party administrator.

Families of Title XXI CMS Network enrollees pay a monthly premium for Florida KidCare coverage. There are no copayments or deductibles for these enrollees. Balance billing is prohibited.

### **Private Insurance**

The primary plan benefit package is used. Services rendered to CMS enrolled clients should be billed to the private insurer. Services not covered by private insurance may be provided with the approval of the local CMS Medical Director, if services are determined to be medically necessary. Documentation of medical necessity will be required.

Applicable co-payments and deductibles will apply. The family is generally responsible for meeting the deductible or covering the co-payment.

### **Reimbursement Rates for CMS Network Clients**

Except for services covered by private insurance, Medicaid reimbursement rates are used for all other services provided to CMS Network clients regardless of funding source. Medicaid policy is used with regard to service coding and coding appropriateness. Medicaid reimbursement rates are defined as:

- The published current year Medicaid rate for the provided service.
- The rate Medicaid would pay for a prior approval, by report, or miscellaneous coded service using Medicaid policy.

Medical/dental services that do not have Medicaid rates, under special situations approved by the local CMS Medical Director, will be reimbursed at no more than 60% of the provider's usual and customary fee.

**Claims Submission** Physicians/dentists should submit claims for payment within 90 days of the date of service.

Physicians/dentists may not receive dual compensation for the

interpretation of diagnostic tests during a clinic visit.

Florida Statutes mandate that CMS funds are residual to all other resources. Therefore, CMS physicians/dentists must bill third party payers, including Medicaid, before seeking reimbursement from Children's Medical Services.

### **CMS or Medicaid Funding**

When State funding for a service is accepted as payment by a physician or dentist, that reimbursement must be considered "payment in full." Neither the client, family, nor third party payer can be billed for the balance of the service.

### **Private Insurance**

When a third party reimburses a physician or dentist less than the Medicaid rate, CMS may be billed for the difference up to the allowable Medicaid rate. Clients or families may not be additionally billed for the services.

## **Records and Quality Assurance**

The physician/dentist will maintain client records in a manner that is current, detailed, and organized in a manner that permits effective and confidential patient care.

The physician/dentist will maintain records and information including, but not limited to, information relating to the provision of covered services to CMS children, the cost of said services, and payment received by the provider on behalf of the client.

The physician/dentist will make medical records available to other healthcare providers, subject to applicable confidentiality requirements, when such records are necessary for evaluating and treating the client.

Client records must be retained for **at least ten (10) years** from date of service.

A CMS client's records will be made available to the client or their family (for dependent children) upon request. Applicable records request fees may apply for copies of such records.

Physician/dentist records will be made available for review to CMS as necessary for quality assurance reviews or as necessary to comply with the provisions of Florida laws and regulations.

Participating CMS physicians and dentists agree to remain licensed to practice medicine in the State of Florida and shall comply with all laws and regulations pertaining to such practice. Physicians and dentists are required to comply with CMS approval and renewal processes to maintain active CMS provider participation status.

**Physician Extenders** An approved CMS physician must provide primary, secondary and tertiary physician services to CMS enrollees. When a physician extender (ARNP or PA) is employed by the physician and involved in the care of a CMS enrollee, the physician shall include a note in the record that documents that the physician has examined the child, concurs with the findings and is managing the overall care of the child. Payment for services provided to CMS children through this collaborative arrangement is made to the physician.

The physician extender may see CMS enrollees independently of the physician, if the physician has a presence in the practice location and the physician extender has completed the CMS Approval Process. *Refer to the CMS Provider Handbook - Licensed Non-Physician Healthcare Professionals.*

Primary care/specialty physician extenders may provide on-call coverage for supervising primary care physicians (Pediatrician, Family Practice, Internal Medicine) as long as the extender's protocols address the following two issues:

- The name of the CMS approved physician who will admit for the physician extender in the event that the supervising physician is unavailable; and
- The name of the CMS approved physician who will provide back-up supervision in the event that the supervising physician is unavailable.

### **Malpractice Coverage**

Physicians and dentists shall maintain the minimum required liability insurance coverage or otherwise maintain and be able to demonstrate compliance with the mandatory financial responsibility requirements and policies relating to those engaged in the practice of medicine as set forth in the provider's relevant practice act in the Florida Statutes.

Under certain circumstances for services provided within the scope of the physician's or dentist's participation in the CMS network on a case by case basis, the physician/dentist may be considered an agent of the state within the meaning of Section 768.28, Florida Statutes (Sovereign Immunity).

It is a matter of prudence and good sense, as well as in the best interests of CMS and the provider that CMS physicians and dentists carry appropriate insurance for their own protection (as well as for licensure purposes), in the event that the provider is sued and is determined by the courts to not be agents of the state under the circumstances of the particular lawsuit.

In the event of a lawsuit, however, the Department of Health will continue its practice to evaluate each case on its own merits and particular factual circumstances. Invariably, the Department has provided such assistance as it can under the particular circumstances of each case. In appropriate cases, such as *Stoll v. Noel*, the Department can add its voice to the

proposition that the physician/dentist should be considered an agent of the state under the facts and circumstances of the particular case.

**Dispute Resolution** With exception of professional malpractice issues, the parties shall first attempt in good faith to resolve any dispute, controversy, or claim arising out of the professional relationship between the physician/dentist and CMS. In the event that the dispute remains unresolved, the physician or dentist should contact the local CMS Medical Director or local Early Steps Director. *Refer to Complaint & Grievance Policy & Procedure Section.*

**Termination from Participation** In the event that a physician's or dentist's participation with CMS is terminated by either the provider or by CMS, a 90-day notice shall be provided to the other party and to CMS children receiving services from the physician or dentist. The 90-day notice is to assure adequate time to transfer care of the child to another CMS provider.

**CMS Complaint & Grievance Policy & Procedures** For Medicaid provider issues involving eligibility or reimbursement, the provider must utilize the Medicaid Program grievance procedure to access the Florida Division of Administrative Hearings or the court system.

For complaints regarding CMS Area Office issues, please contact the CMS Medical Director for the specific office. For complaints regarding local Early Steps issues, please contact the local Early Steps Director.

**Federal Anti-Kickback Laws** Each provider will have read and understand the federal requirements outlined in 42 CFR 1001.1001 and 1001.1051 and 42 USC 1320a -7b (criminal penalties for acts involving Federal health care programs). <http://oig.hhs.gov/fraud/docs/safeharborregulations/safefs.htm>

**SECTION III – APPLICATION PROCESS & GENERAL CRITERIA**

The Children’s Medical Services (CMS) provider application and approval process is not a licensure process, but a quality assurance process to ensure that participating CMS physicians and dentists meet established minimum standards deemed necessary for the provision of quality medical services to children, adolescents, and young adults with special healthcare needs.

**Physician & Dentist Provider Types (currently credentialed):**

- Doctor of Medicine (MD)
- Doctor of Osteopathic Medicine (DO)
- Doctor of Dental Medicine (DMD)
- Doctor of Dental Surgery (DDS)
- Doctor of Podiatric Medicine (DPM)
- Doctor of Chiropractic (DC)

**Application Process**

To assure timely review of provider qualifications consistent with national quality standards, the entire provider approval process must be completed within 180 days of the signed/electronically submitted application. However, CMS Central Office Provider Management staff strive to accomplish the entire application process within (30) days and maintain an approval process tracking system to ensure compliance with required timeframes.

**Begin your online application at [www.cmskidsproviders.com](http://www.cmskidsproviders.com)**

Hardcopy (paper) applications are no longer accepted.

*Be sure to submit your online application (**click on submit**) to initiate a review of the application by the Provider Management team.*

You will be notified of receipt of application documentation by the Provider Management team within (7-10) business days of receipt. If the application is incomplete, you will be requested to submit the required documentation within (21) days. Failure to achieve a complete application within the thirty (30) day time frame may result in the application process being stopped or dismissed.

Please see the **Physician & Dentist Application Checklist** at [www.cms-kids.com](http://www.cms-kids.com) under the Provider tab for streamlined application process instructions.

**CMS Physician Participation Criteria**

Physicians wishing to participate as a CMS provider **must provide the following items in addition to their online application:**

- Copy of **Form W9(s)** for each pay to/remit practice affiliation (solo/group/hospital) to ensure accurate claims payment.
- Copy of current **Curriculum Vitae** documenting previous five (5) year work/educational history in a month/year timeline, *with explanation of any gaps longer than 90 days in employment.*
- Copy of current, valid **State of Florida Medical Quality Assurance (MQA) license**

- Individual **National Provider Identification (NPI)** number
- Copy of **Board Certification** in the specialty for which you are requesting approval. Review the Board Certification\* section below for exceptions and additional information.
- Copy of current **DEA Certification**, if applicable.
- **Level II Security Background** investigation pursuant to Florida Statute Chapter 435 standards completed within the past 12 months.
- Summary of professional liability claim(s) pending or filed against you within the past five (5) years. Provide detailed information as indicated on the **Professional Liability Claim Form**, if applicable.
- Summary of **Medicaid and Medicare sanctions** within the past five (5) years, if applicable. Provide date of occurrence, amount paid and brief summary of events for each sanction.
- Copy of **Letter of Transfer Agreement** or a copy of an existing agreement on file with an AHCA approved facility, signed and dated within the last year (*Pediatrics, Internal and Family Medicine only*).
- Current **malpractice coverage** in accordance to your specific Florida Statute practice act or bond that complies with the physician's relevant practice act in the Florida Statutes.

#### **\*Board Certification**

CMS will require all participating physicians to be board certified in their area of practice.

- Board Certifications will be verified from one of the following sources:
  - ❖ American Board of Medical Specialties (ABMS)
  - ❖ Copy of Board Certificate from the appropriate specialty board
- Non-board certified applicants who meet requirements for board certification examination may be approved for active status pending completion of board certification. The provider must achieve board certification before their three (3) year renewal date.
- A previously approved and board certified physician, whose board certification has lapsed at the time of renewal will be given a three year grace period to renew their board certification.
- Specialty physician providers who have not yet obtained their specialty board certification must be certified by their primary board, when applicable, before they will be eligible to provide specialty services to CMS children.
  - ❖ Non-board certified specialty physicians must achieve specialty board certification before their three-year renewal

date to continue to provide specialty services to CMS children, unless certification process is a multiphase process.

- ❖ For those specialties that have a multiphase certification process, the physician must have passed the first step of the board certification process and they must demonstrate an active, continuing pursuit of board certification at the time of their renewal review to continue to provide specialty services to CMS children.
- Subspecialty physicians not providing primary care services are not required to maintain active certification from their primary board.

Under special circumstances and when in the best interests of CMS participants, the CMS Deputy Secretary of Health may grant, upon recommendation from CMS Medical Director, CMS approved provider status to any physician or dentist licensed in the State of Florida.

**CMS Dentist,  
Podiatrist, and  
Chiropractor  
Participation Criteria**

Dentists, podiatrists and chiropractors wishing to participate with CMS **must provide the following items in addition to their online application:**

- Copy of **Form W9(s)** for each pay to/remit practice affiliation (solo/group/hospital) to ensure accurate claims payment.
- Copy of current **Curriculum Vitae** documenting previous five (5) year work/educational history in a month/year timeline, *with explanation of any gaps longer than 90 days in employment.*
- Copy of current, valid **State of Florida Medical Quality Assurance (MQA) license**
- Individual **National Provider Identification (NPI)** number
- Copy of any **Specialty Certifications** (*Dentists, Podiatrists, Chiropractors only*)
- Copy of current **DEA Certification**, if applicable.
- **Level II Security Background** investigation pursuant to Florida Statute Chapter 435 standards completed within the past 12 months.
- Summary of professional liability claim(s) pending or filed against you within the past five (5) years. Provide detailed information as indicated on the **Professional Liability Claim Form**, if applicable.
- Summary of **Medicaid and Medicare sanctions** within the past five (5) years, if applicable. Provide date of occurrence, amount paid and brief summary of events for each sanction.

**Specialty Program  
Participation Criteria**

***Please be sure to review the specific participation criteria and provisions in Section IV for the specialty programs that you wish to participate in.***

## SECTION IV - SPECIALTY PROGRAM CRITERIA & PROVISIONS (PHYSICIANS)

In addition to the information outlined in Section II and III, physicians participating in some CMS Specialty Programs will be required to meet and comply with additional program-specific provisions and criteria.

### Children's Medical Services Specialty Programs

- Early Steps (ES)
- Child Protection Team (CPT)
- Medical Foster Care (MFC)
- Regional Perinatal Intensive Care Centers (RPICC)

### EARLY STEPS (ES)

Early Steps is administered by Children's Medical Services in accordance with Part C of the Individuals with Disabilities Education Act (IDEA). Early Steps offers early intervention services for families with infants and toddlers (birth to thirty-six months) who have developmental delays or an established condition likely to result in a developmental delay. Fifteen (15) contracted local Early Steps offices across the state coordinate the delivery of needed support and services with community agencies and other contracted providers.

Local Early Steps (LES) offices also implement the Developmental Evaluation and Intervention Programs (DEI) to identify and serve at risk infants in neonatal intensive care units, based on the availability of funds.

Florida has a wide range of children and families, providers, community programs and agencies that comprise the early intervention system. Given the diversity in Florida regarding socioeconomic levels, geographic location, cultural, linguistic, and ethnic backgrounds, as well as diversity in disability type, personnel development must include knowledge and skills adequate to meet the needs of a broad range of children and families. The service delivery system is family-centered and focuses on young children with special needs and their families. Services accommodate families by being flexible, individualized, and respectful of cultural diversity and support families to mobilize their resources to meet their needs.

In addition to the information outlined in the General Provisions section, physicians participating in the Early Steps (ES) program will meet and comply with the following ES specific criteria and requirements.

#### Early Steps Participation Criteria

- A current, active Medicaid numbers (Early Intervention Services) is required prior to serving Medicaid children.
- Medicaid numbers (EIS) are not required prior to CMS/ES temporary (one year) approval and are only required for those provider types eligible for enrollment with Medicaid.
- For those providers in temporary status, at the time of their renewal, if they have not obtained the appropriate Medicaid number, they will be removed from Early Steps participation.

#### ES Provider

All Early Steps Medical Directors and physicians providing direct medical

**Standards** services or medical oversight functions for children enrolled in Early Steps must be a member of the CMS Approved Provider Panel, and are therefore subject to the requirements and process outlined in this handbook for attaining active CMS participation status.

**ES Access to Care** Participating CMS Early Steps physicians will neither differentiate nor discriminate in the treatment of or in the quality of services delivered to Early Steps clients on the basis of race, color, national origin, religion, disability or gender. Providers may not refuse to provide a covered service to assigned or referred Early Steps clients, as long as the services are within the providers’ capabilities and resources.

Participating physicians must agree to provide care in accordance with the following Part C of the Individuals with Disabilities Education Act (IDEA) service definitions:

- **Medical Services** means services provided by a licensed physician for diagnostic or evaluation purposes to determine a child's developmental status and need for early intervention services.
- **Health Services** means services necessary to enable a child to benefit from the other early intervention services during the time that the child is receiving the other early intervention services. 20 U.S.C.1432(4)(E)

**ES Terms & Conditions** As an approved CMS Early Steps provider, the following terms and conditions will apply:

1. CMS approved Early Steps healthcare professionals are eligible to provide services in the Early Steps system through a provider agreement with a Local Early Steps program.
2. Local Early Steps programs are under no obligation to employ or contract with a health care professional based solely on the fact that the professional has been approved as a CMS Early Steps provider.

**ES Authorizations & Referrals** Approved CMS Early Steps physicians will provide early intervention services as authorized by the Local Early Steps (LES) offices and through the child’s Individualized Family Support Plan (IFSP).

For services provided to CMS Early Steps children who are enrolled in the Medicaid program, the physician will be bound by laws and regulations administered by the Agency for Health Care Administration (AHCA).

**ES Reimbursement** Refer to Component 1 of the *Early Steps Handbook and Operations Guide* at <http://www.cms-kids.com/home/resources/policies.html>

**ES Claims Submission** Physicians should submit claims for payment within 60 days of the date of service.

Part C of the Individuals with Disabilities Education Act (IDEA) mandates

that CMS Early Steps funds are residual to all other resources. Therefore, CMS Early Steps physicians must bill third party payers, including Medicaid, before seeking reimbursement from CMS Early Steps (Part C). When Part C funding for a service is accepted as payment by a physician, this reimbursement must be considered "payment in full". Neither the family, nor third party payers, can be billed for the balance of the service.

Additional information related to this topic may be found in *Component 1 of the Early Steps Handbook and Operations Guide*.

### CHILD PROTECTION TEAM (CPT)

CPT supports the Department of Children and Families and designated sheriff’s offices to serve children who are reported to the child abuse hotline. The Child Protection Teams provide screening for all hotline reports to identify children, mandated by law, who are referred to a child protection team for assessment. The teams provide individualized, medically directed, multidisciplinary team assessments and make recommendations to the Department of Children and Families. The assessment includes an analysis of risk factors and recommendations for the objective of preventing further abuse.

In addition to the information outlined in the General Provisions section, physicians participating in the Child Protection Team (CPT) program will meet and comply with the following CPT specific criteria and requirements.

- CPT Physician and Medical Director Participation Criteria**
- Must be credentialed/CMS approved
  - Must be Board Certified in Pediatrics
  - Must have demonstrated interest in and received training in child abuse and neglect diagnosis; maintain direct medical skills in medical evaluations of child abuse and be willing, as directed by CMS, to continue child abuse and neglect in-service training.

**CPT Physician and Medical Director Standards** All physicians providing direct medical services or medical oversight functions for a Child Protection Team must be a member of the CMS Approved Provider Panel, and are therefore subject to the requirements and processes outlined in this handbook for attaining active CMS physician status.

The CPT Statewide Medical Director, Associate Medical Director, and the CPT Medical Director must be available 24 hours a day, 7 days a week, or have arranged coverage by another CPT Medical Director.

#### Child Protection Team Medical Director

CMS physicians desiring to be a Child Protection Team Medical Director must be an approved CMS physician, must be recommended by the designated statewide Child Protection Team Medical Director, be board-certified in pediatrics, have demonstrated interest in and received training in child abuse and neglect diagnosis, maintain direct medical skills in medical evaluations of child abuse and be willing, as directed by CMS, to

continue child abuse and neglect in-service training. Under special or extenuating circumstances, the Deputy Secretary of CMS may waive the provision of board certification in pediatrics for a specified period of time.

By law, appointment to the position of a CPT Medical Director requires the concurrence of the State Surgeon General of the Florida Department of Health and the Secretary of the Florida Department of Children and Families.

### **Statewide CPT Medical Director**

The above standards also apply to the position of statewide CPT Medical Director.

### **CPT Statewide Medical Oversight**

The Department of Health contracts for statewide medical oversight of the Child Protection Team Program and designates a statewide Child Protection Team (CPT) Medical Director to oversee the program. Functions of the statewide director include the evaluation of services provided by individually appointed team medical directors. The statewide CPT Medical Director provides these oversight functions under the direction of the Children's Medical Services (CMS) Deputy Secretary of Health.

### **CPT Local Area Medical Services and Oversight**

#### **CPT Medical Oversight**

While working functionally under the statewide Medical Director, individual CPT Medical Directors are employed by the department, and are under the overall direction of the CMS Deputy Secretary of Health. In addition to other duties, a team CPT Medical Director is responsible for supervision and review of medical personnel work providing medical evaluation services for a team.

#### **CPT Medical Evaluation Services**

Medical services for a team are provided by CMS physician providers and other licensed medical personnel. Services can include abuse report screening, medical evaluation of or medical consultation for a specific child. Remuneration for these services is provided by the administering agency of the local team.

#### **Local CPT Administering Agencies**

The department contracts with a variety of non-profit and public agencies to administer team services throughout the state. These agencies provide and purchase medical, legal, and other professional services as needed to provide team services in their designated local areas. CMS physician direct medical evaluation services and travel expenses related to CPT functions are paid by the local administering agency.

#### **Child Protection Team Program Handbook**

For more information on the Child Protection Team Program, please refer to the *CPT Program Handbook*. This handbook may be obtained from

your local area Team Coordinator.

**CPT Dispute Resolution**

With exception of professional malpractice issues, the parties shall first attempt in good faith to resolve any dispute, controversy, or claim arising out of the professional relationship between the physician and CMS. In the event that the dispute remains unresolved, the CPT physician should contact the appropriate level of the following three positions: the team CPT Medical Director, the statewide CPT Medical Director, or the CMS Deputy Secretary of Health.

**MEDICAL FOSTER CARE (MFC)**

The MFC Program is a coordinated effort between the Florida Medicaid Program within the Agency for Health Care Administration, the Children’s Medical Services, Department of Health and the Child Welfare and Community Based Care Program within the Department of Children and Families. The program provides family-based care for medically complex children under 21 years old, in the legal custody of the Department of Children and Families, who have been assessed and referred to MFC by the Children’s Multidisciplinary Assessment Team (CMAT). The MFC team for each area consists of a registered nurse, social worker, nursing supervisor, medical director, and trained medical foster parents, who are also Medicaid providers.

In addition to the information outlined in the General Provisions section, physicians participating in the Medical Foster Care (MFC) program will meet and comply with the following MFC specific criteria and requirements.

**MFC Physician and Medical Director Participation Criteria**

MFC Physicians and Medical Directors are appointed by the local CMS area office medical director and approved by the CMS Deputy Secretary of Health.

**MFC Specific Services/Activities Provided**

The MFC Program establishes and supervises the oversight and training of foster parents to provide MFC services for children with medically complex needs. Medical Foster Parents receive child specific training provided by a MFC team in order to take care of the child’s physical, emotional, and health care needs.

MFC parents also serve as role models to train the birth family on how to care for their child’s special medical needs so the child can return home. Each parent maintains a very comprehensive in-home record book that documents all the care provided to the child. This book also includes the plan of care which lists out for the parent exactly what care is to be provided with instructions in how to provide the care. Services provided by the team include 24-hour call-in system, support and care coordination, education on medical care, reunification with birth parents, adoption assistance, and follow-up services.

**MFC Statewide Physician Consultant**

The statewide MFC physician consultant is a CMS-approved pediatrician appointed by the DOH Deputy Secretary for CMS. The statewide MFC physician consultant assures that each local MFC Program has strong and available medical direction which addresses each MFC child’s medical needs. The statewide MFC physician consultant provides statewide consultation to local treating physicians caring for MFC children

and CMS Central Office staff regarding the MFC Program.

### **MFC Medical Director**

The MFC Medical Director is a pediatric CMS provider appointed by the local CMS area office medical director and approved by the CMS Deputy Secretary. All MFC medical directors will designate a back-up MFC medical director in their absence that must also be a pediatric CMS provider and approved by the CMS area office medical director.

Responsibilities of the MFC MD or their MD designee include but are not limited to:

- Reviewing each MFC child's medical record including the plan of care and current medical orders;
- Attending regularly scheduled meetings with MFC staff;
- Monitoring each MFC child's health status;
- Providing medical direction for the MFC Program;
- Providing consultative services;
- Notifying DCF or its CBC provider regarding a child who is at risk or is experiencing a significant medical condition(s) in which loss of life may occur;
- Determining Level of Reimbursement for MFC children when necessary;
- Reviewing and recommending the placement of each MFC child to MFC Program personnel who will, in turn, notify DCF or CBC;
- Participation in dispute resolution activities regarding the recommended placement of MFC children;
- Reviewing the on-going quality and appropriateness of MFC services and home requirements provided by MFC parents;
- Approving MFC parents and homes that meet MFC program standards;
- Providing corrective action to MFC parents when needed;
- Determining if a MFC parent should be withdrawn from the MFC Program, and
- Documenting the above activities in the appropriate record.

For more information on the Medical Foster Care Program, please refer to the *Medical Foster Care Statewide Operational Plan*. This plan can be found on the CMS Network Division SharePoint in the Quality Management Section.

### **REGIONAL PERINATAL INTENSIVE CARE CENTERS (RPICC)**

The Regional Perinatal Intensive Care Center (RPICC) Program serves high risk pregnant women and sick or low birth weight babies requiring Neonatal Intensive Care Unit (NICU) services. The RPICC Program provides inpatient and outpatient services at eleven (11) regional centers, and community-based, consultative obstetrical services for high-risk pregnant women at

eight (8) satellite clinic sites.

In addition to the information outlined in the General Provisions section, physicians participating in the Regional Perinatal Intensive Care Centers (RPICC) program will meet and comply with the following MFC specific criteria and requirements.

**RPICC Physician and Medical Director Participation Criteria** All RPICC Medical Directors and physicians providing direct medical services or medical oversight functions for a RPICC center or OB Satellite clinic must be a member of the CMS Approved Provider Panel, and are therefore subject to the requirements and process outlined in this handbook for attaining active CMS physician status.

**RPICC Neonatal Medical Director**

Must be board certified in Neonatology.

**RPICC Neonatologist**

Must be board certified in Neonatology or eligible to take the written Neonatology examination and must demonstrate an active, continuing pursuit of board certification at the time of CMS renewal review.

**RPICC Obstetrical Medical Director**

Must be board certified in Obstetrics-Gynecology or has passed the written OB-GYN exam and is an active candidate to take the oral exam, and must be board Certified in Maternal Fetal Medicine or has passed the written MFM exam and is an active candidate to take the oral exam.

**RPICC Obstetrician**

Must be board certified in Obstetrics or must have passed the written examination of the OB/GYN board certification process and they must demonstrate an active, continuing pursuit of board certification at the time of CMS renewal review.

**Maternal Fetal Medicine Physician**

Must be board certified in Obstetrics-Gynecology or has passed the written OB-GYN exam and is an active candidate to take the oral exam, and must be board Certified in Maternal Fetal Medicine or has passed the written MFM exam and is an active candidate to take the oral exam.

**RPICC Obstetric Satellite Clinic Physician**

Must be board certified in Obstetrics-Gynecology or has passed the written OB-GYN exam and is an active candidate to take the oral exam, and must be board Certified in Maternal Fetal Medicine or has passed the written MFM exam and is an active candidate to take the oral exam

**RPICC Reimbursement**

**Medicaid RPICC Clients**

Payment for obstetrical outpatient services should be billed using Medicaid fee-for-service reimbursement.

Payment for neonatal and obstetrical inpatient services is based on one of the diagnosis-related groups for obstetrics and neonates listed below:

- OBCG - Obstetrical Care Group
- NCG – Neonatal Care Group

The RPICC payment is a global fee that covers all physician services or procedures performed by the RPICC provider group. All other Medicaid fee-for-service reimbursement must be billed through the non-RPICC provider group number.

RPICC services cannot be reimbursed by Medicaid for recipients who have other health insurance.

Reimbursement for RPICC services to a Medicaid HMO recipient must be negotiated between the RPICC provider group and the respective HMO.

Providers can be reimbursed only for emergency services provided to aliens who are not eligible for full Medicaid benefits due to their alien status.

Providers cannot receive reimbursement through the RPICC program for Medically-Needy recipients. Medically Needy recipients are not financially eligible for the RPICC Program.

**RPICC Claims Submission**

**Physician Services**

RPICC billing for Medicaid reimbursement of OBCG or NCG payments is done through the RPICC Data System except for the following exceptions, which must be billed on paper claims:

- Neonatal claims with multiple RPICC facility transfers.
- Obstetrical claims with multiple antepartum hospitalizations, sterilizations, or hysterectomies.

When Medicaid funding for a service is accepted as payment by a physician, that reimbursement must be considered "payment in full". Neither the child or family nor third party payers can be billed for the balance of the service costs.

**Allied Health Professionals**

Outpatient services and nurse midwife services including those provided under the personal supervision of the RPICC physician are reimbursed using the Medicaid fee-for-service methodology.

**RPICC Participation Termination**

In the event that a physician’s participation with CMS is terminated by the physician, the RPICC Program or by CMS Program, notice shall be provided to Medicaid to terminate the physician’s participation with the RPICC provider group.

A RPICC neonatal physician may be terminated from participation in the RPICC Program upon failure to demonstrate an active, continuing pursuit of board certification as demonstrated by failure to pass the neonatal boards or failure to take the written neonatal examination at the first opportunity after completion of training in an ACGME approved Neonatal-Perinatal Medicine Fellowship Training Program.

A RPICC obstetric physician may be terminated from participation in the RPICC Program upon failure to demonstrate an active, continuing pursuit of board certification as demonstrated by failure to pass the Obstetrics-Gynecology Boards.

## SECTION V - APPROVAL PROCESS & PARTICIPATION STATUS

The CMS provider approval process incorporates standards and recommendations from the Joint Commission for the Accreditation of Health Care Organizations (JCAHO) National Commission for Quality Assurance (NCQA), and CMS Medical Directors.

### Initial Approval Process

Physicians and dentists who meet all CMS participation criteria with no history of liability claims, Medicaid or licensure sanctions/disciplinary action will be approved for CMS participation. Those providers who meet participation criteria but have a history of liability claims, Medicaid or licensure sanctions/disciplinary action will be reviewed by the CMS Physician Review Committee (PRC). Please see Section VI for further information regarding the Physician Review Committee.

### Participation Status Active Status

Physicians and dentists approved for active participation status have met all approval process criteria and are placed on the CMS Approved Provider Panel for a period of three (3) years. To remain an active provider, physicians and dentists will be required to comply with the CMS renewal process every three (3) years.

### Physician Emeritus Designation

In order to provide CMS with the continued medical and historical expertise of retired CMS approved physician providers, an additional physician participation status is recognized. A designation as Physician Emeritus allows retired physicians to serve in an administrative-only capacity for various CMS programs. Emeritus status will be a lifetime designation.

Physicians meeting all of the following criteria may be conferred Physician Emeritus status by the CMS Deputy Secretary of Health:

- Ten (10) years of experience as a CMS physician provider
- Retired in good standing from active practice
- Recommendation by a CMS Medical Director
- Valid, active or inactive State of Florida medical license

Prior to consideration, a physician candidate must submit the following items:

- Copy of **Form W9(s)** for each pay to/remit practice affiliation (solo/group/hospital) to ensure accurate claims payment.
- Copy of current **Curriculum Vitae** documenting previous five (5) year work/educational history in a month/year timeline, *with explanation of any gaps longer than 90 days in employment.*
- Summary of professional liability claim(s) pending or filed against you within the past five (5) years. Provide detailed information as

indicated on the **Professional Liability Claim Form**, if applicable.

- Summary of **Medicaid and Medicare sanctions** within the past five (5) years, if applicable. Provide date of occurrence, amount paid and brief summary of events for each sanction.
- Completed and signed CMS attestation.

### **Temporary Status**

Under special circumstances a physician or dentist may be granted Temporary Provider status for a period of up to one (1) year.

### **Emergency Approval**

Upon request by the local CMS area office Medical Director, emergency provider participation approval may be granted by the CMS Deputy Secretary of Health to provide continuity of care or access to care to CMS enrollees. Emergency approval is time limited, not to exceed 90 days, pending submission of a completed CMS provider application.

### **Non-approved Status**

In rare instances, physicians or dentists may be denied, suspended, or terminated from participation with CMS. Such instances include, but are not limited to, the following:

- the revocation, suspension or limitation of a provider's healthcare license, certification, medical or clinical privileges at any licensed facility, or the authorization to dispense or prescribe narcotic drugs;
- the revocation, suspension or limitation of a provider's right to participate in the Medicaid program;
- findings of professional misconduct or incompetence by any governmental entity or professional organization with competent jurisdiction;
- failure to provide competent service or to comply with CMS patient care standards;
- findings of fraud, embezzlement, acts of moral turpitude, dishonesty, or any other acts which might adversely affect Children's Medical Services, or CMS clients or families;
- legal incompetence, repeated or untreated substance abuse or total and/or permanent incapacity;
- failure to refer within the CMS network of providers (this excludes referrals made in the best interest of the child which have been prior authorized by the local CMS Medical Director)
- failure to comply with CMS Provider approval and renewal processes and criteria;
- failure to notify CMS of change of address resulting in loss of

contact with provider.

Notification of provider status will be mailed to applicant within fifteen (15) days of status determination. CMS will notify a participating provider upon identifying information that may adversely affect the provider's continued participation with CMS. *Refer to Provider's Rights Section.*

## Renewal Process

### **Temporary Status**

Ninety (90) days before the end of the one-year anniversary of CMS temporary participation approval date, CMS Provider Management staff will mail a renewal notice with instructions on how to complete the renewal application process.

The physician/dentist must complete and submit the electronic online application within (30) days to determine Temporary or Active provider status.

The renewal application process proceeds exactly as the initial application process, including verifications, review, and approval.

### **Active Status**

Ninety (90) days before the end of the three-year anniversary of CMS active participation approval date, CMS Provider Management staff will mail a renewal notice with instructions on how to complete the renewal application process.

The physician/dentist must complete and submit the electronic online application within (30) days to maintain Active provider status.

The renewal application process proceeds exactly as the initial application process, including verifications, review, and approval.

## Interim Reviews

To ensure on-going quality assurance, participating providers may be subject to interims reviews through the following mechanisms:

- **Practice Site Reviews** – conducted as part of the initial approval process for CMS primary care physicians; or
- **Ad Hoc Reviews** – as determined by the CMS Deputy Secretary of Health triggered by any of the following criteria:
  - Questions concerning medical decision making;
  - Complaints, grievances or concerns regarding quality;
  - Issues identified during the provider renewal process;
  - Increased incidence of morbidity; and
  - Child deaths.

## SECTION VI - PHYSICIAN REVIEW COMMITTEE

**The Physician Review Committee (PRC) is responsible for reviewing provider applications that contain special circumstances and then provide recommendations to the Deputy Secretary of Health for participation status determination. The PRC helps to assure the provision of high quality medical and dental services to children with special health care needs while helping to ensure that provider rights are protected.**

**Structure** The CMS Deputy Secretary of Health is directly responsible for the CMS provider approval processes and the PRC.

The CMS Deputy Secretary of Health appoints the PRC members to conduct reviews of provider application files providing technical knowledge reviews that focus on quality of care, particularly for determining participation status in special circumstances.

Special circumstances include providers who meet established CMS criteria but have potential quality issues identified; including but not limited to: those with sanctions, adverse actions, performance deficits, and paid, pending or settled liability claims. The committee will discuss each individual case and present their recommendations to the CMS Deputy Secretary of Health at regularly scheduled committee meetings. The Deputy Secretary makes the final decision to approve, disapprove or terminate a provider's CMS participation status.

**Committee Composition** The Physician Review Committee is composed of six (6) appointed members, including:

- Four (4) Florida licensed, board certified pediatric physicians who actively participate in CMS and routinely provide care to CMS children.
- Two (2) physicians who are board certified in a pediatric subspecialty; and

Ad hoc consultants may be used to review files of subspecialty providers.

A Committee Chair is elected by majority vote of the PRC and approved by the Deputy Secretary of Health.

**Membership Terms** Each PRC member serves a three-year term and may be reappointed for a consecutive three year term. The PRC uses a staggered rotation process, rotating members off each year to provide PRC continuity. After a one-year hiatus, a member may serve another three-year term. Due to the need to approve provider participation in a timely manner, a PRC member who does not participate in a minimum of 75% of scheduled meetings will be removed from PRC participation.

**Function** The PRC will use their technical knowledge to conduct reviews of provider applications with quality issues and special circumstances for the determination of participation and renewal status. The PRC will receive

and review:

- A list of the names of providers who meet established CMS provider criteria and have no potential quality issues identified. The PRC may choose to review the credentials of those that meet criteria; and
- The credentials of providers who do not meet established CMS criteria and/or have potential quality issues identified. Exception cases include, but are not limited to those with sanctions, adverse actions, performance deficits, and paid, pending or settled lawsuits or lack board certification.

The PRC will recommend approval, disapproval, suspension or termination to the CMS Deputy Secretary of Health. The recommendations will be based on established CMS requirements for CMS participation and applicable standards of care, as well as reasons for termination listed in the CMS Provider Handbooks. The CMS Deputy Secretary of Health will make final participation status determination.

## Meeting Process

CMS Provider Management staff facilitates the PRC's meetings by preparing and sending files to PRC members prior to a scheduled meeting. CMS Provider Management staff (RN Consultant) attends PRC meetings to represent CMS Central Office.

The PRC will be provided the meeting agenda. The agenda will list all applicants and providers due for approval, renewal or other review by region and specialty. To facilitate a quality review process, the applicants and providers will be listed on the agenda and minutes in a blind format. The agenda will identify and describe any approval process element defined as an exception. Complete files will be available to the PRC for review and discussion.

Following PRC review and thoughtful consideration of a provider's credentials, a vote will be taken recommending one of the following participation statuses:

- **Approved (Active)** - Approve provider for participation for (3) years.
- **Temporary** - Approve provider for participation for up to (1) year.
- **Disapproved** - The applicant does not meet stated professional requirements.
- **Pending** - The committee may request additional information or research in order to make a recommendation. In this case, the application will be pending until the next meeting.
- **Suspension** - For substantive information differences or when a CMS patient's health and safety may be in eminent danger an emergency suspension may be invoked pending a hearing process and final resolution.
- **Terminated** - Approved provider reviewed for renewal does not meet the stated professional requirements.

Where a real or perceived conflict of interest may occur, a PRC member shall abstain from voting on any applicant. In situations where the PRC cannot reach a decision, the provider's file will be submitted to the CMS Deputy Secretary of Health for participation status determination.

**Frequency of Meetings**

PRC meetings will be scheduled monthly. The meetings may be conducted via conference call with necessary review information supplied confidentially to each member by mail prior to the meeting.

Additional meetings may be called by the CMS Deputy Secretary of Health on an as needed basis to emergently review quality issues that may adversely affect the provision of quality medical services within the CMS network of providers.

## SECTION VII - PROVIDER RIGHTS

The Children's Medical Service's (CMS) provider approval process is not a licensure process, but a quality assurance process to ensure that participating CMS providers meet established minimum standards deemed necessary for the provision of quality medical services to children with special health care needs.

The CMS provider approval process focuses on verification of credentials and qualifications. The renewal process focuses on re-verification of credentials and an historical review of the professional's relationship with CMS based on defined criteria for continued participation status.

CMS recognizes a provider's interest in the information used to determine acceptance into or continued participation in the CMS Approved Provider Panel. CMS intends to provide a high quality and efficient method of healthcare delivery without actively seeking to impair an individual's right to fully practice his or her profession. Thus, CMS intends to provide fair procedures before excluding or terminating providers and recognizes the following provider's rights.

**Right to Review**            Providers are notified of their right to review information used to evaluate their approval applications and update incorrect information. In the event that a provider would like to stop the application process, they can submit a written and signed statement to withdraw their application to the Provider Management team.

**Notification**                CMS Deputy Secretary of Health will notify an applicant upon identifying adverse information concerning a provider that varies substantially from the information provided to CMS by the provider. If the applicant fails to provide an explanation or correction within 30 days of receipt of notification, the application is considered withdrawn and the approval process halts.

CMS Deputy Secretary of Health will notify a participating CMS provider upon identifying adverse information concerning the provider that varies substantially from the information provided to CMS by the provider. Failure to provide a plausible and verifiable explanation or correction within 30 days of receipt of notification will be deemed a voluntary termination of participation by the provider.

For substantive information differences or when a CMS client's health and safety may be in eminent danger, an emergency suspension will take place with hearing procedures described below. If the suspension continues more than 14 days, the provider will be given notice and an opportunity for a hearing. The provider's approval will remain suspended pending final resolution. During any suspension period a provider may not provide health care services to CMS clients.

In rare instances, a provider may be suspended or terminated from the CMS Approved Provider Panel. Such instances include, but are not limited to, the following:

- the revocation, suspension or limitation of a provider's healthcare license, medical or clinical privileges at any licensed facility, or authorization to dispense or prescribe narcotic drugs;
- the revocation, suspension or limitation of a provider's right to participate in the Medicaid program;
- findings of professional misconduct or incompetence by any governmental entity or professional organization with competent jurisdiction;
- failure to provide competent service or to comply with CMS patient care standards;
- findings of fraud, embezzlement, acts of moral turpitude, dishonesty, or any other acts which might adversely affect Children's Medical Services or CMS children or families;
- legal incompetence, repeated or untreated substance abuse or total or permanent incapacity;
- failure to refer within the CMS network of providers (this excludes referrals made in the best interest of the child which have been prior authorized by the local CMS Medical Director);
- failure to comply with CMS approval and renewal criteria;
- failure to notify CMS of change of address resulting in loss of contact with provider.

CMS will notify a participating provider upon identifying information concerning the provider that indicates the provider has failed to maintain:

- Florida state licensure with adequate professional liability insurance or bond, as required by state law;
- Appropriate board certification in practice area;
- Hospital privileges, or Letter of Transfer agreement with a approved CMS physician (physicians only).

All new or corrected information submitted by the provider or on behalf of the provider must be in writing to CMS.

CMS will notify a participating physician or dentist when initiating Physician Review Committee action to limit or terminate participation.

## Right to Hearing

A provider has a right to request a hearing on a proposed review action. The request must be in writing and made within 30 days of the notification. The Hearing Panel will be comprised of at least the following CMS participating providers:

- one professional of the same specialty;
- the local CMS or Early Steps Medical Director; and
- one member of the CMS Physician Review Committee;

The right to a hearing will be forfeited if the provider fails without good cause to appear.

The provider will be notified no less than 30 days from the date of the hearing. The provider will submit to CMS within ten days prior to the hearing a list of the witnesses.

The provider may have representation, may call, examine, and cross-examine witnesses, and may present evidence and may submit a written statement at the close of the hearing. The provider may have a record made of the proceeding or may obtain copies of such record upon payment of charges associated with the preparation of the record.

The provider may submit a written statement within five (5) days of the close of the hearing.

The provider will receive the written recommendations of the Hearing Panel within 20 days of the hearing adjournment. Within seven days of receipt of the recommendation, the provider will be notified in writing of the CMS Deputy Secretary of Health's decision.

The provider may appeal the CMS Deputy Secretary's decision to the State Surgeon General of the Florida Department of Health (DOH). The Surgeon General's decision is final.

**Right to Appeal** The provider may appeal the recommended decision by filing a written appeal within 30 days of notice. The written appeal should demonstrate why the recommended decision is not supported by evidence or is arbitrary and capricious.

The State Surgeon General's decision is final and may not be appealed by either the provider or the Hearing Panel.

In cases in which CMS denies a provider participation approval or terminates a participating provider as a result of conduct based on competence or professional conduct, the CMS Deputy Secretary of Health will report such final actions to the relevant agencies such as, Department of Health Medical Quality Assurance, to the extent required or permitted by law.

**Notice of Administrative Rights** To contest an action that adversely affects the provider's ability to participate in Children's Medical Services, providers have the right to request an administrative hearing under sections 120.569 and 120.57, Florida Statutes. A request for a hearing must be in writing and submitted to CMS Central Office within 21 days of receipt of Notice of Administrative Rights. The request will state the grounds for a hearing, including a statement of all disputed issues of material fact, if any, and why it is felt that the agency's action is improper. Unless waived by all parties, if the provider disputes issues of material fact, section 120.57(1) (formal proceedings) applies. Unless otherwise agreed, section 120.57(2) (informal proceedings) applies in all other cases.

Administrative hearing procedures are governed by Chapter 28-106, Florida Administrative Code. The provider's failure to timely request a hearing shall be deemed a waiver of his or her rights to an administrative hearing and the agency decision shall become final agency action. Mediation is not available. The provider may request judicial review within 30 days of rendition of the final agency action, as prescribed in section 120.68, Florida Statutes, and Florida Rules of Appellate Procedure, by filing a notice of appeal and appropriate filing fees with the appropriate district court of appeal.

A copy of the notice of appeal must be sent to:

Agency Clerk  
Department of Health,  
4052 Bald Cypress Way, Bin A02  
Tallahassee, FL 32399-1703

***For recent updates and provider alerts***  
within Children's Medical Services,  
please visit our website at:

**[www.cms-kids.com](http://www.cms-kids.com)**

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