Children's Medical Services

PROVIDER HANDBOOK

NON-LICENSED HEALTHCARE PROFESSIONALS

2013

Florida HEALTH

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2013 CMS PROVIDER HANDBOOK • NON-LICENSED HEALTHCARE PROFESSIONALS

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SECTION I - INTRODUCTION

Purpose

This handbook was developed to provide CMS non-licensed healthcare professionals an overview of Children's Medical Services programs, provider participation criteria and requirements.

Statutory Authority

Children's Medical Services (CMS): Chapter 391, Florida Statutes (F.S.)

- Florida KidCare: Chapters 391.026 and 409.813-409.814, F.S.
- Titles V, XIX, and XXI, Social Security Act

Child Protection Team (CPT) Program: Chapter 39.303, F.S.

Regional Perinatal Intensive Care Centers (RPICC): Chapter 383.15-21, F.S.

Early Steps (ES): IDEA, Part C, 34 CFR Part 303

CMS Program Overview

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.

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.

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.

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 providers agree to provide or arrange to provide all necessary covered services including emergency services to CMS enrolled children referred to the provider. The provider 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.

Participating CMS providers agree to provide covered services to all assigned or referred CMS children. The provider 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. Providers 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.

Providers may not refuse to provide a covered service to assigned CMS children, as long as the services are within the providers' capabilities and resources.

Authorizations and Referrals

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

If the healthcare professional provides services to a CMS child who is enrolled in the Medicaid program, the provider 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

Providers should submit claims for payment within 90 days of the date of service.

Providers 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 providers 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 provider,

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

The provider 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 provider 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.

Provider 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 providers are required to comply with CMS approval and renewal processes to maintain active CMS provider participation status.

Malpractice Coverage

Solo providers shall maintain individual professional 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 provision of healthcare.

Under certain circumstances for services provided within the scope of the provider's participation in the CMS network on a case by case basis, the provider 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 healthcare providers carry appropriate insurance for their own protection 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 provider 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 provider and CMS. In the event that the dispute remains unresolved, the provider 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 provider'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 provider. 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.

Non-licensed Provider Types (currently credentialed):

Early Steps Only

- Infant Toddler Developmental Specialists (ITDS)
- Hearing Specialists
- Vision Specialists

CMS & Early Steps

- Board Certified Behavior Analysts (BCBA)
- Board Certified Associate Behavior Analysts (BCABA)

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

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 **Non-Licensed Healthcare Professional Application Checklist** at www.cms-kids.com under the Provider tab for streamlined application process instructions.

CMS Participation Criteria

Non-licensed healthcare professionals 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 any **Specialty Certifications**
- **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.
- Copy of required education from accredited University/College. (Early Steps only)
- Current professional liability insurance coverage.
- Documentation of appropriate Professional Early Intervention Experience. (Early Steps Only)

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

In addition to the information outlined in Section II and III, providers 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 for Non-Licensed Healthcare Professionals

- Early Steps (ES)

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, providers participating in the Early Steps (ES) program will meet and comply with the following ES specific criteria and requirements.

Non-licensed healthcare professionals may enroll as an early intervention provider in only one of the professions listed in Chapter 1 of the Medicaid Early Intervention Services Coverage and Limitations Handbook, even if they hold licenses in more than one of those professions.

The following Non-licensed healthcare professional provider types can be credentialed within the Early Steps Specialty Program:

- Infant Toddler Developmental Specialists (ITDS)
- Hearing Specialists
- Vision Specialists
- Board Certified Behavior Analysts (BCBA)
- Board Certified Associate Behavior Analysts (BCABA)

ES Infant Toddler Developmental Specialist (ITDS)

Licensed healthcare professionals are not eligible to enroll as an Infant Toddler Developmental Specialist (ITDS). Licensed healthcare paraprofessionals are eligible to enroll as ITDS providers if they are able

to meet the enrollment criteria.

ITDSs may not apply as a provider through the CMS Provider Management System until they have obtained an ITDS Certificate issued by the Early Steps State Office through a process facilitated by the Local Early Steps office in the provider's area. Refer to Early Steps Policy Handbook and Operations Guide, Component 10 at: http://www.cms-kids.com/home/resources/policies.html

1. **If an ITDS applicant has an ITDS certificate from approved coursework or an approved waiver request for the ITDS modules for certification, the education requirement is:** have a Bachelor's degree or higher from an accredited college or university in early childhood education, early childhood/special education, child and family development, family life specialist, communication sciences, psychology or social work.

   The following may substitute for the degrees specified above:

   - **An equivalent degree based on a transcript review**. In order for their degree to be considered "equivalent", the applicant:
     - Must have completed a minimum of 18 credit hours (typically six courses) in one of the approved fields of study
     - Will be required to submit their transcript and/or a catalog description from the university or college as verification.
     - May use placement, internship or practicum hours to meet either the education requirement or the experience requirement, but not both.

     OR

     - An out-of-field degree and a minimum of five years documented post-degree professional experience in early intervention, which must be hands-on experience with children from birth up to five years old.

2. **ITDS applicants with an ITDS certificate from an approved coursework or an approved waiver request, the work requirement is**: have and be able to document one-year of post-degree professional experience in early intervention.
   - One year of professional experience in early intervention equals 1600 hours of hands-on experience with children aged from birth up to 5 years-old with special needs and/or developmental delays and their families.
   - Time spent in a practicum or internship situation (up to 400 hours) may apply toward the 1600 hours of hands on experience.

- Mentorship may be offered by a Local Early Steps office, but mentorship will not substitute for experience for ITDS providers.
- Volunteer work is not considered professional experience for enrollment requirements.

3. **If an ITDS applicant does not have an ITDS certificate from an approved university or college, the applicant must have a "highly qualified" waiver based on**:
   - Master's degree or higher from an accredited college or university in early childhood education or early childhood/special education, child and family development, family life specialist, communication sciences, psychology, social work, or equivalent degree; or a bachelor's degree in any of the above required fields, or equivalent degree, and one of the following:
     - Department of Education Pre-kindergarten Disabilities Endorsement
     - Certification in SKI*HI, VIISA, INSITE or completion of university certificate in hearing specialist or vision specialist in early intervention
     - Early Intervention Credential or equivalent certificate from another state
   - An ITDS applicant with a highly qualified designation must have one year of documented experience.

4. All ITDS providers that are providing services to a child receiving Medicaid must follow the requirements set forth in the Florida Medicaid, Early Intervention Services, Coverage and Limitations Handbook.
   - Medicaid numbers (therapy, TCM, or 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. (Refer to *Application and Approval Process* section)
   - Current, active Medicaid numbers are required prior to working in CMS/ES if serving Medicaid children.
   - For those providers in temporary status, at the time of their renewal, if they have not obtained the appropriate Medicaid numbers, they will be removed from Early Steps participation.

5. All ITDS providers must have a Level II (FBI) Background Screening: This must be submitted to allow you to begin providing services.
6. All ITDS providers must document completion of Early Steps Online Orientation Modules (1-3): Completion of the Early Steps Orientation Training Modules is not required prior to CMS/ES temporary approval.

ES Board Certified Behavioral Analyst (BCBA)

1. Board Certification from Behavior Analyst Certification Board (BACB)
2. BCBA applicants must document one-year post-degree professional experience in early intervention.
    - One year of experience in early intervention equals 1600 hours of hands-on experience with children aged from birth up to 5 years-old with special needs and/or developmental delays and their families. Time spent in a practicum or internship situation (up to 400 hours) may apply toward the 1600 hours of hands on experience.
    - Without one-year experience: In lieu of one-year experience, you must complete the Early Steps Provider Mentorship Form within six months of being given a status.
        - Completion of mentorship is not required prior to enrolling in the CMS Provider Management System but a documented relationship with their local Early Steps office is required prior to enrollment.
        - Mentorship must be provided by an approved Early Steps provider of the same discipline who is working in the Early Steps system.
        - For those providers in temporary status, at the time of their renewal, if they have not completed their mentorship, they will be removed from Early Steps participation.
    - Practicum or internship experiences completed in a Local Early Steps within the past 18 months, that match those of the mentorship can be documented on the Early Steps Mentorship Documentation Form and apply to the mentorship.
    - Volunteer work is not considered professional experience for enrollment requirements
3. Level II (FBI) Background Screening: This must be submitted to allow you to complete a mentorship, if required, and/or begin providing services.
4. Completion of Early Steps Online Orientation Modules (1-3): Completion of the Early Steps Orientation Training Modules is not required prior to CMS/ES temporary approval.

ES Board Certified Associate/Assistant Behavioral Analyst (BCABA)

1. Board Certification from Behavior Analyst Certification Board (BACB)
2. Board Certified Associate Behavior Analysts must provide the name of their supervising BCBA who must be an enrolled and approved provider with the same specialty program approvals they are seeking.
3. Board Certified Associate/Assistant Behavior Analyst applicants must document one-year post-degree professional experience in early

intervention.

- One year of experience in early intervention equals 1600 hours of hands-on experience with children from birth up to 5 years-old with special needs and/or developmental delays and their families. Time spent in a practicum or internship situation (up to 400 hours) may apply toward the 1600 hours of hands on experience.
- Mentorship in lieu of one year of experience is not an option for associates and assistants.
- Volunteer work is not considered professional experience for enrollment requirements

4. Level II (FBI) Background Screening
5. Completion of Early Steps Online Orientation Modules (1-3): Completion of the Early Steps Orientation Training Modules is not required prior to CMS/ES temporary approval.

ES Hearing Specialist

1. Bachelor's degree or higher in Communication/Speech Disorders, Speech Pathology, Audiology, Deaf Studies or a related field with evidence of additional coursework/training (minimum of 9 hours) specific to infant and toddlers who are deaf or hard of hearing and completion of the Early Steps ITDS Modules

   OR

   Bachelor's degree or higher in Communication/Speech Disorders, Speech Pathology, Audiology, Deaf Studies or a related field with a copy of SKI*HI certificate and at least one year of professional post-degree documentable experience serving infants and toddlers who are deaf and hard of hearing

   OR

   Bachelor's degree or higher in Communication/Speech Disorders, Speech Pathology, Audiology, Deaf Studies or a related field with a copy of SKI*HI certificate and completion of the Early Steps ITDS Modules.

2. Hearing Specialists applicants must document one-year post-degree professional experience in early intervention.
   - One year of experience in early intervention equals 1600 hours of hands-on experience with children aged from birth up to 5 years-old with special needs and/or developmental delays and their families. Time spent in a practicum or internship situation (up to 400 hours) may apply toward the 1600 hours of hands on experience.
   - Without one-year experience: In lieu of one-year experience, you must complete the Early Steps Provider Mentorship Documentation Form within six months of being employed or

contracted by a Local Early Steps.

- Volunteer work is not considered professional experience for enrollment requirements

3. Practicum or internship experiences completed in a Local Early Steps within the past 18 months, that match those of the mentorship can be documented on the Early Steps Mentorship Documentation Form and apply to the mentorship.
4. Level II (FBI) Background Screening: This must be submitted to allow you to complete a mentorship, if required, and/or begin providing services.
5. Completion of Early Steps Online Orientation Modules: Completion of the Early Steps Orientation Training Modules is not required prior to CMS/ES ***temporary*** approval.

ES Vision Specialist

1. Bachelor's degree or higher in Rehabilitation with coursework related to serving visually impaired (or Vision Rehabilitation), Orientation & Mobility, Early Childhood/Special Education or a related field; with evidence of at least one year professional post-degree experience serving infants and toddlers who are blind or visually impaired and a VIISA or INSITE Certification.

   OR

   Bachelor's degree or higher in Rehabilitation with coursework related to serving visually impaired (or Vision Rehabilitation), Orientation & Mobility, or Early Childhood/Special Education or a related field; with evidence of additional coursework related to serving the visually impaired (minimum 9 hours) and completion of the Early Steps ITDS modules**;**

   OR

   Bachelor's degree or higher in Rehabilitation with coursework related to serving visually impaired (or Vision Rehabilitation), Orientation & Mobility, or Early Childhood/Special Education or a related field; a VIISA or INSITE certification and completion of the Early Steps ITDS modules.

2. Vision Specialists applicants must document one-year post-degree professional experience in early intervention.
   - One year of experience in early intervention equals 1600 hours of hands-on experience with children aged from birth up to 5 years-old with special needs and/or developmental delays and their families. Time spent in a practicum or internship situation (up to 400 hours) may apply toward the 1600 hours of hands on experience.
   - Without one-year experience: In lieu of one-year experience, you must complete the Early Steps Provider Mentorship Documentation Form within six months of being employed or

contracted by a Local Early Steps.

- Volunteer work is not considered professional experience for enrollment requirements

3. Practicum or internship experiences completed in a Local Early Steps within the past 18 months, that match those of the mentorship can be documented on the Early Steps Mentorship Documentation Form and apply to the mentorship.
4. Level II (FBI) Background Screening: This must be submitted to allow you to complete a mentorship, if required, and/or begin providing services.
5. Completion of Early Steps Online Orientation Modules (1-3): Completion of the Early Steps Orientation Training Modules is not required prior to CMS/ES temporary approval.

ES Provider Standards

All Early Steps providers providing direct medical 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 providers 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 providers 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 provider 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 providers 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

Providers 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 providers 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.*

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

Non-licensed healthcare professionals 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. Please see Section VI for further information regarding the Physician Review Committee.

Participation Status

Active Status

Non-licensed healthcare professionals 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.

Temporary Status

Under special circumstances a provider 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, providers 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;
- 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 provider 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 provider 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 providers; 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 sub-specialty; 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 than14 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

Thank you for your support of Children's Medical Services!

Children's Medical Services