



# Children's Medical Services Managed Care Plan

## Managed Medical Assistance (MMA) Title 19 Provider Manual

**March 19, 2017**

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# I. CONTACT INFORMATION

| WHEN YOU NEED: | CONTACT: |
|---|---|
| To verify member eligibility | Use the FLMMIS provider portal online:<br>https://sso.flmmis.com/adfs/ls/?wa=wsignin1.0&wreply=https%3a%2f%2fhome.flmmis.com%2fhome%2f&wct=2014-07-22T18%3a16%3a00Z&wctx=618047b6-b997-44b2-9c53-7402eb4429d2 |
| To have a claims question answered | Use eINFOsource online (https://cms.einfosource.MED3000.com)<br>or call:<br>MED3OOO Customer Service<br>Phone: (800) 664-0146<br>Fax: (866) 246-2094<br>Hours: Monday – Friday, 8:30 a.m. – 5:30 p.m. (EST) |
| Utilization management issues: Authorization of services, requests for UM policies and procedures | **For Ped-I-Care:**<br>MED3OOO Medical Department<br>Phone: (800) 492-9634<br>Fax: (866) 256-2015<br>Hours: 24 hours a day, 7 days a week<br><br>**For CCP:**<br>CCP Medical Mgmt. Dpt.<br>Phone: (866) 209-5022<br>Fax: (844) 806-0397<br>Hours: 24 hours a day, 7 days a week |
| To sign up for eINFOsource | MED3OOO Help Desk<br>Phone: (800) 664-0146 |
| To access eINFOsource | https://cms.einfosource.MED3000.com |
| To get information on the benefits package and reimbursement | http://mymedicaid-florida.com/ |
| To submit your paper claims for services | CMS Plan MMA Specialty Plan Title XIX<br>PO Box 981648<br>El Paso, TX 79998-1648 |
| To appeal claims that have been denied or underpaid | **For Ped-I-Care:**<br>Ped-I-Care<br>Claims Appeals<br>1699 SW 16th Avenue<br>Third Floor<br>Gainesville, FL 32608<br><br>Phone: (352) 627-9100<br>or (866) 376-2456<br>Fax: (352) 294-8092<br><br>**For CCP:**<br>CCP<br>Attn: CMS Claims Appeals<br>1643 Harrison Parkway<br>Building H, Suite 200<br>Sunrise, FL 33323<br><br>Phone: (866) 209-5022 |
| To make arrangements for members or have questions answered regarding pharmacy services | The CMS Plan Nurse Care Coordinator for the member; located in Children's Medical Services Offices, found on page 7 |

| | | |
|---|---|---|
| To notify the ICS of provider/practice changes, address, telephone number, tax ID, etc.<br><br>OR<br><br>To resolve contracting or procedural questions, or to request staff orientation or education | **For Ped-I-Care:**<br>Ped-I-Care<br>Provider Relations Department<br>1699 SW 16th Avenue<br>Gainesville, FL 32608<br><br>Or call/fax:<br>Phone: (352) 627-9100 or<br>(866) 376-2456;<br>ask for Provider Relations<br>Fax: (352) 294-8081 | **For CCP:**<br>CCP<br>Provider Relations Department<br>1643 Harrison Pkwy,<br>Building H, Suite 200<br>Sunrise, FL 33323<br><br>Or call:<br>Phone: (855) 819-9506 |
| To apply for or inquire after CMS provider credentialing | Visit https://www.cmskidsproviders.com or<br>Email cmsproviderhelp@flhealth.gov or Call (850) 245-4215 | |
| To arrange for non-emergency transportation for a member | **For Ped-I-Care:**<br>TMS of Florida<br>(866) 411-8920 | **For CCP:**<br>LogistiCare<br>(866) 250-7455 |
| To provide notifications of behavioral health services | **For Ped-I-Care,** emergency service providers must make a reasonable attempt to notify MED3OOO (800) 492-9634 within 24 hours of the enrollee's presenting for emergency behavioral health services.<br><br>**For CCP,** emergency service providers must make a reasonable attempt to notify Concordia at (800) 294-8642 within 24 hours of the enrollee's presenting for emergency behavioral health services. | |
| Pharmacy Information | Call Magellan: (800) 603-1714 | |

## Ped-I-Care Office

G.L. Schiebler CMS Center
1699 SW 16th Avenue
Third Floor
Gainesville, FL 32608

Phone: (352) 627-9100
Toll-Free: (866) 376-2456
Fax: (352) 334-1589

## CCP Office

1643 Harrison Parkway
Building H, Suite 200
Sunrise, FL 33323

Phone: (855) 819-9506

## CMS Area Offices

Children's Medical Services Statewide Offices:
http://www.floridahealth.gov/AlternateSites/CMS-Kids/home/contact/area_offices.html

**CMS - Gainesville**
Toll-free: (800) 523-7545

**CMS - Ocala**
Phone: (352) 369-2100
Toll-free: (888) 326-7485

**CMS - Daytona Beach**
Phone: (386) 238-4980
Toll-free: (866) 827-5197

**CMS - Jacksonville**
Phone: (904) 360-7070
Toll-free: (800) 340-8354

**CMS - Pensacola**
Phone: (850) 484-5040
Toll-free: (800) 381-3685

**CMS - Panama City**
Phone: (850) 872-4700
Toll-free: (800) 299-4700

**CMS - Tallahassee**
Phone: (850) 487-2604
Toll-free: (800) 226-2604
Fax: (850) 488-8852

**CMS - Tampa**
Phone: (813) 396-9743
Toll-free: (866) 300-6878

**CMS - St. Petersburg**
Phone: (727) 217-7800
Toll-free: (800) 336-1612

**CMS - Lakeland**
Phone: (863) 413-3580
Toll-free: (800) 741-2250

**CMS - Orlando**
Phone: (407) 858-5555
Toll-free: (800) 226-6530

**CMS - Viera**
Phone: (321) 639-5888
Toll-free: (800) 226-6530 (Orlando office)

**CMS - Miami-Dade County**
Toll-free: (866) 831-9017

**CMS - Monroe County**
Toll-free: (800) 342-1898

**CMS - Broward County**
Toll-free: (800) 204-2182

**CMS WPB - Palm Beach County**
Toll-free: (877) 822-5203

**CMS Naples - Collier County**
(239) 552-7400

**CMS Ft. Myers - Glades, Hendry & Lee Counties**
Toll-free: (800) 226-3290

**CMS Sarasota - Charlotte, Desoto, Manatee Counties**
Toll-free: (800) 235-9717

**CMS Ft. Pierce - Indian River, Martin, Okeechobee, St. Lucie**
Toll-free: (800) 226-135

## Medicaid Area Offices

**Area 1 Medicaid Program Office**
Serving Escambia, Santa Rosa, Okaloosa and Walton Counties
Toll-free: (800) 303-2422

**Area 4 Medicaid Program Office**
Serving Baker, Clay, Duval, Flagler, Nassau, St. Johns and Volusia Counties
Toll-free: (800) 273-5880 or (904) 353-2100

**Area 5 Medicaid Program Office**
Serving Pasco and Pinellas Counties
Toll-free: (800) 299-4844

**Area 6 Medicaid Program Office**
Serving Hillsborough, Highlands, Hardee, Polk, and Manatee Counties.
Toll-free: (800) 226-2316

**Area 7 Medicaid Program Office**
Serving Brevard, Orange, Osceola, and Seminole Counties
Toll-free: (877) 254-1055

**Area 8 Medicaid Program Office**
Serving Sarasota, DeSoto, Charlotte, Lee, Hendry, Glades and Collier Counties
Toll-free: (800) 226-6735

**Area 10 Medicaid Program Office**
Serving Broward County
Toll-free: (866) 875-9131

**Area 11 Medicaid Program Office**
Serving Miami-Dade and Monroe Counties
Toll-free: (800) 303-2422

**Medicaid Choice Counseling**
Toll Free: (866) 454-3959  TDD: (866) 467-4970

# II. BACKGROUND & SERVICES

## About Medicaid, CMS Plan, SMMC, and the ICSs

Under the Managed Medical Assistance (MMA) component of the Statewide Medicaid Managed Care (SMMC) program, Children's Medical Services (CMS) has formed a Medicaid health plan known as Children's Medical Services Managed Care Plan (CMS Plan). In 2014, CMS Plan signed a contract with the Florida Agency for Health Care Administration (AHCA) to provide Medicaid services in the SMMC. The SMMC was authorized by the 2011 Florida Legislature through House Bill 7107, creating Part IV of Chapter 409, F.S. It was designed to establish the Florida Medicaid Program as a statewide, integrated managed care program for all covered services, including long-term care services.

CMS Plan has contracted with Ped-I-Care (in 51 counties) and Community Care Plan (CCP) in 16 counties, to provide a number of administrative services for the plan. (CCP was formerly known as the South Florida Community Care Network, or SFCCN.)

*The purpose of the CMS Plan is to provide care to children with special health care needs up to the age of 21 years. It has been implemented in collaboration with the local CMS offices, which continue to provide nurse care coordination for the members and providers.*

**Ped-I-Care covers the following counties:**
Alachua, Baker, Bay, Bradford, Brevard, Calhoun, Citrus, Clay, Columbia, Dixie, Duval, Escambia, Flagler, Franklin, Gadsden, Gilchrist, Gulf, Hamilton, Hardee, Hernando, Highlands, Hillsborough, Holmes, Jackson, Jefferson, Lafayette, Lake, Leon, Levy, Liberty, Madison, Marion, Nassau, Okaloosa, Orange, Osceola, Pasco, Pinellas, Polk, Putnam, Santa Rosa, Seminole, St. Johns, Sumter, Suwannee, Taylor, Union, Volusia, Wakulla, Walton, and Washington.

**CCP covers the following counties:**
Broward, Charlotte, Collier, DeSoto, Glades, Hendry, Indian River, Lee, Manatee, Martin, Miami-Dade, Monroe, Okeechobee, Palm Beach, Sarasota, and St. Lucie.

**CMS website with map:** http://www.floridahealth.gov/programs-and-services/childrens-health/cms-plan/about/index.html

The purpose of the CMS Plan is to provide care to children with special health care needs (CSHCN) up to the age of 21 years. It has been implemented in collaboration with the local CMS offices, which continue to provide nurse care coordination for the members and providers.

Ped-I-Care and CCP are sometimes referred to as, "The ICSs," with ICS as an abbreviation for Integrated Care System. Ped-I-Care is a program operating under the auspices of The University of Florida, College of Medicine's Department of Pediatrics. CCP is a collaboration of 2 of the largest public health systems in Florida, Broward Health and Memorial Health Systems. Both Ped-I-Care and CCP are under contract to the Department of Health's (DOH) Children's Medical Services (CMS) Division.

The program is designed to respond to the legislative intent to create a statewide initiative to provide for a more efficient and effective service delivery system that enhances quality of care and client outcomes in the Florida

Medicaid program. Our goal, therefore, has been to develop a program that is sensitive and responsive to the special needs of children participating in CMS, and yet function cost-effectively within the Medicaid funding environment.

**The objectives are to:**

- Develop and maintain a comprehensive provider network that offers community-based primary care and ancillary services, as well as high-quality specialty care and hospital services;
- Deliver and coordinate quality primary and specialty care; and
- Evaluate and continually improve the quality of service delivery, including participation in preventive care, such as Child Health Check-ups and immunizations, as well as assessment of member satisfaction.

The CMS Managed Care Plan does not impose enrollment fees, premiums, or similar charges on Indians served by an Indian health care provider; Indian Health Service; an Indian Tribe, Tribal Organization, or Urban Indian Organization; or through referral under contract health services, in accordance with the American Recovery and Reinvestment Act of 2009.

The University of Florida Department of Pediatrics and Community Care Plan are committed to caring for children and have an established track record of collaboration with CMS and CMS Plan in providing services to children with special health care needs. Accepting responsibility for implementing this health plan to participate in MMA is an important step in continuing to pursue our role as providers of health care in the environment of cost containment. We invite all our providers to work closely with us as we pursue this new and exciting opportunity to offer quality care to children with special health care needs who receive Florida Medicaid benefits.

**Ped-I-Care**
(352) 627-9100 or
(866) 376-2456
For questions regarding CMS Plan policies and procedures, provider relations support, or member services support

**CCP Provider Relations**
(855) 819-9506

**CCP Member Services**
(866) 209-5022
For questions regarding authorizations & member services

**Third-Party Administrator**
**MED3OOO**
(800) 492-9634
24/7 access to providers for questions and service authorizations

## Network Management

The ICS office staff assist providers' offices with policies and procedures related to CMS Plan. They respond to provider requests, questions and concerns.

**Examples of issues ICS staff may assist with include:**

- Administrative issues: Assistance with billing and claims payment, how to follow up on claim status, notification of changes in the practice;
- Patient-related issues: Primary Care Physicians (PCP) wanting to change assignment criteria or capacity; and
- Medical management issues: Clarification on Utilization Management, e.g. benefit limits, how to get services authorized, quality improvement procedures and reports.

Ped-I-Care and CCP help providers obtain training, consultations, and other resources to help improve the management of children with special health care needs. Any provider is welcome to call us at any time:

- **For Ped-I-Care:** (352) 627-9100 or (866) 376-2456 (toll free)
- **For CCP:** (855) 819-9506 (toll free)

## Member Services

The role of Member Services is to assist members/families to obtain needed services and navigate the system with ease.

- The local number **for Ped-I-Care** member services is (352) 627-9100; toll-free is (866) 376-2456 (press 1 for Member Services). These phone lines are staffed from 8:00 a.m. until 8:00 p.m. (EST), Monday through Friday.
- The local number **for CCP** member services is (866) 209-5022. These phone lines are staffed from 8:00 a.m. until 7:00 p.m. (EST), Monday through Friday.

**Member Services also assists providers and CMS with:**

- Patient-related issues
- Information on covered and non-covered services
- Education of members/families on CMS Plan or Ped-I-Care processes and policies
- Facilitation of member access to services
- Accepting and tracking member complaints and grievances
- Changing PCP assignment at the request of members/families
    - **For Ped-I-Care:** Ped-I-Care's Member Services department can help with this, in addition to NCCs at the local CMS area offices.
    - **For CCP:** The CMS local area offices will be the principal PCP changes assigner

At enrollment into CMS Plan, every family will be sent a Member Handbook, Provider Directory, a letter of verification of enrollment and an identification card (see Section IV). If the family has not chosen a PCP or been assigned incorrectly to a PCP, an ID card will still be sent along with instructions on how to select the PCP of their choice, and a statement indicating that a new ID card will be sent upon PCP selection.

If, for any reason, a member wishes to change from the assigned PCP, services, and/or location, the member may request a re-assignment by notifying Member Services. The request may be submitted at any time; however if it is received after the 15th of the month, the effective date of the change will be made the 1st of the following month, **unless it is urgent.** The member will receive a new ID card indicating the new PCP. The originally-assigned PCP is expected to continue providing care until the effective date of the change, and to provide copies of all records to the new PCP.

## Third-Party Administrator

The CMS Plan has contracted with a third-party administrator, MED3OOO, to perform several functions required to operate the plan. MED3OOO provides the Management Information System that receives and tracks membership information and adjudicates, processes and pays claims on behalf of CMS. We are pleased that MED3OOO is a member of our team.

**For Ped-I-Care,** MED3OOO provides Utilization Management support through the authorization process. MED3OOO is also responsible for concurrent reviews of inpatients.

# III. PROGRAM OVERVIEW

## Providing Medical Care

The goal of CMS Plan and the ICSs is to provide family-centered medical care, which includes the following elements: Whenever possible, care for all children in the family is provided by the same provider(s); the family is consulted on treatment plans; and providers work in collaboration with the CMS Nurse Care Coordinator (NCC). The NCC assists providers in maintaining family contact and compliance. They also conduct assessments of medical and psychosocial needs, and provide education and anticipatory guidance. They coordinate all services needed by the member, including those offered outside the Ped-I-Care and CCP network. (Please note that Ped-I-Care and CCP work together as separate, but unified entities under contract to CMS Plan, and therefore each organization honors the other's provider network.) Network providers should submit copies of their chart notes to the assigned NCC to facilitate care coordination.

CMS Plan follows the Florida Medicaid handbooks and pay according to the Florida Medicaid fee schedules. They are posted at: http://portal.flmmis.com/FLPublic/Provider_ProviderSupport/tabId/39/Default.aspx. There are no copays applied or allowed for CMS Plan members.

## Primary Care Physician

Every participant in CMS Plan has an assigned Primary Care Physician (PCP) who provides primary care and coordinates specialty care and other covered services. The PCP provides members with a medical home that ensures continuity of care and coordination of information among providers and the family. The PCP provides preventive care and anticipatory guidance according to the guidelines established by the American Academy of Pediatrics (AAP) and Florida Medicaid. PCPs provide access to phone consultation for families 24 hours a day, 365 days a year to help families maintain the health of their children and avoid unnecessary trips to the emergency department. They track participation in preventive care and other services through documentation of care rendered and referral to specialty services. PCP specific responsibilities are outlined in the PCP provider contract.

**Ped-I-Care Provider Relations**
(352) 627-9100 or
(866) 376-2456

**CCP Provider Relations**
(855) 819-9506

The PCPs determine the number of CMS Plan participants they will accept. They also specify any other criteria for accepting patients. When initially enrolled in the network, PCPs will be asked about limits and guidelines for assignment of patients. The practice may change these guidelines at any time by contacting provider relations:

- **For Ped-I-Care:** (352) 627-9100 or (866) 376-2456
- **For CCP:** (855) 819-9506

## Child Health Check-Ups (CHCUPs)

**Children should receive health check-ups at:**

- Birth or neonatal examination
- 2-4 days for newborns discharged in less than 48 hours after delivery
- By 1 month
- 2, 4, 6, 9, 12, 15, 18, 24 and 30 months
- Once a year for age 3 years through 20 years

**A Well Child Check-up includes:**

- Comprehensive health and developmental history including assessment of medical history, developmental history and behavioral health status
- Nutritional assessment
- Developmental assessment
- Comprehensive unclothed physical examination
- Dental screening, when required
- Vision screening including objective testing, when required
- Hearing screening including objective testing, when required
- Laboratory tests including blood lead testing, when required
    - Federal regulation requires that all children receive a blood lead test at 12 and 24 months of age and between the ages of 36 and 72 months if not previously tested
- Appropriate immunizations
- Tuberculosis screening
- Health education, anticipatory guidance
- Family planning when appropriate
- Diagnosis and treatment
- Referral and follow-up, as appropriate.*

*It is not necessary to obtain a referral number from MED3OOO; however many specialists do require a referral or consultation request from the requesting provider.

*PCPs' coverage of services must consist of an answering service, call forwarding, provider call coverage or other customary means approved by The Florida Agency for Health Care Administration (AHCA).*

*The chosen method of 24-hour coverage must connect the caller to someone who can render a clinical decision or reach the provider for a clinical decision.*

*The after-hours coverage must be accessible using the medical office's daytime telephone number.*

Please refer to the most recent version of Florida Medicaid Child Health Check-up Coverage and Limitations Handbook for additional information on specific requirements. It can be accessed at http://portal.flmmis.com/flpublic/Provider_ProviderServices/Provider_ProviderSupport/Provider_ProviderSupport_ProviderHandbooks/tabid/53/desktopdefault/+/Default.aspx.

**Other helpful resources include:**

- The American Academy of Pediatrics' Bright Futures Recommendations for Preventive Pediatric Health Care for CHCUP requirements: http://www.aap.org/en-us/professional-resources/practice-support/Periodicity/Periodicity%20Schedule_FINAL.pdf
- Immunization Schedules: http://www.cdc.gov/vaccines/schedules/hcp/child-adolescent.html
- The Childhood Lead Poisoning Screening Map of high-risk zip codes: http://www.floridahealth.gov/healthy-environments/lead-poisoning/county-map.html

- The Florida Lead Poisoning Prevention Program: http://www.floridahealth.gov/healthy-environments/lead-poisoning/index.html
- Tuberculosis Risk Screening Form: https://com-peds-pedicare.sites.medinfo.ufl.edu/files/2014/09/TB-Lead-Risk-Assessment-July-22-2016.pdf

All providers must maintain complete and accurate medical records in compliance with Ped-I-Care standards and provide timely care to participants in CMS Plan as follows:

- PCPs provide well-child care within 1 month of the request for service.
- Routine sick patient symptomatic care is provided within 1 week of the request and urgent care within 1 day.
- Specialty evaluation and treatment for a member's condition is to be provided within 30 days of the request for services by the PCP. If the PCP experiences problems getting timely care from in-network providers he/she should contact the ICS to request assistance with expediting an appointment.
- All providers shall offer hours of operation that are no less than the hours of operation offered to non-CMS Plan members.

## Primary Care Providers' On-Call Coverage

PCPs' coverage of services must consist of an answering service, call forwarding, provider call coverage or other customary means approved by The Florida Agency for Health Care Administration (AHCA). The chosen method of 24-hour coverage must connect the caller to someone who can render a clinical decision or reach the provider for a clinical decision. The after-hours coverage must be accessible using the medical office's daytime telephone number.

Ped-I-Care and CCP each have a comprehensive network of providers; however, if a provider determines that a child needs specialty or ancillary services that are not included in the network, the ICS works with the referring provider to ensure access to needed services for members. Please note that Ped-I-Care and CCP work together as separate, but unified entities under contract to CMS Plan, and therefore each organization honors the other's provider network.

The CMS Nurse Care Coordinators (NCCs) assist providers in maintaining the health of children and coordinating medical care. They help to ensure that children and their families participate in needed care and follow providers' advice. Providers should have a system in place to follow-up on children who do not come for a scheduled visit and have not called to reschedule. The office should contact "no shows" by sending a letter or making a phone call to the family to encourage them to reschedule the visit.

**Ped-I-Care Member Services**
(352) 627-9100 or
(866) 376-2456

**CCP Member Services**
(866) 209-5022

If the family does not reschedule missed appointments or misses two visits without calling ahead to cancel or reschedule, the provider's office should call the NCC and ask for intervention with the family. NCCs assist the family with participating in ongoing care, through identification and resolution of barriers. If the provider finds that families are not following the recommended treatment plan developed for the child, the NCC should be contacted to assist the family with engaging as active participants in promoting the health of their child through good home care and following of the provider's recommendations. For information on how to contact the NCC assigned to your patients, see the CMS Offices information in Section I of this manual.

If the provider encounters problems with patients that are not being resolved with the intervention of the NCC, the office should contact the ICS Member Services office, which works with the provider and the NCC to address

and resolve the issue(s).

- **For Ped-I-Care's** Member Services: (352) 627-9100 or (866) 376-2456
- **For CCP's** Member Services: (866) 209-5022

## Coordinating Care

CMS Plan recognizes that in order to be effective in caring for children, the PCP needs to be involved in all services delivered to their members. The PCP should know who is providing care to the child and what recommendations have been made for additional services, including tests and procedures.

It is not necessary to obtain a referral number from MED3OOO; however many specialists do require a referral or consultation request from the requesting provider. If an in-network provider is not available, PCPs should submit a prior authorization request to MED3OOO (TPA), following the procedures outlined in the Utilization Management section referenced below, for the member to obtain said services.

As explained earlier, NCCs work with providers and families to facilitate coordination of care. NCCs work closely with the families to ensure understanding of and compliance with needed services and recommendations for home care. PCPs and other providers furnish copies of chart notes/reports to the NCCs to facilitate this measure of support.

If PCP and/or specialist is requesting discharge of member(s) from their care, a written notice via certified mail is required to be sent to the ICS (Ped-I-Care or CCP) enrollee services department 30 days prior to discharge of member in order to coordinate care accordingly. The provider must continue providing care until the effective date of the change. The provider should instruct the enrollee to seek assistance from the ICS (Ped-I-Care or CCP) Enrollee Services Department.

## Administrative Updates

Providers should notify the ICS with which they are contracted (Ped-I-Care or CCP) regarding practice changes. This should be done in writing or by phone at least 30 days prior to the effective date.

> **For Ped-I-Care** you may call (352) 627-9100 or (866) 376-2456, or use our Provider Update form located at https://com-peds-pedicare.sites.medinfo.ufl.edu/files/2014/09/Provider-Update-Form-July-2015.pdf.
>
> **For CCP** you may call (855) 819-9506.

Changes that need to be conveyed to Ped-I-Care or CCP include:

- Change of location, mailing address, or phone number
- Change in tax ID number
- Change of practice name
- Practice closing
- Provider being added to or leaving the practice
- Addition/deletion of hospital privileges
- Addition or deletion of service sites
- Loss of CMS credentialing
- Termination from Medicaid, license suspension or termination, or exclusion from participation in federally funded programs
- Changes to National Provider Identifier

## Providers' Background Screening Requirements

In addition to the Children's Medical Services credentialing requirements, CMS Plan providers are required to meet background screening requirements.

This includes:

- A satisfactory Level II background check pursuant to s. 409.907, F.S., for all treating providers not currently enrolled in Medicaid's fee-for-service program.

1. Providers referenced above are required to submit fingerprints electronically following the process described on the Agency's Background Screening website. The provider's Medicaid eligibility shall be verified through the Agency's electronic background screening system.
2. The ICSs shall not contract with anyone who has a record of illegal conduct; i.e., found guilty of, regardless of adjudication, or who entered a plea of nolo contendere or guilty to any of the offenses listed in s. 435.04, F.S.
3. Individuals already screened as Medicaid providers or screened within the past 12 months by the Agency or another Florida agency or department using the same criteria as Medicaid are not required to submit fingerprint electronically but shall document the results of the previous screening.
4. Individuals listed in s. 409.907 (8) (a), F.S., for whom criminal history background screening cannot be documented must provide fingerprints electronically following the process described on the Agency's background screening website.

# PLACEHOLDER – INSERT PIC PROVIDER UPDATE FORM

# PLACEHOLDER – INSERT CCP PROVIDER UPDATE FORM

# Member Eligibility, Identification, & Assignment

## Member Eligibility

CMS Plan members are children who are enrolled in CMS because they have special health care needs and are eligible for health insurance through Florida Medicaid. Members are eligible from birth to their 21st birthday.

Eligibility begins at the beginning of a month and is renewed on a monthly basis. This results in a month-to-month eligibility status. Members are issued an identification (ID) card within days of their initial enrollment in CMS Plan. If they have not chosen a PCP they are sent a letter verifying eligibility until they choose a PCP and receive their ID cards. (See the sample card in this section.) **Because members can drop off the program at any time after the card is issued, eligibility should always be checked before providing services, even if there is an active authorization for services on the system.**

Verification of enrollment can be checked by using AHCA's FMMIS Web Portal. Secondarily, it may be checked by using eINFOsource, the web-based database available from MED3OOO. Eligibility and PCP assignment is available online to all providers. To gain access to eINFOsource, contact the MED3OOO Help Desk at (866) 703-1444.

If a patient who is no longer enrolled in CMS Plan presents for services, please contact the CMS nurse who is assigned to the child immediately. **Please do not refuse care before contacting the CMS Nurse.**

**To Get Access to eINFOsource:**
Contact the MED3OOO Help Desk at (866) 703-1444

- *Always verify eligibility before providing services.*
- *Please do not refuse care before contacting the CMS nurse. See page 7 for a listing of CMS offices.*

## New Patients

CMS Plan respects the importance of physician-patient relationships and will make every attempt to support existing relationships. Newly-enrolled members are assigned to their current primary care provider, if possible. If their provider is not in the Ped-I-Care network, and chooses not to become a participating provider (or there is no ongoing provider), the member will have to choose a new PCP. If a member does not choose a PCP, one will be assigned to them and they will receive a card with the PCP assignment. The PCP may be changed by the member at any time.

Patients newly-enrolled in CMS Plan appear on the enrollment information sent to PCPs at the beginning of each month. If the member is new to the practice, the office should schedule an appointment to get to know the child and request medical records from the prior PCP. The provider may contact Member Services for assistance in reaching the member and scheduling an appointment. The PCP should assess the current status of care the child has received and provide services as appropriate.

The CMS Nurse Care Coordinator (NCC) contacts the newly-assigned PCP to help the PCP and office staff get to know the new member. The NCC offers information from the assessment and the care plan developed for the

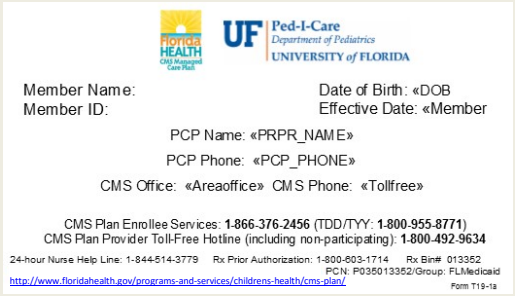
member. The NCC may also help to obtain the prior medical records. Transfer requests may be initiated by the member or the member's legal guardian. The member will receive a new ID card indicating the new PCP. The previously assigned PCP is expected to continue providing care until the effective date of the change.

## Sample Ped-I-Care Member ID Card

This card is to be used by Ped-I-Care patients for all services, **except** pharmacy benefits, for which their Florida Medicaid card should be used.

**FRONT**

1. Member Name
2. Effective Date
3. Medicaid ID#
4. Date of Birth
5. PCP Name
6. PCP Phone #




**BACK**

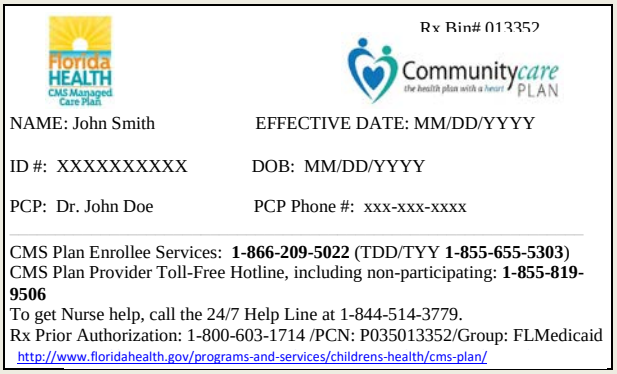
1. Important Phone #s
2. Claims Address

## Sample CCP Member ID Card

This card is to be used by CCP patients for all services, except pharmacy benefits, for which their Florida Medicaid card should be used.

**FRONT**

1. Member Name
2. Effective Name
3. Medicaid ID#
4. DOB
5. PCP Name
6. PCP Phone #




**BACK**

1. Important Phone #s
2. Claims Address

Present this card each time you seek healthcare services.
Call your Primary Care Physician (PCP) for any health care questions.
For Transportation, please call
LogistiCare **1-866-250-7455** (Reservations)
**1-866-251-9161** (Ride Assistance)
Medical Pre-Authorization call: 1-866-209-5022
Mental Health & Substance Abuse Pre-Authorization or questions call:
**1-800-294-8642** (PCP REFERRAL NOT REQUIRED)
Dental Services Pre-Authorization call: **1-866-209-5022**
Vision Services Pre-Authorization call: **1-866-209-5022**
Eligibility Verification and Claims: eInfoSource
https://cms.einfosource.med3000.com or 800-664-0146

For Medical Claims:

CMS Plan MMA Specialty Plan Title XIX
Attn: CLAIMS
P.O. Box 981648
El Paso, TX 79998-1648

# V. Covered Services

**The services provided by CMS Plan through Ped-I-Care and CCP for Title 19 are as follows:**

- Advanced Registered Nurse Practitioner Services
- Ambulatory Surgical Center Services
- Assistive Care Services
- Behavioral/Mental Health Services
- Birth Center Services
- Case Management/Care Coordination
- Child Health Check-Up Services
- Chiropractic Services
- Clinic Services
- Community Behavioral Health Services
- County Health Department Services
- Dental Services
- Dialysis Services
- Durable Medical Equipment and Medical Supplies
  - Including Prostheses and Orthoses
- Emergency Services (including Behavioral Health)
- Family Planning Services and Supplies
- Federally Qualified Health Center Services
- Healthy Start Services
- Hearing Services
- Home Health Care Services
- Hospice Services
- Hospital Services – Inpatient*
- Hospital Services – Outpatient
- Imaging
- Immunizations*
- Laboratory Services
- Licensed Midwife Services
- Optometric and Vision Services
- Partners In Care Services
  - Some services are excluded
- Physician Assistant Services
- Physician Services
- Podiatry Services
- Portable X-ray Services
- Prescribed Drug Services
- Private Duty Nursing and Nursing Facility Services
- Program of All-Inclusive Care for Children
- Radiology Services
- Rural Health Clinic Services
- Targeted Case Management
  - Some of these services are billed to FFS Medicaid
- Therapy Services: Occupational
- Therapy Services: Physical
- Therapy Services: Respiratory
- Therapy Services: Speech
- Transplant Services
- Transportation Services
- Vision and Optometric Services

**Notes regarding covered services:**

- ✓ Prior authorization required for all non-emergency inpatient hospital admissions.
- ✓ CMS Plan Title 19 members are eligible to receive vaccines through the Vaccines for Children (VFC) Program. **VFC vaccines should be used for all CMS Plan Title 19 members.** Note: VFC vaccines should not be used for Title 21 (CHIP) members.*
- ✓ CMS Plan follows the Florida Medicaid Provider Handbooks for prior authorization and pays according to the Florida Medicaid fee schedules.
- ✓ NCCs coordinate any needed school-based services.
- ✓ To request low-protein foods for children with PKU, please contact the patient's CMS Plan Nurse Care Coordinator.
- ✓ Pharmacy is a covered benefit and CMS Plan follows the Florida Medicaid Preferred Drug Formulary. Pharmacy benefits are offered through Florida Medicaid. Any applicable prior authorization requirements are handled by Magellan (Phone: (800) 603-1714). Please visit the following links for more information: http://ahca.myflorida.com/medicaid/prescribed_drug/pharm_thera/fmpdl.shtml

# VI. UTILIZATION MANAGEMENT

Ped-I-Care and CCP have each designed a utilization management program, which emphasizes the important role of the Primary Care Provider (PCP) and intrudes minimally on the delivery of health care by all providers. The benefits offered by CMS Plan are listed above in Section V of this manual, and are defined by the Florida Medicaid Program. The benefit limits are described in the Florida Medicaid Provider Handbooks available on the web at: http://portal.flmmis.com/flpublic/Provider_ProviderServices/Provider_ProviderSupport/Provider_ProviderSupport_ProviderHandbooks/tabid/53/desktopdefault/+/Default.aspx. Please note that benefit limits can be exceeded based on medical necessity; an authorization should be requested.

## Primary Care Services & Specialty Care

PCPs refer to in-network specialty providers for services needed by the child; specialists may also make referrals to other specialists. It is not necessary to obtain a referral number from the third-party administrator; however many specialists do require a referral or consultation request from the requesting provider. If an in-network provider is not available, requesting providers should submit a prior authorization request for the member to see the out-of-network provider to MED3OOO for Ped-I-Care or to CCP as appropriate following the procedures outlined in the Authorization Process section referenced below. Services requiring authorization need an authorization number (see Authorization Process below).

Specialists may request authorization for needed services without going through the PCP's office; however, all specialty and ancillary providers are required to fax/mail their notes/reports to the PCP. All providers follow the Utilization Management guidelines specified by Florida Medicaid and Ped-I-Care or CCP as appropriate. Primary care services provided by the assigned PCP do not require authorization. CMS Plan requests that all specialty providers communicate their clinical findings to the referring provider by providing documentation of visits and consultations.

The Medicaid Summary of Services Manual found at: http://www.fdhc.state.fl.us/Medicaid/flmedicaid.shtml.

***UM Dashboard:***

- *Benefits are defined by Florida Medicaid.*
- *Referral numbers are not needed but certain services do require authorizations.*
- *Primary care services provided by the assigned PCP do not require an authorization.*
- *Most therapy authorizations are valid for up to 6 months.*

## Chronic Conditions/Disease Management

CMS Plan offers a Chronic Conditions/Disease Management Program that strives to evaluate our enrollee populations who are identified with certain chronic conditions. Its goal is that of improving overall health by utilizing a combination of education, provider communication, symptom management, and medication management that is tailored to the individual enrollee's needs. Once clinical eligibility for the CMS Plan program has been established based on the current eligibility screening tool, enrollees may qualify for the Chronic Conditions/Disease Management program based on the CMS Plan Acuity Tool, telephonic interview with the family, review of physician records, diagnosis review, and social/family history. The 4 diagnoses that have been approved for the program include:

- Asthma
- Child and Adolescent Diabetes
- Sickle Cell Anemia
- Attention Deficit/Hyperactivity Disorder

## Quality Improvement (QI)

As part of our Quality Improvement Program, Ped-I-Care and CCP QI nurses evaluate the care provided to our members. The purpose of a QI visit is to interview staff about practice policies and procedures, tour the facility, and review a sample of medical records. Charts are reviewed by a QI nurse to evaluate the measures described in this manual in Section X. The results of the site visit are summarized in a letter sent to the provider. Data related to quality measures of the program are available to participating providers.

**Ped-I-Care's Third-Party Administrator Is MED3OOO:**
(800) 492-9634
Fax: (866) 256-2015

24/7 access to providers for questions and service authorizations, including STAT requests

**CCP's Authorization Inquiries:**
(866) 209-5022

## Use of the Emergency Room/Department

Use of the emergency department (ED) should be limited to emergencies and cases in which it is not in the best interest of the child to wait until the next office day to receive care. Members may utilize any hospital or other appropriate setting for emergency care when needed. Authorization is not required for emergency claims payment.

When a member visits an emergency department (ED), the ED must notify the PCP and MED3OOO within 2 business days. The ED should provide information to the PCP office. The PCP will schedule appropriate follow-up with the member. If families use the emergency department for conditions that could be managed at home or during an office visit, the PCP should contact the CMS Nurse Care Coordinator, who will contact the family to offer education and support to avoid unnecessary use of the emergency department. Ped-I-Care and CCP monitor use of emergency department services and may consult with PCPs and/or NCCs regarding patients who appear to make unnecessary ED visits.

## Hospitalized Patients

Inpatient stays are monitored closely by the Inpatient Case Manager (by either CCP for its members or by MED3OOO for Ped-I-Care's members). The Inpatient Case Manager will monitor in-patient services, with calls to the hospital-based Case Manager. The CMS Nurse Care Coordinators work with the hospital discharge planning team and the CCP (or MED3OOO, for Ped-I-Care) Inpatient Case Manager.

For **Ped-I-Care,** any post-discharge services requiring prior authorization should be submitted to MED3OOO by calling (800) 492-9634 and asking to speak with the Inpatient Case Manager.

For **CCP,** any post-discharge services requiring prior authorization should be submitted to CCP by calling (866) 209-5022 and asking to speak with the Inpatient Case Manager.

## New Members

Services authorized prior to enrollment do not require prior authorization for the first 60 days a member becomes eligible with CMS Plan. For patients who are already hospitalized at the time of enrollment into CMS Plan, the hospital should notify the ICS for continuing inpatient care. Authorizations are required for ongoing services, but not emergencies.

For **Ped-I-Care,** the hospital or PCP should contact MED3OOO at (800) 492-9634 to obtain an authorization. It is necessary for providers to notify MED3OOO of an existing admission, as continuity of care rules will apply.

For **CCP,** the hospital or PCP should contact CCP at (866) 209-5022 to obtain an authorization. It is necessary for providers to notify CCP of an existing admission, as continuity of care rules will apply.

## Authorization Process

InterQual® criteria and the Florida Medicaid Coverage and Limitations Handbooks are used to evaluate requests for medical appropriateness/necessity and benefit determination. Services and items are reimbursed according to the applicable Florida Medicaid fee schedule and guidelines.

Requests for authorization of services **for Ped-I-Care** members should be submitted to MED3OOO via phone [(800) 492-9634], fax [(866) 256-2015], or eINFOsource (https://cms.eINFOsource.MED3000.com). The request must include relevant clinical documentation from the medical record. To arrange for access to eINFOsource call MED3OOO at (866) 703-1444.

Requests for authorization of services **for CCP members** should be submitted to MED3OOO via fax [(844) 806-0397], or eINFOsource https://cms.eINFOsource.MED3000.com). The request must include relevant clinical documentation from the medical record. To arrange for access to eINFOsource call MED3OOO at (866) 703-1444.

**If the request is urgent due to the member's condition, the provider should note the request as "STAT":**

- For **Ped-I-Care,** call (800) 492-9634, and ask for the Utilization Review (UR) nurse to discuss the situation.
- For **CCP,** call (866) 209-5022, and ask for the Utilization Review (UR) nurse to discuss the situation.

Please fax supporting documentation, signed by the requesting provider, while you are on the telephone. The more complete the request, the faster the response will be. Requests for services that lack sufficient information to make a determination may be denied if the requested information is not supplied.

InterQual® criteria and the Medicaid Service-Specific Policies are used to evaluate requests for medical appropriateness/necessity and benefit determination. For Ped-I-Care members, if the request meets all criteria, it will be assigned an authorization number by MED3OOO.

If InterQual® criteria are not met or the requested service exceeds the Medicaid covered allowable or is not a covered benefit, the request will be forwarded to the ICS Medical Director (MD) or Associate Medical Director for review. Only an ICS Medical Director or Associate Medical Director is able to deny or reduce a request for authorization of services. It is important to note that certain services, such as therapy requests, automatically require MD review.

If the child is not enrolled in CMS Plan, MED3OOO notifies the requesting provider that the member is not eligible. **NOTE: An active authorization listed on eINFOsource for a member does not guarantee payment, or that the member is still enrolled. Always check Medicaid eligibility in FMMIS or in eINFOsource before providing services.**

Services may be authorized up to 60 days in advance and the time period covered is often 6 months from the approximate appointment date for medical and surgical specialties, and certain medical supplies. Durable Medical Equipment (DME) and supplies that require prior authorization are only approved for 6 months. Specialty providers will need to request re-authorization of services after the time period expires.

Most authorizations for therapies (occupational, respiratory, speech, and physical), home health services, and durable medical equipment are valid for up to six months (180 days).

The exact time period for all authorizations is specified in eINFOsource. A 7-day grace period will be honored prior to and following the specified authorization time period.

If the provider has requested authorization for payment of a service that is denied or reduced, a letter will be sent to the provider, the member and the CMS Area Office, explaining the reason for the denial or reduction. The letter will be signed by the ICS Medical Director who made the decision. To appeal an authorization denial, please see Utilization Management (Authorization Decision) Appeals at the end of this section.

**Turnaround times for authorization of requested services are as follows:**

- Requests for authorization of non-urgent care will be processed within 7 calendar days of receipt of the request.
    - The timeframe can be extended up to 7 additional calendar days if the member or the requesting provider requests extension or if CMS Plan's contracted ICS (Ped-I-Care or CCP) needs additional information.
- Requests for STAT authorization of urgently needed services will be processed within 48 hours of receipt of the request and communicated immediately to the provider by telephone. The call will be followed up with a written response.
    - The timeframe can be extended up to 2 additional business days if the member or provider requests an extension or if the ICS needs additional information and the decision delay will not negatively impact the member's immediate health condition.

***Criteria for STAT Requests***

*Patients who have a medical condition manifesting itself by acute symptoms of sufficient severity, which may include severe pain or other acute symptoms…could reasonably expect that the absence of immediate medical attention could result in <u>any</u> of the following:*

- *Serious jeopardy to the health of a patient, including a pregnant woman or fetus*
- *Serious impairment to bodily functions*
- *Serious dysfunction of any bodily organ or part*

If a request does not meet STAT criteria, it will be processed as a standard, non-urgent request. **To be considered a STAT request,** there must be a medical condition manifesting itself by acute symptoms of sufficient severity, which may include severe pain or other acute symptoms, such that a prudent layperson who possesses an average knowledge of health and medicine, could reasonably expect that the absence of immediate medical attention could result in any of the following:

- Serious jeopardy to the health of a patient, including a pregnant woman or fetus
- Serious impairment to bodily functions
- Serious dysfunction of any bodily organ or part

PLACEHOLDER – INSERT PRIOR AUTH LIST

### *Regarding prior authorizations, please note:*

- Any request for authorization of services requires a written order by the requesting provider. The provider should be available to answer questions if needed.
- Authorization requests require submission of supporting clinical documentation for medical review; failure to provide clinical information can result in a delay or denial of the request.
- Some services have limitations on the number of times providers will be reimbursed. Exceptions to limitations can be requested through the prior authorization process.
- Authorization for services (such as DME rental, home health, or therapies) will specify the units of service or time period for which authorization is given. A request for continuation of service must be submitted and/or signed by the provider before continuation of service will be pre-authorized for payment. **Authorization requests that do not have the signature of the requesting provider on the authorization form or attached clinical notes will be denied**.
- Prior authorizations by a PCP are not required for behavioral health services.

Information that must accompany a request for authorization is listed below. If you are requesting services that exceed the Medicaid benefit limit, be sure to include this as a specific component to your request. Please have this information ready if you call in the request.

**Requests to continue service require:**

1. Summary of treatment progress to date
2. Assessment of need for further treatment
3. Requested number of units of service and duration
4. Current discharge plan (hospital, therapy)

If the requested service is not available within the network, an authorization to use an out-of-network specialist may be requested.

## Utilization Management (Authorization Decision) Appeals

As stated above, nationally-recognized criteria for medical necessity (InterQual®) and the Medicaid Service-Specific Policies are used to evaluate requests for medical appropriateness/necessity and benefits. If the request meets all the criteria, it will be assigned an authorization number by MED3OOO (for Ped-I-Care members) or by CCP (for CCP members).

If InterQual® criteria are not met or the requested service exceeds the Medicaid covered allowable, is not a covered benefit, or is a request for an out-of-network provider/service, the request will be forwarded to the respective ICS Medical Director for review. Only the ICS Medical Director or Associate Medical Director is able to deny a request for authorization of services.

If the request for authorization for services is denied, a phone call will be made to the provider by MED3OOO within 1 business day of the decision, followed up by a letter from the ICS to the requesting provider, member, primary care provider, and the CMS Nurse Care Coordinator, explaining the reason for the denial. The letter will be signed by the Medical Director who made the decision.

## Plan Appeal of Authorization Denial or Reduction

A plan appeal of Ped-I-Care's or CCP's decision to deny or reduce a service can be requested by the member, parent, provider, or anyone who has been authorized (in writing) by the member or legal guardian. **Additional information for consideration should be submitted with the plan appeal request.** The plan appeal will be reviewed by a Medical Director who was not involved in the initial decision.

### *When to Make the Plan Appeal*

A plan appeal must be made within 60 days from the date the initial denial or reduction decision is received. Plan appeal requests should NOT be sent to MED3OOO.

### *How to Make a Plan Appeal*

**There are 3 ways to make a plan appeal to <u>Ped-I-Care:</u>**

1. Call us at (352) 627-9100 or (866) 376-2456 and ask for the Ped-I-Care UM Appeals Coordinator.
   If the plan appeal is made by phone, then a plan appeal request must be sent in writing within 10 days of the telephone request.

2. Send a written plan appeal to:

   Ped-I-Care UM Appeals Coordinator
   1699 SW 16th Avenue, Third Floor
   Gainesville, FL 32608-1153

3. Fax Ped-I-Care a written plan appeal to: (352) 294-8084.

**There are 3 ways to make a plan appeal to <u>CCP:</u>**

1. Call us at (866) 209-5022 and ask for an appeal.
   - If the appeal is made by phone, then an appeal request must be sent in writing within 10 days of the telephone request.

2. Send a written appeal to:

   CCP Grievance Coordinator
   1643 Harrison Parkway, Bldg. H, Suite 200
   Sunrise, FL 33323

3. Fax CCP a written appeal to: (954) 251-4848.

### *Ped-I-Care's and CCP's Response Times*

The member, provider, and NCC will be notified of ICS's appeal decision within 30 days of receipt of the appeal request, unless it is an expedited plan appeal. The plan appeal timeframe may be extended up to 14 calendar days, if the member or provider requests an extension or if the ICS needs additional information.

### *Expedited Plan Appeals of Authorization Denial or Reduction*

If an expedited plan appeal is requested and it meets the STAT criteria, the ICS will complete its review and will communicate its decision within 72 hours of the time the request is received. Written notice of disposition of the plan appeal is sent to the member within 2 calendar days after the decision is made. STAT timeframes are reserved for situations where waiting for an approval could seriously jeopardize the member's life, health, or ability to obtain, maintain, or regain maximum function. If a request does not meet STAT criteria, it will be processed as a standard, non-urgent request. To be considered a STAT request, there must be a medical condition manifesting itself by acute symptoms of sufficient severity, which may include severe pain or other acute symptoms that the absence of immediate medical attention could result in any of the following:

1. Serious jeopardy to the health of a patient, including a pregnant woman or fetus;
2. Serious impairment to bodily functions; or
3. Serious dysfunction of any bodily organ or part.

### *Continue Previously Authorized Services during a Plan Appeal*

Ped-I-Care and CCP will continue previously-authorized services when a plan appeal is requested if a written

request is submitted to the UM Department 10 calendar days from the date of the Notice of Adverse Benefit Determination, or within 10 calendar days after the date of the member's current services will end or be limited whichever is later.

**Ped-I-Care's** UM Department fax: (352) 294-8084
**CCP's** UM Department fax: (844) 806-0397

The ICS will inform the member that if the plan appeal decision is not overturned, then the member may have to pay for the cost of the services. A member may request a Medicaid Fair Hearing only after having first exhausted the ICS's plan appeals process; this must be done within 120 days of receiving the original decision. A member who chooses to exhaust the appeals process may still request a Medicaid Fair Hearing within 120 days of receiving the Notice of Plan Appeal Resolution.

**Medicaid Fair Hearings Contact Information:**

Agency for Health Care Administration
Medicaid Hearing Unit
P.O. Box 60127
Ft. Myers, FL 33906

(877) 254-1055 *(toll-free)*
239-338-2642 *(fax)*

Email: MedicaidHearingUnit@ahca.myflorida.com
Web: http://www.myflfamilies.com/about-us/office-inspector-general/investigation-reports/appeal-hearings

**Details Regarding Continuation of Services:**

1. The member's benefits will continue during a plan appeal if:
    a. The member or the member's authorized representative files an appeal with the ICS regarding their decision:
        **i.** Within 10 calendar days after the notice of the adverse benefit determination is mailed; or
        **ii.** Within 10 calendar days after the intended effective date of the action, whichever is later.
    b. The plan appeal involves the termination, suspension, or reduction of a previously authorized course of treatment;
    c. The services were ordered by an authorized provider;
    d. The original period covered by the original authorization has not expired; and
    e. The member requests extension of benefits.
2. If, at the member's request, the ICS continues or reinstates the benefits while the appeal is pending, benefits must continue until 1 of the following occurs:
    a. The member withdraws the plan appeal;
    b. 10 calendar days pass after the ICS sends the member the notice of resolution of the appeal against the member, unless the member within those 10 days has requested a Medicaid Fair Hearing with continuation of benefits;
    c. The Medicaid Fair Hearing office issues a hearing decision adverse to the member; or
    d. The time period or service limits of a previously authorized service have been met.
3. If the final resolution of the plan appeal is adverse to the member and the ICS's action is upheld, the ICS may recover the cost of services furnished to the member while the appeal was pending to the extent they were furnished solely because of the continuation of benefits requirement.
4. If the Medicaid Fair Hearing officer reverses the ICS's action and services were not furnished while the plan appeal was pending, the ICS will authorize or provide the disputed services promptly.

5. If the Medicaid Fair Hearing officer reverses the ICS's action and the member received the disputed services while the plan appeal was pending, CMS Plan will pay for those services.

### *Subscriber Assistance Program*

The member has one year to file with the Subscriber Assistance Program (SAP). The SAP will not consider an appeal that has been to a Medicaid Fair Hearing. Members have the right to appeal an adverse benefit determination decision on an appeal to the Subscriber Assistance Program (SAP), including how to initiate such a review and the following:

a. Before filing with the SAP, the enrollee must complete the ICS's plan appeals process;
b. The member must submit the appeal to the SAP within 1 year after receipt of the final decision letter from the CMS Plan;
c. The SAP will not consider an appeal that has already been to a Medicaid Fair Hearing.

**SAP Contact Information:**

Agency for Health Care Administration
Subscriber Assistance Program
Building 3, MS #45
2727 Mahan Drive
Tallahassee, FL 32308

(850) 412-4502 or
(888) 419-3456

## Requests for Therapy Services

Therapy service providers are required to adhere to requirements outlined in the Florida Medicaid Therapy Services Coverage and Limitations Handbook in order to receive reimbursement for services. Therapy is initiated with a prescription. The initial prescription allows for evaluation by the therapist with recommendations made by the therapist and submitted to the primary care physician for approval regarding need for treatment and plan of care. Short term and long term therapy goals must be established that are consistent with the cognitive age and the medical condition of the child. Goals must be measurable with treatment notes supportive of activities that are goal directed during therapy. Signature of the PCP, ARNP or PA designee, or designated physician specialist indicating that they have reviewed the plan of care and prescribed the therapy is required. Therapy services may be authorized for up to a 180-day period. Re-evaluation is required between 150-180 days.

The request for ongoing rehabilitative services (occupational, respiratory, physical, and speech/language therapy) is generally made in two phases, the initial assessment and the treatment plan of care. A primary care or specialty provider makes the request for the initial assessment. If approved, the therapist conducts the assessment and develops a proposed treatment plan. The plan must be approved by the requesting provider, as indicated by his/her signature on the plan, but the actual prior authorization request may be submitted to MED3OOO (for Ped-I-Care members) or CCP (for CCP members) by either the provider or the therapist.

Services may be requested up to 60 days in advance and for a time period of up to 180 days. No more than 12 units of services per therapy will be authorized per week. Up to 3 one-hour treatment visits per week will be authorized per approval from the ICS Medical Director.

Therapists may use the Therapy Service Authorization Checklist (located at https://com-peds-pedicare.sites.medinfo.ufl.edu/files/2014/09/Therapy-Services-Authorization-Checklist-July-2016.pdf) to ensure all the needed information is submitted with service requests.

## Occupational Therapy (OT) Authorization Guidelines

**Overview of OT**

Occupational Therapy intervention includes evaluation and treatment of motor, perceptual, sensory processing, adaptive/self-help, and social/emotional deficits in order to optimize level of functioning, facilitate development, and improve occupational performance.

OT intervention includes but is not limited to therapeutic activities and procedures, functional activities including activities of daily living (ADLs), neuromuscular training, sensory integration, manual therapy techniques, the application of modalities requiring direct contact, and orthosis fitting and training.

1. **Guidelines for OT Interventions**
   The OT evaluation report and subsequent 6 month OT re-assessment report will determine the client's eligibility for OT intervention.
   a. To qualify a client for OT services:
      i. Providers must utilize either comprehensive standardized *or* performance-based measures that assess sensory-motor functioning; and
      ii. Document (clinical findings) the evidence of occupational performance limitation as a result of deficits identified with the assessment measures.

   b. Criteria for eligibility will be as follows:
      i. Performance-based test: Greater than 25% delays in performance in *two or more* developmental skills including motor, perceptual, sensory processing, adaptive/self-help, and social/emotional development.
      ii. Standardized assessment: Greater than 1.5 standard deviations from the norm/mean.
      iii. Clinical Findings: Existence of sensory-motor deficits impacting client's occupational performance.

2. **Authorization of OT Services**
   **The ICSs authorize services that:**
   a. Meet the criteria for eligibility described in Section 2 (Guidelines for OT Intervention);
   b. Are medically necessary, and prescribed by a physician (MD or DO), Advanced Registered Nurse Practitioner (ARNP), or physician assistant (PA);
   c. Are individualized and specific to the client's needs and disability accounting for the severity, intensity, and longevity of the condition;
   d. Are developmentally appropriate;
   e. Are consistent with best practice interventions (evidence-based practice), which include the use of the most appropriate assessment tools, skilled therapeutic procedures, and cost-effective interventions; and
   f. Reflect parental/caregiver's involvement with the identification, implementation, and delivery of services.

   **ICSs will <u>not</u> authorize services that:**
   a. Are primarily educationally relevant;
   b. Are unsupported by the client's progress in functional gains, occupational performances, and/or maintenance of quality of life and safety following OT intervention; or
   c. Reflect inappropriate and unrealistic outcomes that are inconsistent with client's diagnosis, overall prognosis, and rehabilitative expectations.

3. **Plan of Care and Frequency of OT Therapies**
   a. A plan of care (treatment plan) needs to be submitted with the initial evaluation and subsequent 6-month re-assessments to describe:
      i. OT procedures to be utilized;

ii. Short-term and long-term goals;
iii. Frequency of therapy (# units/week; 1 unit = 15 minutes); and
iv. Projected outcome for therapy which includes the functional level to be achieved by the client to map a discharge plan.

b. Guidelines for the utilization and delivery of OT services are as follows:
i. **Intensive Therapy** – Up to 12 units per week for new episode of acute condition or specialized therapy for dyslexia, severe sensory disorders, and related conditions for up to 6 months.
ii. **Moderate Therapy** – Up to 9 units a week for chronic condition or pre-existent condition for up to 6 months.
iii. **Maintenance Therapy** – Up to 6 units a week for developmental disability for up to 6 months.
iv. **Consultative Therapy** – Up to 6 units a month prior to dismissal for up to 3 months.

## Speech/Language Therapy (ST) Authorization Guidelines

1. **Overview of ST**
Speech/Language intervention includes the evaluation and treatment of the following disorders:
a. **Receptive and Expressive Language:** The comprehension and/or the expression of spoken or written language. Disorders in this domain may include one, a combination of, or all of the components of a language system. The components include:
i. **Phonology**: The particular sound system of a language and the rules of the language that govern how sounds are put together.
ii. **Morphology:** The structure of words and the ways in which the rules of language govern how the words are put together to form new words.
iii. **Syntax:** The rules governing the order and combination of words in the formation of sentences and the relationship between the components in the sentence.
iv. **Semantics:** The individual word meanings and combing the word meanings to form the content of a sentence.
v. **Pragmatics:** The sociolinguistic components that govern the use of language in context.
b. **Articulation:** The production of speech sounds for a given age. Disorders in this domain are characterized by abnormal speech production of a given age.
c. **Fluency:** The flow of verbal expression. Disorders in this domain are characterized by impaired rate and rhythm and often accompanied by secondary struggling behaviors.
d. **Voice:** The production of voice. Disorders in this domain are characterized by abnormal initiation/duration, tonal quality, pitch, loudness, and/or resonance.

2. **Guidelines for Speech/Language Interventions**
Initial evaluation and subsequent 6-month re-assessment determine the client's eligibility for speech/language intervention.
a. **Receptive and Expressive Language:** A significant delay in this area is defined as at least 1.5 standard deviations below the mean. Assessment in this area should include:
i. A comprehensive, standardized language measure that assesses both expressive and receptive language;
ii. A secondary measure assessing the area of concern;
iii. A discrepancy of at least one standard deviation between the overall expressive and receptive scores, or a discrepancy of one standard deviation between two or more areas described above, or a discrepancy of one standard deviation between language scores and a non-verbal cognitive measure;
iv. Performance-based measure such as a parent/teacher questionnaire that corroborates with the data obtained on the standardized measure; and

v. Evidence of a passed hearing screening within the past 6 months (initial authorization only).

b. **Articulation Skills**: A significant delay in this area is defined as at least three sounds that are developmentally delayed more than one year based on standardized norms, two sounds that are developmentally delayed more than two years, and one sound that is developmentally delayed more than three years. Assessment in this area should include:
   i. Informal assessment of speech skills based on a conversation sample, to determine level of intelligibility;
   ii. Standardized assessment of articulation skills;
   iii. Performance-based measure such as a parent/teacher questionnaire that corroborates the data obtained on the standardized measure; and
   iv. Oral motor assessment to determine the level of (if any) oral motor involvement.

c. **Fluency Skills:** A significant delay in this area is determined by the use of a standardized assessment for fluency. An informal assessment of connected speech should first be done to determine the need for a formal assessment.

d. **Voice Skills:** Voice skills can be assessed informally by listening to connected speech and completing a voice profile questionnaire. A medical evaluation by an Ear/Nose/Throat (ENT) physician must be done to determine the need for voice therapy.

3. **Authorization of Speech/Language Services**

**The ICSs authorize services that meet the following criteria:**

a. The evaluation criteria addressed in Section 2 (Guidelines for Speech/Language Interventions);
b. If the client is of school age, having documentation that the child is/is not receiving school-based therapy;
   i. If not, the reasons should be documented as to why not.
   ii. If the child is receiving school based treatment, a copy of the child's Individualized Education Plan (IEP) should be included documenting the services provided.
c. Goals are individualized and specific to the client's needs and disability accounting for the severity, intensity, and longevity of the condition;
d. Consistent with the best practice interventions (evidence-based practice) which includes the use of the most appropriate assessment tools, skilled therapeutic procedures, and cost-effective interventions; and
e. Reflecting parental/caregiver's involvement with the identification, implementation, and delivery of service.

**ICSs will <u>not</u> authorize services that:**

a. Are primarily educationally relevant;
b. Are unsupported by the client's progress in functional gains and/or speech performance following ST intervention; or
c. Reflect inappropriate and unrealistic outcomes that are inconsistent with client's diagnosis, overall prognosis, and rehabilitative expectations.

4. **Plan of Care and Frequency of ST Therapies**

a. A plan of care (treatment plan) needs to be submitted with the initial evaluation authorization request and subsequent 6-month re-assessment requests to describe:
   i. Short- and long-term goals;
   ii. Treatment procedures that are evidence-based;
   iii. Frequency of therapy (# units per week; 1 unit = 15 minutes);
   iv. Goals for treatment should reflect the client's needs and severity of disability;
   v. Goals incorporating carryover of skills to areas outside the therapy setting; and
   vi. Projected outcome from therapy that includes the functional level to be achieved by the client to map a discharge plan.

b. Guidelines for the utilization and delivery of ST services are as follows:

i. **Intensive Therapy** – Up to 12 units per week for new episode of acute condition or specialized therapy for dyslexia, severe sensory disorders, and related conditions for up to 6 months.
ii. **Moderate Therapy** – Up to 9 units a week for chronic condition or pre-existent condition for up to 6 months.
iii. **Maintenance Therapy** – Up to 6 units a week for developmental disability for up to 6 months.
iv. **Consultative Therapy** – Up to 6 units a month prior to dismissal for up to 3 months.

## Physical Therapy (PT) Authorization Guidelines

1. **Overview of PT**
    a. Physical Therapy evaluation includes completion of a standardized or a performance-based assessment tool describing motor/sensory involvement.
    b. Criteria for initial treatment is the documentation of atypical muscle control and/or sensory-motor deficits which limit functional skills of the child and the establishment of short and long term goals for the intervention.

2. **Guidelines for PT Interventions**
    a. Therapy must include activities that require participation of licensed therapist or therapist assistant. Therapy must consist of activities that meet at least one of the following criteria:
        i. Will result in improved active participation of the child in normal daily routines or functional activities;
        ii. Will promote the acquisition of functional skills by the child;
        iii. Will assist in the prevention or decrease of musculoskeletal deformity;
        iv. Can be reinforced daily by the primary caregivers of the child in their daily routines; and/or
        v. Will provide pain relief.
    b. Short-term and long-term therapy goals must be established that are consistent with the cognitive age and the medical condition of the child. Goals must be measureable with treatment notes supportive of activities that are goal directed during therapy.
    c. Intensive physical therapy of up to 12 -14 units per week may be approved in the following circumstances:
        i. Intense post-surgical intervention is needed for prolonged duration or increased frequency to allow child to benefit fully from the surgical procedure – example: following dorsal rhizotomy;
        ii. The child has had a recent growth spurt that is associated with change in functional status – example: child with atypical lower extremity muscle tone who has experienced bone growth and associated increased tightness in involved musculature which results in decreased independence in functional skills;
        iii. The child has change in functional status indicating need for increased intervention for specific period to assist in appropriate skill acquisition – example: child has started to walk and additional intervention is needed to facilitate appropriate gait pattern; and/or
        iv. The child has severe involvement and the therapist provides documentation that all appropriate and tolerated therapy activities are not able to be completed in less treatment time.

    d. **Procedure for requesting extended frequency/duration of therapy treatment:**
        i. The therapist must provide documentation that the child has been consistently attending therapy and tolerating treatment sessions of at least 30 minutes twice weekly;
        ii. All requests must include relationship of extended treatment time to functional and measurable treatment goals;
        iii. Documentation must include that the extended time is required to allow for specific handling techniques by a medical professional such as stretching. Extended time should not

be requested for practice activities which can be included in appropriate home program;
iv. Extended treatment time is not for the convenience of family or provider; and
v. Specific gains from extended treatment times must be documented to justify continuation of extended time beyond a 3-month period.

3. **Length of Authorization for Physical Therapy Services**
   a. Physical Therapy Services may be authorized up to six months. The length of authorization is dependent on the diagnosis and the established goals of treatment. For example, a child with atypical muscle tone and global developmental delay may be anticipated to require authorization for six months while a child with an acute ankle injury may require services for 1 to 2 months only. The therapist is notified of the length of authorization following approval of the initial treatment plan.
   b. The therapist is required to submit a new treatment plan including current functional status of the child, progress on established treatment goals, and establishment of new goals which must be approved by the primary care physician to request continued authorization of services. Continued authorization for therapy services must be supported by a measurable response to treatment provided in the subsequent plan of care request.
   c. Consultative/maintenance therapy may be funded to allow therapist to work with primary caregiver regarding handling techniques and updating previously provided home programs as needed. Consultative therapy would be expected not to exceed 6 units per month.

4. **Authorization of PT Services**
   **The ICSs authorize services that:**
   a. Meet the criteria for eligibility;
   b. Are medically necessary, and prescribed by a physician (MD or DO), Advanced Registered Nurse Practitioner (ARNP), or physician assistant (PA);
   c. Are individualized and specific to the client's needs and disability accounting for the severity, intensity, and longevity of the condition;
   d. Are developmentally appropriate;
   e. Are consistent with best practice interventions (evidence-based practice), which include the use of the most appropriate assessment tools, skilled therapeutic procedures, and cost-effective interventions; and
   f. Reflect parental/caregiver's involvement with the identification, implementation, and delivery of services.

   **ICSs will <u>not</u> authorize services that:**
   a. Are primarily educationally relevant;
   b. Are unsupported by the enrollee's progress in functional gains, physical performances, and/or maintenance of quality of life and safety following PT intervention; or
   c. Reflect inappropriate and unrealistic outcomes that are inconsistent with enrollee's diagnosis, overall prognosis, and rehabilitative expectations.

5. **Plan of Care and Frequency of Therapies**
   **a. A plan of care (treatment plan) needs to be submitted with the initial evaluation and subsequent 6-month re-assessments to describe:**
      i. PT procedures to be utilized;
      ii. Short term and long term goals;
      iii. Frequency of therapy (# units/week; 1 unit = 15 minutes); and
      iv. Projected outcome for therapy which includes the functional level to be achieved by the client to map a discharge plan.

   **b. Guidelines for the utilization and delivery of PT services are as follows:**
      i. **Intensive Therapy** – Up to 12 units per week for new episode of acute condition for up to 6 months.

ii. **Moderate Therapy** – Up to 9 units a week for chronic condition or pre-existent condition for up to 6 months.
iii. **Maintenance Therapy** – Up to 6 units a week for developmental disability for up to 6 months.
iv. **Consultative Therapy** – Up to 6 units a month prior to dismissal for up to 3 months.

# PLACEHOLDER – INSERT THERAPY SERVICES CHECKLIST HERE

**("CMS ICS_T19 & T21 Checklist for Requesting Therapy Services_2014-09-04")**

# PLACEHOLDER – INSERT PIC AUTH REQUEST FORM

**("PIC Auth Request Form - 2014-08-21")**

# PLACEHOLDER – INSERT CCP AUTH REQUEST FORM

**("CCP CMS_Authorization Request Form - 2014-09-04")**

# PLACEHOLDER – INSERT PIC GENETIC TEST REQUEST FORM HERE

# PLACEHOLDER – INSERT CCP GENETIC TEST REQUEST FORM HERE

# PLACEHOLDER – INSERT PIC WORK SCHEDULE FORM HERE

**("Ped-I-Care_Verification Form - Work Schedule_Approved 2013-07-02")**

# PLACEHOLDER – INSERT CCP WORK SCHEDULE FORM HERE

**("CCP_Verification Form - Work Schedule")**

# PLACEHOLDER – INSERT PIC SCHOOL SCHEDULE FORM HERE

**("Ped-I-Care_Verification Form - School Schedule_Approved 2013-07-02")**

## Ped-I-Care Medical Review Process

**Requesting an Authorization**
The PCP/Specialist enters the request in eINFOsource or faxes it to MED3OOO at (**866) 256-2015**. Call MED3OOO at (800) 492-9634 if you have questions or a request that meets STAT criterion.

Title 19 timeframes are:
Routine - 7 days, Expedited* - 48 hours
Title 21 timeframes are:
Routine - 14 days, Expedited* - 72 hours, Retro - 30 days

If Expedited criterion are not met, it is processed as a Routine request.

**MED3OOO reviews and tracks each request in FACETs.**

1. If the request and information submitted meets medical necessity based on the Medicaid Service-Specific Policies or InterQual Criteria, MED3000 assigns an authorization number and the request is approved.
2. If it does not meet criteria, is an out-of-network request, or is a mandatory medical review service (such as therapy) MED3OOO sends the review to Ped-I-Care for Medical Director to make a decision to approve, deny, or reduce the request.
3. If more information is needed, MED3OOO requests the information from the person that submitted the request or the ordering provider. If needed, Ped-I-Care sends a letter of **time extension** (7 days) to the member, provider, and NCC. Once the information is received (or nothing new is submitted), MED3OOO follows the steps in

The request is **Approved**. MED3OOO assigns an authorization number and notifies the requesting provider. The CMS CC can locate the approval in FACETs.

**In addition to records supporting medical necessity, requests should include:**

**MRI** – Prior film reports and documentation consistent with medical necessity

**Orthodontic** – The Medicaid score sheet and films and/or photographs if the score doesn't meet Medicaid guidelines

**Out-of-Network/Non-Par Providers and Facilities** – Detailed contact information for the provider and facility, why a participating provider is not being requested, and separate request submissions for the provider and facility

**HHA/PCS** – All parent/caregiver's work/school schedules, explanation from parent/caregiver's doctor of disability and/or limitations (if applicable), documentation of level of care needed, hours/day, and days/week. Please indicate whether another child in the home is receiving the same services.

**PDN/PPEC** – Level of care needed, and requested hours/day and days/week. Please indicate whether another child in the home is receiving the same services.

**PT/OT/ST** – Evaluation, signed plan of care, documentation, units or minutes/day (session), days/week, and all therapies currently receiving

**Residential Treatment** – Documentation of failed attempts of less restrictive treatments and therapies

**The request is sent for Ped-I-Care Medical Director Review.** The MD decides to:

1. Approve, deny, or reduce the request. Ped-I-Care notifies MED3OOO of the decision;
2. Send the request to a consultant for recommendations. Ped-I-Care sends the request to the consultant and the response is sent to the Medical Director for a final decision; or
3. Request more information. (Ped-I-Care sends the request for to MED3OOO to obtain from the requesting or submitting provider. Once the information is obtained [or nothing new is submitted], the Medical Director is notified and step 1. or 2. above is followed.)

The request is **Denied or Reduced.** Ped-I-Care sends a decision letter to the member, provider, and CMS Plan CC with the denial/reduction reason and steps to appeal the decision. MED3OOO enters the decision into FACETs **Only a Medical Director can deny or reduce a request.**

# CCP'S MED REVIEW PROCESS




**PED-I-CARE AUTHORIZATION DENIAL APPEAL REQUEST FORM**

You can fax this form to us at (352) 294-8084 OR mail this form to us at: Ped-I-Care, Attn: Medical Review Coordinator, 1701 S.W. 16th Ave., Bldg. A, Gainesville, FL 32608. You can call us to make an appeal at (866) 376-2456. If you appeal by phone, you must then send an appeal to us in writing within 10 days of your telephone request. If you have questions, please feel free to call us at (866) 376-2456, and ask for our Utilization Management Department; or visit our website at http://pedicare.peds.ufl.edu/. A written decision will be sent to the member, provider(s), and CMS Area Office.

PLEASE DO NOT SEND THIS APPEAL OR ANY MEDICAL INFORMATION BY EMAIL!

Appeal Type: ☐ Standard ☐ Fast (Use only when your doctor thinks it is medically necessary)

☐ Title XIX (19) ☐ Title XXI (21)

Member: _____ DOB: _____ Member ID#: _____

Name of person requesting appeal: _____

Relationship to member: ☐ Parent/Guardian ☐ PCP ☐ Other: _____

Name of provider who ordered the service: _____

Service appealed: _____

Service appealed was: ☐ Denied ☐ Reduced/Limited (Please attach a copy of the Notice of Denial letter that you received)

Check if new information is attached: ☐ Notes ☐ Tests/Studies ☐ Photos ☐ Imaging ☐ Other: _____

| Please use this area to explain why this request should be approved. You may use additional paper, if needed. |
|---|
| |

We may continue your previously authorized services when you file an appeal. For us to continue your services, you must let us know in writing whether you to continue your services by whichever of the following time period is later, either: 1) within 10 business days from the date of this notice; or 2) within 10 business days after the date your current services will end or be limited. Please mark the box to tell us if you would like to continue previously authorized services: ☐ NO ☐ YES (If you mark "yes" and do not win the appeal, you may have to pay for the cost of the services)

**This communication may contain information that is legally protected from unauthorized disclosure. If you have received this message in error, you should notify the sender immediately by telephone and discard this message.**

# PLACEHOLDER – CCP AUTH DENIAL APPEAL REQUEST FORM

# PLACEHOLDER – INSERT PIC MEDICAL REVIEW MATRIX FOR APPEAL PROCESS

# PLACEHOLDER – INSERT CCP MEDICAL REVIEW MATRIX FOR APPEAL PROCESS

**("Ped-I-Care_Medical Review Matrix for Appeal Process - Titles 19 and 21 - 2014-07-17")**

# VII. BILLING & CLAIMS PAYMENTS

CMS Plan claims are processed by the statewide third-party administrator (TPA), MED3OOO. Services are paid for at the prevailing Medicaid rate and will follow Medicaid guidelines for service limits. Payments are made according to the Utilization Management policies described in the Medicaid Handbooks and shall be made in accordance with applicable state and regulatory guidelines.

MED3OOO only processes claims for services provided to children who are enrolled in CMS Plan during the month in which the service is provided. **If a child loses eligibility for CMS Plan, the provider should contact the CMS Office for consultation on payment options.**

Physician extenders (ARNPs and Physician Assistants) may bill "incident to" an enrolled provider in accordance with Medicaid guidelines. The physician must be on-site during the visit/service provided and must sign the chart. If the services rendered by the ARNP are billed with the ARNP as the treating provider, the services must be provided in accordance with the policies and limitations contained in the Medicaid handbook. ARNPs must be currently licensed, operating within the scope of their profession and in accordance with the protocols established by the provider under whose authority they practice. If services are not rendered in accordance with "incident to" guidelines, ARNPs will be paid at 80% of the physician's reimbursement rate. Emergent ambulance transportation providers file claims with MED3OOO according to claims payment rules listed within this manual. Non-emergent transportation providers file claims with Access2Care via the Access2Care client portal or by calling directly at (866) 874-0222, option 1.

When presenting a claim for payment to MED3OOO, the network provider indicates an understanding that they have an affirmative duty to supervise the provision of, and be responsible for, the covered services claimed to have been have been provided, to supervise and be responsible for preparation and submission of the claim. The provider will only present a claim that is true and accurate and that is for CMS Plan covered services that:

- Have actually been furnished to the member by the provider prior to submitting the claim; and
- Are medically necessary.

**Payer IDs**

**Change Healthcare (formerly Emdeon):** EM843
(877) 363-3666
www.changehealthcare.com

**Availity:** M3FL0012
(800) 282-4548
www.availity.com

**In order to be paid, a claim must meet the following criteria:**

1. Member must have been enrolled in the month service was delivered
2. Service is a covered and/or authorized benefit
3. Provider must be enrolled in the Ped-I-Care or CCP network (unless out-of-network services are authorized)
4. Uses HIPAA and Florida law compliant format for claims submission [CMS 1500 (08-05), UB-04, ADA Dental Form]
5. Claim must be complete and accurate
6. Claims for specialty services and procedures need to include the authorization number
7. Procedure must be consistent with the diagnosis code listed on the claim
8. Accurate claims must be submitted **within 365 days** of the date of service

Electronic claims are the preferred method of claims submission. This can be arranged directly with MED3OOO.

**There are two options for electronic filing:**

**Change Healthcare (formerly known as Emdeon)**

- MED3OOO/Ped-I-Care Title 19
- Change Healthcare Electronic Payer ID: EM843
- Change Healthcare can be contacted at (877) 363-3666 to arrange for Electronic Claims filing.
- They may also be contacted via their website at www.changehealthcare.com; choose the appropriate selection from the left-hand side**.**

**Availity**

- MED3OOO/Ped-I-Care or CCP Title 19
- Availity Electronic Payer ID: M3FL0012
- Availity can be contacted at (800) 282-4548 to arrange for Electronic Claims filing or via their website at www.availity.com; choose "Get Started" in the left-hand menu.
- **Please note**: Availity DOES NOT process dental claims.

Providers must register with a clearinghouse above and use the Payer ID listed.

CMS Plan has implemented Electronic Remittance advice (also known as the standard data transaction set 835). Please go to www.changehealthcare.com or call Change Healthcare at (866) 506-2830 to learn more.

Ped-I-Care and CCP providers must accept the payment made by MED3OOO as payment in full and may not request payment or balance bill the CMS Plan members or family members. Providers must not charge members co-payments for covered services. If your claim cannot be paid as submitted, MED3OOO will give the reason for the denial on the Explanation of Benefits (EOB) that will accompany every payment to your office. Claims payments will be made in accordance with state and regulatory guidelines.

If you have questions about the payment or the EOB, please contact MED3OOO Customer Service at (800) 664-0146. They will respond to your questions or concerns. If, after talking with them you wish to appeal a claim that has denied in all or in part for payment, you should follow the procedures described in this manual (see Section VIII).

For those providers who wish to continue to submit paper claims, paper claims should be mailed to:

CMS Plan MMA Specialty Plan Title 19
PO Box 981648
El Paso, TX 79998-1648

**eINFOsource**

MED3OOO offers eINFOsource, a web-based application that will allow providers to check on the status of claims, verify eligibility, request authorization and referral information. This will provide accurate and timely information, while decreasing time spent on the phone. For more information or to establish a login for your office, please contact the MED3OOO Help Desk at (866) 703-1444.

**eINFOsource Functionality**

Primary care providers now have the ability to generate a roster of their members. The link to the roster may be found on the eINFOsource Provider home page on the right navigation bar under "Manage Patients." The link is called "View Member List."

**eINFOsource Training Opportunities**

MED3OOO hosts WebEx training sessions on the use of the eINFOsource web portal. To register, go to

https://mck.webex.com. MED3OOO can be reached by phone at (800) 664-0146 or via email at FL-CustomerService@MED3000.com.

***PLEASE REMEMBER THAT CLAIMS FOR APPROVED AND AUTHORIZED SERVICES WILL BE PAID ONLY IF THE MEMBER IS ENROLLED IN CMS Plan DURING THE MONTH OF SERVICE. ELIGIBILITY CAN CHANGE AND MUST BE VERIFIED PRIOR TO EACH TIME SERVICES ARE GOING TO BE RENDERED.***

Please note that CMS Plan has a Compliance Program which includes auditing claims and reviewing documentation for potential fraud and abuse under the terms of our contract with DOH/AHCA. Please see Section XV for more information about our Compliance Program.

CMS Plan is authorized to take whatever steps necessary to ensure the provider is recognized by the Agency for Health Care Administration and its agent(s) as a participating provider of CMS Plan and that the provider's submission of encounter data is accepted by the Agency.

# VIII. CLAIMS APPEALS/GRIEVANCES

## Appeals Related to Claims Payment Denial

The response to all claims submitted from providers will be documented on the Explanation of Benefits (EOB) sent to the billing provider by MED3OOO. Each claim submitted is noted as paid or denied and will include an explanation of the reason for non-payment.

For **Ped-I-Care and CCP,** if the provider thinks there has been an error in the denial or has any questions about the interpretation of, or disagreement with the adjudication, he/she should contact MED3OOO Customer Service at (800) 664-0146. MED3OOO staff will attempt to clarify or resolve any issues with the claims payment process.

## First-Level Appeal

If not satisfied with this initial response, the provider may submit a formal appeal. This must be done in writing within 60 calendar days from the date of the EOB using the form included in this section (for Ped-I-Care) or submitting an appeal letter for CCP.

**The appeal request must consist of:**

- The completed appeal form
- Documentation supporting the request relevant to the date of service
- Copy of the original claim

**MED3OOO**
**Customer Service**
(800) 664-0146

For questions regarding claims payments and/or denials

**For Ped-I-Care, the appeal should be mailed or faxed to:**

University of Florida/Ped-I-Care
1699 SW 16th Avenue, Third Floor
Gainesville, FL 32608
Attn: Claims Appeals
Fax: (352) 294-8092

**For CCP, the appeal should be mailed to:**

CCP
Attn: CMS Claims Appeals
1643 Harrison Parkway, Bldg. H, Suite 200
Sunrise, FL 33323

For Ped-I-Care, the appeal will be reviewed and researched by Ped-I-Care staff and forwarded to the Manager of Claims Services for final determination.

For CCP, If the appeal is related to an authorization, CCP Utilization Management will review the appeal. If the appeal is not related to an authorization issue, the appeal will be sent to MED3OOO for final determination.

For Ped-I-Care, if the appeal is denied, and the claim payment denial is upheld, the provider will receive a written response within 45 days of the ICS's receipt of the appeal.

For CCP, if payment is denied, the provider will receive a written response from MED3OOO within 45 days of the ICS's receipt of the appeal.

## Second-Level Appeal

If the first-level appeal is denied, the provider may file a second-level appeal that will be submitted in writing to Ped-I-Care/CCP using a copy of the original appeal form or original appeal letter (with "Second-Level Appeal" box checked) or a second completed form with "Second-Level Appeal" noted. Additional supportive documentation should be attached to the appeal form.

The second-level appeal must be submitted within 15 days of the receipt of the denial of the first appeal. The second-level appeal shall be mailed to the appropriate ICS Claims Appeals address listed above.

**CCP Process**

For CCP, if the appeal is related to an authorization, CCP UM will review the appeal. If the appeal is not related to an authorization issue, the appeal will be sent to MED3OOO for final determination. The appeal will be reviewed by the Executive Director (or designee) to determine if it can be paid.

**Ped-I-Care Process**

For Ped-I-Care, the second-level appeal will be reviewed within 15 business days by a committee consisting of the ICS's Executive Director, Assistant Director of Finance, the Assistant Director of Network and Contracting and the ICS Medical Director. If the second-level appeal is denied, the provider will be mailed a denial letter within 5 business days of the decision.

# PLACEHOLDER – INSERT PIC CLAIMS APPEAL FORM HERE

**("Ped-I-Care_Claims Appeal Form_Title 19")**

## Provider Complaints/Grievances

Providers may file a complaint to dispute Ped-I-Care's or CCP's policies, procedures or any aspect of either ICS's administrative functions. Claims may also be disputed.

> To file a complaint with **Ped-I-Care,** providers may call (866) 376-2456 or (352) 627-9100 and ask for the Grievance Coordinator.
>
> To file a complaint with **CCP,** providers may call (855) 819-9506 and ask for a Provider Relations representative.

Complaints that are not related to claims should be filed within 45 days of the incident responsible for initiating the complaint. The Grievance Coordinator will review the complaint, bringing in any other necessary parties to collect all pertinent facts, and respond to the complainant in 3 business days or less. If a complaint is unresolved after 15 days of receipt, a written notice will be given to the provider regarding the status. This will occur every 15 days thereafter until resolved. All complaints are to be resolved within 90 days of receipt, and providers will be given written notice of the disposition and the basis of the resolution within three business days of resolution.

A grievance may be filed on any serious issue or when the usual protocols have been exhausted and the provider is still dissatisfied. To file a grievance, call the Ped-I-Care or CCP office and ask for the Grievance Coordinator. The Grievance Coordinator will send the appropriate form to the provider on which to document the reason(s) for the grievance. A copy of this form is included in this section. If the provider would prefer to file the grievance verbally, the Grievance Coordinator will note the specifics of the grievance. A provider may file a complaint or grievance on behalf of a member.

The ICS Medical Director will convene the Provider Grievance Committee. The Committee will consist of the ICS Medical Director, ICS Executive Director, Network/Provider Relations Manager, a representative from the Risk Management Office, and other specialists/resources appropriate to the situation. The provider may participate in the Grievance Committee meeting. A final decision will be made by the Provider Grievance Committee and communicated by mail to the complainant. The ICS has 90 days to send notice of a decision. There can be a 14-day extension under certain circumstances, within 5 days of determining the need for an extension.

## Other Issues & Concerns

Concerns about CMS Plan members may be directed to the member's CMS Nurse Care Coordinator (NCC) or to the ICS's Member Services office.

- For **Ped-I-Care** Member Services, call (866) 376-2456 or (352) 627-9100.
- For **CCP** Member Services, call (866) 209-5022.

Ped-I-Care and CCP staff can also address other issues and concerns. This process is informal and handled verbally, unless otherwise requested by the provider.

Providers may call Ped-I-Care or CCP and ask for Network Management or Provider Relations staff or express their concerns when Network Management staff make their regular contact with providers.

The Member Services Manager maintains a log of issues of concern to providers and reports them to the ICS Executive Director and to the Quality and Utilization Management Committee (QUMC) at quarterly meetings. These are reviewed and noted as to any trends which would indicate potential need for improvements in the system or services rendered by Ped-I-Care, CCP, or the subcontracted TPA, MED3OOO.

If providers wish to submit comments or concerns in writing, they may be sent to the Network/Provider Relations Manager.

For **Ped-I-Care:**
Network/Provider Relations Manager - Ped-I-Care
1699 SW 16th Avenue
Gainesville, FL 32608

For **CCP:**
Provider Relations Manager – CCP
1643 Harrison Parkway, Bldg. H, Suite 200
Sunrise, FL 33323

If the provider would like a complete description of the provider complaint/grievance system, a request may be sent to the address above or the provider can call Provider Relations at the respective ICS.

- **For Ped-I-Care's** Provider Relations department, call (352) 627-9100 or (866) 376-2456.
- **For CCP's** Provider Relations department, call (855) 819-9506.

# PLACEHOLDER – INSERT PIC GRIEVANCE FORM HERE

**("Ped-I-Care_Grievance Form_Provider")**

# IX. MEMBER RIGHTS, RESPONSIBILITIES, & COMPLAINTS

## Member Rights

Every member receives a handbook when they are enrolled in CMS Plan. Below is an excerpt of the language relevant to members' rights and responsibilities. In addition to the cited CFRs, the Title VI of the Civil Rights Act of 1964 as implemented by regulations at 45 CFR part 80; the Age Discrimination Act of 1975 as implemented by regulations at 45 CFR part 91; the Rehabilitation Act of 1973; Title IX of the Education Amendments of 1972 (regarding education programs and activities); Titles II and III of the Americans with Disabilities Act; and section 1557 of the Patient Protection and Affordable Care Act are acknowledged by AHCA.

*We want you to get the best medical care. We want to help you get the care you need. For that, you have rights and responsibilities. Certain rights are provided for you by law (42 CFR 438.100; 42 CFR 438.102; 45 CFR 164.524 and 45 CFR 164.526).*

*YOUR RIGHTS:*

- *To be treated with respect, courtesy, and dignity.*
- *To protect your privacy.*
- *To ask questions and get answers you understand.*
- *To get the care and services covered by Medicaid.*
- *To get good medical care regardless of race, origin, religion, age, disability, or illness.*
- *To know about your treatment. To know what your options are. To decide about your care. You can refuse treatment.*
- *To ask for and get a copy of your medical records. To request your medical records be changed or amended. Changes can only occur as allowed by law.*
- *To get a second opinion from another doctor.*
- *To get service from out-of-network providers.*
- *To participate in experimental research. (NOTE: This is not covered as a plan benefit.)*
- *To refuse to participate in experimental research.*
- *To change providers at any time. You can ask for another primary care doctor (PCP) or specialist.*
- *To file a complaint, grievance or plan appeal.*
- *To not be restrained or secluded to make you act a certain way or to get back at you.*
- *To get information about Advanced Directives, if you are over 18.*
- *To exercise your rights and not have it affect the way you are treated.*
- *To get information from Children's Medical Services Managed Care Plan (CMS Plan) in the format or language you need. Information like:*
    - *How we approve services (authorization/referral process, medical necessity);*
    - *How we make sure we keep getting better at what we do (Quality Improvement Program);*
    - *How we measure the quality of our services (Performance Measures);*
    - *The prescription drugs covered by CMS Plan;*
    - *How we keep your information confidential;*
    - *How we run the program. How we operate. Our policies; and*
    - *If we have any provider incentive plans.*

*You can get this information at [http://www.floridahealth.gov/programs-and-services/childrens-health/cms-plan/](http://www.floridahealth.gov/programs-and-services/childrens-health/cms-plan/) or call Member Services.*

*YOUR RESPONSIBILITIES:*

- *To call your PCP(s) before getting care unless it is an emergency.*
- *To call your PCP when you get sick and need care.*
- *To listen and work with your providers.*
- *To treat all health care providers and staff with respect, courtesy and dignity.*
- *To give them the information they need for your care.*
- *To talk to your doctor if you have questions or concerns*
- *To carry your ID card at all times.*
- *To call your doctor if you cannot make it to an appointment.*
- *To call Department of Children and Families if your address or telephone number changes.*
- *To tell us or Medicaid if you suspect fraud.*

## Member Complaints & Grievance & Appeals System Procedures

Participants enrolled in CMS Plan have the right to file a complaint or grievance about any aspect of the services or providers. A complaint may be submitted verbally by calling the ICS.

- **For Ped-I-Care** Member Services, call toll-free at (866) 376-2456 or locally at (352) 627-9100.
- **For CCP** Member Services, call toll-free at (866) 209-5022.

If a participant complains to the CMS Nurse Care Coordinator, the complaint will be passed on to the Member Services department of the respective ICS.

There is a difference between a complaint, a grievance, and an appeal. Per contract definition, a complaint is the lowest level of challenge and provides the ICS an opportunity to resolve a problem without it becoming a formal grievance.

**Types of Issues:**

a. A **complaint** is the lowest level of challenge and provides the ICS an opportunity to resolve a problem without its becoming a formal grievance. Complaints not resolved by close of business the day following receipt, will be moved to the grievance system.
b. A **grievance** expresses dissatisfaction about any matter other than an action.
c. An **adverse benefit determination** is any denial, limitation, reduction, suspension, or termination of service; denial of payment; or failure to act in a timely manner.
d. A **plan appeal** is a request for review of an adverse benefit determination.

Please see section XVI, Definitions, for more information.

If the family complains to the provider about the services received through the Ped-I-Care or CCP systems, the provider should give the member the ICS's number and encourage the family to let us know how we can improve our services.

- **For Ped-I-Care,** call (866) 376-2456.
- **For CCP,** call (866) 209-5022.

If the resolution of the complaint is not satisfactory, or the complaint is egregious, the family may file a grievance. A grievance can be filed in writing or verbally. The family may call the Member Services line and the complaint/grievance form will be sent to them with instructions on how to process the form, the time frames and what other remedial steps are available to them. Detailed instructions are contained in the Member Handbook (http://www.floridahealth.gov/programs-and-services/childrens-health/cms-plan/) as follows. (Please note that only one of the 2 ICSs (Ped-I-Care or CCP) is listed in the member handbook sent to each family. In the example

below, we have listed both ICSs and their contact information, for the convenience of providers.)

***COMPLAINTS***

*If you are not happy with our care or services, call Member Services at the number below. Please press 1 to speak to a person. We will try to resolve your issue. We will answer your questions. If you are still not happy, you can file a complaint. A complaint becomes a grievance after 24 hours if not resolved.*

*You can file a complaint about many things. Here are a few examples:*

- *A doctor was rude to you.*
- *You are unhappy with the quality of care you received.*
- *You had to wait too long to see your doctor.*
- *You are not able to get information from the plan.*
- *You are concerned about your privacy or medical records.*

***GRIEVANCES***

*You can file a formal grievance orally or in writing. Your doctor can file it for you if you give your okay in writing. You may file your grievance at any time after the incident. Call Member Services if you need help. If you are deaf or blind, call our TDD line at 1-800-955-8771. Member Services is open between 8:00am and 5:00pm EST. You can talk with the Grievance Coordinator. Ask for a Grievance Coordinator from 8:00am to 5:00pm EST Monday to Friday.*

*You can mail a written grievance and any documentation you want to send with it to:*

*Ped-I-Care Grievance Coordinator*
*1699 SW 16th Avenue*
*Gainesville, FL 32608-1153*

*CCP Grievance Coordinator*
*1643 Harrison Parkway, Bldg. H, Suite 200*
*Sunrise, FL 33323*

*Phone: 1-866-209-5022*
*Fax: 1-954-251-4848*

*We will send you a letter within five (5) days after we received your grievance filed orally or in writing. If you request an expedited resolution, we will not send a letter. We will look at you grievance carefully. We have up to 90 days to take care of your grievance.*

*We might need more time if we need more information. We can take up to 14 more days to review if it is in your best interest. We will send you a letter telling you about this within two (2) days. The letter will include our reason for needing more time. If you need more time, you can ask for up to 14 more days. You can let us know in writing or by calling us. The extension is only for 14 calendar days in addition to the 90 days to review and resolve your grievance.*

*After we review your grievance, we will send you a letter with what we found. If you are not happy with what we told you, you can ask for a plan appeal or Medicaid Fair Hearing.*

*Children's Medical Services Plan (Ped-I-Care) complies with applicable Federal Civil Rights Laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Call member services if you feel you've been discriminated. Ask for the Grievance Coordinator. Call member services if you have access issues.*

***MEDICAID FAIR HEARING (MFH)***

*You can ask for a MFH after you have completed the plan appeal process. If you are not happy with our decision, you have 120 days from our final decision letter to ask for a MFH.*

*You can ask for a MFH by contacting:*

*Agency for Health Care Administration*
*Medicaid Hearing Unit*
*P.O. Box 60127*
*Ft. Myers, FL 33906*
*(877) 254-1055 (toll-free)*
*239-338-2642 (fax)*
*MedicaidHearingUnit@ahca.myflorida.com*

*You will receive a letter from the Medicaid Hearing Unit. It will tell you when the MFH will take place. You can have someone speak for you at the hearing. If you want your doctor to speak for you at the hearing, you need to check with your doctor. In addition, you will need to inform the Hearing Officer.*

***CONTINUATION OF BENEFITS***

*You can ask us to continue your care during an plan appeal or MFH. If the final decision is in favor of CMS Plan and the denial of service stays, you may have to pay for the cost of the services. You may need to return the money for services paid while the plan appeal was pending if the services were continued only because of this request and decision is not in your favor.*

*To continue your benefits, you must ask to continue benefits and:*

- *The plan appeal must involve the ending, suspension or reduction of a previously authorized service;*
- *The authorization must not have expired; and*
- *The services must be ordered by a CMS Plan provider.*

*To continue the services during the plan appeal process, you must ask to continue benefits and:*

- *Send us a letter within 10 calendar days of the date of the plan appeal decision letter, or*
- *Send us a letter within 10 calendar days after the first day our action will take place, whichever is later. If you request a MFH, you must ask to continue benefits and send the request with the Office of Plan appeal Hearings no later than 10 days after the date of the plan appeal decision letter or before the first day the action will take place, whichever is later.*

*We will continue the services until one of the following happens:*

1. *You ask us to stop looking at your plan appeal.*
2. *After 10 calendar days from the date of the plan appeal decision letter you have not asked to continue services.*
3. *The decision from the hearing or plan appeal is in favor of CMS Plan.*

*SUBSCRIBER ASSISTANCE PROGRAM (SAP)*

*After completing the CMS's grievance and plan appeals system and you are still not happy with the decision, you can ask for a review by SAP. You must ask for the review within one (1) year of our final appeal decision letter. SAP will not accept a case that has been to a Medicaid fair hearing.*

*You can ask for a review by writing to:*

*Agency for Health Care Administration*
*Subscriber Assistance Program*
*Building 3, MS #45*
*2727 Mahan Drive*
*Tallahassee, Florida 32308*

*You can also ask for a review by phone. Call toll-free 1-888-419-3456 or (850) 412-4502.*

# X. QUALITY IMPROVEMENT PROGRAM

CMS Plan, made up of CMS, Ped-I-Care at The University of Florida (UF), and The Community Care Plan (CCP) have accepted the responsibility of providing quality health care to Children with Special Health Care Needs (CSHCN). It is the intention of each of these ICSs to continually improve the quality of services provided to CMS Plan members. Achieving this goal requires establishing standards and performance goals for the delivery of care, measuring performance outcomes, and initiating appropriate interventions to improve the system of care and health related outcomes.

In order to ensure services meet the community standard and to discover ways the system can be improved, Ped-I-Care and CCP have each developed a Quality Improvement Program (QIP). The QIP functions under the supervision of the Quality and Utilization Management Committee (QUMC), composed mainly of physicians who have special training and expertise in pediatrics. The complete plan is available upon written request, but is summarized in this section. Certain quality criteria have been identified for providers who participate in the Ped-I-Care and CCP networks. These include CMS credentialing of providers and use of additional provider contracting requirements, which ensure member access and quality care. Primary Care Provider (PCP) requirements include access standards for patients, including taking call and scheduling of timely appointments. Requirements related to medical records, confidentiality, and patient treatment are included in all contracts and/or this manual.

Ped-I-Care and CCP evaluate the following quality indicators:

1. Access to appropriate care - including wait times for scheduling appointments and in-office waiting time, as well as access to primary care physicians through an after-hours call system
2. Mortality
3. Health status indicators:
    a. Immunizations
    b. Child Health Check-Up compliance [Using Healthcare Effectiveness Data and Information Set (HEDIS) measures]
    c. Other health care services utilization
4. Family requests for reassignment of PCPs
5. Member or family perspectives of care, including complaints and grievances
6. Percent of members or families who report positive perceptions of care
7. Provider satisfaction including physician disenrollment rates and satisfaction with payment and authorization systems
8. Compliance with medical record documentation requirements (outlined in Section XI)

Outcome indicators and sources of information used to measure them have been identified. Data from claims, as well as patient and provider satisfaction surveys also are reviewed. In addition to this data driven approach to quality, Ped-I-Care has developed indicators that, when identified, indicate a need for an individual case review of the circumstances and contributing factors. Events that trigger an individualized chart review include conditions such as hospital admission for diabetic coma, bleeding/perforation, or intestinal gangrene.

As part of our Quality Improvement Program, Ped-I-Care and CCP QI nurses evaluate the care provided to our members. The purpose of a QI visit is to interview staff about practice policies and procedures, tour the facility, and review a sample of medical records. Charts are reviewed by a QI nurse to evaluate the measures described in this manual in Section X. The results of the site visit are summarized in a letter sent to the provider. Data related to quality measures of the program are available to participating providers.

## Cultural & Linguistic Competence (CLC) Plan

Fundamental to the provision of quality medical services is the commitment of Ped-I-Care, CCP, and CMS Plan to culturally and linguistically competent (CLC) services. As legislated by the Patient Protection and Affordable Care Act (ACA) of 2014, and as stipulated specifically in the Medicaid Managed Assistance (MMA) contract between the Integrated Care Systems (ICSs) and CMS Plan, the CMS Plan Cultural & Linguistic Competence plan describes how members' needs are met using appropriate tools, training items, support materials, and methods of annual evaluation. It may be viewed online at CMS Plan's website (http://www.floridahealth.gov/programs-and-services/childrens-health/cms-plan/); providers may also request a hard copy, at no charge, by contacting Ped-I-Care or CCP.

- **For Ped-I-Care,** call (352) 627-9196.
- **For CCP,** call (866) 209-5022.

As noted in Ped-I-Care's published research, cultural competence is more than a bureaucratic exercise; it is an authentic grasping of the attitude that every individual has worth and as such their dignity must be respected and preserved. In pursuit of this vision, Ped-I-Care, CCP, and CMS Plan leverage a 4-pronged approach to the provision of culturally and linguistically competent services.

**Ped-I-Care's Department of Communications & Training**
(352) 627-9196 or
(866) 376-2456

**CCP's Department of Communications & Training**
(866) 209-5022

For questions regarding cultural and linguistic competence or the quality enhancements program

**This approach involves:**

- Appropriate Delivery of Care and Services
  - Ped-I-Care and CCP are well-staffed to meet the known linguistic preferences of its members. Additionally, its staff are representative of the larger populations within which they are situated. Staff and leadership are actively involved in a variety of community-based activities.
- Linguistic and Communicative Tools
  - Language lines, translation services, and TTY/TTD services are used to meet the linguistic needs of members.
- Education and Training
  - Ped-I-Care, CCP, CMS Plan, and its networked providers may choose from 3 training sources made freely available online and via hard copy.
  - A resource toolkit of supplemental sources and support is also made available to enhance the CLC efforts of all who interact with CMS Plan clients.
- Continued Research
  - Ped-I-Care is actively involved in furthering the progress of CLC care, by way of self-examination, regular evaluation of scholarly and industry material, and contributions to local, regional, and national discussions on the topic. The conceptual footprint described in this plan have been presented and discussed at national conferences and made available for Continuing Medical Education credits at a 2014 Association of American Medical Colleges' (AAMC) meeting.

## Expectations of Providers Regarding CLC

Providers are encouraged, but not required, to complete CLC training and to offer it to their staff. AHCA-approved CLC training, written and produced by Ped-I-Care, may be freely accessed at http://pedicare.peds.ufl.edu/media/Cultural-and-Linguistic-Competence-Training-Spring-2013.ppt. This training covers such topics as the importance of using people-first language; awareness of verbal and non-verbal communication cues; issues specific to persons with disabilities; and strategies for effective communication.

**Providers are expected to:**

- Treat all patients with courtesy and respect;
- Ask each patient about their language preference and record this information in their chart; and
- Communicate with members in the language and/or manner they require, at no charge to the member, and to post notices in the lobby and/or other patient areas indicating that language translation and/or interpretation services, including sign language and tactile are available at no charge.

## Healthy Behaviors Program

CMS Plan offers healthy behaviors programs to our enrollees. These programs are:

- Smoking/tobacco cessation
- Weight loss*
- Substance abuse recovery program

*Enrollees with a BMI ≥ 40

Providers can call the local CMS area offices for additional information.

## Quality Enhancements Program

CMS Plan in partnership with Ped-I-Care and CCP offer enrollees a resource guide to access information on programs in their community that are freely available, or available at a low cost. Such programs may include (depending on local availability) tobacco cessation assistance, parenting classes and support, domestic violence prevention, assistance for those in domestic violence situations, obesity prevention, assistance with housing, financial information, anti-bullying campaigns, language/linguistic assistance, prenatal care, prevention and treatment of alcoholism and substance abuse, and prevention of juvenile delinquency.

- To obtain this information on behalf of a **Ped-I-Care** member please call (352) 627-9196.
- To obtain this information on behalf of a **CCP** member, please call (866) 209-5022.

The local CMS Plan Care Coordinator may be contacted for more information on the CMS Plan Quality Enhancements Program.

## Prevention of Abuse, Neglect, & Exploitation

Providers who suspect enrollees subject to abuse, neglect and exploitation must report suspected cases to Florida Department of Children and Families (DCF) at:

- Phone: (800) 962-2873
- TDD: (800) 453-51451
- Fax: (800) 914-0004
- Online: https://reportabuse.dcf.state.fl.us/

The Florida DCF is responsible to investigate allegations of abuse and neglect. CMS Plan additionally requires that all staff and providers report the adverse incidents to the local CMS area office or CMS Plan Risk Manager within 24 hours of the incident. Reporting will include information: Member's identity, description of the incident, and outcomes including current status of the member. If the event involves a health and safety issue, CMS Plan case manager will assist to relocate the member from his/her current location to accommodate a safe environment. Documentation related to the suspected abuse, neglect or exploitation, including the reporting of such, must be kept in a file, separate from the member's case file, that is designated as confidential.

- For more information regarding abuse, neglect and exploitation of children, please contact the Florida Department of Children and Families: http://www.myflfamilies.com/service-programs/abuse-

hotline/frequently-asked-questions.

- For additional resources, please visit the DCF website at: http://www.myflfamilies.com/service-programs/abuse-hotline/resouces.

## Critical Incidents

If a provider knows about a critical incident, including but not limited to, member death, major injury or illness, major medication errors, surgical procedures on wrong site or patient, involvement with law enforcement, brain damage, or permanent disfigurement, please contact the member's CMS Nurse Care Coordinator at the local CMS office. Reporting will include the following information: Member's identity, parties involved, description of the incident, and outcomes including current status of the member. Information should be reported within 24 hours of knowledge of the incident.

## Community Outreach and Marketing Prohibitions

CMS Plan has made the decision to not participate in marketing activities. Neither Ped-I-Care nor CCP participate in marketing activities. Providers may choose to do certain types of outreach activities. The Agency for Health Care Administration MMA contracts define how MMA plans and their networked providers advertise the program. CMS Plan requires providers to submit samples of any community outreach materials they intend to distribute; these should be sent to Provider Relations staff to obtain approval from AHCA prior to distribution or display at the office. The ICS will submit the materials to CMS Plan for review and then submit to AHCA within 2 business days of receipt. CMS Plan will send ICS AHCA's response. ICS will send providers written notice of approval or of any changes required by AHCA within 2 business days of receiving notice from AHCA.

ICS Provider Relations staff will give an overview of the community outreach requirement during provider in-service. It will define what provider may or may not do in regards to reaching out to our enrollees.

**Please adhere to the following guidelines relevant to provider outreach:**

- You may display health plan specific materials in your own office.
- You may announce new affiliations with a health plan and give your patients a list of health plans with which you are contracted.
- You may co-sponsor events such as health fairs or advertise as a health care provider.
- You may distribute non-health plan specific information/materials.
- You **may not,** orally or in writing, compare benefits or provider network among health plans other than to confirm participation in a health plan network.
- You **may not** furnish lists of your Medicaid patients to other health plans or entities.
- You **may not** assist with health plan enrollment.

# PLACEHOLDER – INSERT PAGE 1 OF PIC SITE REVIEW FORM HERE

**("Ped-I-Care Provider Site Review Form")**

# PLACEHOLDER – INSERT PAGE 2 OF PIC SITE REVIEW FORM HERE

**("Ped-I-Care Provider Site Review Form")**

# PLACEHOLDER – INSERT PAGE 3 OF PIC SITE REVIEW FORM HERE

**("Ped-I-Care Provider Site Review Form")**

# PLACEHOLDER – INSERT PAGE 4 OF PIC SITE REVIEW FORM HERE

# PLACEHOLDER – INSERT PAGE 1 OF CCP SITE REVIEW FORM HERE

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# PLACEHOLDER – INSERT PAGE 8 OF CCP SITE REVIEW FORM HERE

# PLACEHOLDER – INSERT PAGE 1 OF PIC PCP CHART REVIEW FORM HERE

**("Ped-I-Care PCP Chart Review Form")**

# PLACEHOLDER – INSERT PAGE 2 OF PIC PCP CHART REVIEW FORM HERE

**("Ped-I-Care PCP Chart Review Form")**

# PLACEHOLDER – INSERT PAGE 3 OF PIC PCP CHART REVIEW FORM HERE

**("Ped-I-Care PCP Chart Review Form")**

# PLACEHOLDER – INSERT PAGE 1 OF CCP CHART REVIEW FORM HERE

# PLACEHOLDER – INSERT PAGE 2 OF CCP CHART REVIEW FORM HERE

# XI. MEDICAL RECORDS REQUIREMENTS

Ped-I-Care and CCP network providers are the custodians of their medical records. Providers must retain medical records for a period of time reflective of current state and federal regulations from the date of last entry (or treatment). Medical records should include enough documentation to substantiate the quality, quantity, appropriateness, and timeliness of services performed.

Members have access to their medical records in accordance with state and federal laws. If a member changes providers, the medical record or a copy is forwarded to the newly-designated provider within 10 working days from receipt of the request. The member or authorized representative shall sign and date a release form before any clinical/case records can be released to another party. Clinical/case record release shall occur consistent with state and Federal law. Upon request, network providers allow Ped-I-Care, CCP, the Florida Department of Health, and/or The Florida Agency for Health Care Administration prompt access to all member medical records.

Ped-I-Care and CCP Quality Improvement (QI) nurses visit most primary care providers at least once every 3 years; for behavioral health providers the visits are conducted by Concordia. Audits of other providers are performed as needed. The purpose of the visits is to review a sample of medical records of members. Charts are reviewed by a QI nurse to evaluate the measures described in this manual in Section X. The results of the site visit are summarized in a letter sent to the provider. Data related to quality measures of the program are available to participating providers. Ped-I-Care and CCP will also conduct medical record reviews of all provider sites with a pattern of complaints or poor quality outcomes.

## General Requirements for Medical Records

**All service providers must meet the following requirements:**

1. Each record contains identifying information on the member, including name, address and phone number, member identification number, date of birth and sex, and legal guardianship (if any).
2. Individual pages contain appropriate patient identifying information; such as name, date of birth, and patient identification number.
3. Each record is legible and maintained in detail.
4. Each record reflects the primary language spoken by the member and any translation needs of the member, if not English.
5. Each record identifies members needing communication assistance in the delivery of health care services.
6. For emancipated minors and members over 18 years old, each record contains documentation that the member was provided written information concerning the member's rights regarding advance directives (written instructions for living will or power of attorney) and whether or not the member has executed an advance directive. The record must also contain any advance directives executed by the member.
7. Each record contains a summary of medical problems, illnesses, significant surgical procedures, past and current diagnosis or problems, allergies and new sensitivities, untoward reactions to drugs, and current medications with dosage (prescription, non-prescription or dietary supplement).
8. Each record contains information relating to the use of tobacco products and alcohol/substance abuse.
9. All entries in each record are dated and signed.
10. All entries in each record include the name and profession of the practitioner rendering services (for example: M.D., D.O., or O.D.), including signature or initials of the practitioner.
11. All entries in each record are legible and indicate the chief complaint or purpose of the visit, the objective findings of the practitioner, diagnoses, and medical findings or impression of the provider.
12. Working diagnoses are consistent with findings.
13. All entries in each record indicate appropriate studies as ordered (for example: lab, x-ray, EKG).
14. All entries in each record indicate therapies administered and prescribed.
15. Working diagnoses are consistent with clinical findings and treatment plans are consistent with diagnoses.
16. All entries in each record include the disposition, recommendations, instructions to the member,

evidence of whether there was follow-up, and outcome of services.

17. Encounter forms or notes have a notation, when indicated, regarding follow-up care, calls, visits, or after-hours advice.
18. Each record contains the specific time of return is noted in weeks, months, or as needed.
19. Unresolved problems from previous visits are addressed in subsequent visits.
20. The history and physical examination identifies appropriate subjective and objective information pertinent to the patient's presenting complaints.
21. Each record contains a record of emergency care and hospital discharge summaries with appropriate medically indicated follow up.
22. Each record contains all services provided. Such services include, but are not limited to, family planning services, preventive services, and services for the treatment of sexually transmitted diseases.
23. Each record contains documentation of referrals and that notes were sent back to the referring provider regarding visits, testing, any care provided, and recommendations.
24. Notes in each record matches information on claims.
25. There is appropriate documentation for altered chart notes.
26. Each record contains documentation of contact attempts if appointments are not kept.
27. Each record contains documentation of communication with CMS Plan as appropriate.
28. When appropriate, each record contains documentation that the CMS Plan Chronic Conditions/Disease Management Programs are discussed with the member and appropriate referrals are made.
29. When appropriate, each record contains documentation that the CMS Plan Healthy Behaviors Programs are discussed with the member and appropriate referrals are made.

**In addition to the above requirements, providers are reminded that:**

1. Providers must maintain and safeguard the confidentiality of information obtained in accordance with the privacy and confidentiality requirements of federal and state law, including specifically 42 CFR, Part 431, Subpart F, regarding confidentiality and disclosure of information.
2. Confidentiality of a minor's consultation, examination, and treatment for a sexually transmissible disease in accordance with section 384.30(2), F.S. must be maintained.
3. Providers must maintain compliance with the Privacy and Security provisions of the Health Insurance Portability and Accountability Act (HIPAA).
4. Certain audit tools used by Concordia to conduct the site and chart reviews are available to providers for review.
    a. Behavioral health providers: Visit the Florida Medicaid website to review the audit tools used by Concordia.
    http://www.fdhc.state.fl.us/Medicaid/Policy_and_Quality/Quality/clinical_quality_compliance/BHGroup/index.shtml
        i. Outpatient:
        http://www.fdhc.state.fl.us/Medicaid/Policy_and_Quality/Quality/clinical_quality_compliance/BHGroup/docs/Tools/OutpatientClinicalRecordReviewTool-Definitions.xlsx
        ii. Inpatient:
        http://www.fdhc.state.fl.us/Medicaid/Policy_and_Quality/Quality/clinical_quality_compliance/BHGroup/docs/Tools/InpatientClinicalRecordReviewTool-Definitions.xlsx
        iii. Targeted Case Management:
        http://www.fdhc.state.fl.us/Medicaid/Policy_and_Quality/Quality/clinical_quality_compliance/BHGroup/docs/Tools/TCMDefinitionsTool.xlsx

        http://www.fdhc.state.fl.us/Medicaid/Policy_and_Quality/Quality/clinical_quality_compliance/BHGroup/docs/Tools/TCMRecordReviewTool.xlsx

## Additional Requirements for Primary Care Physicians

In addition to the General Medical Record Requirements, Primary Care Providers must meet the following requirements:

1. Child health check-ups are scheduled according to AAP guidelines.
2. Each record contains an immunization history.
3. Physicals include age-appropriate tests: vision, hearing, hemoglobin, lead, urine, etc.
4. Physicals include age-appropriate anticipatory guidance and risk screenings: TB, lead, STDs, etc.
5. For adolescent females, record has reference to family planning.
6. Providers must include copies of any consent or attestation form used or the court order for prescribed psychotherapeutic medication for a child under the age of 13.

## Additional Requirements for Therapy & Behavioral Health Providers

In addition to the General Medical Record Requirements, Therapy and Behavioral Health providers must meet the following requirements:

1. Maintain a medical record for each member. Each member's medical record:
    a. Includes documentation sufficient to disclose the quality, quantity, appropriateness, and timeliness of services performed;
    b. Is legible and maintained in detail consistent with the clinical and professional practice which facilitates effective internal and external peer review, medical audit, and adequate follow-up treatment; and
2. For each service provided, clear identification as to:
    a. The physician or other service provider;
    b. Date of service;
    c. The units of service provided; and
    d. The type of service provided.
3. Providers must include copies of any consent or attestation form used or the court order for prescribed psychotherapeutic medication for a child under the age of 13.

## Additional Requirements for Hospitals

In addition to the General Medical Record Requirements, Hospitals must meet the following requirements:

1. Each record contains a record of the discharge plan.
2. Each record contains documentation that the member's PCP was notified of the member's hospitalizations, treatments, and medications.

## Additional Requirements for Telemedicine

If services are providedthroughtelemedicine, all records must contain documentation to include the following items:

1. A brief explanation of the use of telemedicine in each progress note;
2. Documentation of telemedicine equipment used for the particular covered services provided;
3. A signed statement from the member or the member's representative indicating their choice to receive services through telemedicine. This statement may be for a set period of treatment or one-time visit, as applicable to the service(s) provided; and
4. For telepsychiatry, the results of the assessment, findings and practitioner(s) plan for next steps.

# XII. DENTAL SERVICES

Dental services are a covered benefit under CMS Plan. Referrals and authorizations are not necessary for routine dental care or initial orthodontia evaluations. An authorization is needed for orthodontia treatment as well as inpatient oral surgery.

To request an authorization for orthodontia, please send request, treatment plan, and clinical notes documenting medical necessity, including photographs and any Panorex, x-rays, etc., to the appropriate UM Department listed below. Please note the request must also include the Medicaid Orthodontic Initial Assessment Form (IAF), which may be found in the Medicaid Dental Services Coverage and Limitations Handbook at: http://portal.flmmis.com/flpublic/Default.aspx.

- **For Ped-I-Care,** send the above items to at MED3OOO (866) 256-2015.
- **For CCP,** send the above items to (844) 806-0397.

Note: Orthodontia for cosmetic purposes is not an approved benefit under CMS Plan. Medical necessity must be documented.

Dental claims should be filed on an American Dental Association Dental Claim Form and mailed to:

MED3OOO/Ped-I-Care or CCP T19
PO Box 981648
El Paso, TX 79998-1648

For electronic claims filing, contact Change Healthcare at (877) 363-3666 or via their website at http://www.changehealthcare.com/.

To request authorizations for orthodontia:

**MED3OOO's UM Department (For Ped-I-Care)**
(866) 256-2015

**CCP's UM Department**
(866) 209-5022

Submit dental claims (using an ADA Dental Claim Form) to:

MED3OOO/Ped-I-Care
or CCP T19
PO Box 981648
El Paso, TX 79998-1648

- Or -

File electronically with Change Healthcare:
www.changehealthcare.com
(877) 363-3666

# XIII. TRANSPORTATION

Emergency and non-emergency transportation are covered benefits.

- **For Ped-I-Care,** the contracted provider for non-emergency transportation services is TMS of Florida. Members should call TMS of Florida at (866) 411-8920 to arrange for transportation to appointments with providers.
- **For CCP,** the contracted provider for non-emergency transportation services is LogistiCare. Members should call LogistiCare at (866) 250-7455 to arrange for transportation to appointments with providers.

Members should give a minimum of 24 hours' notice when scheduling transportation for routine appointments, however 72 hours' notice is preferred. The transportation companies may also be contacted to provide transportation if a member is sick. Every effort will be made to provide transportation with minimal notice in these situations. For members who are dependent on a ventilator or otherwise too medically complex for transport by TMS or LogistiCare, please call the nursing director at the appropriate CMS office, listed on page 7 of this manual.

Authorizations for out of state travel must be made well in advance of anticipated departure time. Such arrangements and authorizations are only granted in cases of medical necessity, when in-state services are not available for the member's specific needs.

# XIV. BEHAVIORAL HEALTH SERVICES

CMS Plan offers a full range of medically-necessary behavioral health services that are consistent with and described in the Florida Medicaid Mental Health Targeted Case Management Coverage, Limitations Handbook (http://portal.flmmis.com/FLPublic/Portals/0/StaticContent/Public/HANDBOOKS/CL_07_070601_MH_Case_Mgmt_ver2_2.pdf) and the Florida Medicaid Community Behavioral Health Services Coverage and Limitations Handbook (http://portal.flmmis.com/FLPublic/Portals/0/StaticContent/Public/HANDBOOKS/Community_Behavioral_Health_Services_Coverage_and_Limitations_Handbook_Adoption.pdf), and applicable fee schedules.

**Ped-I-Care's and CCP's Behavioral Health Services are managed by Concordia Behavioral Health.**

- **For Ped-I-Care members, call Concordia at (877) 698-7789, option 2, option 1.**
- **For CCP members, call Concordia at (800) 294-8642.**

**Concordia's website is http://www.concordiabh.com/.**

Members can receive the following benefits:

a. Inpatient hospital services for behavioral health conditions
b. Outpatient hospital services for behavioral health conditions
c. Psychiatric physician services for behavioral health conditions and psychiatric specialty codes 42, 43, and 44
d. Community behavioral health services for mental health conditions
e. Community behavioral health services for substance abuse conditions
f. Mental Health Targeted Case Management
g. Mental Health Intensive Targeted Case Management
h. Specialized therapeutic foster care
i. Therapeutic group care services
j. Comprehensive behavioral health assessment
k. Behavioral health overlay services in child welfare settings
l. Residential care
m. Statewide Inpatient Psychiatric Program (SIPP) services for individuals under age 21 years.

Neither prior authorizations nor referrals by a PCP are required for behavioral health services.

CMS Plan offers all medically necessary evaluations, psychological testing, and treatment services for children/adolescents referred to CMS Plan by the Department of Children and Families (DCF), the Department of Juvenile Justice (DJJ), and schools (elementary, middle, and secondary). CMS Plan provides court-ordered evaluation and treatment required for children/adolescents members. See the specifications in the Florida Medicaid Community Behavioral Health Services Coverage and Limitations Handbook for more information. CMS Plan does not offer substitute services to members.

**NOTE:** As of February 1, 2017, Applied Behavioral Analysis (ABA) will be referred to as, Behavior Analysis (BA) services. These are part of the Medicaid plan but carved out of CMS Plan covered services. The Agency for Health Care Administration (Agency) has contracted with eQHealth Solutions to administer an authorization review program for Behavior Analysis (BA) services. For questions, contact eQHealth at 1-855-444-3747 and via the web at http://fl.eqhs.org/.

**Commented [JME1]:** Per Florida Medicaid Health Care Alert March 15, 2018

## Emergency Behavioral Health Services

CMS Plan offers emergency behavioral health services pursuant, but not limited, to s. 394.463, F.S.; s. 641.513, F.S.;

and Title 42 CFR Chapter IV.

**For Ped-I-Care,** emergency service providers must make a reasonable attempt to notify MED3OOO (800) 492-9634 within 24 hours of the enrollee's presenting for emergency behavioral health services.

**For CCP,** emergency service providers must make a reasonable attempt to notify Concordia at (800) 294-8642 within 24 hours of the enrollee's presenting for emergency behavioral health services.

In cases in which the enrollee has no identification, or is unable to orally identify himself/herself when presenting for behavioral health services, the provider shall notify the MED3OOO within 24 hours of learning the member's identity.

Providers must ensure the member has a follow-up appointment scheduled within 7 days after discharge; and all required prescriptions are authorized at the time of discharge.

**Ped-I-Care** members and providers can call the Ped-I-Care Mental Health Crisis Hotline at (800) 627-0510. This is available 24 hours a day, 7 days a week for assistance with a mental health crisis. A nurse answers the calls and a psychiatrist provides guidance and supervision.

## Activities

CMS Plan's Behavioral Health program encompasses many activities. These activities are performed by a combination of professionals and laypersons to include the CMS Care Coordinators and social workers, the Family Health Partner, the Primary Care Physician, the specialty physician, and the Ped-I-Care and CCP Member Services, Provider Relations, and Quality Improvement staff.

1. Through the process of enrollment, assessments, care planning, and service provision the opportunity for behavioral health services is shared with members. The CMS Plan Care Coordinators (CCs) are supervised by the CMS Plan Nursing Director of each CMS Plan Area Office.
2. Ped-I-Care and CCP Members Services staff maintain an active role in outreach. Specifically, staff provide accurate member materials and send them out to members in a timely manner. Member education includes information about the importance of good mental health and what resources are in our network for this service.
3. Ped-I-Care and CCP Quality Improvement Nurses perform visits to PCPs and Behavioral Health Providers. Facilities and charts are audited for compliance with standards and areas needing attention are identified. The providers are educated on the findings and the CMS Plan Care Coordinators are notified of any outreach and education they can provide to assist members and providers in meeting established standards.
4. Concurrent reviews of hospitalizations are monitored daily through our third-party administrator (TPA), MED3OOO. Concurrent review nurses coordinate services with the member, family, providers, case manager, discharge planner/social worker, home health agencies, community resource organizations with the county, and CMS Plan Care Coordinators. The CMS Plan Care Coordinators and social workers participate in discharge planning, appointment follow up, and assist the member and family in coordinating any resources that they need.
5. Behavioral Health Case Review Meetings are held bi-monthly to discuss complicated **Ped-I-Care** cases. The multi-disciplinary team includes the Ped-I-Care Behavioral Health Medical Director who is a board-certified psychiatrist in addition to nurses, social workers, other professionals, and community agencies involved in the care of the member. The CMS Plan Care Coordinator of each child implements and coordinates the recommendations of the team with the member, family, and providers.
6. Providers with pediatric patients who have a psychiatric disorder or behavioral health issue **assigned to Ped-I-Care** can call the University of Florida, Child Psychiatry Access Program at (877) 506-2720 for a free consultation with a board-certified psychiatrist. Providers with pediatric patients **assigned to CCP** with a psychiatric disorder or behavioral health issue can call the Behavioral Health Provider, Concordia, at (800) 294-8642 for a free consultation with a board-certified psychiatrist.

## Drug Utilization Review

CMS Plan's drug utilization review (DUR) program encourages coordination between a member's primary care physician and a prescriber of a psychotropic or similar prescription drug for behavioral health problems. The DUR program identifies those medications for other serious medical conditions (such as hypertension, diabetes, neurological disorders, or cardiac problems), where this is a significant risk to the member posed by potential drug interactions between drugs for these conditions and behavioral-related drugs. After the plan identifies the potential for such problems, the NCC notifies all related prescribers that certain drugs may be contraindicated due to the potential for drug interactions and encourages the prescribers to coordinate their care. Notice may be provided electronically or via mail, or by telephonic or direct consultation, as deemed appropriate.

An NCC may become aware of the use of a psychotropic drug or other Behavioral Health drug for a patient by parent/patient report, clinic notes from the PCP or specialty physician, from a pharmacist, during care coordination meetings, or from concurrent review reports. When this occurs, the NCC takes actions based on the CMS Plan Care Coordination Guidelines.

## Informed Consent for Psychotropic Medication

CMS Plan requires that prescriptions for psychotropic medication prescribed for a member under the age of 13 be accompanied by the express written and informed consent of the member's parent or legal guardian. Psychotropic (psychotherapeutic) medications include antipsychotics, antidepressants, anti-anxiety medications, and mood stabilizers. Anti-convulsants and attention-deficit/hyperactivity disorder (ADHD) medications (stimulants and non-stimulants) are not included at this time. In accordance with s. 409.912(51), F.S., Ped-I-Care and CCP providers must comply with the following requirements:

1. The prescriber must document the consent in the child's medical record and provide the pharmacy with a signed attestation of the consent with the prescription.
2. The prescriber must ensure completion of an appropriate attestation form.
3. Sample consent/attestation forms that may be used and pharmacies may receive are located at the following link: http://ahca.myflorida.com/Medicaid/Prescribed_Drug/med_resource.shtml.
4. The completed form must be filed with the prescription (hardcopy of imaged) in the pharmacy and held for audit purposes for a minimum of 6 years.
5. Pharmacies may not add refills to old prescriptions to circumvent the need for an updated informed consent form.
6. Every **new** prescription will require a **new** informed consent form.
7. The informed consent forms do not replace prior authorization requirements for non-PDL medications or prior authorized antipsychotics for children and adolescents from birth through age 17.

## Release of Psychiatric Records

The member or authorized representative must sign and dates a release form before any psychiatric records can be released to another party. NCCs request current behavioral health care provider information on all new members upon enrollment. NCCs give the ICS Provider Liaisons contact information of providers that are not in the network; this is done for possible recruitment.

## Outreach Program

CMS Plan has an outreach program including but not limited to referral, training, consultation, and other behavioral health resources designed to assist PCPs and other non-behavioral health providers in the identification, management and treatment of:

- Members with severe and persistent mental illness;
- Children/adolescents with severe emotional disturbances; and
- Members with clinical depression.

## Physician Services

Physician services are those services rendered by a licensed physician who possesses the appropriate medical

specialty requirements, when applicable. A psychiatrist must be Florida licensed and certified as a psychiatrist by the American Board of Psychiatry and Neurology or the American Osteopathic Board of Neurology and Psychiatry, or have completed a psychiatry residency accredited by the Accreditation Council for Graduate Medical Education (ACGME) or the Royal College of Physicians and Surgeons of Canada.

Physician services include specialty consultations for evaluations. A physician consultation includes an examination and evaluation of the member with information from family member(s) or significant others as appropriate. The consultation includes written documentation on an exchange of information with the attending provider. The components of the evaluation and management procedure code and diagnosis code must be documented in the member's medical record. A hospital visit to a member in an acute care hospital for a behavioral health diagnosis must be documented with a behavioral health procedure code and behavioral health diagnosis code. All procedures with a minimum time requirement are documented in the member's medical record to show the time spent providing the service to the member.

Physicians are required to coordinate medically necessary behavioral health services with the PCP and other providers involved with the member's care. CMS Plan has protocols that indicate when such coordination is required.

## Community Mental Health Services

Community mental health services include behavioral health services that are provided for the maximum reduction of the member's behavioral health disability and restoration to the best possible functional level. Such services can reasonably be expected to improve the member's condition or prevent further regression. CMS Plan offers medically necessary community mental health services rendered or recommended by a physician or psychiatrist and included in a treatment plan. Services are provided to members of all ages. Services emphasize the value of early intervention, are age-appropriate, and are sensitive to the member's developmental level. The term "community" is not intended to suggest that the services must be provided by state-funded facilities or to preclude state-funded centers from providing these services.

**Details:**

1. Services meet the intent of those covered in the Florida Medicaid Community Behavioral Health Services Coverage and Limitations Handbook (http://portal.flmmis.com/FLPublic/Portals/0/StaticContent/Public/HANDBOOKS/Community_Behavioral_Health_Services_Coverage_and_Limitations_Handbook_Adoption.pdf).
2. MED3OOO (working under contract to Ped-I-Care) and CCP maintain medical necessity criteria, including those for admission, continuing stay, and discharge, for all mandatory and optional services. Criteria are specific to member ages and diagnoses and accounts for orders for involuntary outpatient placement pursuant to Florida Statute.
3. Treatment Plan Development and Modification
    a. Treatment planning includes working with the member, the member's natural support system, and all involved treating providers to develop an individualized plan for addressing identified clinical needs. A behavioral health care provider must complete a face-to-face interview with the member during the development of the plan.
    b. In addition to the handbook requirements, the individualized treatment plan should:
        i. Be recovery-oriented and promote resiliency
        ii. Be member-directed
        iii. Accurately reflect the presenting problems of the member
        iv. Be based on the strengths of the member, family, and other natural support systems
        v. Provide outcome-oriented objectives for the member
        vi. Include an outcome-oriented schedule of services that will be provided to meet the member's needs
        vii. Include the coordination of services not covered by CMS Plan
    c. Individualized treatment plan reviews are conducted at 6-month intervals to assure that the services being provided are effective and remain appropriate for addressing individual member

needs. Additionally, a review is expected whenever clinically-significant events occur or when treatment is not meeting the member's needs. The provider is expected to use the individualized treatment plan review process in the utilization management of medically necessary services. For further guidance, see the most recent Florida Medicaid Community Behavioral Health Services and Coverage Handbook.

## Evaluation and Assessment Services

Evaluation and testing services include psychological testing (standardized tests) and evaluations that assess the member's functioning in all areas. Evaluations completed prior to provision of treatment must include a holistic view of factors that underlie or may have contributed to the need for behavioral health services. Diagnostic evaluations are included in this category. Diagnostic evaluations must be comprehensive and must be used in the development of an individualized treatment plan. All evaluations must be appropriate to the age, developmental level, and functioning of the member. All evaluations must include a clinical summary that integrates all the information gathered and identifies the member's needs. The evaluation should prioritize the clinical needs, evaluate the effectiveness of any prior treatment, and include recommendations for interventions and mental health services to be provided. All new members who appear for treatment services should receive an evaluation unless there is sufficient collateral information that a new evaluation would not be necessary.

**Details:**

1. Evaluation services, when determined medically necessary, must include assessment of mutual status, functional capacity, strengths, and service needs by trained mental health staff.
2. Before receiving any community mental health services, children ages 0-5 must have a current assessment (within 1 year) of presenting symptoms and behaviors; developmental and medical history; family psychosocial and medical history; assessment of family functioning; a clinical interview with the primary caretaker and an observation of the child's interaction with the caretaker; and an observation of the child's language, cognitive, sensory, motor, self-care, and social functioning.

## Medical & Psychiatric Services

These services include medically-necessary interventions that require the skills and expertise of a psychiatrist, psychiatric ARNP, or physician. Medical psychiatric interventions include the prescribing and management of medications, monitoring side effects associated with prescribed medications, individual or group medical psychotherapy, psychiatric evaluation (for diagnostic purposes and for initiating treatment), psychiatric review of treatment records for diagnostic purposes, and psychiatric consultation with a member's family or significant others, PCPs, and other treatment providers. Interventions related to specimen collections, taking vital signs, and administering injections are also covered services. Treatment services are distinguished from the physician services outlined above in that they are provided through a community mental health provider.

## Behavioral Health Therapy Services

Therapy services include individual and family therapy, group therapy, and behavioral health day services. These services may include psychotherapy or supportive counseling focused on assisting members with the problems or symptoms identified in an assessment. The focus should be on identifying and utilizing the strengths of the member, family, and other natural support systems. Therapy services should be geared to the individual needs of the member and should be sensitive to the age, developmental level, and functional level of the member.
Family and marital therapy are also included in this category. Examples of interventions include those that focus on resolution of a life crisis or an adjustment reaction to an external stressor or developmental challenge.

Behavioral health day services are designed to enable members to function successfully in the community in the least restrictive environment and to restore or enhance ability for social and pre-vocational life management services. The primary functions of behavioral health day services are stabilization of the symptoms related to a behavioral health disorder to reduce or eliminate the need for more intensive levels of care, to provide transitional treatment after an acute episode, or to provide a level of therapeutic intensity not possible in a traditional outpatient setting.

## Community Support & Rehabilitative Services

Psychosocial rehabilitation services may be provided in a facility, home, or community setting. These services assist members in functioning within the limits of a disability or disabilities resulting from a mental illness. Services focus on restoration of a previous level of functioning or improving the level of functioning. Services are individualized and directly related to goals for improving functioning within a major life domain.

The coverage includes a range of social, educational, vocational, behavioral, and cognitive interventions to improve members' potential for social relationships, occupational/educational achievement, and living skills development. Skills training development is also included in this category and includes activities aimed toward restoration of members' skills/abilities that are essential for managing their illness, actively participating in treatment, and conducting the requirements of daily independent living. Providers must offer the services in a setting best suited for desired outcomes, i.e., home or community-based settings.

Psychosocial rehabilitative services may also be provided to assist members in finding or maintaining appropriate housing arrangements or to maintain employment. Interventions should focus on the restoration of skills/abilities that are adversely affected by the mental illness and supports required to manage the member's housing or employment needs. The provider must be knowledgeable about TANF and is responsible for medically necessary mental health services that assist the individual in finding and maintaining employment.

## Therapeutic Behavioral On-Site Services (TBOS) for Children & Adolescents

TBOS services are community services and natural supports for children/adolescents with serious emotional disturbances. Clinical services include provision of a professional level therapeutic service that may include teaching problem-solving skills, behavioral strategies, normalization activities, and other treatment modalities that are determined to be medically necessary. These services should be designed to maximize strengths and reduce behavior problems or functional deficits stemming from the existence of a mental health disorder. Social services include interventions designed for the restoration, modification, and maintenance of social, personal adjustment, and basic living skills.

TBOS services are intended to maintain the child/adolescent in the home and to prevent reliance upon a more intensive, restrictive, and costly mental health placement. They are also focused on helping the child/adolescent possess the physical, emotional, and intellectual skills to live, learn, and work in the home community. Coverage includes the provision of these services outside of the traditional office setting. The services are provided where they are needed, in the home, school, childcare centers, or other community sites.

## Day Treatment Services

Child/adolescent day treatment services include therapy, rehabilitation and social interactions, and other therapeutic services that are designed to redevelop, maintain, or restore skills that are necessary for children/adolescents to function in their community. The approach must take into consideration developmental levels and delays in development due to emotional disorders. If the child/adolescent is school age, the services are coordinated with the school system. All therapeutic day treatment interventions for children/adolescents must have a component that addresses caregiver participation and involvement. Services for all children/adolescents should be coordinated with home care to the greatest extent possible. Day treatment services must include an array of programs with the following functions:

1. Stabilize the symptoms related to a behavioral health disorder to reduce or eliminate the need for more intensive levels of care;
2. Provide transitional treatment after an acute episode, admission to an inpatient program, or discharge from a residential treatment setting;
3. Provide a therapeutic intensity not possible in a traditional outpatient setting; and
4. Assist the child/adolescent in redeveloping age-appropriate skills required to conduct activities of everyday living in the community.

Staff providing children/adolescent day treatment services must have appropriate training and experience.

Behavioral health care providers must be available to provide clinical services when necessary.

## Services for Children Ages 0 through 5 Years

Services include behavioral health day services and therapeutic behavioral on-site services for children ages 0 through 5 years. Prior to receiving these services, the members in this age group must have an assessment that meets the criteria in the Florida Medicaid Community Behavioral Health Services Coverage and Limitations Handbook.

## Mental Health Targeted Case Management

CMS Plan offers targeted case management services to children/adolescents with serious emotional disturbances as defined below. CMS Plan accepts a provider's mental health targeted case management certification program if it was approved by AHCA or another health plan. Individual practices are responsible for maintaining documentation of such approval and provider certification in the provider's personnel file.

At a minimum, case management services are to incorporate the principles of a strengths-based approach. Strengths-based case management services are an alternative service modality for working with individuals and families. This method stresses building on the strengths of individuals that can be used to resolve current problems and issues, countering more traditional approaches that focus almost exclusively on individual's deficits or needs.

### *Target Populations*

Mental health targeted case management services are available to all members:

1. Who require numerous services from different providers and also require advocacy and coordination to implement or access services;
2. Who would be unable to access or maintain consistent care within the service delivery system without case management services;
3. Who do not possess the strengths, skills, or support system to allow them to access or coordinate services;
4. Who may benefit from case management but lack the skills or knowledge necessary to access services; or
5. Who do not meet these criteria but may still be eligible for limited targeted case management services by meeting handbook exception criteria.

CMS Plan offers case management services to children/adolescents who have a serious emotional disturbance, which are:

1. A defined mental disorder
2. A level of functioning which requires two or more coordinated behavioral health services to be able to live in the community
3. At imminent risk of out-of-home behavioral health treatment placement.

### *Required Services*

Mental health targeted case management services include working with the member and the member's natural support system to develop and promote a service plan. The service plan reflects the services or supports needed to meet the needs identified in an individualized assessment of the following areas: education or employment, physical health, mental health, substance abuse, social skills, independent living skills, and support system status. The approach used should identify and utilize the strengths, abilities, cultural characteristics, and informal supports of the member, family, and other natural support systems. Targeted case managers focus on overcoming barriers by collaborating and coordinating with providers and the member to assist in the attainment of service plan goals. The targeted case manager takes the lead in both coordinating services/treatment and assessing the effectiveness of the services provided.

When targeted case management recipients enrolled in CMS Plan are hospitalized in an acute care setting or held in a county jail or juvenile detention facility, NCCs document efforts to ensure that contact is maintained with the member and participates actively in the discharge planning processes. Case managers are also responsible for coordination and collaboration with the parents or guardians of children/adolescents who receive mental health

targeted case management services. Case managers should make and document reasonable efforts to include the parents or guardians of members in the process of providing targeted case management services. Integration of the parent's input and involvement with the case manager and other providers is reflected in medical record documentation and monitored through Ped-I-Care's and CCP's quality of care monitoring activities. Involvement with the child/adolescent's school and/or childcare center is also a component of case management with children/adolescents. CMS Plan offers mental health targeted case management services to children/adolescents in the care or custody of the state who need them.

### *Additional Requirements for Targeted Case Management*

Providers/practices must have a case management program, including guidelines and protocols that address:

1. Caseloads set to achieve the desired results. Size limitations must clearly state the ratio of members to each individual case manager. The limits are specified for children/adolescents, with a description of the clinical rationale for determining each limitation. If "mixed" caseloads, *i.e.*, children/adolescents and adults, are utilized a separate limitation is expected along with the rationale for the determination. Ratios must be no greater than the requirements set forth in the Florida Medicaid Mental Health Targeted Case Management Coverage and Limitations Handbook (http://portal.flmmis.com/FLPublic/Portals/0/StaticContent/Public/HANDBOOKS/CL_07_070601_MH_Case_Mgmt_ver2_2.pdf).
2. A system to manage caseloads when positions become vacant
3. A description of the modality of service provision and the location that services will be provided
4. The expected frequency, duration, and intensity of the service with service limits and criteria no more restrictive than those in Medicaid policy
5. Issues related to recovery and self-care, including services to help members gain independence from the behavioral health and case management system
6. Services based on individual needs of the members receiving the service. The service system should also address the changing needs and abilities of members.
7. Case management staff with expertise and training necessary to competently and promptly assist members in working with Social Security Administration or Disability Determination in maintaining benefits from SSI and SSDI. For members who wish to work, case management staff must have the expertise and training necessary to help members access Social Security Work Incentives.

## Intensive Case Management

This service is available to members for whom it is determined to be medically necessary, including members who meet the following criteria:

1. Has resided in a state mental health treatment facility for at least 6 of the past 36 months;
2. Resides in the community and has had 2 or more admissions to a state mental health treatment facility in the past 36 months;
3. Resides in the community and has had 3 or more admissions to a crisis stabilization unit, short-term residential facility, inpatient psychiatric unit, or any combination of these facilities within the past 12 months; or
4. Resides in the community and, due to a mental illness, exhibits behavior or symptoms that could result in long-term hospitalization if frequent interventions for an extended period of time were not provided.

Intensive case management services are frequent and intense and focus on helping the member attain skills and supports needed for independent living. Case management services are provided primarily in the member's residence and include community-based interventions.

This service should be provided in the least restrictive setting with the goal of improving the member's level of functioning, and providing ample opportunities for rehabilitation, recovery, and self-sufficiency. Intensive case management services are accessible 24 hours per day, 7 days per week.

## Community Treatment of Patients Discharged from State Mental Health Facilities

CMS Plan offers medically-necessary behavioral health services to members who have been discharged from any state mental health treatment facility, including, but not limited to, follow-up services and care. All members who have previously received services at a state mental health treatment facility must receive follow-up care.

**Details:**

1. The plan of care should be aimed at encouraging members to achieve a high quality of life while living in the community in the least restrictive environment that is medically appropriate and reducing the likelihood that the members will be readmitted to a state mental health treatment facility.
2. Mental health targeted case managers must follow the progress of members.
3. CMS Plan is not responsible for court-ordered treatment.

## Community Services for Medicaid Recipients Involved with the Justice System

The CMS Plan Nurse Care Coordinator/Social Worker makes every effort as follows to provide medically necessary community-based services for Ped-I-Care members who have justice system involvement (juvenile justice system for members under 18 years and correctional system for members 18 and older):

1. Ensure a linkage to pre-booking sites for assessment, screening or diversion related to behavioral health services;
2. Provide psychiatric services within 24 hours of release from jail, juvenile detention facility, or other justice facility to assure that prescribed medications are available for all members.
3. Ensure a linkage to post-booking sites for discharge planning and assuring that prior Ped-I-Care members receive necessary services upon release from the facility. Ped-I-Care members should be linked to services and receive routine care within 7 days from the date they are released.
4. Provide outreach to homeless and other populations of Ped-I-Care members at risk of justice system involvement, as well as those CMS Plan members currently involved in this system, to assure that services are accessible and provided when necessary.

CMS Plan is not responsible when juvenile members are incarcerated while awaiting trial, etc.; the local facility housing the child is responsible for their medical needs. The Juvenile Justice System (JJS) is responsible for coordinating services at the time of release. JJS holds a staffing 30 days prior to release and puts a plan in place such as return home, group home, an independent living situation, etc. JJS coordinates with the Juvenile Probation Officer to ensure services occur. Refer to the Health Services section of the Department of Juvenile Justice's (DJJ) Frequently Asked Questions website at http://www.djj.state.fl.us/AboutDJJ/faq.html for more information. CMS Plan NCCs and the DJJ strive to ensure that the children and adolescents we serve have no unmet health needs and that there are no lapses in health care services.

## Treatment & Coordination of Care for Members with Medically-Complex Conditions

CMS Plan, through the provider network, ensures that appropriate resources are available to address the treatment of complex conditions that reflect both mental health and physical health involvement.

CMS Plan offers medically-necessary community mental health services to members who exhibit mental health disorders due to or involving a general medical condition, and eating disorders. The plan of care must include all appropriate collateral providers necessary to address the complex medical issues involved. Clinical care criteria address modalities of treatment that are effective for each diagnosis.

## Coordination of Children's Services

The delivery and coordination of child/adolescent mental health services are provided for all who exhibit the symptoms and behaviors of an emotional disturbance. The delivery of services addresses the needs of any child/adolescent served in an Emotional/Behavioral Disabilities school program. Developmentally-appropriate early

childhood mental health services are available to children age birth to 5 years and their families.

CMS Plan offers services for all children/adolescents within a strengths-based, culturally-competent service design. The service design recognizes and ensures that services are family-driven and include the participation of family, significant others, informal support systems, school personnel, and any state entities or other service providers involved in the child/adolescent's life.

For all children/adolescents receiving services from CMS Plan, the provider works with the parents, guardians, or other responsible parties to monitor the results of services and determine whether progress is occurring. Active monitoring of the child/adolescent's status occurs to detect potential risk situations and emerging needs or problems.

When the court mandates a parental behavioral health assessment, and the parent is a member, the provider completes an assessment of the parent's mental health status and the effects on the child. Time frames for completion of this service are determined by the mandates issued by the courts.

## Transition Plan for Members Changing from Non-Participating to Participating Providers

A transition plan is a detailed description of the process of transferring members from non-participating providers to the behavioral health care provider network to ensure optimal continuity of care. The transition plan includes, but is not limited to, a timeline for transferring members, description of provider clinical record transfers, scheduling of appointments, and proposed prescription drug protocols and claims approval for existing providers during the transition period.

## Individuals with Special Health Care Needs

In accordance with CFR 438.208(c)(3), an individualized treatment plan for a member determined to need a course of treatment or regular care monitoring must be:

1. Developed by the member's direct service mental health care professional with member participation and in consultation with any specialists caring for the member;
2. Approved by CMS Plan if approval is required; and
3. Developed in accordance with any applicable AHCA quality assurance and utilization review standards.

## Discharge Planning

Discharge planning is the evaluation of a member's medical care needs, behavioral health service needs, and substance abuse service needs in order to arrange for appropriate care after discharge from one level of care to another. Upon the admission of a member, the provider must make a good faith effort to ensure the member's smooth transition to the next service or to the community and requires that behavioral health care providers:

1. Oversee the care given to the member
2. Develop an individualized discharge plan, in collaboration with the member where appropriate, for the next service or program or the member's discharge, anticipating the member's movement along a continuum of services
3. Document all significant efforts related to these activities, including the member's active participation in discharge planning
4. Monitor and ensure that clinically indicated behavioral health services are offered and available to members within 7 calendar days of discharge from an inpatient setting

## Functional Assessments

Behavioral health care providers must administer functional assessments using the functional assessment rating scales (FARS) for all members over the age of 18 and child functional assessment rating scale (CFARS) for all members age 18 and under. Behavioral health care providers must administer and maintain the FARS and CFARS for all members receiving behavioral health services and upon termination of providing such services. The results of the

FARS and CFARS assessments must be maintained in each member's clinical record.

## Behavioral Health Clinical Records

CMS Plan behavioral health providers must maintain a behavioral health clinical record of services for each member. The member's record includes, but is not limited to the member's demographics and eligibility information, is provided in accordance with the clinical documentation requirements of the Medicaid handbooks applicable to behavioral health.

Each member's behavioral health clinical record must:

1. Include documentation sufficient to disclose the quality, quantity, appropriateness, and timeliness of behavioral health services performed;
2. Be legible and maintained in detail consistent with the clinical and professional practice that facilitates effective internal and external peer review, medical audit, and adequate follow-up treatment; and
3. For each service provided, clearly identify:
    a. The physician or other service provider;
    b. Date of service;
    c. The units of service provided; and
    d. The type of service provided.

## Behavioral Health Quality Improvement (QI) Requirements

CMS Plan's QI plan includes a behavioral health component in order to monitor and assure that CMS Plan's behavioral health services are sufficient in quantity, of acceptable quality, and meet the needs of the members.

**Treatment plans must:**

1. Identify reasonable and appropriate objectives;
2. Provide necessary services to meet the identified objectives; and
3. Include retrospective reviews that confirm that the care provided, and its outcomes, were consistent with the approved treatment plans and appropriate for member needs.

In determining if behavioral health services are acceptable according to current treatment standards, in most cases, Ped-I-Care or Concordia coordinates the scheduling of provider audits with selected providers. CMS Plan uses AHCA-approved tools for clinical and mental health targeted case management tools when reviewing provider records.

AHCA-approved review tools:

a. Behavioral health providers: Visit the Florida Medicaid website to review the audit tools used by Concordia.
http://www.fdhc.state.fl.us/Medicaid/Policy_and_Quality/Quality/clinical_quality_compliance/BHGroup/index.shtml
    iv. Outpatient:
    http://www.fdhc.state.fl.us/Medicaid/Policy_and_Quality/Quality/clinical_quality_compliance/BHGroup/docs/Tools/OutpatientClinicalRecordReviewTool-Definitions.xlsx
    v. Inpatient:
    http://www.fdhc.state.fl.us/Medicaid/Policy_and_Quality/Quality/clinical_quality_compliance/BHGroup/docs/Tools/InpatientClinicalRecordReviewTool-Definitions.xlsx
    vi. Targeted Case Management:
    http://www.fdhc.state.fl.us/Medicaid/Policy_and_Quality/Quality/clinical_quality_compliance/BHGroup/docs/Tools/TCMDefinitionsTool.xlsx

    http://www.fdhc.state.fl.us/Medicaid/Policy_and_Quality/Quality/clinical_quality_compliance/BHGroup/docs/Tools/TCMRecordReviewTool.xlsx

Elements of these reviews include, but are not limited to:

1. Management of specific diagnoses
2. Appropriateness and timeliness of care
3. Comprehensiveness of and compliance with the plan of care
4. Evidence of special screening for high risk members and/or conditions
5. Evidence of appropriate coordination of care
6. Evidence of compliance with Medicaid handbooks including, but not limited to, the Medicaid Mental Health Targeted Case Management Coverage & Limitations Handbook (http://portal.flmmis.com/FLPublic/Portals/0/StaticContent/Public/HANDBOOKS/CL_07_070601_MH_Case_Mgmt_ver2_2.pdf) and the Community Behavioral Health Services Coverage & Limitations Handbook (http://portal.flmmis.com/FLPublic/Portals/0/StaticContent/Public/HANDBOOKS/Community_Behavioral_Health_Services_Coverage_and_Limitations_Handbook_Adoption.pdf).

## Stakeholder Satisfaction Survey

In all service areas in which CMS Plan offers behavioral health services, CMS Plan, through The Institute for Child Health Policy (ICHP), annually conducts a behavioral health services stakeholder satisfaction survey in both English and Spanish.

# PLACEHOLDER – CONCORDIA BEHAVIORAL HEALTH CHART REVIEW

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# XV. PREVENTION OF FRAUD, WASTE, & BILLING ABUSE

The Agency for Health Care Administration (AHCA) and Children's Medical Services (CMS) require that CMS Plan have a compliance program. This program is dedicated to the prevention and detection of fraud, waste, and billing abuse through a collaborative effort. Appropriate enforcement measures based on compliance findings will be undertaken after consultation with or notification of AHCA and CMS. Medicaid provider and member fraud can manifest in multiple ways and we solicit and anticipate the cooperation of diligent providers and members to uncover and report this type of activity.

Our goal is to prevent, detect, and correct any violations. CMS Plan, Ped-I-Care and CCP actively attempt to prevent and identify suspected incidents of Medicaid fraud, waste, and billing abuse. All activities seen as fraud, waste, and/or billing abuse will be reported to the Ped-I-Care or CCP Compliance Department for investigation and follow-up. Providers must comply with all aspects of Ped-I-Care's and CCP's Compliance Programs and its fraud, waste, and billing abuse plan/requirements.

***Compliance Dashboard:***

- *Our goal is to prevent, detect, and correct any form of Medicaid fraud and/or abuse.*
- *Ped-I-Care's training is recommended, but not required, and may be accessed at: http://pedicare.peds.ufl.edu/compliance/index.html.*
- *CCP's online training tutorial is found at: http://ccpcares.org/providers/sfccn-provider-alerts.*

## Compliance Activities and Investigations

Ped-I-Care and CCP proactively conduct both prospective and retrospective searches and analyses to seek potential fraud, waste, and billing abuse using resources such as (but not limited to) claims, utilization management, quality management, grievance/appeals, complaints, and random chart audits. Pursuant to Medicaid regulations, in the event of suspected fraud, waste, and/or abuse, chart audits may be conducted without prior notice. Findings suggestive of fraud, waste, and/or billing abuse will be reported to the Medicaid Office of Program Integrity as appropriate and needed. Note that any resolution to audit findings and investigations in no way binds the State of Florida nor precludes the State of Florida from taking further action for the circumstances that brought rise to the matter.

## Provider Training

The Ped-I-Care/CCP Compliance Programs train CMS Plan providers and their staff members and investigate fraud, waste, and billing abuse. Ped-I-Care's provider webpage is http://pedicare.pediatrics.med.ufl.edu/for-providers/claims-forms-support/ and CCP's compliance webpage is http://ccpcares.org/providers/compliance-plan. Each contains educational information for providers regarding fraud, waste, and billing abuse. Providers and practices are responsible for ensuring they and their staff are adequately trained regarding the prevention of fraud, waste, and billing abuse. Ped-I-Care's online training tutorial is available at http://pedicare.peds.ufl.edu/compliance/index.html. CCP's online training tutorial is available at

http://ccpcares.org/providers/sfccn-provider-alerts. CMS Plan providers may use both tutorials, as Ped-I-Care and CCP work together under contract to CMS Plan. Completion of Ped-I-Care/CCP's online training is not mandatory but is recommended and may be utilized as a resource for practices to train providers and staff.

### *Compliance Requirements*

Ped-I-Care providers are expected to adhere to the following guidelines for medical records and claims. Note that it is not an all-inclusive list; it is a list of findings commonly identified during medical record and claims audits.

**Providers/practices must:**

1. Ensure documentation is legible;
2. Ensure documentation supports what is billed on the claim;
3. Ensure documentation supports billed modifiers;
4. Ensure the site/practice location of where services were rendered is documented in the note (*if a practice has multiple locations, the location for each encounter must be clear in each note*);
5. Ensure the Chief Complaint is documented (*the medical reason for a "follow-up" visit must be documented*);
6. Ensure each note's documentation is unique and specific to the presenting problem(s)/reason for the encounter (be careful of copy/paste, cloning, and bringing forward information from other encounters);
7. Ensure notes do not contain conflicting information (*i.e. an assessment of Acute Respiratory Infection with no complaint of cough, runny nose, or difficulty breathing and normal respiration, lungs, ears, nose, and throat documented on the exam*);
8. Ensure the exam and service(s) rendered support the medical necessity of the reason for the encounter/presenting problem(s);
9. Ensure all procedures are documented in medical record;
10. Ensure subsequent pages of each note contain patient identifying information;
11. Ensure if billing based on time, that the medical record documentation includes a statement regarding the total time spent with the patient AND a concise description of the content of the counseling that was provided;
12. Ensure notes are signed in a timely manner (*providers are expected to sign all records within a reasonable time frame, usually 48-72 hours of an encounter*);
13. Ensure electronic signatures are dated;
14. Ensure the claim is NOT billed before the note is signed by the attending provider;
15. Ensure each claim is submitted in the name of the provider that actually rendered services and signed (or co-signed in accordance with incident-to requirements) the note; and
16. Ensure errors in the chart are corrected appropriately.

**From the Medicare Handbook (Medicaid guidelines follow Medicare):**

| | | Signature Requirement | |
|---|---|---|---|
| | | **Met** | **Not Met** |
| **1** | Legible full signature | X | |
| **2** | Legible first initial and last name | X | |
| **3** | Illegible signature over a typed or printed name | X | |
| **4** | Illegible signature where the letterhead, addressograph, or other information on the page indicates the identity of the signatory.<br><br>*Example: An illegible signature appears on a prescription. The letterhead of the prescription lists (3) physicians' names. One of the names is circled.* | X | |
| **5** | Illegible signature NOT over a typed/printed name and NOT on letterhead, but the submitted documentation is accompanied by: a signature log, or an attestation statement | X | |
| **6** | Illegible signature NOT over a typed/printed name, NOT on letterhead, and the documentation is UNaccompanied by: a signature log, or an attestation statement | | X |
| **7** | Handwritten initials over a typed or printed name | X | |
| **8** | Handwritten initials NOT over a typed/printed name but accompanied by: a signature log, or an attestation statement | X | |
| **9** | Handwritten initials NOT over a typed/printed name UNaccompanied by: a signature log, or an attestation statement | | X |
| **10** | Unsigned typed note with provider's typed name | | X |
| **11** | Unsigned typed note without providers typed/printed name | | X |
| **12** | Unsigned handwritten note, the only entry on the page | | X |
| **13** | Unsigned handwritten note where other entries on the same page in the same handwriting are signed. | X | |
| **14** | "signature on file" | | X |

## Excluded Provider Notification

CMS Plan, Ped-I-Care and CCP routinely monitor the Health and Human Services (HHS) Office of the Inspector General's List of Excluded Individuals and Entities (LEIE), System for Award Management (SAM) (which includes the former Excluded Parties List System [EPLS]), Medicaid Termination lists, Florida Department of Health (DOH) license notifications, and AHCA Final Orders to identify individuals excluded from participation in Florida Medicaid, and therefore CMS, Ped-I-Care, and CCP. Providers, facilities, and groups must notify both CMS and the ICSs immediately if they become ineligible to participate in federally-funded programs or receive federal money.

## Reporting Fraud, Waste, & Billing Abuse

Confidentiality will be maintained for the suspect person or entity and the person reporting, and all rights afforded to both providers and members will be reserved and enforced during the investigation process.

You may report suspected cases of fraud, waste, and billing abuse anonymously. You may also report confidentially without fear of retaliation. You may report in one or more of the following ways:

- By phone to any of the following hotlines:
  1. The **Ped-I-Care** Compliance Fraud, Waste, and Billing Abuse Hotline toll-free at (866) 787-4557 or locally at (352) 627-9300
  2. The **CCP** Compliance Fraud, Waste, and Billing Abuse Hotline toll-free at (855) 843-1106
  3. The Florida Medicaid Fraud, Waste, and Billing Abuse Hotline at (888) 419-3456
  4. The Department of Health and Human Services Office of the Inspector General (OIG) at (800) 447-8477
  5. The Florida Attorney General's Hotline for Reporting Medicaid fraud, waste, and billing abuse at (866) 966-7226
- Online by filling out the Medicaid Fraud and Abuse Complaint Form (to report suspected fraud, waste, and/or billing abuse in the Florida Medicaid system) at: https://apps.ahca.myflorida.com/InspectorGeneral/fraud_complaintform.aspx

- **For Ped-I-Care,** by emailing information to pedicarecd@peds.ufl.edu, faxing it to (352) 294-8080, or mailing it to:

  Ped-I-Care Compliance Department
  1699 SW 16th Avenue, Room 3132
  Gainesville, FL 32608-1153

- **For CCP,** by mailing it to:

  CCP Compliance Department
  1643 Harrison Pkwy., Bldg. H, Ste. 200
  Sunrise, FL 33323

If you report suspected fraud and your report results in a fine, penalty, or forfeiture of property from a doctor or other health care provider, you may be eligible for a reward through the Attorney General's Fraud Rewards Program [(866) 966-7226 or (850) 414-3990]. The reward may be up to 25% of the amount recovered, or a maximum of $500,000 per case (Florida statutes Chapter 409.9203). You can talk to the Attorney General's Office about keeping your identity confidential and protected.

## Definitions & Examples

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

**Examples of Provider Fraud:**

- Billing for an office visit when there was none, or adding additional family members' names to bills
- Billing for services that were not provided, e.g., a chest x-ray that was not taken
- Billing for more time than was actually provided, i.e., counseling, anesthesia, etc.
- Requiring the recipient to return to the office for more visits when another appointment is not necessary
- Ordering unnecessary x-rays, blood work, etc.
- Upcoding (billing for a more involved or time-consuming service than was actually provided), e.g., providing a simple office visit and billing for a comprehensive visit
- Billing for transportation that is not medically necessary or is not related to health care
- Billing for services that are not medically necessary, or are not for a medical purpose

- Accepting payment from another provider, including sharing in the reimbursement paid by the Medicaid program, as a result of referring a patient to the other provider
- Duplicate billing such as billing Medicaid and another payer and/or the recipient for the same service
- Having an unlicensed person perform services that only a licensed professional should render, and billing as if the professional provided the service
- Unbundling codes (billing separately for each component of the code) which results in increased payment, when one comprehensive code includes all related services at a lesser reimbursement rate. This also includes incidental procedures that are typically done as part of a larger procedure and, because they take little extra effort, are not usually reimbursed separately. Examples include laboratory blood test panels, surgical procedures, etc.

**Examples of Member Fraud:**

- Intentionally under-reporting income, assets, resources etc.
- Loaning a Medicaid Identification card to another person
- Using multiple ID cards and/or Medicaid numbers
- Forging or altering a prescription or fiscal order
- Intentionally receiving duplicative, excessive, contraindicated or conflicting health care services or supplies
- Re-selling items provided by the Medicaid program
- Misrepresentation of a medical condition

**Waste:** Overutilization of services or other practices that, directly or indirectly, result in unnecessary health care costs. It is not generally considered to be caused by criminally negligent actions, but by the misuse and/or mismanagement of resources.

**Examples of Waste:**

- **Failures of care delivery** – Poor execution or lack of widespread adoption of best practices, such as effective preventive care practices or patient safety best practices, which can result in patient injuries, worse clinical outcomes, and higher costs
- **Failures of care coordination** – Fragmented and disjointed care can lead to unnecessary hospital readmissions, avoidable complications, and declines in functional status, especially for the chronically ill
- **Overtreatment**
    - Excessive use of antibiotics
    - Care that is rooted in outmoded habits
    - Ordering clinical procedures, tests, medications, and other services that may not benefit patients
    - Providers' preferences for treatment that is beyond/outside of that considered necessary and appropriate by industry standards
    - Ordering unnecessary tests or diagnostic procedures to guard against liability in malpractice lawsuits
    - Over-diagnosis stemming from efforts to identify and treat disease in its earliest stages when the disease might never actually progress and when a strategy such as watchful waiting may have been preferred. For example, in July 2012 the US Preventive Services Task Force recommended against prostate-specific antigen-based screening for prostate cancer because of "substantial over-diagnosis" of tumors, many of which are benign. Excessive treatment of these tumors, including surgery, leads to unnecessary harms, the task force said.
- **Administrative complexity** – Lack of standardized forms and procedures can result in needlessly complex and time-consuming work
- **Fraud and abuse** – Fake medical bills and scams

**Abuse:** Provider practices that are inconsistent with generally accepted business or medical practices and that result in an unnecessary cost to the Medicaid program or in reimbursement for goods or services that are not medically necessary or that fail to meet professionally recognized standards for health care, or recipient practices that result in unnecessary cost to the Medicaid program.

**Examples of Provider Abuse:**

- Over-utilization of health care services
- Billing a Child Health Check-up on the same day as a sick visit
- Provider billing irregularities
- Excessive charges for services or supplies
- Claims for services that are not medically necessary
- Improper billing practices
- Billing for services not provided
- Inaccurate coding
- Misrepresentation of professional credentials/licensing/status of licensure

**Examples of Member Abuse:**

- Residing out-of-state
- Tampering with prescriptions
- Drug-seeking behaviors
- Failure to report third-party liability

**Overpayment:** Overpayment defined in accordance with s. 409.913, F.S., includes any amount that is not authorized to be paid by the Medicaid program whether paid as a result of inaccurate or improper cost reporting, improper claiming, unacceptable practices, fraud, abuse, or mistake.

**Examples of Overpayment:**

- Payment for provider, supplier, or physician services after benefits have been exhausted, or where the member was not entitled to benefits.
- Payment for non-covered items and services, including medically unnecessary services or custodial care furnished to a member.
- Payment based on a charge that exceeds the reasonable charge.
- Duplicate processing of charges/claims.
- Payment to a physician on a non-assigned claim or to a member on an assigned claim. (Payment made to wrong payee.)
- Primary payment for items or services for which another entity is the primary payer.
- Payment for items or services rendered during a period of non-entitlement.

# XVI. Definitions

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

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

**Abuse, Neglect, and Exploitation** – In accordance with Chapter 415, F.S., and Chapter 39, F.S.: "Abuse" means any willful act or threatened act by a caregiver that causes or is likely to cause significant impairment to an enrollee's physical, mental, or emotional health. Abuse includes acts and omissions.

"Exploitation" of a vulnerable adult means a person who:

1. Stands in a position of trust and confidence with a vulnerable adult and knowingly, by deception or intimidation, obtains or uses, or endeavors to obtain or use, a vulnerable adult's funds, assets, or property for the benefit of someone other than the vulnerable adult.
2. Knows or should know that the vulnerable adult lacks the capacity to consent and obtains or uses, or endeavors to obtain or uses, the vulnerable adult's funds, assets, or property with the intent to temporarily or permanently deprive the vulnerable adult of the use, benefit, or possession of the funds, assets, or property for the benefit of someone other than the vulnerable adult.

"Neglect" of an adult means the failure or omission on the part of the caregiver to provide the care, supervision, and services necessary to maintain the physical and behavioral health of the vulnerable adult, including, but not limited to, food, clothing, medicine, shelter, supervision, and medical services, that a prudent person would consider essential for the well-being of the vulnerable adult. The term "neglect" also means the failure of a caregiver to make a reasonable effort to protect a vulnerable adult from abuse, neglect, or exploitation by others. "Neglect" is repeated conduct or a single incident of carelessness that produces, or could reasonably be expected to result in, serious physical or psychological injury or a substantial risk of death.

"Neglect" of a child occurs when a child is deprived of, or is allowed to be deprived of, necessary food, clothing, shelter, or medical treatment, or a child is permitted to live in an environment when such deprivation or environment causes the child's physical, behavioral, or emotional health to be significantly impaired or to be in danger of being significantly impaired.

**Activities of Daily Living (ADL)** – Basic tasks of everyday life which include, dressing, grooming, bathing, eating, transferring in and out of bed or chair, walking, climbing stairs, toileting, bladder/bowel control, and the wearing or changing of incontinence briefs.

**Acute Care Services** – Short-term medical treatment that may include, but is not limited to, community behavioral health, dental, hearing, home health, independent laboratory and x-ray, inpatient hospital, outpatient hospital/emergency medical, practitioner, prescribed drug, vision, or hospice services.

**Adjudicated Claim** – A claim for which a determination has been made to pay or deny the claim.

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

**Advanced Registered Nurse Practitioner (ARNP)** – A licensed advanced practice registered nurse who works in collaboration with a practitioner according to Chapter 464, F.S., and protocols filed with the Board of Medicine.

**Adverse Benefit Determination —** The denial or limited authorization of a requested service, including the type or level of service, pursuant to 42 CFR 438.400(b); the reduction, suspension or termination of a previously authorized service. The denial, in whole or in part, of payment for a service; the failure to provide services in a timely manner, as defined by the state; the failure of the Managed Care Plan to act within ninety (90) days from the date the Managed Care Plan receives a grievance, or thirty (30) days from the date the Managed Care Plan receives an appeal; for a resident of a rural area with only one (1) managed care entity, the denial of an enrollee's request to exercise the right to obtain services outside the network; and the denial of an enrollee's request to dispute a financial liability.

**Adverse Incident** – Critical events that negatively impact the health, safety, or welfare of enrollees. Adverse incidents may include events involving abuse, neglect, exploitation, major illness or injury, involvement with law enforcement, elopement/missing, or major medication incidents.

**After Hours** – The hours between five PM (5pm) and eight AM (8am) local time, Monday through Friday inclusive, and all-day Saturday and Sunday. State holidays are included.

**Agency** – State of Florida, Agency for Health Care Administration (AHCA) or its designee

**Aging or Disability Resource Center (ADRC)** – An agency designated by the DOEA to develop and administer a plan for comprehensive and coordinated system of services for older and disabled persons.

**Ancillary Provider** – A provider of ancillary medical services who has contracted with the CMS Plan to serve the CMS Plan's enrollees.

**Assistive Care Services** – A Medicaid service as defined in the Assistive Care Services Coverage and Limitations Handbook.

**Baker Act** – The Florida Mental Health Act, pursuant to ss. 394.451 through 394.47891, F.S.

**Bed Hold Day(s**) – The reservation of a bed in a nursing facility (including beds for individuals receiving hospice services), when a resident is admitted into the hospital or is on therapeutic leave during a Medicaid covered stay.

**Behavioral Health Care Provider** – A licensed or certified behavioral health professional, such as clinical psychologist under Chapter 490, F.S., clinical social worker, mental health professional under Chapter 491, F.S.; certified addictions professional; or registered nurse qualified due to training or competency in behavioral health care, who is responsible for the provision of behavioral health care to patients, or a physician licensed under Chapters 458 or 459, F.S., who is under contract to provide behavioral health services to enrollees.

**Behavioral Health Services** – Services listed in the Community Behavioral Health Services Handbook and the Mental Health Targeted Case Management Coverage and Limitations Handbook as specified in Section V. Covered Services.

**Benefits** – A schedule of health care services to be delivered to enrollees covered by the CMS Plan as set forth in Section V, Covered Services.

**Biometric Technology** – The use of computer technology to identify people based on physical or behavioral characteristics such as fingerprints, retinal or voice scans.

**Blocked Call** – A Call that cannot be connected immediately because no circuit is available at the time the call arrives or the telephone system is programmed to block calls from entering the queue when the queue backs up

behind a defined threshold.

**Business Days** – Traditional workdays, which are Monday, Tuesday, Wednesday, Thursday, and Friday. State Holidays are excluded.

**Care Coordination/Case Management** – A process that assesses, plans, implements, coordinates, monitors and evaluates the options and services required to meet an enrollee's health needs using communication and all available resources to promote quality outcomes. Proper care coordination/case management occurs across a continuum of care, addressing the ongoing individual needs of an enrollee rather than being restricted to a single practice setting.

**Case Record** – A record that includes information regarding the management of services for an enrollee including the plan of care and documentation of care coordination/case management activities.

**Cause** – Special reasons allow mandatory enrollees to change their Managed Care Plan choice outside their open enrollment period. May also be referred to as "good cause." (See 59G-8.600, F.A.C.)

**Centers for Medicaid & Medicaid Services (CMS**) – The agency within the United States Department of Health & Human Services that provides administration and funding for Medicaid under Title XVIII, Medicaid under Title XIX, and the Children's Health Insurance Program under Title XXI of the Social Security Act. May also be referred to as federal CMS.

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

**Check Run Summary File** – Required Managed Care Plan file listing all amounts paid to providers for each provider payment adjudication cycle. For each provider payment in each adjudication cycle, the file must detail the total encounter payments to each respective provider. This file must be submitted along with the encounter data submissions. The file must be submitted in a format and in timeframes specified by the Agency.

**Child Health Check-Up Program (CHCUP)** – A set of comprehensive and preventative health examinations provided on a periodic basis to identify and correct medical conditions in children/adolescents. Policies and procedures are described in the Child Health Check-Up Services Coverage and Limitations Handbook. (See definition of Early and Periodic Screening Diagnosis and Treatment Program).

**Children/Adolescents** – Enrollees under the age of 21.

**Children's Medical Services Network** – A primary care case management program for children from birth through age twenty (20) with special health care needs, administered by the Department of Health for physical health services and the Department of Children and Families for behavioral health.

**Children's Medical Services Managed Care (CMS Plan) Plan** – A Medicaid specialty plan for children with chronic conditions operated by the Florida Department of Health's Children's Medical Services Network as specified in s. 409.974(4), F.S., through a single, statewide contract with the Agency that is not subject to the SMMC procurement requirements, or regional plan limits, but must meet all other plan requirements for the MMA program. Also referred to as the "Managed Care Plan" and "CMS Plan" for purposes of this contract.

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

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

**Cold-Call Marketing** – Any unsolicited personal contact with a Medicaid recipient by the CMS Plan, its staff, its volunteers, or its vendors with the purpose of influencing the Medicaid recipient to enroll in the CMS Plan or either to not enroll in, or disenroll from, another Managed Care Plan.

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

**Community Living Support Plan** – A written document prepared by or on behalf of a mental health resident of an assisted living facility with a limited mental health license and the resident's mental health case manager in consultation with the administrator of the facility or administrator's designee. A copy must be provided to the administrator. The plan must include information about the supports, services, and special needs that enable the resident to live in the assisted living facility and a method by which facility staff can recognize and respond to the signs and symptoms particular to that resident that indicate the need for professional services.
CMS Plan CMS Plan
**Complaint** – Any oral or written expression of dissatisfaction by an enrollee submitted to the CMS Plan or to a state agency and resolved by close of business the following business day. Possible subjects for complaints include, but are not limited to, the quality of care, the quality of services provided, aspects of interpersonal relationships such as rudeness of a provider or CMS Plan employee, failure to respect the enrollee's rights, CMS Plan administration, claims practices or provision of services that relates to the quality of care rendered by a provider pursuant to the CMS Plan's Contract. A complaint is a subcomponent of the grievance system.

**Comprehensive Assessment and Review for Long-Term Care Services (CARES)** – A program operated by the DOEA that is Florida's federally mandated long-term care preadmission screening program for Medicaid Institutional Care Program nursing facility and Medicaid waiver program applicants. An assessment is performed to identify long-term care needs; establish level of care (medical eligibility for nursing facility care); and recommend the least restrictive, most appropriate placement. Emphasis is on enabling people to remain in their homes through provision of home-based services or with alternative placements such as assisted living facilities.

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

**Contract, CMS Plan** – As a result of successfully meeting all MMA plan readiness requirements and pursuant to s. 409.962(6), F.S., and s. 409.974(4), F.S., the agreement between the CMS Plan and the Agency where the CMS Plan will provide Medicaid-covered services to enrollees, comprising the Contract and any addenda, appendices, attachments, or amendments thereto, and be paid by the Agency as described in the terms of the agreement. Also referred to as the "Contract" for purposes of this contract.

**Contracting Officer** – The Secretary of the Agency or designee.

**County Health Department (CHD**) – Organizations administered by the Department of Health to provide health services as defined in Chapter 154, Part 1., F.S., including promoting public health, controlling and eradicating preventable diseases, and providing primary health care for special populations.

**Coverage and Limitations Handbook and/or Provider General Handbook (Handbook**) – A Florida Medicaid document that provides information to a Medicaid provider about enrollee eligibility; claims submission and processing; provider participation; covered care, goods, and services; limitations; procedure codes and fees; and other matters related to participation in the Medicaid program.

**Covered Services** – Those services provided by the CMS Plan in accordance with this Contract, and as outlined in Section V, Covered Services.

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

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

**Department of Elder Affairs (DOEA)** – The primary state agency responsible for administering human services programs to benefit Florida's elders and developing policy recommendations for long-term care in addition to overseeing the implementation of federally funded and state-funded programs and services for the state's elderly population.

**Department of Health (DOH)** – The state agency responsible for public health, public primary care and personal health, disease control, and licensing of health professionals.

**Direct Ownership Interest** – The ownership of stock, equity in capital or any interest in the profits of a disclosing entity.

**Direct Secure Messaging (DSM)** – Enables Managed Care Organizations and providers to securely send patient health information to many types of organizations.

**Direct Service Provider** – An individual qualified by education, training, or experience and credentialed by the plan to provide direct health care or behavioral health care services.

**Disclosing Entity** – A Medicaid provider, other than an individual practitioner or group of practitioners, or a fiscal agent that furnishes services or arranges for funding of services under Medicaid, or health-related services under the social services program.

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

**Disenrollment** – the Agency-approved discontinuance of an enrollee's participation in a Managed Care Plan.

**Downward Substitution** – The use of less restrictive, lower cost services than otherwise might have been provided, that are considered clinically acceptable and necessary to meet specified objectives outlined in an enrollee's plan of treatment, provided as an alternative to higher cost services.

**Dual Eligible** – An enrollee who is eligible for both Medicaid (Title XIX) and Medicare (Title XVII) programs.
**Durable Medical Equipment (DME)** – Medical equipment that can withstand repeated use, is customarily used to serve a medical purpose, is generally not useful in the absence of illness or injury and is appropriate for use in the enrollee's home.

**Early and Periodic Screening, Diagnosis, and Treatment Program (EPSDT)** – As defined by 42 CFR 440.40(b)(2012) or its successive regulation, means: (1) Screening and diagnostic services to determine physical or mental defects in recipients under age 21; and (2) Health care, treatment, and other measures to correct or ameliorate any defects and chronic conditions discovered. Pursuant to s. 42 CFR 441.56 (2012) or its successive regulation, this is a program about which all eligible individuals and their families must be informed. EPSDT includes screening (periodic comprehensive child health assessments): consisting of regularly scheduled examinations and evaluations

of the general physical and mental growth, development, and nutritional status of infants, children, and youth. As a minimum, these screenings must include, but are not limited to: (a) comprehensive health and developmental history, (b) comprehensive unclothed physical examination, (c) appropriate vision testing, (d) appropriate hearing testing, (e) appropriate laboratory tests, (vi) dental screening services furnished by direct referral to a dentist for children beginning at 3 years of age. Screening services must be provided in accordance with reasonable standards of medical and dental practice determined by the Agency after consultation with recognized medical and dental organizations involved in child health care. Requirements for screenings are contained in the Medicaid Child Health Check-Up Coverage and Limitations handbook. Diagnosis and treatment include: (a) diagnosis of and treatment for defects in vision and hearing, including eyeglasses and hearing aids, (b) dental care, at as early an age as necessary, needed for relief of pain and infections, restoration of teeth and maintenance of dental health; an (c) appropriate immunizations. (If it is determined at the time of screening that immunization is needed and appropriate to provide at the time of screening, then immunization treatment must be provided at that time.) (See definition of Child Health Check-up program).

**Early Intervention Services (EIS)** – A Medicaid program designed for children receiving services through the Department of Health's Early Steps program. Early Steps serves eligible infants and toddlers from birth to thirty-six (36) months who have development delays or a condition likely to result in a developmental delay. EIS services are authorized in the child's Early Steps Individualization Family Support Plan and are delivered by Medicaid-enrolled EIS providers throughout the state.

**Eligible Plan** – In accordance with S. 409.962(6), F.S., a health insurer authorized under Chapter 624, an exclusive provider organization (EPO) authorized under Chapter 627, a health maintenance organization (HMO) authorized under Chapter 641, F.S., or an accountable care assistance (MMA) SMMC program, the term also includes a provider service network (PSN) authorized under s. 409.912(4)(d), the Children's Medical Services Network ( or Children's Medical Service Network (CMS Plan) authorized under Chapter 391, or comprehensive long-term care plans authorized under s. 409.962(4), F.S.

**Emergency Behavioral Health Services** – Those services required to meet the needs of an individual who is experiencing an acute crisis, resulting from a mental illness, which is a level of severity that would meet the requirements for an involuntary examination (see s. 394.463, F.S.), an in the absence of a suitable alternative or psychiatric medication, would require hospitalization.

**Emergency Medical Condition** – (a) A Medical condition manifesting itself by acute symptoms of sufficient severity, which may include severe pain or other acute symptoms, such that a prudent layperson who possesses an average knowledge of health and medicine, could reasonable expect that the absence of immediate medical attention could result in any of the following: (1) serious jeopardy to the health of a patient, including a pregnant women or fetus; (2)serious impairment to bodily functions; (3) serious dysfunction of any bodily organ or part. (b)With respect to a pregnant woman: (1) that there is inadequate time to effect safe transfer to another hospital prior to delivery; (2) that a transfer may pose a threat to the health and safety of the patient or fetus; (3) that there is evidence of the onset or persistence of uterine contractions or rupture of the membranes (see s. 395.002, F.S.).

**Emergency Services and Care** – Medical screening, examination and evaluation by a physician or, to the extent permitted by applicable laws, by other appropriate personnel under the supervision of a physician, to determine whether an emergency medical condition exists. If such a condition exists, emergency services and care include the care or treatment necessary to0 relieve or eliminate the emergency medical condition within the service capability of the facility.

**Emergency Transportation** – The provision of emergency transportation services in accordance with s. 409.908(13)(c)4.,F.S.

**Encounter Data** – A record of diagnostic or treatment procedures or other medical, allied or long-term care provided to the CMS Plan's Medicaid enrollees, excluding services paid by the Agency on a fee-for-service basis.

**Enrollees** – A Medicaid recipient enrolled in a Managed Care Plan.

**Enrollees with Special Health Care Needs** – Enrollees who face physical, behavioral or environmental challenges daily that place at risk their health and ability to fully function in society. This includes individuals with mental retardation or related conditions; individuals with serious chronic illnesses, such as human immunodeficiency virus (HIV), schizophrenia or degenerative neurological disorders; individuals with disabilities resulting from many years of chronic illness such as arthritis, emphysema, or diabetes; children/adolescents and adults with certain environmental risk factors such as homelessness or family problems that lead to the need for placement in foster care; and all enrollees in LTC Managed Care Plans.

**Enrollment** – The process by which an eligible Medicaid recipient signs up to participate in a Managed Care Plan.

**Enrollment Broker** – The state's contracted or designated entity that performs functions related to outreach, education, enrollment, and disenrollment of potential enrollees into a Managed Care Plan.

**Enrollment Files** – X-12 834 files sent by the Agency's Medicaid fiscal agent to the Managed Care Plans to provide the Managed Care Plans with their official Medicaid enrollment broker; these files contain additional demographic data and provide choice data not available on the X-12 834 enrollment files.

**Excluded Parties List System (EPLS)** – the EPLS, or its equivalent, is a federal database containing information regarding entities debarred, suspended, proposed for debarment, excluded, or disqualified under the non-procurement common rule, or otherwise declared ineligible from receiving federal contracts, certain subcontracts, and certain federal assistance and benefits.

**Expanded Benefit** – A benefit offered to all enrollees in specific population groups, covered by the Managed Care Plan for which the Managed Care Plan receives no direct payment from the Agency. These specific population groups are as follows : TANF; SSI No Medicare, non-LTC eligible; SSI with Medicare, non-LTC eligible; Dual Eligible, LTC eligible, Medicaid Only, LTC eligible; HIV/AIDS Specialty Population, with Medicare; HIV/AIDS Specialty Population, No Medicare; and Child Welfare Specialty Population. Expanded benefits are not available to CMS Plan enrollees.

**Expedited Appeal Process** – The process by which the appeal of a Managed Care Plan's adverse benefit determination is accelerated because the standard timeframe for resolution of the plan appeal could seriously jeopardize the enrollee's life, health or ability to obtain, maintain or regain maximum function.

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

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

**Facility-Based** – As the term relates to services, services the enrollee receives from a residential facility in which the enrollee lives. Under this Contract, assisted living facility services, assistive care services, adult family care homes and nursing facility care are facility-based services.

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

**Federally Qualified Health Center (FQHC)** – An entity that is receiving a grant under section 330 of the Public

Health Service Act, as amended. (Also see s. 1905(I)(2)(B) of the Social Security Act.) FQHCs provide primary health care and related diagnostic services and may provide dental, optometric, podiatry, chiropractic and behavioral health services.

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

**Fee Schedule** – A list of medical, dental or mental health services or products covered by the Florida Medicaid program which provides the associated reimbursement rates for each covered service or product and are promulgated into rule.

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

**Fiscal Year** – The State of Florida's Fiscal Year, which starts July 1 and ends on June 30.

**Florida Medicaid Management Information System (FMMIS or FL MMIS)** – The information system used to process Florida Medicaid claims and payments to Managed Care Plans, and to produce management information and reports relating to the Florida Medicaid program. This system is used to maintain Medicaid eligibility data and provider enrollment data.

**Florida Medical School Quality Network** – The network as specified in s. 409.975(2), F.S.

**Florida Mental Health Act** – Includes the Baker Act that covers admissions for persons who are considered to have an emergency mental health condition (a threat to themselves or others) as specified in ss. 394.451 through 394.47891, F.S.

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

**Full-Benefit Dual Eligible** – an enrollee who is eligible for full Medicaid benefits under Medicaid (Title XIX) and Medicare (Title XVIII) programs.

**Full-Time Equivalent (FTE) Position/Employee** – The equivalent of one (1) full-time employee who works forty (40) hours per week.

**Good Cause** – See Cause.

**Grievance** – An expression of dissatisfaction about any matter other than an adverse benefit determination. Possible subjects for grievances include, but are not limited to, the quality of care, the quality of services provided and aspects of interpersonal relationships such as rudeness of a provider or CMS Plan employee, failure to respect an enrollee's rights, or an enrollee dispute of an extension of time proposed by the CMS Plan to make an authorization decision.

**Grievance Process** – The procedures for addressing enrollees' grievances.

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

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

**Healthcare Effectiveness Data and Information Set (HEDIS)** – The data and information set developed and published by the National Committee for Quality Assurance. HEDIS includes technical specifications for the calculation of performance measures.

**Health Care-Acquired Condition (HCAC)** – A condition, occurring in any inpatient hospital or inpatient psychiatric hospital setting, including crisis stabilization units (CSUs), identified as a hospital-acquired condition (HAC) by the Secretary of Health and Human Services under section 1886(d)(4)(D)(iv) of the Social Security Act for purposes of the Medicare program as specified in the Florida Medicaid State Plan. By federal law, Deep Vein Thrombosis (DVT)/Pulmonary Embolism (PE), as related to total knee replacement or hip replacement surgery in pediatric and obstetric patients, are not reportable PPCs/HCACs. HCACs also include never events.

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

**Health Information Exchange (HIE)** – The secure, electronic exchange of health information among authorized stakeholders in the health care community – such as care providers, patients, and public health agencies – to drive timely, efficient, high-quality, preventive, and patient-centered care.

**Health Insurance Premium Payment (HIPP) Program** – A program that reimburses part or all of a Medicaid recipient's share of employer-sponsored health care coverage, if available and cost-effective.

**Healthy Behaviors (MMA Managed Care Plans Only)** – A program offered by Managed Care Plans that encourages and rewards behaviors designed to improve the enrollee's overall health.

**Health Information Technology for Economic and Clinical Health (HITECH) Act** – A federal law enacted in 2009 to promote the adoption and meaningful use of health information technology. The Health Information Technology Act, found in Title XIII of the American Recovery and Reinvestment Act of 2009, Public Law 111-005.

**Health Insurance Portability and Accountability Act (HIPAA)** – Enacted in 1996. Public Law 104-191.

**Hospital** – A facility licensed in accordance with the provisions of Chapter 395, F.S., or the applicable laws of the state in which the service is furnished.

**Hospital Contract** – The agreement or contract between the CMS Plan and a hospital to provide medical services to the CMS Plan's enrollees.

**Home and Community Based Services (HCBS)** – Services offered in the community setting designed to prevent or delay nursing facility placement of elderly or disabled adults.

**Hub Site** – The telecommunication distance site in Florida at which the consulting physician, dentist or therapist is delivering telemedicine services.

**Incentive** — Related to an MMA Healthy Behaviors Program, something offered to an enrollee that encourages or motivates him or her to take action. For example, an incentive may be offered for enrolling in a series of educational classes focused on the target behavior. Incentives should be linked to effective engagement strategies.

For example, providing a financial incentive to address a substance abuse problem must be supported by an effective, evidence-based approach/program. Financial incentives are not available to CMS Plan enrollees.

**Indirect Ownership** – Ownership interest in an entity that has direct or indirect ownership interest in the disclosing entity. The amount of indirect ownership in the disclosing entity that is held by any other entity is determined by multiplying the percentage of ownership interest at each level. An indirect ownership interest must be reported if it equates to an ownership interest of five percent (5%) or more in the disclosing entity. Example: If "A" owns ten percent (10%) of the stock in a corporation that owns eighty percent (80%) of the stock of the disclosing entity, "A's" interest equates to an eight percent (8%) indirect ownership and must be reported.

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

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

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

**Insurer** – Pursuant to s. 624.03, F.S., every person engaged as indemnitor, surety, or contractor in the business of entering into contracts of insurance or of annuity.

**Instrumental Activities of Daily Living (IADL)** – Activities related to independent living which include, but are not limited to, preparing meals, taking medications, using transportation, managing money, shopping for groceries or personal items, performing light or heavy housework and using a telephone.

**Kick Payment (MMA Managed Care Plans only)** – The method of reimbursing Managed Care Plans in the form of a separate one (1) time fixed payment for specific services. Kick payments do not apply to the CMS Plan.

**Level of Care (LOC)** – The type of Long-Term care required by an enrollee based on medical needs. The criteria for Intermediate LOC (Level I and II) are described in 59G-4.180, FAC, and the criteria for Skilled LOC are described in 59G-4.290, FAC. Department of Elder Affairs CARES staff establish level of care for Medicaid enrollees.

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

**Licensed Practitioner of the Healing Arts** – A psychiatric nurse, registered nurse, advanced registered nurse practitioner, physician assistant, clinical social worker, mental health counselor, marriage and family therapist, or psychologist.

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

**Long-Term Care Plan (LTC Plan)** – A Managed Care Plan that provides the services described in s. 409.98, F.S., for the long-term care program of the statewide Medicaid managed care program.

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

**Managed Care Plan** – An eligible plan under Contract with the Agency to provide services in the LTC or MMA Statewide Medicaid Managed Care Program.

**Managed Care Plan Report Guide** – A companion guide to the SMMC LTC and MMA Managed Care Plan Contracts that provides detailed information about standard reports required by the Contract to be submitted by the Managed Care Plans to the Agency. Such detailed information includes report-specific format and submission requirements, instructions for completion, and report templates and supplemental tables.

**Mandatory Assignment** – The process the Agency uses to assign enrollees to a Managed Care Plan. The Agency automatically assigns those enrollees required to be in a Managed Care Plan who did not voluntarily choose one.

**Mandatory Enrollee** – The categories of eligible Medicaid recipients who must be enrolled in a Managed Care Plan.

**Mandatory Potential Enrollee** – A Medicaid recipient who is required to enroll in a managed Care Plan but has not yet made a choice.

**Marketing** – Any activity or communication conducted by or on behalf of any Managed Care Plan with a Medicaid recipient who is not enrolled with the Managed Care Plan or an individual potentially eligible for Medicaid that can reasonably be interpreted as intended to influence such individual to enroll in the particular Managed Care Plan.

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

**Medicaid Fair Hearing** – An administrative hearing conducted by DCF to review an action taken by a Managed Care Plan that limits, denies, or stops a requested service.

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

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

**Medicaid State Plan** – A written plan between a state and the federal government that outlines the state's Medicaid eligibility standards, provider requirements, payment methods, and health benefit packages. A Medicaid State Plan is submitted by each state and approved by the Centers for Medicare and Medicaid Services (CMS).

**Medical Assistance Plan (MMA Plan)** – A Managed Care Plan that provides the services described in s. 409.973, F.S., for the medical assistance (MMA) Statewide Medicaid Managed Care (SMMC) Program.

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

**Medically Complex** – An individual who is medically fragile who may have multiple co-morbidities or be technologically dependent on medical apparatus or procedures to sustain life.

**Medically Fragile** – An individual who is medically complex and whose medical condition is of such a nature they are technologically dependent, requiring medical apparatus or procedures to sustain life, e.g., requires total parenteral nutrition (TPN), is ventilator dependent, or is dependent on a heightened level of medical supervision to sustain life, and without such services is likely to expire without warning as defined in Chapter 59G 1.010 FAC.

**Medically Necessary or Medical Necessity** – Services that include medical, allied, or long-term care, goods or services furnished or ordered to:

1. Meet the following conditions:
    a. Be necessary to protect life, to prevent significant illness or significant disability or to alleviate severe pain;
    b. Be individualized, specific and consistent with symptoms or confirm diagnosis of the illness or injury under treatment and not in excess of the patient's needs;
    c. Be consistent with the generally accepted professional medical standards as determined by the Medicaid program, and not be experimental or investigational;
    d. Be reflective of the level of service that can be furnished safely and for which no equally effective and more conservative or less costly treatment is available statewide; and
    e. Be furnished in a manner not primarily intended for the convenience of the enrollee, the enrollee's caretaker or the provider.
2. For those services furnished in a hospital on an inpatient basis, medical necessity means that appropriate medical care cannot be effectively furnished more economically on an outpatient basis or in an inpatient facility of a different type.
3. The fact that a provider has prescribed, recommended or approved medical, allied, or long-term care goods or services does not, in itself, make such care, goods or services medically necessary, a medical necessity or a covered service/benefit.

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

**Meds AD** – Individuals who have income up to 88% of federal poverty level and assets up to $5,000.00 ($6,000.00 for a couple) and who do not have Medicare, or who have Medicare and are receiving institutional care or hospice care, are enrolled in PACE or an HCBS waiver program, or live in an assisted living facility or adult family care home licensed to provide assistive care services.

**Mental Health Targeted Case Manager** – An individual who provides mental health targeted case management services directly to or on behalf of an enrollee on an individual basis in accordance with 65E-15, F.A.C. and the Florida Medicaid Mental Health Targeted Case Management Coverage and Limitations Handbook.

**Mixed Services** –

Medicaid services that include the following services: assistive care services, home health and nursing care (intermittent and skilled nursing), hospice services, medical equipment and supplies (including durable medical equipment), therapy services (physical, occupational, respiratory and speech) and non-emergency transportation services.

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

**Never Event (NE)** – As defined by the National Quality Forum (NQF), an error in medical care that is of concern to both the public and health care professionals and providers, clearly identifiable and measurable (and thus feasible to include in a reporting system), and of a nature such that the risk of occurrence is significantly influenced by the policies and procedures of the health care organization. Currently, in Florida Medicaid, never event health care settings are limited to inpatient hospitals and inpatient psychiatric hospitals, including CSUs.

**Newborn** – A live child born to an enrollee who is a member of the CMS Plan.

**Nominal Value**– A gift of nominal value as indicated below:

1. Nominal value is defined as an individual item/service worth fifteen dollars ($15.00) or less (based on the retail value of the item).
2. If a nominal gift is one large gift that is enjoyed by all in attendance (e.g., a concert), the total retail cost must be fifteen dollars ($15.00) or less when it is divided by the estimated attendance.

Nominal gifts may not be in the form of cash or other monetary rebates. Nominal gifts that are cash are prohibited even if their worth is less than fifteen dollars ($15.00).

**Non-Covered Service** – A service that is not a benefit under either the Medicaid State Plan or the CMS Plan.

**Non-Participating Provider** – A person or entity eligible to provide Medicaid services that does not have a contractual agreement with the CMS Plan to provide services. In order to receive payment for covered services, non-participating providers, other than pharmacy providers, must be eligible for a Medicaid provider agreement and recognized in the Medicaid system (FMMIS) as either actively enrolled Medicaid providers or as CMS Plan registered providers.

**Normal Business Hours** – The hours between eight AM (8 a.m.) and five PM (5 p.m.) local time, Monday through Friday inclusive. State holidays are excluded.

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

Open Enrollment – The sixty (60)-day period before the end of certain enrollees' enrollment year, during which the enrollee may choose to change Managed Care Plans for the following enrollment year.

Other Provider-Preventable Condition (OPPC) – A condition occurring in any health care setting that:

- Is identified in the Florida Medicaid State Plan,
- Is reasonable preventable through the application of procedures supported by evidence-based guidelines,
- Has a negative consequence for the beneficiary,
- Is auditable, and
- Includes, at a minimum, the following:
    - Wrong surgical or other invasive procedure performed on a patient
    - Surgical or other invasive procedure performed on the wrong body part, and
    - Surgical or other invasive procedure performed on the wrong patient.

**Office of Fair Hearing (Office) —** The hearing authority within the Agency for Health Care Administration designated to conduct Medicaid fair hearings per s. 409.985(2), F.S.

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

**Overpayment** – Overpayment defined in accordance with s. 409.913, F.S., includes any amount that is not authorized to be paid by the Medicaid program whether paid as a result of inaccurate or improper cost reporting, improper claiming, unacceptable practices, fraud, abuse, or mistake.

**PACC Annual Recertification Period** – On an annual basis, by a date determined by the Agency, children participating in the PACC program must be recertified as medically eligible for the PACC program. To recertify, the child's primary care provider or specialty physician must recertify that the child remains diagnosed with a potentially life threatening condition and is at risk for a death event prior to reaching 21 years of age.

**Participating Provider** – A health care practitioner or entity authorized to do business in Florida and contracted with the CMS Plan to provide services to the CMS Plan's enrollees. The CMS Plan uses Medicaid's pharmacy provider network; therefore, no separate pharmacy contract with the CMS Plan is required.

**Participating Specialist** – A physician, licensed to practice medicine in the state of Florida, who contracts with the CMS Plan to provide specialized medical services to the CMS Plan's enrollees.

**Peer Review** – An evaluation of the professional practices of a provider by the provider's peers. The evaluator assesses the necessity, appropriateness and quality of care furnished by comparing the care to that customarily furnished by the provider's peers and to recognized health care standards.

**Penultimate Saturday** – The Saturday preceding the last Saturday of the month.

**Person (entity)** – Any natural person, corporation, partnership, association, clinic, group, or other entity, whether or not such person is enrolled in the Medicaid program or is a provider of health care. (See Florida Medicaid Provider General Handbook.)

**Pharmacy Benefits Administrator** – An entity contracted to or included in a Managed Care Plan that accepts pharmacy prescription claims for enrollees in the Managed Care Plan; assures these claims conform to coverage policy; and determines the allowed payment.

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

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

**Plan Appeal —** A formal request from an enrollee to seek a review of an adverse benefit determination made by the Managed Care Plan pursuant to 42 CFR 438.400(b).

**Plan of Care** – A plan which describes the service needs of each enrollee, showing the projected duration, desired frequency, type of provider furnishing each service, and scope of the services to be provided.

**Portable X-Ray Equipment** – X-ray equipment transported to a setting other than a hospital, clinic or office of a physician or other licensed practitioner of the healing arts.

**Post-Stabilization Care Services** – Covered services related to an emergency medical condition that are provided after an enrollee is stabilized in order to maintain, improve or resolve the enrollee's condition pursuant to 42 CFR 422.113.

**Potential Enrollee** – Pursuant to 42 CFR 438.10(a), an eligible Medicaid recipient who is subject to mandatory assignment or who may voluntarily elect to enroll in a given Managed Care Plan, but is not yet an enrollee of a specific Managed Care Plan.

**Preadmission Screening and Resident Review (PASRR)** – Pursuant to 42 CFR Part 483 and in accordance with rule 59G.1.040, F.A.C., the process of screening and determining if nursing facility services and specialized mental health services or mental retardation services are needed by nursing facility applicants and residents. A DCF Office of Mental Health contractor completes the Level II reviews for those residents identified as having a mental illness. Agency for Persons with Disabilities staff complete reviews for those residents identified with a diagnosis of mental retardation.

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

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

**Prescribed Pediatric Extended Care (PPEC)** – A non-residential health care center for children who are medically complex or technologically dependent and require continuous therapeutic intervention or skilled nursing services.

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

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

**Primary Care Provider (PCP)** – A Managed Care Plan staff or participating provider practicing as a general or family practitioner, internist, pediatrician, obstetrician, gynecologist, advanced registered nurse practitioner, physician assistant or other specialty approved by the Agency, who furnishes primary care and patient management services to an enrollee.

**Primary Dental Provider (PDP)** – A Managed Care Plan staff or subcontracted dentist practicing as a general dentist or pediatric dentist who furnishes primary dental care and patient management services to an enrollee.

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

**Program of All-Inclusive Care for Children (PACC)** – A palliative care program for children enrolled in CMS Plan with a potentially life-limiting condition. PACC is the name of the national program model and the one used by Florida Medicaid.

**Program of All-Inclusive Care for the Elderly (PACE)** – A program that is operated by an approved PACE organization and that provides comprehensive services to PACE enrollees in accordance with a PACE program agreement. PACE provides a capitated benefit for individuals age 55 and older who meet nursing home level of care as determined by CARES. It features a comprehensive service delivery system and integrated Medicare and Medicaid financing. (See ss.1894 and 1934 of the Social Security Act and 42 CFR Part 460.)

**Protected Health Information (PHI)** – For purposes of this Attachment, protected health information shall have the same meaning and effect as defined in 45 CFR 160 and 164, limited to the information created, received, maintained or transmitted by the CMS Plan from, or on behalf of, the Agency.

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

**Provider** – A person or entity eligible for a Medicaid provider agreement. CMS Plan pharmacy providers and PACC providers must have an active Medicaid provider agreement.

**Provider-Preventable Condition (PPC)** – A condition that meets the definition of a health care-acquired condition or other provider-preventable condition as defined in 42 CFR 447.26(b). PPCs include health care-acquired conditions (HCACs) and other provider-preventable conditions (OPPCs) in inpatient hospital and inpatient psychiatric hospital settings, including crisis stabilization units (CSUs).

**Provider Contract** – An agreement between the CMS Plan and a health care provider to serve CMS Plan enrollees.

**Public Event** – An event planned or sponsored by an organization to benefit and educate or assist the community with information concerning health-related matters or public awareness. At least two (2) community organizations not affiliated under common ownership must actively participate in the public event.

**Public Event Materials —** Materials used by the Managed Care Plan to educate or assist the community by providing information concerning health-related topics or topics which require public awareness. Such materials do not require Agency review or approval.

**Quality** – The degree to which a Managed Care Plan increases the likelihood of desired health outcomes of its enrollees through its structural and operational characteristics and through the provision of health services that are consistent with current professional knowledge.

**Quality Enhancements** – Certain health-related, community-based services that the CMS Plan must offer and coordinate access to its enrollees. Managed Care Plans are not reimbursed by the Agency/Medicaid for these types of services.

**Quality Improvement (QI)** – The process of monitoring that the delivery of health care services is available, accessible, timely, and medically necessary. The CMS Plan must have a quality improvement program (QI program) that includes standards of excellence. It also must have a written quality improvement plan (QI plan) that draws on its quality monitoring to improve health care outcomes for enrollees.

**Region** – The designated geographical area within which the CMS Plan is authorized by the Contract to furnish covered services to enrollees. The CMS Plan must serve all counties in the Region(s) for which it is contracted. The 67 Florida counties are divided into 11 regions pursuant s. 409.966(2), F.S. May also be referred to as "service area."

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

**Registered Provider** – A provider that is registered with FMMIS via the CMS Plan. Such providers cannot bill Medicaid through fee-for-service claims submissions. Registered providers are assigned to a Medicaid provider identification number for encounter data purposes only.

**Residential Commitment Facilities** – As applied to the Department of Juvenile Justice, refers to the out-of-home placement of adjudicated youth who are assessed and deemed by the court to be a low or moderate risk to their own safety and to the safety of the public; for use in a level 4, 6, 8, or 10 facility as a result of a delinquency disposition order. Also referred to as a residential commitment program.

**Residential Facility** – Those facilities where individuals live and that are licensed under Chapter 400 or 429, F.S., including nursing facilities, assisted living facilities and adult family care homes.

**Reward —** Related to an MMA Healthy Behaviors Program, if used in the program, something that may be offered to an enrollee after successful completion of a milestone (meaningful step towards meeting the goal) or goal attainment. A reward should be linked to positive behavior change. For example, a reward may be offered after successful completion of the series of educational classes focused on the target behavior.

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

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

**Rural Health Clinic (RHC)** – A clinic that is located in an area that has a health care provider shortage. An RHC

provides primary health care and related diagnostic services and may provide optometric, podiatry, chiropractic and behavioral health services. An RHC employs, contracts or obtains volunteer services from licensed health care practitioners to provide services.

**Sanctions** – In relation to Section VII.F: Any monetary or non-monetary penalty imposed upon a provider, entity, or person (e.g., a provider entity, or person being suspended from the Medicaid program). A monetary sanction under Rule 59G-9.070, F.A.C. may be referred to as a "fine." A sanction may also be referred to as a disincentive.

**Screen or Screening** – A brief process, using standardized health screening instruments, used to make judgments about an enrollee's health risks in order to determine if a referral for further assessment and evaluation is necessary.

**Service Authorization** – The CMS Plan's approval for services to be rendered. The process of authorization must at least include an enrollee's or a provider's request for the provision of a service.

**Service Delivery Systems** – Mechanisms that enable provision of certain health care benefits and related services for Medicaid recipients as provided in s. 409.973, F.S., which include but are not limited to the Medicaid fee-for-service program and the Medicaid Managed Medical Assistance Program.

**Service Location** – Any location at which an enrollee obtains any health care service provided by the CMS Plan under the terms of the Contract.

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

**Social Networking** – Web-based applications and services (excluding the CMS Plan's state-mandated website content, member portal, and provider portal) that provide a variety of ways for users to interact, such as email, comment posting, image sharing, invitation and instant messaging services.

**Span of Control** – Information systems and telecommunications capabilities that the CMS Plan itself operates or for which it is otherwise legally responsible according to the terms and conditions of this Contract. The span of control also includes systems and telecommunications capabilities outsourced by the CMS Plan.

**Special Supplemental Nutrition Program for Women, Infants & Children (WIC)** – Program administered by the Department of Health that provides nutritional counseling; nutritional education; breast-feeding promotion and nutritious foods to pregnant, postpartum and breast-feeding women, infants and children up to the age of five (5) who are determined to be at nutritional risk and who have a low to moderate income, an individual who is eligible for Medicaid is automatically income eligible for WIC benefits. Additionally, WIC income eligibility is automatically provided to an enrollee's family that includes a pregnant woman or infant certified eligible to receive Medicaid.

**Specialty Plan** – An MMA plan that serves Medicaid recipients who meet specified criteria based on age, medical condition, or diagnosis.

**Spoken Script** – Standardized text used by CMS Plan staff in verbal interactions with enrollees and/or potential enrollees designed to provide information and/or to respond to questions and requests. Spoken scripts also include interactive voice recognition (IVR) and on-hold messages. Marketing scripts are intended to influence such individual to enroll in the particular Managed Care Plan.

**Spoke Site** – The provider office location in Florida where an approved service is being furnished through telemedicine. For purposes of this Contract, spoke sites are limited to DOH CMS Network offices and DOH CMS-authorized academic medical centers, provider offices or hospitals.

**State** – State of Florida.

**Statewide Inpatient Psychiatric Program (SIPP)** – A twenty-four (24) hour inpatient residential treatment program funded by Medicaid that provides mental health services to children under twenty-one (21) years of age.

**Statewide Medicaid Managed Care Program** – A program authorized by the 2011 Florida Legislature through House Bill 7107, creating Part IV of Chapter 409, F.S., to establish the Florida Medicaid program as a statewide, integrated managed care program for all covered services, including long-term care services. This program is referred to as statewide Medicaid managed care (SMMC) and includes two programs: one for managed medical assistance (MMA) and one for long-term care (LTC).

**Subcontract** – An agreement entered into by the CMS Plan for the delegation of some of its functions, services or responsibilities for providing services under this Contract.

**Subcontractor** – Any person or entity with which the CMS Plan has contracted or delegated some of its functions, services or responsibilities for providing services under this Contract.

**Substitute Service (MMA only)** – In relation to behavioral health, a service covered by the Managed Care Plan as a downward substitution for a covered behavioral health service for which the Managed Care Plan receives no direct payment from the Agency. Substitute services do not apply to the CMS Plan.

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

**Surplus** – Net worth (i.e., total assets minus total liabilities).

**System Unavailability** – As measured within the CMS Plan's information systems' span of control, when a system user does not get the complete, correct full-screen response to an input command within three (3) minutes after depressing the "enter" or other function key.

**Systems** – See Information Systems.

**Telecommunication Equipment** – Electronic equipment that includes, at a minimum, audio and video equipment permitting two-way, real-time, interactive communication between the enrollee and the provider for the provision of covered services through telemedicine.

**Telemedicine** – The practice of health care delivery using telecommunication equipment by the treating provider (at the spoke site) for the provision of approved covered services by the consulting provider (at the hub site) for the purpose of evaluation, diagnosis, or treatment.

**Telepsychiatry** – The use of telemedicine to provide behavioral health medication management.

**Temporary Assistance to Needy Families (TANF)** – Public financial assistance provided to low-income families through DCF.

**Temporary Loss Period** – Period in which an enrollee loses eligibility and regains it, allowing the recipient to be re-enrolled in the Managed Care Plan in which the recipient was enrolled prior to the eligibility loss.

**Timely Files –** When an enrollee files for continuation of benefits on or before the later of the following:

1. Within ten (10) days of the CMS Plan sending the notice of adverse benefit determination; or

2. The intended effective date of the CMS Plan's proposed adverse benefit determination.

**Transportation** – An appropriate means of conveyance furnished to an enrollee to obtain Medicaid

authorized/covered services.

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

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

**Urgent Behavioral Health Care** – Those situations that require immediate attention and assessment within twenty-three (23) hours even though the enrollee is not in immediate danger to self or others and is able to cooperate in treatment.

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

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

**Violation** – A determination by the Agency that a Managed Care Plan failed to act as specified in this Contract or applicable statutes, rules or regulations governing Managed Care Plans. For the purposes of this Contract, each day that an ongoing violation continues shall be considered to be a separate violation. In addition, each instance of failing to furnish necessary and/or required medical services or items to each enrollee shall be considered to be a separate violation. As well, each day that the Managed Care Plan fails to furnish necessary and/or required medical services or items to enrollees shall be considered to be a separate violation.

**Voluntary Enrollee** – A Medicaid recipient who is not mandated to enroll in a Managed Care Plan, but chooses to do so.

**Well Care Visit** – A routine medical visit for one of the following: CHCUP visit, family planning, routine follow-up to a previously treated condition or illness, adult physical or any other routine visit for other than the treatment of an illness.