Dear Doctor,

Welcome to Simply Healthcare Plans' Statewide Medicaid Managed Care (SMMC) Managed Medical Assistance (MMA) Provider Network. We are pleased that you have decided to participate in our plan specifically for Medicaid Members.

Simply Healthcare Plans takes a positive approach toward managing Medicaid Members by working collaboratively with their Primary Care Physician to support a system of optimal utilization management and clinical quality. We believe that this system of management is the formula for our mutual success.

This Provider Manual highlights the key points related to the Medicaid MMA Program and Simply Healthcare Plans. The Provider Manual does not constitute a contract. It is intended to be a guideline to facilitate and inform you and your staff of what the Florida Medicaid MMA Program is about, what we need from you, and what you can expect from Simply Healthcare Plans. By following the guidelines outlined in this manual, we can assist you in providing caring, responsive service for your Medicaid Members.

We look forward to a lasting, productive future with you and your staff. If you need assistance, we are only a telephone call away.

Sincerely,

[Signature]

Lourdes T. Rivas, CEO/Plan President
Simply Healthcare Plans, Inc.
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Give all women of childbearing age HIV counseling and offer them HIV testing. See Chapter 381, F.S. .................................................................................................................. 58
Screen all pregnant enrollees receiving prenatal care for the Hepatitis B surface antigen (HBsAg) ......................................................................................................................... 58
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**Websites:** [simplyhealthcareplans.com/providers](http://www.simplyhealthcareplans.com/providers)  
[http://www.clearhealthalliance.com/providers.html](http://www.clearhealthalliance.com/providers.html)

<table>
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<tr>
<th>Departments</th>
<th>Contact Information</th>
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</thead>
</table>
| Provider Relations/Credentialing Department | 9250 W. Flagler Street, Suite 600  
Miami, FL 33174-3460  
- Toll-Free Phone Number: 1-877-915-0551  
- Toll-Free Fax Number: 786-441-4601 |
| Member Services Department | 9250 W. Flagler Street, Suite 600  
Miami, FL 33174-3460  
- Toll-Free Phone Number: 1-800-887-6888 (Simply)  
1-877-577-9043 (CHA)  
- Toll-Free Fax Number: 1-877-577-0114 |
| Health Services | 9250 W. Flagler Street, Suite 600  
Miami, FL 33174-3460  
- Toll-Free Phone Number: 1-877-915-0551, Opt. 2  
- Toll-Free Fax Number: 1-800-283-2117 |
| Referrals/Pre-Certification Services |  
- All medically necessary  
STAT/URGENT or Expedited Requests should be faxed to the plan with the option of following up with a call to the Providers Services line at 1-877-915-0551, Option 2 to inquire of status following the submission of an urgent request.  
- Please provide all documentation for medical necessity determination available when making a request. |
| Care Management Services | 9250 W. Flagler Street, Suite 600  
Miami, FL 33174-3460  
- Toll-Free Phone Number: 1-877-915-0551, Opt. 6  
- Toll-Free Fax Number: 786-441-4607 Attn: Case Management  
- Toll-Free Phone Number: 1-855-459-1566 (CHA)  
- Toll-Free Fax Number: 1-877-577-0117 |
| Health Services | 9250 W. Flagler Street, Suite 600  
|                | Miami, FL 33174-3460 |
|                | • Toll-Free Phone Number for HH/DME/Infusion: 1-877-915-0551, Opt. 7  
|                | • Toll-Free Authorization Request and Clinical Information Fax Number: 1-855-431-1605  
|                | • Toll-Free Authorization Request and Clinical Information Fax Number for Central FL: 1-877-577-9985 |
| Pharmacy Department | 9250 W. Flagler Street, Suite 600  
|                    | Miami, FL 33174-3460 |
|                    | • Toll-Free Phone Number: 1-877-915-0551, Opt. 5  
|                    | • Toll-Free Fax Number: 305-408-5883 |
| Claims Department | Simply Healthcare Plans, Inc.  
|                   | or Clear Health Alliance  
|                   | Attn: Claims  
|                   | PO BOX 21535  
|                   | Eagan, MN 55121  
|                   | UPS/FedEx Address:  
|                   | Simply Healthcare Plans, Inc.  
|                   | or Clear Health Alliance  
|                   | c/o Smart Data Solutions  
|                   | 960 Blue Gentian Rd  
|                   | Eagan, MN 55121  
|                   | Electronic submission (EDI) Availability: Simply Healthcare Plans Payor ID # 00199  
|                   | Emdeon: Simply Healthcare Plans Payor ID # 27094  
|                   | • Toll-Free Phone Number: 1-877-915-0551, Opt. 3 |
| Behavioral Health Services | Beacon Health Options  
|                           | 10200 Sunset Drive  
|                           | Miami, FL 33173  
|                           | • Toll-Free Telephone Number: 1-800-221-5487  
|                           | • Toll-Free Fax Number: 1-800-370-1116  
|                           | Website: [https://www.beaconhealthoptions.com](https://www.beaconhealthoptions.com) |
| Durable Medical Equipment (DME) | 9250 W. Flagler Street, Suite 600  
|                          | Miami, FL 33174-3460 |
| Home Health Care (HHC) | Infusion |
|                     | • Toll-Free Telephone Number: 1-877-915-0551, Opt. 2  
<p>|                     | • Toll-Free Fax Number: 1-800-283-2117 |</p>
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<tr>
<th>Dental Services</th>
<th>DentaQuest</th>
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<tr>
<td>Information for Dental Providers</td>
<td>• Toll-Free Telephone: 1-877-468-5581</td>
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<tr>
<td>• Toll-Free Provider Phone Number:</td>
<td>▪ Authorizations &amp; Referrals (Standard) 1-888-313-2883 or 1-262-241-7150</td>
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<td>▪ Authorizations &amp; Referrals (Emergency) 1-262-387-3736</td>
<td>▪ Claims: 1-262-834-3452</td>
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<tr>
<td>• Provider Portal Information:</td>
<td>▪ Credentialing: 1-262-241-4077</td>
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<tr>
<td><a href="http://www.dentaquest.com/state-">http://www.dentaquest.com/state-</a></td>
<td>• Website: <a href="http://www.dentaquest.com">www.dentaquest.com</a></td>
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<td>plans/regions/florida/fl-dentist-</td>
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<tr>
<td>Hearing Services</td>
<td>HearUSA</td>
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<tr>
<td>• Toll-Free Telephone Number: 1-800-731-3277</td>
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<td>• Website: <a href="http://www.hearusa.com">www.hearusa.com</a></td>
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<td>Chiropractic Services</td>
<td>Chiro Alliance</td>
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<td>• Toll-Free Telephone Number: 1-727-319-6199</td>
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<tr>
<td>Laboratory Services</td>
<td>Quest Diagnostics</td>
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<tr>
<td>• Toll-Free Telephone Number: 1-866-697-8378</td>
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<td>• Website: <a href="http://www.questdiagnostics.com">http://www.questdiagnostics.com</a></td>
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<td>Ophthalmology Services</td>
<td>Premier Eye Care</td>
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<td>• PCP’s to call for Authorizations</td>
<td>• Toll-Free Telephone Number: 1-800-738-1889</td>
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<tr>
<td>• Local Telephone Number: 561-455-9002</td>
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<tr>
<td>• Toll-Free Fax Number: 1-800-523-3788</td>
<td></td>
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<tr>
<td>• Website: <a href="http://www.premiereyecare.net">www.premiereyecare.net</a></td>
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<tr>
<td>Optometry Services</td>
<td>Florida Eye Care Corporation</td>
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<td>• Toll-Free Telephone Number: 1-855-373-7627</td>
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<tr>
<td>• Local Telephone Number: 786-441-8466</td>
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<tr>
<td>• Fax Number: 305-402-0890</td>
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<tr>
<td>• Website: <a href="http://www.myicarehealth.com">www.myicarehealth.com</a></td>
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<tr>
<td>Grievance &amp; Appeals Department</td>
<td>9250 W. Flagler Street, Suite 600 Miami, FL 33174-3460</td>
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<tr>
<td></td>
<td>• Toll-Free Telephone Number: 1-855-915-0551</td>
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<td></td>
<td>• Toll-Free Fax Number: 305-408-5880</td>
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<tr>
<td>Compliance Officer</td>
<td>9250 W. Flagler Street, Suite 600 Miami, FL 33174-3460</td>
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<td></td>
<td>• Telephone Number: 305-921-2653</td>
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<td></td>
<td>• Toll-Free Fax Number: 786-441-8218</td>
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<td>Special Investigations Unit</td>
<td>9250 W. Flagler Street, Suite 600 Miami, FL 33174-3460</td>
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<td></td>
<td>• Toll-Free Telephone Number: 1-877-253-9251</td>
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<td></td>
<td>• Toll-Free Fax Number: 786-441-4625</td>
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<tr>
<td>Transportation (Non-Emergent)</td>
<td>Access2Care</td>
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<tr>
<td></td>
<td>• SHP Toll-Free Telephone Number: 1-866-201-9969</td>
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<tr>
<td></td>
<td>• CHA Toll-Free Telephone Number: 1-866-201-9971</td>
</tr>
<tr>
<td></td>
<td>• Website: <a href="http://www.access2care.net/">http://www.access2care.net/</a></td>
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Section 2. Medicaid MMA Program

Overview and Goals
The Florida Legislature created a new program called Statewide Medicaid Managed Care (SMMC). As a result, the Agency for Healthcare Administration (AHCA) has changed how some individuals receive healthcare from the Florida Medicaid program.

The goals of Florida Managed Medical Assistance (MMA) program are to provide:
- Coordinated healthcare across different healthcare settings.
- A choice of the best managed care plans to meet recipients’ needs.
- The ability for healthcare plans to offer different, or more, services.
- The opportunity for recipients to become more involved in their healthcare.
- There are two (2) components that make up the Statewide Medicaid Managed Care program:
  - Florida Long-Term Care Managed Care Program
  - Florida Managed Medical Assistance Program

The changes are “not” due to National Healthcare Reform or the Affordable Care Act. Medicaid recipients who qualify and become enrolled in Simply Healthcare Plans d/b/a Clear Health Alliance MMA program will receive all healthcare services other than long-term care through our plan.

Simply Healthcare Plans (SHP) shall disseminate bulletins as needed to incorporate any needed changes to the Provider Manual.

Cultural Competency
SHP will assure that Plan employees, network providers and delegated contractors and subcontractors are culturally diverse and competent to interact with our culturally diverse members. As required, the Cultural Competency Plan (CCP) describes how providers, SHP employees, and systems will effectively provide services to people of all cultures, races, ethnic backgrounds, and religions in a manner that recognizes values, affirms and respects the worth of the individual enrollees and protects and preserves the dignity of each. The National Standards on Culturally and Linguistically Appropriate Services (CLAS) is followed to educate our employees, enrollees, and providers on the importance of communication in a preferred language and respect for cultural health beliefs.

The CCP implicitly commits to compliance with all contractual requirements of the MMA contract. SHP will complete an annual evaluation of the effectiveness of the previous year’s CCP and will develop interventions for elements of the CCP that do not perform to expectations as specified within the CCP or expressed by the Agency for Healthcare Administration (AHCA).

Five (5) essential elements contribute to a system or organization’s ability to become more culturally competent. These include:
1) Valuing diversity
2) Having the capacity for cultural self-assessment
3) Being conscious of the dynamics inherent when cultures interact
4) Having institutionalized cultural knowledge
5) Having developed adaptations to service delivery reflecting an understanding of cultural diversity

These five elements should be manifested at every level of a culturally competent organization including policy- making, administration, and practice. Further these elements should be reflected in the attitudes, structures, policies, and services of the organization. (Reference: Cross, T., Bazron, B., Dennis, K., & Isaacs,

The Plan provides educational and informational materials regarding all available services in English and other languages. Translation and interpreter services are available through the Plan’s Member Services department for all enrollees who speak another language. Understanding and addressing poor health literacy among some Plan members has been identified as an important element in assuring organization-wide cultural competence. Communication challenges between members and providers may result in a provider’s inability to solicit a patient’s impression or input about their illness, making effective care more difficult and increasing patient frustration. The provider may also be uncertain about the patient’s compliance to treatment. Educational material will be provided to all network providers and enrollees. Plan providers are prohibited from patient discrimination based on race, color, ethnicity, national origin, ancestry, religion, sex, marital status, sexual orientation, age, perception, and source of payment or health status. The Plan will provide community based medical linkage that supports racial and ethnic minorities and the disabled to ensure community resources are accessible to enrollees with special needs.

The CCP is available online on the provider website portal. The complete CCP is also posted on the providers’ website. Network providers may request a hard copy of the SHP Cultural Competency Plan at no cost by calling SHP’s Provider Relations Department.

The Cultural Competency Plan is found on the Plan’s website:

**Sensitivity Training**
All providers participating in the Clear Health Alliance plan will be offered and encouraged to attend sensitivity training on how to work effectively with people living with HIV/AIDS.

**Websites**
Both Simply Healthcare Plans and Clear Health Alliance maintain websites which allow providers to access rich sources of information. These websites may be found at:

Simply Healthcare:  http://www.simplyhealthcareplans.com/providers
Clear Health Alliance:  http://www.clearhealthalliance.com/providers.html

On the homepage of either site, Providers can access the “Providers” page and download the most current versions of the following:

- Provider Manual
- Provider Forms:
  - Claims Review Form
  - Referral and Authorization Form
  - Quick Authorization Form
  - Beacon Health Options Case Management Referral Form
  - Pregnancy Notification Form
  - Case Management Referral Form
  - State of Florida Acknowledgment of Receipt of Hysterectomy Information
  - State of Florida Exception to Hysterectomy Acknowledgement Requirement Form
  - Newborn/Unborn Activation Form- AHCA Form 5240-006
  - Abortion Certification Form
  - Incident Report Form
- Sterilization Consent Form - English
- Sterilization Consent Form - Spanish
- Florida Department of Health, Practitioner Disease Report Form
- HIPAA Breach Report Form
Section 3. Enrollment, Eligibility and Disenrollment

Clear Health Alliance (CHA) is an HIV/AIDS specialty plan, offered by Simply Healthcare Plans. CHA can only accept Medicaid recipients living with HIV/AIDS.

The eligibility information in the following sections pertains to Medicaid only. Individuals may meet requirements for receiving Medicaid and for enrolling in Simply Healthcare, without meeting the requirements for enrollment in Clear Health Alliance.

Member Eligibility and Enrollment

The following Medicaid recipients are required to enroll:
- Temporary Assistance to Needy Families (TANF)
- SSI (Aged, Blind and Disabled)
- Hospice
- Low Income Families and Children
- Institutional Care
- Medicaid (MEDS) – Sixth Omnibus Budget Reconciliation Act (SOBRA) for children born after 09/30/83 (age 18 to 19)
- MEDS AD (SOBRA) for aged and disabled
- Protected Medicaid (aged and disabled)
- Full Benefit Dual Eligible (Medicare and Medicaid FFS)
- Full Benefit Dual Eligible – Part C – Medicare Advantage Plans Only; and
- The Florida Assertive Community Treatment Team (FACT Team)

The following Medicaid recipients are not required but may choose to enroll:
- Certain recipients may voluntarily enroll in a Managed Care Plan to receive services. These recipients are not subject to mandatory open enrollment periods.
  - Voluntary recipients for MMA and Comprehensive LTC managed care plans are specified in the MMA Exhibit.
  - Voluntary recipients for LTC and Comprehensive LTC managed care plans are specified in the LTC Exhibit.

The Managed Care Plan may 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 following Medicaid recipients are not allowed to enroll:
- Presumptively eligible pregnant women
- Family planning waiver
- Women enrolled through the Breast and Cervical Cancer Program
- Emergency shelter/Department of Juvenile Justive residential
- Emergency assistance for aliens
- Qualified Individual (QI)
- Qualified Medicare beneficiary (QMB)
- Specified low-income beneficiaries (SLMB); and
- Working disabled
- Recipients eligible for the Medically Needy program
- Full-benefit Dual Eligibles enrolled in Part C – Medicare Advantage Dual Special Needs Plans
- Full-Benefit Dual Eligibles enrolled in Part C – Medicare Advantage Plans that are fully liable for all Medicaid
services covered under this Contract.

- Recipients in the Health Insurance Premium Payment (HIPP) program

How will recipients know if they need to select a managed care plan?
Recipients will be sent a letter that explains whether or not they are required to enroll in the Florida Managed Medical Assistance Program and, if they are required to enroll, how to choose a plan.

How will recipients know what plans are available?
Information on participating plans and service providers will be available before the Florida Managed Medical Assistance Program begins to help eligible recipients choose the plan that best fits their needs.

How will recipients know if they need to select a managed care plan?
Recipients will be sent a letter that explains whether or not they are required to enroll in the Florida Managed Medical Assistance Program and, if they are required to enroll, how to choose a plan.

How will recipients know what plans are available?
Information on participating plans and service providers will be available before the Florida Managed Medical Assistance Program begins to help eligible recipients choose the plan that best fits their needs.

How will enrollment occur for medicaid recipients who are required to enroll in the Florida managed medical assistance program?
Eligible Medicaid recipients will receive a letter with enrollment information, including information on how to enroll. Eligible recipients who must enroll will have thirty (30) days to choose a managed care plan from the plans available in their region. Enrollees will have ninety (90) days after enrollment to choose a different plan.

After ninety (90) days, enrollees will remain in their plans for the remainder of the twelve (12) month period unless they meet certain criteria.

Newborns will be automatically enrolled in their mother’s plan at the time of birth. However, their mother may choose another plan for the baby within ninety (90) days of enrollment.

Recipients are encouraged to choose the managed care plan that best meets their needs; however, if a recipient who is required to enroll does not choose a plan within thirty (30) days, AHCA will automatically enroll the recipient into a managed care plan. Before automatically enrolling the recipient into a managed care plan, AHCA will consider:

- Whether the plan is able to meet the recipient’s needs; and
- Whether the recipient has previously received services from one of the plan’s primary care providers.

**Effective Date of Enrollment**
For complete information on effective dates and process of the State to enroll Medicaid members you may access the AHCA website at [http://ahca.myflorida.com/](http://ahca.myflorida.com/). Following are key points you may want to know.

With the exception of newborns, Medicaid Recipients who are eligible for enrollment with Simply Healthcare Plans will be effective as follows:

- Members will be effective on the date determined by AHCA or its Agent,
- AHCA or its Agent will send notification to members identifying the chosen or auto-assigned health plan. If the member has not chosen a PCP, the confirmation notification will advise the member that the health plan will assign a PCP.
- Mandatory Members, based on continued eligibility, will have a Lock-In period of twelve (12) consecutive months. After an initial ninety (90) day change period, Mandatory Members will only be able to disenroll from the health plan for cause.
AHCA or its Agent will notify members prior to the Lock-In period ending date that they have the opportunity to change health plans. For those members who do not make a choice they will be deemed as having decided to remain with the current health plan.

In the event the member has a temporary loss of eligibility, defined as less than sixty (60) calendar days, he/she will automatically be re-enrolled into the health plan where he/she was most recently enrolled.

**Newborn Enrollment**

Upon notification that a member has given birth to a newborn, the Plan shall notify the Department of Children and Families (DCF) and follow the newborn enrollment processes in accordance with the Plan’s Medicaid Contract with the Agency.

- PCP’s are required to notify us within two (2) working days of the first prenatal visit and/or positive pregnancy test by completing the Pregnancy Notification Form (Refer to the Forms section at the end of the Handbook). Once this form is received, we will notify the designated DCF Customer Support of a member’s pregnancy.
- Hospitals are required to notify the Plan when a pregnant member presents to the hospital for delivery. This notification is to be done as per the approved Plan process. Once notified, we will research if the newborn has an existing record on FMMIS that is waiting activation. Upon notification of a delivery, we will notify the Florida State Medicaid of the delivery.
- The Plan will be responsible for payment of covered services for each enrolled newborn for up to the first (1st) three (3) months of life, provided the newborn was enrolled through the Unborn Activation Process. If it is determined that the Plan was not notified of a member’s pregnancy and the first step of the Unborn Activation Process was not completed before the member presented to the hospital for delivery, the newborn will not be a member of the Plan upon birth. As a result, we will not be responsible for payment of any services rendered to the newborn until such time that the newborn becomes a member of the Plan. If the Unborn Activation Process was not followed, we will not be responsible of covered services provided by the hospital, the pregnant member’s attending physician and the newborn’s attending or consulting physician. Providers will be required to file claims for services provided to the newborn through the Medicaid Fee-for-Service process.

**Inpatient at Time of Enrollment**

The MMA Plan that the enrollee is enrolled in at the time of admission has responsibility for covering the Hospital facility IP stay until the date of discharge. Under DRG Payment there is no pro-rating of facility payment. The professional (non-facility) fees for services rendered while in the hospital, for specific DOS is dependent on Plan member is enrolled in that DOS.

**Member Eligibility**

Eligibility for Medicaid is determined on a monthly basis by The Department of Children and Families (DCF), Office of Economic Self-Sufficiency. The Plan’s provider contracts place the responsibility for eligibility verification on the provider rendering those services. A member’s eligibility status can change at any time.

Providers may confirm current eligibility through the following processes:

- Access the our website at [http://www.simplyhealthcareplans.com/providers](http://www.simplyhealthcareplans.com/providers) (contact your Provider Relations representative for further information)
- Contact our Provider Services Department at 1-877-915-0551.

Verification is always based on the data available at the time of the request, and since subsequent changes in eligibility may not yet be available, verification of eligibility is never a guarantee of coverage or payment. See your Provider Agreement for additional details.

Providers should consider requesting and copying a member’s identification card, along with additional proof of identification, such as a photo ID, and file them in the patient’s medical record.
Simply Healthcare Plans Member Identification Card
Member identification cards are intended to identify plan members and facilitate their interactions with physicians and other healthcare providers. Information found on the member identification card may include the member’s name, identification number, Primary Care Physician’s name and telephone number, health plan contact information and claims filing address. Possession of the member identification card does not guarantee eligibility or coverage. The physician or provider is responsible for verification of the current eligibility of the cardholder.

It is very important that you verify eligibility at least once a month, because patients may keep their cards during months when they are not eligible for Medicaid, so please check monthly for status change via Member Services.

SAMPLE OF SHP MEMBER ID CARD

Clear Health Alliance Member (CHA) Identification Card
Member identification cards are intended to identify plan members and facilitate their interactions with physicians and other healthcare providers. Information found on the member identification card may include the member’s name, identification number, Primary Care Physician’s name and telephone number, health plan contact information and claims filing address. Possession of the member identification card does not guarantee eligibility or coverage. The physician or provider is responsible for verification of the current eligibility of the cardholder.

It is very important that you verify eligibility at least once a month, because patients may keep their cards during months when they are not eligible for Medicaid, so please check monthly for status change via Member Services.

CHA Member Identification Cards carry a non-descriptive logo, which is also used for all Clear Health materials. Please refer to the sample below:

SAMPLE OF CHA MEMBER ID CARD

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SAMPLE OF CHA MEMBER ID CARD
Section 4. Provider Responsibilities

Overview
This section of the Provider Handbook addresses the responsibilities of Simply Healthcare Plans participating physicians, which will include standards that address non-discrimination, access to care, Primary Care Physician (PCP) offices Plan services, PCP responsibilities, member confidentiality, medical record documentation, newborn notification, member outreach information, and others.

Non-Discrimination
In applying all of the expected standards identified in this section, participating providers agree to adhere to non-discrimination against any member and that all members will receive fair and consistent treatment regardless of:

- Race, Ethnicity, National origin, Religion or Genetic information
- Sex or Sexual orientation
- Mental or physical disabilities
- Age
- Source of payment

Access to Care
The Plan is committed to ensure that members are provided timely access to care. To ensure that all healthcare services are provided in a consistent, timely manner Primary Care Physician (PCP) or designated covering healthcare provider must be available twenty four (24) hours a day/seven days a week/365 days a year, for members requiring emergency services. This access availability may be provided by telephone. PCP responsibility includes any member that is assigned as a patient to him/her. Access standards are noted below,

<table>
<thead>
<tr>
<th>Appointment Access to Care Standards</th>
<th>Care Type</th>
<th>Access Wait Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Well Care Visit</td>
<td>Within 30 days</td>
<td></td>
</tr>
<tr>
<td>Routine Sick Care</td>
<td>Within 7 days</td>
<td></td>
</tr>
<tr>
<td>Urgent Care</td>
<td>Within 1 day</td>
<td></td>
</tr>
<tr>
<td>Emergency Care</td>
<td>Available by telephone 24/7/365</td>
<td></td>
</tr>
<tr>
<td>Office Waiting Time</td>
<td>In-office wait time for scheduled appointments should not routinely exceed 45 minutes, including time in the waiting room and examining room</td>
<td></td>
</tr>
</tbody>
</table>

The Plan routinely monitors providers’ adherence to access to-care standards and appointment wait times. Providers not meeting one or more of these standards will receive an in-service and will be reaudited to ensure compliance. Continued noncompliance will result in the request for a corrective action plan.

Support from the Plan to PCP Offices
We will provide support to our participating PCP offices in the form of services including, but not limited to:

- Support from Provider Relations, Member Services, Utilization Management, Claims, Community Outreach, Care Management, Disease Management, Chronic Care Improvement Program
- Information and assistance with care managing your members, including discharge planning
- Access to available healthcare resources through the Plan’s participating network of providers, hospitals, and ancillary services

Primary Care Physician (PCP) Responsibilities
The following is a summary of responsibilities that are required of PCP’s providing services to Plan members:
• Ensure 24/7/365 availability as outlined in the Access to Care section noted above.
• Render services and administer benefits in accordance to Medicaid guidelines.
• Identify, coordinate, and supervise the delivery and transition of care needs/services to each member.
• Ensure newly enrolled members receive an initial office visit and health assessment within ninety (90) days of enrollment in the Plan and assignment to the PCP.
• Maintain a ratio of members to Full-Time Equivalent (FTE) healthcare providers, as follows:
  • For Simply Healthcare: One (1) FTE physician per 1,500 Plan members.
  • For Clear Health Alliance: One (1) FTE physician per 500 Plan members (if an Infectious Disease Specialist is acting as a PCP, this ratio will apply).
  • One (1) Advanced Registered Nurse Practitioner (ARNP) or Physician Assistant (PA) for every 750 Plan members above 1,500 members.
• Ensure members utilize Plan participating network providers. If unable to locate a participating provider for services required, contact Utilization Management for assistance.
• Provide preventative healthcare screening services, as per nationally recognized guidelines/protocols – see links in Section 8 of this Handbook.
• Have a procedure for non-compliant members: documentation and verbal or written notification to the member.
• Provide regular appointments for adult healthcare, assessments and treatment, as indicated, or upon request for those members twenty one (21) years of age and older.
• Perform physical examinations within seventy two (72) hours or immediately if required for children taken into protective custody, emergency shelter or into the foster care program by the Department of Children and Families (DCF).
• Provide Child Health Check-Ups (CHCUP) as per the approved guidelines (Refer to CHCUP section below).
• Provide immunizations as per the approved guidelines.
• Participate in the Vaccines for Children (VFC) program for members eighteen (18) years of age and younger (Refer to Children’s Vaccines section below).
• Providers will administer only VFC-supplied vaccinations for all members eighteen (18) years of age and younger that are supplied free to the provider through the VFC Program.
• Provide immunization information to the Department of Children and Families (DCF) upon receipt of the member’s written permission and DCF’s request, for members requesting temporary cash assistance from DCF.
• Ensure members are aware of the availability of medical non-emergency transportation and/or public transportation, where available, by contacting Member Services for assistance.
• Ensure translation services are available for those members requiring translation needs, including members requiring services for the deaf, by contacting Member Services for assistance.
• Ensure members are aware of available community services/resources that are available to the member by contacting Member Services or a Care Manager.
• Provide access to the Plan or its designee to examine thoroughly the Primary Care offices, books, records, and operations of any related organization or entity.
• Provide access to the Plan or its designee to conduct medical record audits, as per regulatory requirements or indicated.
• Submit an encounter for each visit where the provider sees the member or the member receives a HEDIS® (Healthcare Effectiveness Data and Information Set) service.
• Submit encounters on a CMS-1500 Form or UB04.
Adult Health Screening
An adult health screening should be performed at least once a year to assess the health status of all Plan members twenty one (21) years of age or older. The adult member should receive an appropriate assessment and interventions, as indicated or upon request.

The screening should also include: BMI, screening for domestic violence, smoking and substance abuse. Members with these problems should be referred to the pertinent programs, described later in the Handbook. You may also call the UM Department for more information.

CDC Guidelines for HIV Screening and Treatment Administration
The below excerpt is from the CDC and provider guidelines on the treatment and administration of HIV/AIDS members (http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5514a1.htm).

Recommendations for Adults and Adolescents
CDC recommends that diagnostic HIV testing and opt-out HIV screening be a part of routine clinical care in all healthcare settings while also preserving the patient's option to decline HIV testing and ensuring a provider-patient relationship conducive to optimal clinical and preventive care. The recommendations are intended for providers in all healthcare settings, including hospital EDs, urgent-care clinics, inpatient services, STD clinics or other venues offering clinical STD services, tuberculosis (TB) clinics, substance abuse treatment clinics, other public health clinics, community clinics, correctional health-care facilities, and primary care settings. The guidelines address HIV testing in healthcare settings only; they do not modify existing guidelines concerning HIV counseling, testing, and referral for persons at high risk for HIV who seek or receive HIV testing in nonclinical settings (e.g., community-based organizations, outreach settings, or mobile vans).

Screening for HIV Infection
In all healthcare settings, screening for HIV infection should be performed routinely for all patients aged 13-64 years. Healthcare providers should initiate screening unless prevalence of undiagnosed HIV infection in their patients has been documented to be <0.1%. In the absence of existing data for HIV prevalence, healthcare providers should initiate voluntary HIV screening until they establish that the diagnostic yield is <1 per 1,000 patients screened, at which point such screening is no longer warranted.

All patients initiating treatment for TB should be screened routinely for HIV infection.

All patients seeking treatment for STDs, including all patients attending STD clinics, should be screened routinely for HIV during each visit for a new complaint, regardless of whether the patient is known or suspected to have specific behavior risks for HIV infection.

Repeat Screening
Healthcare providers should subsequently test all persons likely to be at high risk for HIV at least annually. Persons likely to be at high risk include injection-drug users and their sex partners, persons who exchange sex for money or drugs, sex partners of HIV infected persons, and MSM or heterosexual persons who themselves or whose sex partners have had more than one sex partner since their most recent HIV test.

Healthcare providers should encourage patients and their prospective sex partners to be tested before initiating a new sexual relationship.

Repeat screening of persons not likely to be at high risk for HIV should be performed on the basis of clinical judgment.

Unless recent HIV test results are immediately available, any person whose blood or body fluid is the source of an occupational exposure for a healthcare provider should be informed of the incident and tested for HIV.
infection at the time the exposure occurs.

**Consent and Pretest Information**
Screening should be voluntary and undertaken only with the patient's knowledge and understanding that HIV testing is planned.

Patients should be informed orally or in writing that HIV testing will be performed unless they decline (opt-out screening). Oral or written information should include an explanation of HIV infection and the meanings of positive and negative test results, and the patient should be offered an opportunity to ask questions and to decline testing. With such notification, consent for HIV screening should be incorporated into the patient's general informed consent for medical care on the same basis as are other screening or diagnostic tests; a separate consent form for HIV testing is not recommended.

Easily understood informational materials should be made available in the languages of the commonly encountered populations within the service area. The competence of interpreters and bilingual staff to provide language assistance to patients with limited English proficiency must be ensured.

If a patient declines an HIV test, this decision should be documented in the medical record.

**Diagnostic Testing for HIV Infection**

All patients with signs or symptoms consistent with HIV infection or an opportunistic illness characteristic of AIDS should be tested for HIV.

Clinicians should maintain a high level of suspicion for acute HIV infection in all patients who have a compatible clinical syndrome and who report recent high-risk behavior. When acute retroviral syndrome is a possibility, a plasma RNA test should be used in conjunction with an HIV antibody test to diagnose acute HIV infection.

Patients or persons responsible for the patient's care should be notified orally that testing is planned, advised of the indication for testing and the implications of positive and negative test results, and offered an opportunity to ask questions and to decline testing. With such notification, the patient's general consent for medical care is considered sufficient for diagnostic HIV testing.

Similarities and differences between current and previous recommendations for adults and adolescents.

Aspects of these recommendations that remain unchanged from previous recommendations are as follows:

- HIV testing must be voluntary and free from coercion.
- Patients must not be tested without their knowledge.
- HIV testing is recommended and should be routine for persons attending STD clinics and those seeking treatment for STDs in other clinical settings.
- Access to clinical care, prevention counseling, and support services is essential for persons with positive HIV test results.

Aspects of these recommendations that differ from previous recommendations are as follows:

- Screening after notifying the patient that an HIV test will be performed unless the patient declines (opt-out screening) is recommended in all healthcare settings. Specific signed consent for HIV testing should not be required. General informed consent for medical care should be considered sufficient to encompass informed consent for HIV testing.
- Persons at high risk for HIV should be screened for HIV at least annually.
- HIV test results should be provided in the same manner as results of other diagnostic or screening tests.
- Prevention counseling should not be required as a part of HIV screening programs in healthcare settings.
- Prevention counseling is strongly encouraged for persons at high risk for HIV in settings in which risk
behaviors are assessed routinely (e.g., STD clinics) but should not have to be linked to HIV testing.

- HIV diagnostic testing or screening to detect HIV infection earlier should be considered distinct from HIV counseling and testing conducted primarily as a prevention intervention for uninfected persons at high risk.

**Recommendations for Pregnant Women**

These guidelines reiterate the recommendation for universal HIV screening early in pregnancy but advise simplifying the screening process to maximize opportunities for women to learn their HIV status during pregnancy, preserving the woman's option to decline HIV testing, and ensuring a provider-patient relationship conducive to optimal clinical and preventive care. All women should receive HIV screening consistent with the recommendations for adults and adolescents. HIV screening should be a routine component of preconception care, maximizing opportunities for all women to know their HIV status before conception. In addition, screening early in pregnancy enables HIV infected women and their infants to benefit from appropriate and timely interventions (e.g., antiretroviral medications [43], scheduled cesarean delivery [44], and avoidance of breastfeeding* [46]). These recommendations are intended for clinicians who provide care to pregnant women and newborns and for health policy makers who have responsibility for these populations.

**HIV Screening for Pregnant Women and Their Infants**

**Universal Opt-Out Screening**

All pregnant women in the United States should be screened for HIV infection.

Screening should occur after a woman is notified that HIV screening is recommended for all pregnant patients and that she will receive an HIV test as part of the routine panel of prenatal tests unless she declines (opt-out screening).

HIV testing must be voluntary and free from coercion. No woman should be tested without her knowledge.

Pregnant women should receive oral or written information that includes an explanation of HIV infection, a description of interventions that can reduce HIV transmission from mother to infant, and the meanings of positive and negative test results and should be offered an opportunity to ask questions and to decline testing.

No additional process or written documentation of informed consent beyond what is required for other routine prenatal tests should be required for HIV testing.

If a patient declines an HIV test, this decision should be documented in the medical record. Addressing reasons for declining testing providers should discuss and address reasons for declining an HIV test (e.g., lack of perceived risk; fear of the disease; and concerns regarding partner violence or potential stigma or discrimination).

Women who decline an HIV test because they have had a previous negative test result should be informed of the importance of retesting during each pregnancy.

Logistical reasons for not testing (e.g., scheduling) should be resolved.

Certain women who initially decline an HIV test might accept at a later date, especially if their concerns are discussed. Certain women will continue to decline testing, and their decisions should be respected and documented in the medical record.

**Timing of HIV Testing**

To promote informed and timely therapeutic decisions, healthcare providers should test women for HIV as early as possible during each pregnancy. Women who decline the test early in prenatal care should be encouraged to be tested at a subsequent visit.
A second HIV test during the third trimester, preferably <36 weeks of gestation, is cost-effective even in areas of low HIV prevalence and may be considered for all pregnant women. A second HIV test during the third trimester is recommended for women who meet one or more of the following criteria: women who receive healthcare in jurisdictions with elevated incidence of HIV or AIDS among women aged 15-45 years. In 2004, these jurisdictions included Alabama, Connecticut, Delaware, the District of Columbia, Florida, Georgia, Illinois, Louisiana, Maryland, Massachusetts, Mississippi, Nevada, New Jersey, New York, North Carolina, Pennsylvania, Puerto Rico, Rhode Island, South Carolina, Tennessee, Texas, and Virginia.

- Women who receive healthcare in facilities in which prenatal screening identifies at least one
- HIV infected pregnant woman per 1,000 women screened.
- Women who are known to be at high risk for acquiring HIV (e.g., injection-drug users and their sex partners, women who exchange sex for money or drugs, women who are sex partners of HIV infected persons, and women who have had a new or more than one sex partner during this pregnancy).
- Women who have signs or symptoms consistent with acute HIV infection. When acute retroviral syndrome is a possibility, a plasma RNA test should be used in conjunction with an HIV antibody test to diagnose acute HIV infection.

**Rapid Testing During Labor**

Any woman with undocumented HIV status at the time of labor should be screened with a rapid HIV test unless she declines (opt-out screening).

Reasons for declining a rapid test should be explored (see Addressing Reasons for Declining Testing). Immediate initiation of appropriate antiretroviral prophylaxis should be recommended to women on the basis of a reactive rapid test result without waiting for the result of a confirmatory test.

**Postpartum/Newborn Testing**

When a woman's HIV status is still unknown at the time of delivery, she should be screened immediately postpartum with a rapid HIV test unless she declines (opt-out screening).

When the mother's HIV status is unknown postpartum, rapid testing of the newborn as soon as possible after birth is recommended so antiretroviral prophylaxis can be offered to HIV exposed infants. Women should be informed that identifying HIV antibodies in the newborn indicates that the mother is infected.

For infants whose HIV exposure status is unknown and who are in foster care, the person legally authorized to provide consent should be informed that rapid HIV testing is recommended for infants whose biologic mothers have not been tested.

The benefits of neonatal antiretroviral prophylaxis are best realized when it is initiated <12 hours after birth.

**Confirmatory Testing**

Whenever possible, uncertainties regarding laboratory test results indicating HIV infection status should be resolved before final decisions are made regarding reproductive options, antiretroviral therapy, cesarean delivery, or other interventions.

If the confirmatory test result is not available before delivery, immediate initiation of appropriate antiretroviral prophylaxis (42) should be recommended to any pregnant patient whose HIV screening test result is reactive to reduce the risk for perinatal transmission.

Similarities and Differences between Current and Previous Recommendations for Pregnant Women and Their Infants Aspects of these recommendations that remain unchanged from previous recommendations are as
follows:

- Universal HIV testing with notification should be performed for all pregnant women as early as possible during pregnancy.
- HIV screening should be repeated in the third trimester of pregnancy for women known to be at high risk for HIV.
- Providers should explore and address reasons for declining HIV testing.
- Pregnant women should receive appropriate health education, including information regarding HIV and its transmission, as a routine part of prenatal care.
- Access to clinical care, prevention counseling, and support services is essential for women with positive HIV test results.
- Aspects of these recommendations that differ from previous recommendations are as follows:
  - HIV screening should be included in the routine panel of prenatal screening tests for all pregnant women. Patients should be informed that HIV screening is recommended for all pregnant women and that it will be performed unless they decline (opt-out screening).
  - Repeat HIV testing in the third trimester is recommended for all women in jurisdictions with elevated HIV or AIDS incidence and for women receiving healthcare in facilities with at least one diagnosed HIV case per 1,000 pregnant women per year.
  - Rapid HIV testing should be performed for all women in labor who do not have documentation of results from an HIV test during pregnancy. Patients should be informed that HIV testing is recommended for all pregnant women and will be performed unless they decline (opt-out screening). Immediate initiation of appropriate antiretroviral prophylaxis should be recommended on the basis of a reactive rapid HIV test result, without awaiting the result of confirmatory testing.

Additional Considerations for HIV Screening
The central goal of HIV screening in healthcare settings is to maximize the number of persons who are aware of their HIV infection and receive care and prevention services. Definitive mechanisms should be established to inform patients of their test results. HIV negative test results may be conveyed without direct personal contact between the patient and the healthcare provider. Persons known to be at high risk for HIV infection also should be advised of the need for periodic retesting and should be offered prevention counseling or referred for prevention counseling. HIV positive test results should be communicated confidentially through personal contact by a clinician, nurse, mid-level practitioner, counselor, or other skilled staff. Because of the risk of stigma and discrimination, family or friends should not be used as interpreters to disclose HIV positive test results to patients with limited English proficiency. Active efforts are essential to ensure that HIV infected patients receive their positive test results and linkage to clinical care, counseling, support, and prevention services. If the necessary expertise is not available in the healthcare venue in which screening is performed, arrangements should be made to obtain necessary services from another clinical provider, local health department, or community-based organization. Healthcare providers should be aware that the Privacy Rule under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) prohibits use or disclosure of a patient's health information, including HIV status, without the patient's permission.

Rapid HIV tests
Because of the time that elapses before results of conventional HIV tests are available, providing patients with their test results can be resource intensive and challenging for screening programs, especially in episodic care settings (e.g., EDs, urgent-care clinics, and STD clinics) in which continuing relationships with patients typically do not exist. The use of rapid HIV tests can substantially decrease the number of persons who fail to learn their test results and reduce the resources expended to locate persons identified as HIV infected. Positive rapid HIV test results are preliminary and must be confirmed before the diagnosis of HIV infection is established.

Participants in HIV vaccine trials
Recipients of preventive HIV vaccines might have vaccine-induced antibodies that are detectable by HIV antibody tests. Persons whose test results are HIV positive and who are identified as vaccine trial participants might not be infected with HIV and should be encouraged to contact or return to their trial site or an associated trial site for the
confirmatory testing necessary to determine their HIV status.

Documenting HIV test results
Positive or negative HIV test results should be documented in the patient's confidential medical record and should be readily available to all healthcare providers involved in the patient's clinical management. The HIV test result of a pregnant woman also should be documented in the medical record of her infant. If the mother's HIV test result is positive, maternal health-care providers should, after obtaining consent from the mother, notify pediatric care providers of the impending birth of an HIV exposed infant and of any anticipated complications. If HIV is diagnosed in the infant first, healthcare providers should discuss the implications for the mother's health and help her to obtain care.

Clinical Care for HIV Infected Persons
Persons with a diagnosis of HIV infection need a thorough evaluation of their clinical status and immune function to determine their need for antiretroviral treatment or other therapy. HIV infected persons should receive or be referred for clinical care promptly, consistent with USPHS guidelines for management of HIV infected persons (96). HIV exposed infants should receive appropriate antiretroviral prophylaxis to prevent perinatal HIV transmission as soon as possible after birth (42) and begin trimethoprim-sulfamethoxazole prophylaxis at age 4-6 weeks to prevent Pneumocystis pneumonia. They should receive subsequent clinical monitoring and diagnostic testing to determine their HIV infection status (113).

Partner Counseling and Referral
When HIV infection is diagnosed, healthcare providers should strongly encourage patients to disclose their HIV status to their spouses, current sex partners, and previous sex partners and recommend that these partners be tested for HIV infection. Health departments can assist patients by notifying, counseling, and providing HIV testing for partners without disclosing the patient's identity (114). Providers should inform patients who receive a new diagnosis of HIV infection that they might be contacted by health department staff for a voluntary interview to discuss notification of their partners.

Special Considerations for Screening Adolescents
Although parental involvement in an adolescent's healthcare is usually desirable, it typically is not required when the adolescent consents to HIV testing. However, laws concerning consent and confidentiality for HIV care differ among states (79). Public health statutes and legal precedents allow for evaluation and treatment of minors for STDs without parental knowledge or consent, but not every state has defined HIV infection explicitly as a condition for which testing or treatment may proceed without parental consent. Healthcare providers should endeavor to respect an adolescent's request for privacy (79). HIV screening should be discussed with all adolescents and encouraged for those who are sexually active. Providing information regarding HIV infection, HIV testing, HIV transmission, and implications of infection should be regarded as an essential component of the anticipatory guidance provided to all adolescents as part of primary care.

Prevention Services for HIV Negative Persons Risk screening
HIV screening should not be contingent on an assessment of patients' behavioral risks. However, assessment of risk for infection with HIV and other STDs and provision of prevention information should be incorporated into routine primary care of all sexually active persons when doing so does not pose a barrier to HIV testing. Even when risk information is not sought, notifying a patient that routine HIV testing will be performed might result in acknowledgement of risk behaviors and offers an opportunity to discuss HIV infection and how it can be prevented. Patients found to have risk behaviors (e.g., MSM or heterosexuals who have multiple sex partners, persons who have received a recent diagnosis of an STD, persons who exchange sex for money or drugs, or persons who engage in substance abuse) and those who want assistance with changing behaviors should be provided with or referred to HIV risk-reduction services (e.g., drug treatment, STD treatment, and prevention counseling).

Prevention Counseling
In healthcare settings, prevention counseling need not be linked explicitly to HIV testing. However, because certain patients might be more likely to think about HIV and consider their risks at the time of HIV testing, testing might present an ideal opportunity to provide or arrange for prevention counseling to assist with behavior changes that can reduce risks for acquiring HIV infection. Prevention counseling should be offered or made available through referral in all healthcare facilities serving patients at high risk for HIV and at facilities (e.g., STD clinics) in which information on HIV risk behaviors is elicited routinely.

**HIV/AIDS surveillance risk factor ascertainment for HIV infected persons**

CDC recommends that providers ascertain and document all known HIV risk factors. Healthcare providers can obtain tools and materials to assist with ascertainment and receive guidance on risk factors as defined for surveillance purposes from HIV/AIDS surveillance professionals in their state or local health jurisdiction. This risk factor information is important for guiding public health decisions, especially for prevention and care, at clinical, local, state, and national levels.

**HIV/AIDS case reporting**

All states require that healthcare providers report AIDS cases and persons with a diagnosis of HIV infection to the state or local health department. Case report forms are available from the state or local health jurisdiction.

**Pediatric exposure reporting**

CDC and the Council for State and Territorial Epidemiologists recommend that all states and territories conduct surveillance for perinatal HIV exposure and contact providers after receiving reports of exposed infants to determine the infant's HIV infection status. Information concerning dates of maternal HIV tests, receipt of prenatal care, maternal and neonatal receipt of antiretroviral drugs, mode of delivery, and breastfeeding is collected on the pediatric HIV/AIDS case report form.

**Monitoring and Evaluation**

Recommended thresholds for screening are based on estimates of the prevalence of undiagnosed HIV infection in U.S. healthcare settings, for which no accurate recent data exist. The optimal frequency for retesting is not yet known. Cost-effectiveness parameters for HIV screening were based on existing program models, all of which include a substantial counseling component, and did not consistently consider secondary infections averted as a benefit of screening. To assess the need for revised thresholds for screening adults and adolescents or repeat screening of pregnant women and to confirm their continued effectiveness, screening programs should monitor the yield of new diagnoses of HIV infection, monitor costs, and evaluate whether patients with a diagnosis of HIV infection are linked to and remain engaged in care. With minor modifications, laboratory information systems might provide a practical alternative for clinicians to use in determining HIV prevalence among their patients who are screened for HIV.

**Child Health Check-Up Program**

Child Health Check-Up (CHCUP) is a mandatory Medicaid child health program of early and periodic screening, diagnosis and treatment services for beneficiaries under the age of 21. It used to be called EPSDT. All children of these ages who are Plan members must receive these examinations, including the required focus areas. The program ensures access to necessary health resources and assists parents and guardians in appropriately using those resources.

PCP’s receive a list of eligible members at the beginning of each month who have chosen or been assigned to the PCP as of that date. It is the responsibility of the provider to contact members and encourage the member, or legal guardian, to be seen for the CHCUP. Each time a provider performs a CHCUP screening, the provider must submit an encounter form using the appropriate CPT and ICD-10 codes.

The program provides for regular health check-ups that include:

- A comprehensive health and developmental history (including assessment of behavioral health status).
- A comprehensive physical exam.
• Nutritional and developmental assessment.
• Vision, hearing and dental screenings.
• Lab tests, including testing for lead poisoning.
• Appropriate immunizations.
• Health education/anticipatory guidance.
• Diagnosis and treatment.
• Referral and follow-up, as needed.
• Referral to a dentist begins at 3 years of age or earlier as medically necessary, with subsequent examinations by a dentist every 6 months, or more frequently as prescribed by a dentist or other authorized provider.
• One fluoride varnish application for children 6 months to 3 ½ years, in the physician’s office.
• Includes counseling with the child’s primary caregiver and referral to a dentist.

Eligible children and young adults should have health check-ups at:
• Birth
• 2 - 4 days for newborns discharged in less than 48 hours after delivery.
• By 1 month, 2 months, 4 months, 6 months, and 9 months.
• 12 months, 15 months, and 18 months.
• Once every year for ages 2 – 20 years.
• Individuals may also request a CHCUP at other times if they think their child needs it.

The following recommendations are based on federal guidelines that should be included in each Well Child Care examination, based on the specified age groups.

Providers are encouraged to review the Florida Medicaid CHCUP Coverage and Limitations Handbook which provides valuable information and tools, including the American Academy of Pediatrics Recommendations for Preventative Healthcare. This can be viewed by going to the following internet site: http://ahca.myflorida.com/Medicaid/childhealthservices/chc-up/index.shtml

Members can be offered scheduling assistance in making treatment appointments and obtaining transportation.

**Child Health Check-Up Visits Coding Requirements**
The codes to be used to document the receipt of a Child Health Check-Up (CHCUP) are as follows:

**Option 1: Initial or Periodic Screening visit**

<table>
<thead>
<tr>
<th>Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient;</th>
</tr>
</thead>
<tbody>
<tr>
<td>• 99381 - infant (age younger than 1 year)</td>
</tr>
<tr>
<td>• 99382 - early childhood (age 1 through 4 years)</td>
</tr>
<tr>
<td>• 99383 - late childhood (age 5 through 11 years)</td>
</tr>
<tr>
<td>• 99384 - adolescent (age 12 through 17 years)</td>
</tr>
<tr>
<td>• 99385 - 18-39 years</td>
</tr>
<tr>
<td>Referred for New Services</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient;</th>
</tr>
</thead>
<tbody>
<tr>
<td>• 99391 - infant (age younger than 1 year)</td>
</tr>
<tr>
<td>• 99392 - early childhood (age 1 through 4 years)</td>
</tr>
</tbody>
</table>

28
Office visits with E&M Codes may be used, but to be counted for a CHCUP visit one of the following CPTs must be paired with one of the following V codes:

<table>
<thead>
<tr>
<th>Procedure code:</th>
<th>With the following Diagnosis code:</th>
</tr>
</thead>
<tbody>
<tr>
<td>New Patient Office or other outpatient visit for the evaluation and management of a new patient, which requires 3 key components.</td>
<td>V20 Health supervision of infant or child (Health supervision of foundling)</td>
</tr>
<tr>
<td>99202 (typically 20 minutes face-to-face)</td>
<td>V20.1 Other healthy infant or child receiving care</td>
</tr>
<tr>
<td>99203 (typically 30 minutes face-to-face)</td>
<td>V20.2 Routine infant or child health check</td>
</tr>
<tr>
<td>99204 (typically 45 minutes face-to-face)</td>
<td>V20.3 Newborn health supervision</td>
</tr>
<tr>
<td>99205 (typically 60 minutes face-to-face)</td>
<td>V20.31 Health supervision for newborn under 8 days old</td>
</tr>
<tr>
<td>Established Patient Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of 3 key components.</td>
<td>V20.32 Health supervision for newborn 8 to 28 days old</td>
</tr>
<tr>
<td>99213 (typically 15 minutes face-to-face)</td>
<td>V70.0 General medical examination</td>
</tr>
<tr>
<td>99214 (typically 25 minutes face-to-face)</td>
<td>(Routine general medical examination at a healthcare facility)</td>
</tr>
<tr>
<td>99215 (typically 40 minutes face-to-face)</td>
<td>V70.3 Other medical examination for administrative purposes</td>
</tr>
</tbody>
</table>

NOTE: The codes provided are only a guide for listing codes compliant for CHCUP. The above code lists include a high-level description and not all detailed requirements to determine the appropriate procedure and/or diagnosis code for the services provided.

**Referrals**

If the PCP is unable to provide all the components of the CHCUP exam, or if screenings indicate a need for evaluation by a specialist, a referral to a participating provider, in accordance with the Plan’s referral procedures, may be requested. The member’s medical record must indicate where the member was referred.

**Blood Lead Level Testing**
The Centers for Medicaid and Medicare Services (CMS) and the State of Florida Medicaid Program requires that all children be tested for blood lead at 12 months and again at 24 months of age, or between 36 and 72 months of age if not previously tested. Filter paper testing is an accepted method to obtain blood lead levels and is covered by the Plan.

Immunizations
Providers are encouraged to review valuable immunization information on the Department of Health and Human Services, Center for Disease Control and Preventions website, which provides recommended vaccines and schedules for children at [http://www.cdc.gov/vaccines/](http://www.cdc.gov/vaccines/).

Birth – 18 years
Medicaid eligible members from birth through eighteen (18) years of age are eligible to receive free vaccines through the Federal Vaccine for Children (VFC) Program. We will reimburse the provider the administration fee for the vaccine as per their contract. Providers must bill using the appropriate assigned HCPCS procedure code to the vaccine and a modifier code, as indicated.

The provider must enroll with the VFC Program of the Department of Health to receive the vaccines free of charge and have sufficient supplies of the vaccines. Information regarding the VFC Program is available by contacting the State of Florida Department of Health, Bureau of Immunizations, at (800) 4VFC-KID or (800) 483-2543, HSDI 4052 Bald Cypress Way, BIN A11, Tallahassee, FL 32399-1719, or visit the website and click on immunization services: [www.immunizeflorida.org/vfc](http://www.immunizeflorida.org/vfc).

For eligible members from birth through eighteen (18) years of age, the following vaccines and combination vaccines are available free to the enrolled VFC provider through Florida’s VFC Program:
- Diphtheria-Tetanus-Acellular Pertussis (DTaP)
- Haemophilus influenzae type b (HIB)
- Hepatitis A
- Hepatitis B
- Human Papillomavirus (HPV)
- Influenza
- Meningococcal Conjugate (MCV4)
- Measles-Mumps-Rubella (MMR)
- Measles-Mumps-Rubella-Virace (MMRV)
- Pneumococcal Conjugate (PCV13)
- Polio (IPV)
- Rotavirus
- Tetanus-Diphtheria (Td)
- Tetanus-Diphtheria-Acellular Pertussis (Tdap)
- Varicella
- Combination Vaccines (Pediarix®, Comvax®, Pentacel®, Kinrix®, and ProQuad®)

The following vaccines are available by request or for high-risk areas only through the VCF program:
- Pneumococcal Polysaccharide (PPV23)

Vaccines Excluded from the VFC Program
- Please contact the Simply Healthcare Plans UM Pre-Certification Department prior to administering a vaccine that is not covered by the VFC Program. We may reimburse the cost of the vaccine and the administration fee for all eligible members’ birth through eighteen (18) years of age who receive vaccines not covered by the VFC program, according to the terms of your contract.
- Title XXI MediKids enrollees do not qualify for the VFC program. You need to bill Medicaid fee- for-service directly for immunizations provided to Title XXI MediKids participants.
19 – 20 years
Those Medicaid members nineteen (19) through twenty (20) years of age may receive vaccines through their healthcare provider. We will reimburse the cost of the vaccine and the administration fee as per the provider’s contract.

For eligible members ages nineteen (19) through twenty (20) years of age who lack evidence of immunity (e.g., lack documentation of vaccination), or require the vaccinations, the following vaccines and combination vaccines are reimbursable:

- Hepatitis A
- Meningococcal conjugate (MCV4)
- Hepatitis B
- Meningococcal Polysaccharide (MPSV4)
- HPV
- Pneumococcal Polysaccharide (PPV)
- Influenza Td
- MMR
- Varicella

21 and older
The Plan covers the immunizations that are part of the Plan’s expanded benefits for members who are twenty one (21) years of age or older.

Domestic Violence and Abuse Screening
Physicians should identify indicators of domestic violence and abuse, including physical, psychological, sexual and substance abuse. If you suspect domestic violence or abuse please contact a Nurse Case Manager at our UM Department and/or contact the Florida Department of Children and Families (DCF) at:

- Abuse Hot Line: To report suspected abuse, neglect or exploitation of children and elderly or disabled adults, call the toll-free number (800) 96-ABUSE (962-2873) or TDD (800) 453-5145
- Domestic Violence Hotline: To report domestic violence or to seek help, call the toll-free number (800) 500-1119. Members can also call themselves if they need help.
- Substance Abuse and Mental Health:
  - Contact the Plan’s Behavioral Health Provider, Beacon Health Options at 1-800-221-5487 or visit the website at [https://www.beaconhealthoptions.com](https://www.beaconhealthoptions.com)
  - Contact the Utilization Management Department and ask to speak with a Nurse Case Manager; or
  - View the DCF website [http://www.myflorida.com/accessflorida/](http://www.myflorida.com/accessflorida/) or contact your local DCF

Smoking Cessation
Physicians provide an important role in helping members make decisions about their healthcare. A Quick Reference Guide for Clinicians on Treating Tobacco Use and Dependence is available for you on the Plan website at: [http://www.simplyhealthcareplans.com/sites/default/files/TQL_Quick%20Reference%202008%20Update_0.pdf](http://www.simplyhealthcareplans.com/sites/default/files/TQL_Quick%20Reference%202008%20Update_0.pdf)

The Plan also offers a smoking cessation program to support your efforts in helping members break both the physical and psychological addiction to cigarettes. To access Plan services for your members who smoke or desire to quit smoking, including smokeless tobacco products, please call or ask the member to call the Member Services Department or a Simply Healthcare Care Manager. The Care Manager will educate the member on resources that offer assistance, as well as the options available to the member through services provided by the Plan. Additionally, the Plan can assist OB providers when they identify pregnant members who are at risk as a result of smoking. See Section 21 for more information regarding the Plan’s Healthy Behaviors Programs.

Providers are also encouraged to refer members to the Area Health Education Center (AHEC) at 1-877-848-6696 for information on classes and resources to quit smoking. Additional valuable information and educational materials are available through the following Websites:
Members with Special Healthcare Needs
The Primary Care Physician (PCP) is essential for identifying members with special needs. These members are defined as adults, children, and adolescents who face physical, mental or environmental challenges daily that increase their health risks and ability to fully function in society. Examples of members with special needs may include, but are not limited to:

- Members with mental retardation or related conditions.
- Members with serious chronic illnesses such as HIV, schizophrenia or degenerative neurological disorders.
- Members with disabilities resulting from years of chronic illness.
- Members with certain environmental risk factors, such as homelessness or family problems, that lead to the need for placement in foster care.
- Member under 21 years old with private nursing duty (PND) services, residing in a nursing home or attending a prescribed pediatric extended care (PPEC) program.

Physicians who render healthcare services to Plan members identified as having special healthcare needs will be responsible to:

- Assess the member and develop a treatment plan.
- Coordinate, review and update the treatment plan with the member/legal representative or caregiver and the member’s case/disease manager as applicable.
- Identify and coordinate all transition of care needs, including direct access through standing referrals or approved visits, as indicated for the member’s healthcare needs.
- Coordinate services with the Plan and member’s case/disease manager as appropriate, as well as, other healthcare or community services to share information to prevent duplication of services and provide early identification of the member’s needs.
- Ensure the member’s privacy is protected as appropriate during the coordination process.

Children Medical Services (CMS)
Children with special healthcare needs are those children under age 21 whose serious or chronic physical or developmental conditions require extensive preventive and maintenance care beyond that required by typically healthy children. These Medicaid-eligible children with special healthcare needs have the option of enrolling with the Children’s Medical Services (CMS) Network. The CMS Network is administered by the Florida Department of Health.

The CMS Network provides a family centered, managed system of care for children with special healthcare needs. CMS offers a full range of care, which includes prevention and early intervention services; primary and specialty care; as well as long-term care for medically complex, fragile children. Examples of chronic conditions are short gut syndrome, leukemia, and other conditions.

CMS determines the medical eligibility for the program. If you have a member who may benefit from CMS services please call us at the UM Department at 1-877-915-0551, Option 2, or contact CMS directly at 1-850-245-4200. You may find additional information at [http://www.floridahealth.gov/AlternateSites/CMS-Kids/](http://www.floridahealth.gov/AlternateSites/CMS-Kids/).

Living Will and Advance Directives
The law indicates that each Plan member age 18 years or older of sound mind receive information and have the opportunity to sign and Advance Directive Acknowledgment Form to make their decisions known in advance. This will allow a member to designate another person to make decisions for them if they should become mentally or physically unable to do so.
Advance Directive forms should be made available in providers’ offices and discussion with the member as well as the completed forms should be documented and filed in the member’s medical record. A provider shall not, as a condition of treatment, require a member to execute or waive an advance directive.

Providers are encouraged to review valuable information, educational materials and forms available through the AHCA Website for Advance Directives – The Patient’s Right to Decide at:

Also refer to the Advanced Directives subsection in Section 8, Members’ Rights and Responsibilities.

**After-Hours, Weekends and Holiday Services**
The PCP must be available after regular office hours, weekends, and holidays to offer advice and to assess any condition that might require immediate care. This includes referral to the nearest hospital emergency room or urgent care center in the event of a serious illness.

To ensure accessibility and availability, PCPs must provide one of the following:
- A 24-hour answering service; or
- Answering system with option to page the physician; or
- An advice nurse with access to the PCP or on-call physician.

The chosen method of 24/7 coverage must connect the caller to someone who can render a clinical decision or reach the PCP for a clinical decision. The after-hours coverage must be accessible using the medical office’s daytime telephone number. After-hours, the office telephone number may be forwarded to the provider on-call’s cellphone number.

We will routinely monitor providers’ adherence to after-hours access standards. Providers not meeting the after-hours requirements will receive an in-service. We will re-audit to assure compliance. Continued noncompliance will result in the request for a corrective action plan.

**PCP Coverage**
The Primary Care Physician (PCP) will notify the Plan, in writing, of anytime that he will be on leave from his/her practice. This may include vacation, medical leaves, etc. He/she is responsible for coordinating medical coverage by a participating, credentialed Plan provider for his/her members during the leave and of advising the Plan as to who will be covering and the dates of coverage.

The PCP should assist the Plan in coordinating the transition of care needs and accepting the transfer of members receiving care out of network or out of the Plan’s service area if the transfer is considered medically acceptable by the Plan physician and/or the out-of-network attending physician.

NOTE: For PCP’s who accept CHA enrollees, coverage must be provided by a Medicaid eligible provider with demonstrated experience in the provision and management of medical and psychosocial healthcare for persons with HIV/AIDS.

**Physician Panel Changes**
If a PCP decides to close his/her panel to new members or to accept transferring of Plan members, the PCP must complete the following steps:
- Submit a written request to the Plan providing at least sixty (60) calendar days prior to the effective date of closing his/her panel.
- Maintain his/her panel open to all Plan members who were provided services prior to the closing of his/her panel.
• When a re-open date is determined, then he/she will submit written notice to the Plan of the specific effective date of his/her panel re-opening; the effective date will be the first day of the following month.

Additionally, when reviewing the panel size of the PCP, the Plan reserves the right to close the PCP’s panel if the PCP has more than allowed number of members assigned (1500 per Simply Healthcare Plan provider and 500 per Clear Health Alliance provider) and does not have additional physicians or mid-level practitioners (ARNP or PA) to treat members. (Refer to PCP Responsibilities noted above).

The PCP should not close the panel to Plan members while having their panel open to other Medicaid health plans.

**PCP’s Request to Disenroll a Member from their Panel**

A Plan physician or provider may not seek or request to terminate a member on his/her panel or transfer a member to another healthcare provider based on the member’s medical condition, the amount or type of care required by the member or the cost of covered services required by the member.

If a member is approved for transfer, the membership acceptance must be without regard to color, gender, race, religious belief, national origin or handicap of the member.

It is the responsibility of the provider to document in the member’s medical record his/her efforts to develop and maintain a successful professional/member relationship, as well as the failure of members to show for their appointments and the failure to follow the plan of care prescribed. In addition, providers may request assistance from Member Services in contacting the member or referring him/her to Care Management in cases of non-compliance.

If it is determined that a successful professional/member relationship cannot be established or maintained, the physician or provider will notify the Plan in writing of the problem, with detailed supporting written documentation. The PCP will continue to provide medical care to the member, until the time that the Plan has reviewed and transferred the member from the physician’s or provider’s panel to a new physician or provider and notified the PCP that a transfer has been completed. AHCA and the Plan will be monitoring such activities.

For a PCP to request to disenroll a member from their panel for non-compliance, the following needs to occur and there needs to be documentation on the medical record:

1) Reasons for failure to establish and maintain a relationship with the patient.
2) The PCP has made every effort to help the member in correcting the situation, i.e., failure to show to appointments (at least 3 consecutive appointments within 6 months) or failure to follow the plan of care.
3) The PCP has notified the member and the Plan via certified mail of his/her intention to terminate the doctor-patient relationship. The letter must state the intended effective date (at least 30 days after the date on the letter) and information that the PCP will continue to provide care until the date of change, as well as instructions to obtain additional assistance and change of PCP by calling the Member Services number on the back of their Member ID card.

**Family Planning**

Providers must encourage and make available:

• To all pregnant women and mothers with infants to receive, and provide documentation in the medical records of, scheduled postpartum visit for voluntary family planning including discussion of all methods of contraception as appropriate.
• Counseling and services for family planning to all women and their partners.

See also Family Planning on Section 7.
Diagnosis and Treatment of Tuberculosis
All providers are required by law to report all tuberculosis suspects and/or cases with 72 hours of diagnosis to the health department in the county in which the patient lives or your office is located. For reporting codes, see Florida Administrative Code 64D03.

Responsibilities of All Providers
The remainder of this section identifies responsibilities for all Plan providers. The following are responsibilities for all participating physicians and providers:

- Preserve all members’ dignity and observe the rights of members which include, but are not limited to:
  - Members’ awareness and understanding of their diagnoses, prognoses and expected outcomes of recommended medical, surgical, and medication regimens.
  - No discrimination, in any manner, between Plan Members and Non-Plan Members.
  - Fully disclosing to members their treatment options and allow them to be involved in treatment planning.
- Informing members of specific healthcare needs which require follow-up and provide, as appropriate, training in self-care and other measures members may take to promote their own health.
- Coordinate with the Plan to ensure that members with special needs have an ongoing primary care giver responsible for coordinating the healthcare services provided to the member; this may be the PCP or, if indicated, a participating specialist.
- Refer to a participating Plan specialist or other healthcare provider for services or treatment outside of his/her normal scope of practice.
- Only refer members to non-participating physician or providers if a participating physician or provider is not available or in the event of an emergency; an authorization is required except in an emergency.
- Admit members only to participating hospitals, SNFs and other inpatient care facilities except in an emergency or if participating facilities cannot provide the necessary level of care.
- Authorization required except in emergencies.
- Ensure that all member records and information will be treated confidentially, as per HIPAA guidelines/requirements.
- Member records or information are not to be released without the written consent of the member or legal guardian, except as allowed or needed and within compliance with state and federal law.
- Identify members that are in need of services related to children’s health, domestic violence, abuse, pregnancy prevention, pre and postpartum care, smoking cessation or substance abuse. If indicated, providers must refer members to Plan-sponsored or community-based programs.
- Maintain an office that complies with environmentally safety/hygiene regulations, as per city, state and federal regulations.
- Promptly respond promptly to Plan requests for medical records in order to comply with regulatory requirements.
- Always inform the Plan in writing within 24 hours of any revocation or suspension of the physician or provider’s suspension, limitation or revocation of the license, certification or other legal credential authorizing him/her to practice and prescribe within the State of Florida.
- Inform us in writing immediately of changes in licensure status, tax identification numbers, telephone numbers, addresses, status at participating hospitals, loss of liability insurance and any other change which would affect his or her status with the Plan.
- Not bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from or have any recourse against any Plan member, subscriber, or enrollee other than for supplemental charges, co-payments or fees for non-covered services furnished on a “fee-for-service” basis.
- If copayments are waived as an expanded benefit, the provider must not charge enrollees copayments for covered services; and if copayments are not waived as an expanded benefit, the amount paid to providers
shall be the contracted amount, less any applicable copayments.

- Non-covered services are services not covered in the member’s Plan contract.
- Apply for a Clinical Laboratory Improvement Amendments (CLIA) certificate, if applicable, and provide a copy of the certificate to the Plan.
- Refer the member to community based services/support groups, where available.
- Maintain quality medical records and adhere to all Plan policies governing the content of medical records as outlined in the Plan’s Quality Improvement Guidelines.
- Utilize either disposable equipment or proper sterilization methods for instruments used to perform procedures.
- Ensure the office staff is trained on the proper use of safety, emergency and fire extinguishing equipment.
- Maintain a comprehensive emergency plan, including cardiopulmonary resuscitation (CPR), and an evacuation plan on which all office personnel are instructed.
- Have emergency medications on hand (i.e., Epi-pen and ambu bag at a minimum) in case an emergency occurs while a member is in the office.
- Timely communicate clinical information between Plan providers. Communication will be monitored during medical/chart review.
- Make available to all authorized federal and state oversight agencies, including but not limited to AHCA and the Florida Attorney General, any and all administrative, financial and medical records and data relating to the delivery of items and services to Plan members and access to any place of business.
- Report any suspected cases of healthcare fraud, waste, and abuse on the part of members, associates, employees or any providers, pharmacies, suppliers, outreach, and any other areas to our Compliance Officer at 1-877-253-9251. More information in Section 17.
- Submit an encounter for each visit where the provider sees the member or the member receives a HEDIS® (Healthcare Effectiveness Data and Information Set) service. Submit encounters on a CMS-1500 form to the Plan’s Claims Department.

**Physician Use of Healthcare Extenders (ARNP’s and PA’s)**

Physicians must, in accordance with federal and state regulations and accepted professional standards, use physician extenders appropriately. Advanced Registered Nurse Practitioners (ARNPs) and Physician Assistants (PAs) may provide healthcare services to members within the scope or practice established by the rules and regulations of the State of Florida and Plan guidelines.

The physician will:

- Assume responsibility, to the extent of the law, when supervising ARNP's and PA's.
- Inform the Plan of all their healthcare extenders and provide their licenses and other credentialing documentation to the Plan.
- Ensure that the ARNP’s or PA’s scope of practice does not extend beyond statutory limitations.
- Ensure that ARNP’s and PA’s always identify themselves as such and not allow the members to assume that the healthcare professional providing care is a physician.
- Provide treatment for any member that is in need of healthcare services that extends beyond the ARNP’s or PA's statutory limitations and/or scope of knowledge.
- Honor all member requests to be seen by a physician, rather than the ARNP or PA.
- Ensure that ARNP’s or PA’s refer members who require consultation and/or treatment services to the appropriate participating Plan specialist or facility.
- Ensure that all required state and/or national licenses/certifications are current at all times.
- Ensure that the physician extenders are credentialed by the Plan.

**Additional Specialist Responsibilities**

Simply Health Care will maintain a specialty network to ensure access and availability to specialists for all members. A provider is considered a specialist if he or she has a provider agreement with Simply to provide
specialty services to members.
Specialist must adhere to the following access guidelines:

<table>
<thead>
<tr>
<th>Appointment Access to Care Standards</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Care Type</strong></td>
</tr>
<tr>
<td>Routine visits</td>
</tr>
<tr>
<td>Urgent Care, nonemergency visits</td>
</tr>
</tbody>
</table>

- Specialists are responsible for treating members referred to them by the PCP and communicating with the PCP and/or our Utilization Management Pre-Certification Department for authorization requests.
- Specialists may not refer a member to another Plan specialist; care must be coordinated through the PCP.

**NOTE:** The management of postsurgical care is the responsibility of the operating surgeon.

**Member Information and Confidentiality**
All consultations or discussions involving the member will always be conducted discreetly and professionally in accordance with all applicable state and federal laws, including HIPAA Privacy and Security regulations. If there is a discrepancy between a state, Federal and/or other legal entity the more stringent is to prevail.

Confidentiality procedures need to apply, but are not limited to, oral, written and electronic communication and information.

It is expected that all reasonable steps are taken to protect the confidentiality, security and physical safety of the data and information of the members. All healthcare personnel should receive initial and annual refresher training on HIPAA Privacy and Security regulations. All practices are recommended to have in place:

- A privacy officer identified on staff
- A policy and procedure in place for confidentiality of members’ Protected Health Information (PHI)
- Documentation that the practice is following the procedures and are obtaining appropriate authorization forms from members prior to the release of PHI, as required by applicable state and federal law

All members have the right to confidentiality, and any healthcare professional or individual person who deals directly or indirectly with the member or his/her medical record must honor this right.

When an individual enrolls in the Plan, federal law allows the healthcare provider permission to release his or her medical records to the Plan, members of the provider network or agencies conducting regulatory or accreditation reviews and business associates.

The Notice of Privacy Practice (NPP) informs the patient or member of their member rights under HIPAA and how the provider and/or health plan may use or disclose the members’ PHI. HIPAA regulations require each provider and health plan to give an NPP to each new patient or member accordingly.

**Changes in Provider Information**
Prior notice to the Plan is required for any changes in the information below and according to the terms of your contract.

- 1099 Mailing Address
- Physical or billing address
- Tax Identification Number or Entity Affiliation (W-9 required) – sixty (60) day notice
- Group name or affiliation
- Telephone and/or fax number
• E-mail address

Notice to Plan shall be in accordance to contract communication section.

Provider Termination
In addition to the information included in the Provider Agreement with the Plan, the provider must adhere to the following terms:

• Any contracted provider must ensure at least ninety (90) calendar days prior written notice to the Plan of “without cause” termination of a contracted provider’s participation. Please refer to your contract for the details regarding the specific required days for providing termination notice.

• Unless otherwise provided in the termination notice, terminations occur on the last day of the month. For example: A termination letter is dated September 15. The required notice is ninety (90) days. Termination is therefore effective on December 31st.

• Providers who receive a termination notice from the Plan may submit an appeal within thirty (30) calendar days of the receipt of the termination notice. The appeals notice must be submitted in writing to the Provider Appeals Coordinator, to the Plan’s address. No additional or separate right of appeal to the Agency of Healthcare Administration (AHCA) is created as a result of the health Plan’s termination of the provider.

• The Plan shall notify the provider and members in his/her active care at least sixty (60) days before the effective date of the suspension or termination of a provider from the network. If the termination was “for cause”, the plan shall provide notice to all appropriate agencies the reasons for termination.

• In cases in which a patient’s health is subject to imminent danger or a physician’s ability to practice medicine is effectively impaired by an action of the Board of Medicine or other governmental agency, notice to both the provider and the BMHC shall be immediate.

Provider-Required Incident Reporting
All participating and direct service providers are required to report:

1) All Plan member adverse incident to the Agency for Healthcare Administration (AHCA) immediately and no more than twenty four (24) hours of the incidents; and

2) All Plan member adverse incidents to the Plan within twenty four (24) hours of the incidents.

Adverse incidents include events involving abuse, neglect, exploitation, major illness, involvement with law enforcement, elopement/missing, or major medication incidents.

Unusual incidents that occur on the property of the provider should be reported to the designated individual at the provider’s office, who will document and report the incident to the Plan’s Risk Management Department. The following are examples of potential risk management cases:

• An incident/injury/slip and fall of a Plan member, accompanying person or caregiver at a Plan’s participating provider premises.

• A Plan member, accompanying person or caregiver who becomes abusive (physically or verbally) at the Plan’s participating provider premises.

• Other incidences that are required to be communicated to the Plan include any of the following that involve a Plan member:
  • A medication error or a reaction to medication or procedure, requiring treatment
  • A theft or loss of medical records or electronic devices containing PHI from the provider’s office or property.
  • Malfunction or damage of equipment during treatment
  • Accusations of malpractice by a patient or family member
  • Non-compliance with potential to be life-threatening
Adverse Incidents
An Adverse Incident, is an injury of an enrollee occurring during delivery of Managed Care Plan covered services; that is associated in whole or in part with service provision rather than the condition for which such service provision occurred; and is not consistent with or expected to be a consequence of service provision. It could occur as a result of service provision to which the patient has not given his informed consent; or occur as the result of any other action or lack thereof on the part of the staff of the provider.

Adverse incidents, whether occurring in a facility of one of the Plan's providers or arising from healthcare prior to admission to a facility, must be reported immediately to the Plan, as well as to the AHCA. These are the incidents, which are defined as adverse incidents:

- Enrollee death
- Enrollee brain damage
- Enrollee spinal damage
- Permanent disfigurement
- Fracture or dislocation of bones or joints
- Any condition requiring definitive or specialized medical attention, which is not consistent with the routine management of the patient’s case or patient’s preexisting physical condition
- Any condition requiring surgical intervention to correct or control
- Any condition resulting in transfer of the patient within or outside the facility to a unit providing a more acute level of care
- Any condition that extends the enrollee’s length of stay
- Any condition that results in a limitation of neurological, physical, or sensory function, which continues after discharge from the facility

Other Reportable Conditions

- Abuse /Neglect/Exploitation (Suspected)*
- Delay in Diagnosis/Care/treatment
- Medication Incident/Incorrect Administration of Drug*
- Fall/Trip Attended/Unattended
- Member Death-Suicide in Facility*
- Member Death-Homicide in Facility*
- Member Attempt—Suicide in Facility*
- Member Involvement with Law Enforcement*
- Member Elopement/Missing/Escape from Facility*
- Suspected Unlicensed ALF or AFCH*
- Sexual/Physical Assault/Abuse/Battery*
- Loss or destruction of enrollee records
- Maternal Death/serious morbidity associated w/labor & delivery
- Intravascular embolism resulting in death/neurological damage
- Hemolytic Blood Transfusion reaction from ABO Incompatibility
- Infant discharge to wrong family / Child abduction
- Altercations in facility requiring medical intervention*
- Transportation Vendor- Vehicle Accident

Reporting of these incidents must include the member’s identity, description of the incident, the outcome, and the current status of the member. Additionally, pursuant to 408.812 F.S., participating providers are required to report suspected unlicensed ALF’s and AFCH to the Agency for Healthcare Administration.
How to Report
To report an adverse incident to the Plan, please complete the Provider Incident Reporting Form located in the Forms section of this handbook and submit it via regular mail, fax or as a secure e-mail to the Plan's Risk Manager. You may also report the incident via a telephone call. The contact information for the Plan’s Risk Manager is:

Deborah L. Polynice, LHCRM
Simply Healthcare Plans, Inc. (or Clear Health Alliance)
9250 W. Flagler Street, Suite 600
Miami, FL 33174-3460
Phone Number: 786-264-0786
Fax Number: 786-441-8218
E-mail: RiskManagement@simplyhealthcareplans.com

A copy of the Provider Incident reporting form may also be found on our websites:

Simply Healthcare:  http://www.simplyhealthcareplans.com/providers
Clear Health Alliance:  http://www.clearhealthalliance.com/providers.html

Community Outreach
Providers should only outreach to the community using the Plan’s name or logo in their capacity as a participating provider of the Plan’s network and only in coordination with the specific guidelines concerning community outreach. Providers should contact the Plan’s Community Outreach department or their Provider Relations representative to discuss and coordinate permissible activities.

All outreach materials describing the Plan’s organization in any way must first obtain the prior written approval of the Plan and include the Plan's name and/or logo as well as the provider’s name and/or logo. These materials must adhere to the guidelines and approval of the Plan, CMS and AHCA as appropriate.

Plan Responsibility
- The Plan is responsible for communication of the provider requirements as it relates to participation in the health plan and community outreach activities.
- The Plan is required to request that Providers communicate educational material with all staff that is not present during the initial Community Outreach in-service.
- The Plan will schedule visits as necessary.
- The Plan is vicariously liable for non-compliance with the AHCA contract.
- The Plan will request trainees’ signature and acknowledgment of participation of the training upon completion.

Permissible and non-permissible activity
- Healthcare providers may display health-plan-specific materials in their own offices.
- Healthcare providers cannot orally or in writing compare benefits or provider networks among health plans, other than to confirm whether they participate in a Health Plan’s network.
- Healthcare providers may announce a new affiliation with a Health Plan and give their patients a list of health plans with which they contract.
- Healthcare providers may co-sponsor events, such as health fairs and advertise with the Health Plan in indirect ways; such as television, radio, posters, fliers, and print advertisement.
- Healthcare providers shall not furnish lists of their Medicaid patients to the Health Plan with which they contract, or any other entity.
- Providers may not furnish other health plans’ membership lists to the Health Plan.
- Providers may not assist with Health Plan enrollment.
For the Health Plan, healthcare providers may distribute information about non-health-plan-specific healthcare services and the provision of health, welfare and social services by the State of Florida or local communities as long as any inquiries from prospective enrollees are referred to the member services section of the Plan or the Agency's choice counselor/enrollment broker.

**Delegated Providers**
Simply Healthcare Plans, Inc. (SHP or the Plan) Delegation Program is a component of SHP’s Compliance Program. This program’s intent is to assure quality of care and service from contracted entities with delegated functions, prior to delegation of any function, and to assure compliance with all the Federal, State, accreditation and organizational requirements (CMS, AHCA (“the Agency” or BMHC), and AAAHC), related to the delegated function. The delegation Program describes the plan’s process for performing an objective and systematic review of the delegated functions in a consistent manner for all contracted networks or entities with a delegated function(s).

SHP may delegate to a qualified provider group/entity the authority to perform selected medical management and administrative functions on its behalf. The qualified contracted provider group/entity is expected to perform such functions in a manner that is consistent with all SHP standards, state and federal laws, rules, regulations and accreditation organization standards.

SHP shall be responsible and liable for all administrative and operational functions of the Plan described in SHP’s contract with the Agency. Should the plan delegate any operational/administrative functions to an entity, written Agency approval will be obtained. The delegated group/entity is additionally expected and required to comply with all the requirements of the Plan’s Medicaid (AHCA) Contract. At all times the Plan retains the accountability and overall responsibility, as well as the right to monitor and rescind the delegation function.

All provider/entity contracts with delegated functions shall include a delegation addendum, specific to the function (i.e. Claims, UM, Credentialing, Network Development/Maintenance and Servicing). The Plan does not delegate the following functions:

- Member Grievance and Appeals
- Enrollment
- Fulfillment
- Community Outreach
- Quality Improvement

The Simply Healthcare Plans Delegation Oversight Program is divided into three phases as follows:

- Phase 1: Pre-assessment
  - Phase 1.a Pre-Assessment Documents
  - Phase 1.b Pre-Assessment Review
- Phase 2: Oversight and Monitoring
  - Phase 2a. Annual Audit
  - Phase 2b. On-going Monitoring and Oversight
- Phase 3: De-delegation

**Quality Enhancement Programs**
We provide special programs to help enrollees have Simply Healthcare Plans. To find out how to enroll a patient in one of these programs, please contact your representative. You may also review the Health Behaviors on Section 21.

**Children’s Programs**
General wellness programs targeted specifically toward enrollees from birth to age five, offered by existing community children's programs. Our children's programs promote increased use of prevention and early
intervention services for at-risk enrollees. This Plan authorizes covered services recommended by the Early Intervention Program when medically necessary.

We offer our providers annual training that promote proper nutrition, breast-feeding, immunizations, CHCUP, wellness, prevention and early intervention services.

**Domestic Violence**
Offering screening and referral services to appropriate agencies.

**Pregnancy Prevention**
Open to all enrollees, regardless of age, gender, pregnancy status or parental consent.

**Prenatal/Postpartum Pregnancy Programs**
Home visits, counseling and educational materials, coordinated with the local Health Start care coordinator/case manager to prevent duplication of services.

**Behavioral Health Programs**
Outreach to homeless and other populations of enrollees at risk of justice system involvement, to assure that services are accessible and provided when necessary. This activity is oriented toward preventive measures to assess behavioral health needs and provide services that can potentially prevent the need for future inpatient services or possible deeper involvement in the forensic or justice system.
Section 5. Utilization Management Department

Overview
Our Utilization Management (UM) Department will be responsible for the following processes:

- Notifications
- Referral and Quick Authorization Forms
- Prior Authorizations (Pre-service requests)
- Discharge planning assistance
- Care Management services, including case management, disease management, chronic care and transition of care needs

Plan members are entitled to confidentiality of Protected Health Information (PHI). The UM Department will ensure that all member documents containing personal and medical data are maintained in a confidential manner compliant with HIPAA Privacy Regulations and all state and federal confidentiality regulations.

Medical Necessity
The Plan reimburses for services that are determined medically necessary, do not duplicate another provider's service, and are:

- Necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain.
- Individualized, specific, consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the recipient's needs.
- Consistent with generally accepted professional medical standards as determined by the Plan, and not experimental or investigational.
- Reflect the level of services that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available in the Plan's service area; and
- Furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider.

“Medically necessary” or “medical necessity” for inpatient hospital services requires that those services furnished in a hospital on an inpatient basis could not, consistent with the provisions of appropriate medical care, be effectively furnished more economically on an outpatient basis or in an inpatient facility of a different type.

The fact that a provider has prescribed, recommended, or approved medical or allied care, goods, or services, does not, in itself, make such care, goods, or services medically necessary or a covered service.

Notification
Notifications are either communications to the Plan, either telephonically or written, that inform the Plan of a service(s) requested or rendered or an admission to a facility. These include acute inpatient, observation status, acute inpatient rehabilitation, skilled nursing facility (SNF), and custodial care admissions.

Notification to the Plan of prenatal services is required within two (2) working days of the first prenatal visit. This enables the Plan to identify members for inclusion in the PreNatal Program and identify potential High Risk OB members who may benefit from the High-Risk Pregnancy Program.

Referrals or Prior Notifications
A referral or prior notification is a request by a PCP or a participating specialist for a member to be evaluated and/or treated by a participating specialty physician and/or facility. The Plan uses two types of forms and processes:
1. Quick Authorization Form
   For those services included on the Plan’s Quick Authorization Form (QAF) (see the Forms Section of this handbook) a referral request to the Plan is NOT required. Primary Care Physicians (PCP’s) can refer a member to a participating specialist and to many frequently requested services and procedures at free-standing facilities with the Simply Healthcare Plans QAF without contacting the health plan for prior authorization.

   IMPORTANT NOTE: All inpatient services, outpatient hospital services (including diagnostics), prenatal care referrals and ambulatory surgery center (ASC) services do require an authorization (see section below).

   **The QAF form is not valid for any inpatient or outpatient hospital services or for any consultations or procedures not listed on the form, or for out-of-network providers.**

   The PCP or specialist ordering the consultation or test is required to fax or mail a copy of the completed QAF to the participating provider or facility that will be providing the service(s), or to give a copy to the member so that it is presented at the time of the service. The QAF should not be submitted directly to the Plan.

   Services that Do NOT Require Prior Authorization or QAF:
   - Family Planning*
   - Participating Office/free standing laboratory tests at labs consistent with CLIA guidelines
   - Emergent transportation services
   - Urgent or emergent care at participating Urgent Care centers or any Emergency Room
   - County Health Departments (CHD), Federally Qualified Health Centers, Rural Health Clinics and federally funded migrant health centers when providing:
     - Vaccines
     - STD diagnosis/treatment
     - Rabies diagnosis/immunization
     - Family planning services and related pharmaceuticals
     - School health services and urgent services

   *NOTE: If the member receives Family Planning Services from a non-network Medicaid provider, the Plan will reimburse the provider at the Medicaid reimbursement rate, unless another payment rate is negotiated.

2. Prior Authorizations
   Prior authorization (pre-service requests) allows for the use of quality, cost-efficient covered healthcare services and helps to ensure that effective transition of care planning is done so that members receive the most appropriate level of care within the most appropriate setting. Prior authorization must be obtained for all services not included on the Quick Authorization Form (QAF) for PCP’s (see section above) that require an authorization.

   Our UM Pre-Certification Department evaluates requests for services/procedures and makes determinations based on medical necessity, covered benefits and appropriateness based on approved utilization criteria (Simply Healthcare Plans Medical Policy) and evidence- based, nationally recognized clinical guidelines. Only a Medical Director may issue an adverse determination, with the exception of denials due to benefit issues. No provider or any other individual or Plan employee or associate is rewarded for issuing denials of coverage or care. Financial incentives will NOT encourage decisions that would result in underutilization nor are incentives to create barriers to care and services.

   Prior Authorization Requests are to be made through our UM Pre-Certification Department. This applies to any medically necessary service to enrollees under the age of twenty-one (21) years when the service is not listed in the service-specific Florida Medicaid Coverage and Limitations Handbook, Florida Medicaid Coverage Policy, or
the associated Florida Medicaid fee schedule, or is not a covered service of the plan; or the amount, frequency, or duration of the service exceeds the limitations specified in the service-specific handbook or the corresponding fee schedule.

Prior Authorization or Notification Process

Providers are to fax the Referral & Authorization Form (refer to Forms Section) to our UM Pre-Certification Department at Fax number 1-800-283-2117 or entered through the Provider Portal. Routine (NOT EXPEDITED) requests are processed within 7 days and no more than fourteen (14) calendar days of the Plan receiving the authorization request and having received all supporting clinical information.

- Expedited requests are processed within 48 hours of the Plan receiving the request and having received the supporting clinical information.

  **Expedited requests** are those in which taking longer than 48 hours to process could jeopardize the member’s life, health, or ability to regain maximum function in serious jeopardy.

Expedited Request for Authorizations should be faxed to the plan. After 48 hrs, providers have with the option of following up with a call to the Providers Services line at 1-877-915-0551, option 2 to inquire of status following the submission of an urgent request.

These requests should always meet the defined medical criteria for such which are:

- Each Referral & Authorization Form received from the provider’s offices will be date and time-stamped, manually or electronically and is reviewed for completeness, eligibility, benefits, PCP and specialist network affiliation.
- The Referral & Authorization Form must be accompanied by supporting clinical information for medical necessity determination.

An authorization number will be provided, via fax, to the PCP, specialist and other provider(s) that will provide services to the member, when the request is completed and approved.

- All authorization requests and documentation of supporting clinical information will be entered and maintained within the Plan’s computer system for future reference and claims payment.

When faxing a Prior Authorization Request, the Plan’s Referral & Authorizations Form must be completed. The requesting provider is reminded to include:

- Member demographic information (i.e. name, sex, DOB, member’s current telephone number, Plan Member Number).
- Provider demographic information
  - Requesting provider (i.e. name, Plan Provider Number, phone number, fax number, contact person).
  - Referred-to specialist/facility (i.e. name, Plan Provider Number, address, phone number, fax number, date of service, and identification if PAR (Plan participating provider/facility) or Non-PAR (not a Plan participating provider/facility).
- Diagnoses for authorization request, including ICD-10 Code(s).
- Procedure(s) for authorization request, including CPT/HCPCS Code(s).
- Number of visits requested, frequency and duration.
- Pertinent medical history and treatment, laboratory and/or radiological data, physical examinations/referrals that support the medical necessity for the requested service(s).

Requests that do not meet medical necessity, based upon approved criteria, are reviewed by the Medical Director for a final determination. The Medical Director may conduct a peer-to-peer discussion with the
requesting provider, if indicated.
All of the following procedures and services require Prior Plan Notification and must be provided in a Plan-participating facility:

- Planned Inpatient and Observation Admissions, as noted above
- Admission to any rehabilitation and skilled nursing facility
- All surgical procedures, inpatient or outpatient

The following have special reporting requirements (refer to Forms Section):

- Abortions
- Hysterectomies
- Sterilization procedures

Cosmetic or Reconstructive Surgery, including but not limited to:

- Breast reconstruction or reduction
- Blepharoplasty
- Venous procedures
- Sclerotherapy

Services and items:

- Allergy (immunotherapy), except for those services identified on the QAF
- Ambulance transportation (non-emergent)
- Amniocentesis
- Cardiac and pulmonary rehabilitation programs
- Circumcisions after 12 weeks of age
- Court-ordered services
- Chemotherapy
- Dialysis
- DME, including apnea monitors and bili-blankets
- Upper endoscopies at colonoscopies at hospitals
- Genetic testing
- Gamma Knife, Cyberknife
- Hearing aids
- Home Health Services
- Hospice care
- Hyperbaric Oxygen Therapy (HBO)
- Investigational and experimental procedures and treatments
- IV Infusions
- Laboratory services in POS 22 and 24
- Lithotripsy
- Mental Health (See Mental Health Section)
- Nutritional counseling
- MRI’s, MRA’s
- Oral Surgery
- Oxygen therapy and equipment
- Out-of-Network Services
- Pain Management and or Pain Injections
- PET Scans
- Prenatal care
- Orthotics and Prosthetics, including Cranial Orthotics
- Physical, Occupational and Speech Therapy
• Radiation therapy
• SPECT scans
• Transplants and pre and post-transplant evaluations
• Wound Care and wound vacuums
• Drugs that require pre-authorization
• Any services or procedures not listed on the Quick Authorization Form (QAF)

*Unless the service is only available in a non-participating facility.

Emergency Services

Emergency services are not subject to prior authorization requirements and are available to our members twenty four (24) hours a day, seven days a week, 365 days a year. This is defined as necessary services to prevent loss of life, irreparable physical damage, or loss or serious impairment of a body function.

An emergency medical condition is a medical condition manifesting itself by acute symptoms of sufficient severity, which may include severe pain or other acute symptoms, such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect that the absence of immediate medical attention could reasonably be expected to result in any of the following:

• Serious jeopardy to the health of the member, including a pregnant woman or fetus
• Serious impairment to bodily functions
• Serious dysfunction of any bodily organ or part
• A pregnant woman having contractions

The Plan shall not:

• Require prior authorization for an enrollee to receive pre-hospital transport or treatment or for emergency services and care;
• Deny payment for treatment obtained when a representative of the Plan instructs the enrollee to seek emergency services.
• Specify or imply that emergency services and care are covered by the Plan only if secured within a certain period of time;
• Use terms such as "life threatening" or "bona fide" to qualify the kind of emergency that is covered; or
• Deny payment based on a failure by the enrollee or the hospital to notify the Plan before, or within a certain period of time after, emergency services and care were given.
• Deny claims for emergency services and care received at a hospital due to lack of parental consent.

Pre-hospital and hospital-based trauma services and emergency services and care will be authorized. The Plan shall cover all screenings, evaluations, and examinations that are reasonably calculated to assist the provider in arriving at the determination as to whether the member has an emergency medical condition. If the provider determines that an emergency medical condition does not exist, the Plan is not required to cover services rendered subsequent to the provider's determination unless authorized by the Plan.

If the provider determines that an emergency medical condition exists, and the enrollee notifies the hospital or the hospital emergency personnel otherwise have knowledge that the patient is a member of the Plan, the hospital must make a reasonable attempt to notify the enrollee's PCP, if known, or the Plan, if the Plan has previously requested in writing that it be notified directly of the existence of the emergency medical condition.

If the hospital, or any of its affiliated providers, do not know the enrollee's PCP, or have been unable to contact the PCP, the hospital must notify the Plan as soon as possible before discharging the enrollee from the emergency care area; or notify the Plan within twenty four (24) hours or on the next business day after the enrollee's inpatient admission.
If the hospital is unable to notify the Plan, the hospital must document its attempts to notify the Plan, or the circumstances that precluded the hospital's attempts to notify the Plan. The Plan shall not deny coverage for emergency services and care based on a hospital's failure to comply with the notification requirements of this section.

The Plan shall cover any medically necessary duration of stay in a non-contracted facility, which results from a medical emergency, until the Plan can safely transport the member to a participating facility. The Plan may transfer the member, in accordance with state and federal law, to a participating hospital that has the capability to treat the member’s emergency medical condition. The attending emergency physician, or the provider actually treating the member, is responsible for determining when the member is sufficiently stabilized for transfer, and that determination is binding.

**Emergencies at Out-of-State Hospitals**

Emergency services provided in out-of-state hospitals are reimbursable when an emergency arises from an accident or illness, the health of the recipient would be endangered if the care or services were postponed until he returned to Florida or if the health of the recipient would be endangered if he undertook travel to return to Florida.

**Post-stabilization Care Services**

Post-stabilization care services will be covered without authorization, regardless of whether the enrollee obtains a service within or outside the Plan's network for the following situations:

- Post-stabilization care services that were pre-approved by the Plan
- Post-stabilization care services that were not pre-approved by the Plan because the Plan did not respond to the treating provider's request for pre-approval within one (1) hour after the treating provider sent the request
- The treating provider could not contact the Plan for pre-approval

The post-stabilization care services that a treating physician viewed as medically necessary after stabilizing an emergency medical condition are non-emergency services. The Plan can choose not to cover them if they are provided by a non-participating provider, except in those three circumstances identified above.

**Hospital Inpatient Services**

Inpatient services are medically necessary services ordinarily furnished by a state-licensed acute care hospital for the medical care and treatment of inpatients provided under the direction of a physician or dentist in a hospital maintained primarily for the care and treatment of patients with disorders other than mental diseases.

Inpatient services include, but are not limited to:

- Rehabilitation hospital care (which are counted as inpatient hospital days).
- Medical supplies, drugs and biologicals, diagnostic and therapeutic services.
- Use of facilities, room and board, nursing care.
- All supplies and equipment necessary to provide adequate care (Refer to the Medicaid Hospital Service Coverage & Limitations Handbook).
- Inpatient care for any diagnosis including tuberculosis and renal failure when provided by general acute care hospitals in both emergent and non-emergent conditions.
- Physical therapy services when medically necessary and when provided during an enrollee’s inpatient stay.

**Prior Notification for Hospital Admissions**

All inpatient admissions, including maternity, acute hospital, skilled nursing facilities, rehabilitation facilities and hospice require notification to the Plan.

- Elective Admissions: Notification is required at least fourteen (14) calendar days prior to the scheduled
procedure or admission.

- Emergency Admissions: Notification required within one (1) day of an emergency of urgent admission.
- Inpatient admission after Ambulatory Surgery: required within one (1) day of the inpatient admission.

**Pre-Admission Screening and Resident Review (PASRR)**

The Plan shall:

- Ensure that the care coordinator verifies that the PASRR required in Rule 59G-1.040, F.A.C. is in the enrollee’s nursing facility record.
- Report the most recent PASRR date for enrollees entering or residing in a nursing facility in accordance with Chapter 18, Reporting Requirements and the Managed Care Plan Report Guide.

**Inpatient Hospital Care Limits**

- Inpatient hospital care for non-pregnant adults (over 21) who are Medicaid recipients is limited to forty-five (45) days per Florida state fiscal year (July 1 through June 30).
- For all child/adolescent members (up to age 21) and pregnant adults, the Plan shall provide up to 365 days of health-related inpatient care, including behavioral health for each state fiscal year (July 1 through June 30).

**Obstetrical Admissions**

- For normal deliveries, hospital stay will be covered for no less than forty-eight (48) hours after the delivery.
- For Cesarean sections, no less than ninety six (96) hours after the surgery.
- In both cases, the hospital length of stay is required to be decided by the attending physician in consultation with the mother.

**Dental Services in the Hospital**

Hospitalization solely for dental treatment that is not covered under the Plan’s Medicaid Dental benefit is not reimbursable in the inpatient or outpatient hospital setting.

Dental treatment is provided in the inpatient or outpatient hospital setting when one of the following conditions is met:

- The recipient’s health will be so jeopardized that the procedures cannot be performed safely in the office.
- The recipient is uncontrollable due to emotional instability or developmental disability and sedation has proven to be an ineffective intervention.
- The necessity for treatment in a hospital or ambulatory surgery center must be clearly documented in the recipient’s dental record.
- A primary diagnosis of mental retardation is not, in and of itself, a reason to hospitalize a patient for the provision of dental services.

**Hospice**

To qualify for the Medicaid hospice program, all recipients must:

- Be eligible for Medicaid hospice.
- Be certified by a physician as terminally ill with a life expectancy of six months or less if the disease runs its normal course.
- Voluntarily elect hospice care for the terminal illness.
- Sign and date a statement electing hospice care.

In accordance with Section 2302 of the Affordable Care Act (ACA), children under twenty-one (21) years who meet hospice criteria may receive hospice services while concurrently receiving all other Medicaid services, including curative treatment for their terminal diagnosis.

**Observation Services**
Observation services are those furnished on a hospital’s premises, including use of a bed and periodic monitoring by a hospital’s nursing or other staff and are reasonable and necessary to evaluate an outpatient’s condition or determine the need for a possible admission to the hospital as an inpatient. Such services are covered when provided by the order of a physician, criteria is met for Observation status, as per Simply’s Medical Policy Criteria guidelines and when they are not followed by an inpatient admission, up to 48 hours.

Services for routine post-operative monitoring during a normal recovery period must not be billed as observation services. Hospitals are not expected to substitute outpatient observation services for medically appropriate inpatient admissions. Observation services must be billed one claim per observation day, in the same manner as all other outpatient services. Consecutive days of observation must be billed one claim per day.

**Pregnancy**
PCP’s or obstetricians are required to notify the Plan of the first prenatal visit and/or positive pregnancy test within two (2) working days by completing the Pregnancy Notification Form (refer to the Forms Section), whether the pregnancy was identified through medical history, examination, testing or otherwise.

The Plan will allow pregnant enrollees to choose in-network obstetricians as their PCP if the obstetrician is willing to participate as a PCP.

If a pregnant member has not selected a PCP for her unborn child, the Plan will assign a pediatrician for the care of their newborn babies no later than the beginning of the last trimester of gestation.

If a provider treating a pregnant member for prenatal care decides to terminate the contract with the Plan, the Plan will allow the member to continue care with that provider until completion of the postpartum care.

If the provider knows the recipient is pregnant and that her unborn child does not have a Medicaid ID number, the provider may have the newborn assigned a number by sending a CF-ES 2039, Medical Assistance Referral Form to the Department of Children and Families (DCF) regional office. The forms may be downloaded at [https://eds.myffamilies.com/DCFFormsInternet/Search/DCFFormSearch.aspx](https://eds.myffamilies.com/DCFFormsInternet/Search/DCFFormSearch.aspx) or the member may call the DCF to notify them of her pregnancy and obtain the Unborn ID Number and later call our Member Services with the number.

** Please review Section 5 for Pregnancy-Related Requirements **

**Global Obstetric (OB) Authorizations**
The Plan makes every effort to identify pregnant women as early as possible for referral to the Plan’s Maternity Program and, if upon evaluation, potential high risk is identified, referral to the Plan’s High-Risk OB Program.

To ensure timely Plan notification and Global Obstetric authorization, PCPs or obstetricians are required to notify the Plan within two (2) working days of the first prenatal visit and/or positive pregnancy test by completing the Pregnancy Notification Form (refer to the Forms Section).

- Upon identification of a pregnancy, the member will be referred to a Nurse Case Manager who will:
  - Contact the member and complete a Health Risk Assessment.
  - Initiate referrals to the OB/GYN (Global OB Authorization) or other providers, as indicated and request a copy of the OB Provider Pregnancy Assessment Form (refer to Forms Section).
  - Enroll the member in our Maternity Program, if risk factors are identified.
    - *NOTE: Pregnant members are not required to see their PCP for a referral for prenatal care.*

The Global OB authorization includes:
- 10 Prenatal visits for normal pregnancies.
• 14 Prenatal visits for high-risk pregnancies; the high-risk diagnosis must be included on the global referral.
• One (1) OB ultrasound in the obstetrician’s office or in a network free-standing diagnostic facility.
• For high-risk pregnancies, two (2) OB ultrasounds in the OB’s office or participating free-standing facility.

**Florida Healthy Start and WIC Referrals**
Provider will be primarily responsible for completing the screening and referral, if applicable, to the Healthy Start Program. In the same way, the provider will be responsible for completing the referral form for the Woman, Infant, and Children (WIC) Program. The Plan’s Nurse Case Managers will assist the provider in the education of the member and with referrals as needed.

The Plan’s Nurse Case Managers will assist the provider in the education of the member and assistance, if needed, to the Florida Healthy Start Program and the Women, Infants, and Children (WIC) Program.

**Newborn Deliveries**
• Hospitals are required to notify the Plan of all births by Plan members, complete the required Form DCF-ES 2039 if the baby does not have a Medicaid ID number and indicate the Plan’s name as the referring Agency.
• If the baby already has a Medicaid ID number, providers must activate the unborn record by completing a Newborn Activation Form (AHCA Form 5240-006) and faxing it to the Medicaid fiscal agent, with copy to the Plan’s OB Coordinator at the UM Department. The Plan ensures that these steps are completed. A newborn whose mother is enrolled in the Plan is not automatically enrolled in the Plan.

**Out-of-Network Requests for Non-Emergency Services**
The Plan will provide timely approval or denial of authorization of out-of-network use through the assignment of a prior authorization number. Written follow-up documentation of the decision will be sent to the out-of-network provider within one (1) business day from the decision. The member will be liable for the cost of unauthorized services from non-participating providers.

**County Health Departments (CHD)**
• Upon receipt of a request for a physical screening of a child or adolescent from the DCF or other protective agency or shelter, the UM Pre-Certification Department will coordinate an urgent (within 72 hours, or immediately if needed) physical screening by the member’s PCP, or another participating provider if the PCP is not available.
• Claims of CHCUP screenings done while the child/adolescent was in the care and custody of DCF and was later determined to be a member of the Plan will be approved and later forwarded to AHCA.
• Emergency shelter medical screenings for members who are DCF clients will be authorized retrospectively to CHDs.

**Behavioral Health**
Behavioral health referrals and services are processed and determinations issued by Beacon Health Options:
• By calling 1-800-221-5487, or
• Via the web at [https://www.beaconhealthoptions.com](https://www.beaconhealthoptions.com), or by fax at 305-722-3018. Use the Beacon Health Options Case Management Referral Forms (Refer to the Section 24; Forms, Beacon Health Options Case Management Referral Form Only a licensed psychiatrist may authorize a denial for an initial or concurrent authorization of any request for behavioral health services.
• The Plan’s mental health services include medically necessary evaluation, testing, counseling, therapy, rehabilitation and other related treatments. They include inpatient and outpatient hospital services and psychiatrists and psychologists; they may also be coordinated with the school system.
• Members will call Beacon Health Options to make appointments and obtain the names of several
providers in their area. They may select an alternative behavioral health provider within the network and may receive care at doctor's offices, community centers and in schools.

- If a member was receiving mental health or psychiatric treatment before joining the Plan, please call Beacon Health Options or our Member Services so that the care is not interrupted.
- Members can receive psychiatry services within 24 hours of release from jail, juvenile detention or other justice facility. Call Beacon Health Options at 1-800-221-5487.
- Services include individual, group and family therapy or evaluations, treatment planning, social rehabilitation, day treatment for adults and children.
- Inpatient hospital services: up to forty five (45) days in the hospital for inpatient admission for a mental or behavioral problem for each contract year (A contract year is July 1 through June 30).
- Inpatient Rehabilitation for Pregnant Substance Abusers: inpatient hospital substance abuse treatment program for pregnant substance abusers who meet certain rules. Call Member Services to find out more.
- If a member has reached the forty five (45) day max and needs an emergency admission, such as during a Baker Act, this must be approved (even if it is beyond forty five (45) days).
- Children have 365 days inpatient for the MMA contract, there are no limits.

**Behavioral or Mental Health Services Not Covered by the Plan**
Please call the local Medicaid Office (1-800-953-0555) or the DCF (1-866-762-2237) office to ask how your patient can get these services under Medicaid. You may also call our Member Services to assist you.

- Specialized therapeutic foster care;
- Therapeutic group care services;
- Behavioral health overlay services;
- Community substance abuse services;
- Residential care;
- Clubhouse services;
- Comprehensive behavioral assessment;
- Inpatient rehabilitation for non-pregnant substance abusers
- If the member is enrolled with the Child Welfare Prepaid Mental Health Plan (PMHP) through the Florida Safe Families Network, the Plan cannot provide their mental or behavioral healthcare. Please call the Community Based Care Partnership at 1-800-327-5542 or the local Medicaid Office for more information;
- If the member is assigned to a FACT team by the DCF Substance Abuse and Mental Health Program (SAMH) Office.

**Emergency Mental Health Services In and Outside of the Service area**

- Members are advised to call 911 or go to the nearest emergency room if they need emergency mental healthcare, and to call their PCP as soon as they can.
- The Plan will cover all emergency mental healthcare whether the member is in or outside the service area, at any time.
- Members may call Beacon Health Options at 1-800-221-5487 for assistance finding behavioral care in the area where they are.
- After the initial emergency treatment, the Plan will cover the post-stabilization care services, even without authorization. Crisis intervention services are covered.

**Requests for a Second Medical Opinion**
Second Opinion is a consultation by a physician other than the member's PCP, whose specialty is appropriate to the need, and whose services are obtained when the member disputes the appropriateness or necessity of a surgical procedure, is subject to a serious injury or illness, including failure to respond to the current treatment plan.
The member will be advised to contact the PCP and request a consultation with the necessary specialty provider. The member may select a contracted provider listed in the provider directory supplied by the Plan or a non-contracted provider in the Plan's geographic area. The UM Pre-Certification Department will contact the member's PCP, or admitting physician if the member is in the hospital if necessary to assist in the second opinion process.

The Plan shall pay the amount of all charges which are usual, reasonable and customary in the community for second opinion services performed by a physician not under contract with the Plan, but the member may be responsible for part of the bill.

The Plan's physician's professional judgment concerning the treatment of a member derived after review of a second medical/surgical opinion shall be controlling as to the treatment obligations of the Plan.

Treatment not authorized by the Plan is at the member's expense.

Any tests/procedures deemed necessary by a second opinion consultant, and/or non-contract physician, are to be performed by a Plan-contracted provider. The UM Pre-Certification Department will coordinate the care between the provider and the member to ensure continuity of care.

**Standing Referrals for Members with Chronic and/or Disabling Conditions**

Members with chronic and disabling conditions, which require ongoing specialty care, will be issued standing referrals to the appropriate specialists and/or services. The PCP needs to submit a referral for the course of treatment to be provided by a specialist and/or ancillary provider.

The Plan may request reports on the ongoing status of the member's condition from the provider.

**Continuity and Transition of Care Needs**

1. **Termination of a provider:**
   Upon the termination of a contract between the Plan and a treating provider for any reason other than cause, members in active treatment with such provider will be allowed to continue medically necessary care with the provider until:
   - The member selects another treating provider, or
   - During the next open enrollment period offered by the Plan whichever is longer, but no longer than 6 months after the contract was terminated.

For pregnant members, both the Plan and the OB provider shall allow the member who has initiated a course of prenatal care to continue care and coverage until the completion of the postpartum care, regardless of the trimester in which care was initiated.

2. **New members:**
   For all new Plan members, for the first sixty (60) days of enrollment, the Plan accepts any authorizations from another plan or the Medicaid program for care or services the member is receiving, or will need to receive, or for which the member has scheduled an appointment. This includes prescriptions and care or services from doctors and providers not on the Plan. The authorization is effective until the member’s Plan PCP reviews the services and determines that the member can be safely transferred to a Plan doctor/provider. This can occur before the 60 days. If a member has an authorization, is taking medications, and/or has an appointment to see a doctor or have a test or procedure performed, please encourage the member to contact the Plan. Please assist the member by providing any information to facilitate the processing of the authorization for services.

**Post Discharge Planning/Transition of Care**
Discharge planning begins upon notification of an acute inpatient, observation status, rehabilitation or skilled nursing facility admission. Early identification and planning of the member’s transition of care needs is essential in providing quality discharge care and ensuring that the member is discharged to the appropriate level of care to prevent readmissions and unscheduled transition of care.

The Plan’s UM In-patient Coordinator will be responsible for working with the member, attending physician, the PCP, the hospital/facility staff, and all ancillary service providers in completing all discharge needs for the member. He/she will also identify any on-going care needs and refer, as indicated, to our Care Management Team.

**Care Management Services**
The Plan is committed to early identification of those members who may be at risk for healthcare needs/services. These members are identified through multiple resources which include, but are not limited to the Health Risk Assessment and Stratification, provider referrals, member/legal guardian self-referrals, nursing, social services and other ancillary provider referrals, utilization and pharmacy data and others.

Our Care Management Team will regularly monitor members with ongoing medical conditions and coordination of services for over and underutilization patterns, and care needs, such that the following functions are addressed as appropriate:

- Serve as a liaison between the member and providers.
- Ensure the member is receiving routine medical care and that the member has adequate support systems at home.
- Identify and coordinate transition of care needs.
- Provide and refer the member/legal guardian available community resources to assist in manage the member's medical condition.
- Sharing with providers and/or other health plans serving the member, as part of the Interdisciplinary Care Team (ICT), the results of its identification and assessment of any member with special healthcare needs so that those activities need not be duplicated.

Those members that are identified or referred for Care Management Services will be evaluated and assigned a level of acuity, based on the evaluation results, and will be referred for on-going Care Management or Disease Management Services available through the Plan.

Our Care Management Team follows the Interdisciplinary Care Team (ICT) approach, with the PCP as the primary point of contact. The ICT is composed of a team of providers from different professional disciplines or services who work together to deliver care services that are focused on care planning/transition of care needs and to provide support for the member/legal guardian, caregiver and/or the family.

Individual Care Plans are developed with the support of the ICT in identifying specific problems or needs and goals for resolution. The member/legal guardian and/or caregiver is encouraged to actively participate in the development, implementation, and on-going assessment of the Care Plan.

Members may be referred to the Plan’s UM Care Management Team by calling 1-855-893-5170 or fax our Case Management Referral Form (refer to Section 24. Forms; Case Management Referral Form) to 1-877-577-0117.

**For Clear Health Alliance (CHA) Members**
All case managers follow treatment adherence for members via access to Catamaran (our PBM that provides real time for prescription fills). Case Managers contact provider offices if there are questions/concerns regarding particular treatment regimens. The Plan also communicates issues of concern to the Pharmacy Department.
Providers are encouraged to contact the CHA Case Management Queue at 1-855-459-1566 to speak to the Case Management Department directly about any concerns.

**Disease Management**
The Plan offers the following Disease Management programs:
- Diabetes
- Asthma
- Congestive Heart Failure
- Hypertension
- OB/Maternity Program
- Oncology
- HIV/AIDS

In all cases, an assessment is completed for each enrollee to identify any necessary services. Coordination of care is arranged through the Case Manager, Disease Manager, and/or Care Coordinator and communicated back to the PCP. Simply Healthcare Plans will assure appropriate ongoing treatment reflecting the highest standards of medical care designed to minimize further deterioration and complication of the enrollee.

For more information on our Disease Management programs, contact your Provider Relations representative. Members may be referred to the Plan’s Disease Management Program by calling 1-855-893-5170 or fax our Case Management Referral Form (refer to Section 24. Forms; Case Management Referral Form) to 1-877-577-0117.

**The Plan’s Utilization and Medical Criteria Resources**
The following sources are utilized by the Plan in helping to make determinations. These include, but are not limited to:
- American Academy of Pediatrics guidelines
- American College of Physicians guidelines
- Department of Health & Human Services, U.S. Preventative Services Task Force (USPSTF)
- Florida Medicaid Medical Services Coverage and Limitations Handbook
- Florida Medicaid Hospital Services Coverage & Limitations Handbook
- Florida Medicaid Handbooks
- Centers for Medicare and Medicaid Services (CMS)
- Nationally recognized, evidence-based guidelines
- Simply Healthcare Plans Medical Policy and Utilization Management Guidelines
- McKesson Interqual guidelines (1) LOC: Rehabilitation, (2) LOC: Long-Term Acute Care, (3) LOC: Acute Pediatric, and (4) LOC: Acute Adult.
- Simply Healthcare Plan’s Medicaid Managed Care (SMMC) MMA Contract with the Florida Agency for Healthcare Administration.
- Florida Medicaid Handbooks and Fee Schedules
- Florida Agency for Healthcare Administration Adopted Rules
- Simply Healthcare Plans adopted Medical Policy and Utilization Management Guidelines
- Simply Healthcare Plans adopted, nationally recognized, evidence-based clinical practice guidelines (See Section 9 of this Handbook).
- McKesson Interqual guidelines (1) LOC: Rehabilitation, (2) LOC: Long-Term Acute Care, (3) LOC: Acute Pediatric, and (4) LOC: Acute Adult.

**Adverse Determinations**
The Plan follows all federal and state regulations and guidelines in making an authorization’s final determination. If the final determination is adverse (denial) for requested service(s) the Plan will:
- Ensure that only a Medical Director may issue an adverse determination (denial), with the exception of
denials due to benefit issues.

- A written denial will be faxed to the provider and mailed to the member within two (2) working days after the subscriber or provider is notified of the adverse determination with information about the appeals process and utilization review criteria.

Please see Section 15 for member appeals.
Section 6. Pregnancy-Related Requirements

It is expected and necessary that the most appropriate and highest level of quality care is provided for all pregnant enrollees. Required care includes the following:

Florida's Healthy Start Prenatal Risk Screening
Florida's Healthy Start prenatal risk screening must be offered to each pregnant enrollee as part of her first prenatal visit, as required by the State of Florida:

1) You must use the DOH prenatal risk form (DH Form 3134), which can be obtained from the local CHD or at: https://www.prestigehealthchoice.com/pdf/provider/itn/communications/prenatal-risk-screen.pdf
2) Keep a copy of the completed screening form in the member's medical record and provide a copy to the member.
3) Submit the completed DH Form 3134 to the CHD in the county where the prenatal screen was completed within ten (10) business days of completion of the screening.
4) Collaborate with the Healthy Start care coordinator within the member’s county of residence to assure delivery of risk-appropriate care.

In addition, the Plan’s Nurse Case Managers will work with you and the member to coordinate services and strive for excellent outcomes.

Florida's Healthy Start Infant (Postnatal) Risk Screening Instrument
The Health Plan shall ensure that Florida Hospitals contracting with the Health Plan electronically file the Florida Healthy Start Infant (Postnatal) Risk Screening Instrument (DH Form 3135) and the Certificate of Live Birth with the CHD in the county where the infant was born within five (5) business days of the birth. The Health Plans that contract with the birthing facilities not participating in the Department of Health electronic birth registration system shall ensure that the provider files required birth information with the CHD within five (5) business days of the birth, keeps a copy of the completed DH Form 3135 in the enrollee’s medical record and mails a copy to the enrollee.

Pregnant enrollees or infants who do not score high enough to be eligible for Healthy Start care coordination may be referred for services, regardless of their score on the Healthy Start risk screen, in the following ways:

5) If the referral is to be made at the same time the Healthy Start risk screen is administered, the provider may indicate on the risk screening form that the enrollee or infant is invited to participate based on factors other than score; or
6) If the determination is made subsequent to risk screening, the provider may refer the enrollee or infant directly to the Healthy Start care coordinator based on assessment of actual or potential factors associated with high risk, such as HIV, Hepatitis B, substance abuse or domestic violence

Refer all infants, children up to age five (5), and pregnant, breast-feeding and postpartum women to the local WIC office.

7) You must complete the following:
   • A completed Florida WIC program medical referral form available at: http://www.floridahealth.gov/programs-and-services/wic/health-providers/_documents/medical-referral-form.pdf with the current height or length and weight, taken within sixty (60) calendar days of the WIC appointment;
   • Hemoglobin or hematocrit; and
• Any identified medical/nutritional problems.

8) For subsequent WIC certifications, coordinate with the local WIC office to provide the above referral data from the most recent CHCUP.
9) Each time you complete a WIC referral form, you must give a copy of the form to the member and keep a copy in the member's medical record.

Give all women of childbearing age HIV counseling and offer them HIV testing. See Chapter 381, F.S.

10) You must offer all pregnant women counseling and HIV testing at the initial prenatal care visit and again at twenty eight (28) and thirty two (32) weeks.
11) You must attempt to obtain a signed objection if a pregnant woman declines an HIV test. See s.384.31, F.S. and 64D-3.019, F.A.C.
12) Ensure that all pregnant women who are infected with HIV are counseled about and offered the latest antiretroviral regimen recommended by the U.S. Department of Health & Human Services (Public Health Service Task Force Report entitled Recommendations for the Use of Antiretroviral Drugs in Pregnant HIV 1 Infected Women for Maternal Health and Interventions to Reduce Perinatal HIV 1Transmission in the United States).

Screen all pregnant enrollees receiving prenatal care for the Hepatitis B surface antigen (HBsAg)

13) During the first prenatal visit.
14) Perform a second HBsAg test between twenty eight (28) and thirty two (32) weeks of pregnancy for all pregnant enrollees who tested negative at the first prenatal visit and are considered high-risk for Hepatitis B infection. This test shall be performed at the same time that other routine prenatal screening is ordered.
15) All HBsAg-positive women shall be reported to the local CHD and to Healthy Start, regardless of their Healthy Start screening score.

All infants born to HBsAg-positive members:
Must receive Hepatitis B Immune Globulin (HBIG) and the Hepatitis B vaccine once they are physiologically stable, preferably within twelve (12) hours of birth, and shall complete the Hepatitis B vaccine series according to the vaccine schedule established by the Recommended Childhood Immunization Schedule for the United States.

16) Test infants born to HBsAg-positive enrollees for HBsAg and Hepatitis B surface antibodies (anti-HBs) six (6) months after the completion of the vaccine series to monitor the success or failure of the therapy.
17) Report to the local CHD a positive HBsAg result in any child age twenty four (24) months or less within twenty four (24) hours of receipt of the positive test results.
18) Refer infants born to enrollees who are HBsAg-positive to Healthy Start regardless of their Healthy Start screening score.

Report to the Perinatal Hepatitis B Prevention Coordinator at the local CHD all prenatal or postpartum enrollees who test HBsAg-positive.

You also need to report said enrollees’ infants and contacts to the Perinatal Hepatitis B Prevention Coordinator.

19) Report the following information – name, date of birth, race, ethnicity, address, infants, contacts, laboratory test performed, date the sample was collected, the due date or estimated date of confinement, whether the enrollee received prenatal care, and immunization dates for infants and contacts.
20) Use the he Practitioner Disease Report Form (DH Form 2136) for reporting purposes.
Maintain all documentation of Healthy Start screenings, assessments, findings and referrals in the members’ medical records.

Prenatal Care – Other Plan Requirements:

1) A pregnancy test and a nursing assessment are required with referrals to a physician, PA or ARNP for comprehensive evaluation for prenatal care;
2) Care coordination/case management through the gestational period according to the needs of the enrollee.
3) Request any necessary referrals and follow-up;
4) Schedule return prenatal visits at least every four (4) weeks until week thirty two (32), every two (2) weeks until week thirty six (36), and every week thereafter until delivery, unless the member’s condition requires more frequent visits;
5) Contact those enrollees who fail to keep their prenatal appointments as soon as possible, and arrange for their continued prenatal care
6) Assist enrollees in making delivery arrangements, if necessary; and
7) Screen all pregnant enrollees for tobacco use and make certain that you make available to pregnant enrollees smoking cessation counseling and appropriate treatment as needed.

Nutritional Assessment/Counseling
Supply nutritional assessment and counseling to all pregnant enrollees.

8) Ensure the provision of safe and adequate nutrition for infants by promoting breast-feeding and the use of breast milk substitutes;
9) Offer a mid-level nutrition assessment;
10) Provide or refer the member to individualized diet counseling and a nutrition care plan by a public health nutritionist, a nurse or physician following the nutrition assessment; and
11) Ensure documentation of the nutrition care plan in the medical record by the person providing counseling.

Obstetrical Delivery
Develop and use generally accepted and approved protocols for both low-risk and high-risk deliveries reflecting the highest standards of the medical profession, including Healthy Start and prenatal screening.

1) Document preterm delivery risk assessments in the enrollee’s medical record by week twenty eight (28).
2) If you determine that the enrollee’s pregnancy is high risk, ensure that the obstetrical care during labor and delivery includes preparation by all attendants for symptomatic evaluation and that the member progresses through the final stages of labor and immediate postpartum care.

Newborn Care
Provide the highest level of care for the newborn beginning immediately after birth. Such level of care shall include, but not be limited to, the following:

1) Instilling of prophylactic eye medications into each eye of the newborn;
2) When the mother is Rh negative, securing a cord blood sample for type Rh determination and direct Coombs test;
3) Weighing and measuring of the newborn;
4) Inspecting the newborn for abnormalities and/or complications;
5) Administering one half (.5) milligram of vitamin K;
6) APGAR scoring;
7) Any other necessary and immediate need for referral in consultation from a specialty physician, such as the Healthy Start (postnatal) infant screen; and
8) Any necessary newborn and infant hearing screenings (to be conducted by a licensed audiologist pursuant to Chapter 468, F.S., a licensed M.D. or D.O., or an individual who has completed documented training specifically for newborn hearing screenings and who is directly or indirectly supervised by a licensed physician or a licensed audiologist).

Postpartum Care

9) Provide a postpartum examination for the enrollee within six (6) weeks after delivery; including a visit on or between 21 and 56 days after delivery;
10) Provide for voluntary family planning, including a discussion of all methods of contraception, as appropriate;
11) Refer the newborn to a pediatrician for completion of Child Health Check Up (CHCUP) screenings.
Section 7. Covered Services

The Plan covers all of the benefits required by Medicaid, which can be found in the Florida Medicaid Summary of Services (MSS) at: http://ahca.myflorida.com/medicaid/flmedicaid.shtml

You should also refer to the Florida Medicaid Coverage & Limitations Handbook, available through the FLMMIS portal at:

It is agreed that the Plan will provide patient management for the following services for each patient:

- Advanced Registered Nurse Practitioner Services
- Ambulatory Surgical Centers
- Assistive Care Services
- Birth Center Services
- Child Health Check-Up Services, Healthy Start Services
- Immunizations
- Chiropractic Services
- Clinic Services
- Community Mental Health Services
- County Health Department Services
- Dental Services
- Dermatology Services
- Renal Dialysis Services
- Durable Medical Equipment and Medical Supplies
- Emergency Room Services
- Family Planning Services
- Federally Qualified Health Center Services
- Freestanding Dialysis Centers
- Hearing Services
- Hospice
- Home Health Services
- Nursing Care
- Laboratory Services
- Licensed Midwife Services
- Physician Services
- Physician Assistant Services
- Podiatric Services
- Primary Care Case Management Services
- Prescribed Drug Services
- Rural Health Clinic Services
- Targeted Case Management
- Therapy Services
- Transplant Services
- Transportation Services
- Vision Services
- X-Ray Services including portable x-rays
- Behavioral Health Services
- Hospital Services
• Nursing Facility Services
Family Planning Services
Family Planning Services include education, planning and referral, counseling, initial examination, diagnostic procedures and routine laboratory studies, contraceptive drugs and supplies. Members have freedom of choice in choosing a contraceptive method covered under the Medicaid program, including Medicaid-covered implants, where there are no medical contra-indications and the services are voluntary.

These services may not be provided to members under 18 unless one of the following is met:
- The member is a parent, pregnant or married, has written consent the member’s authorized representative or in the opinion of a physician, the plan participant may suffer health hazards if services are not provided.
- The Family Planning Services Program does not include sterilization. Members can go to any provider that participates with Medicaid, including the County Health Department, for these services without a referral from the PCP.

A provider may refuse to furnish any contraceptive or family planning service, supplies, or information for medical or religious reasons and the provider shall not be held liable for such refusal. Please call the Plan for assistance in referring the member to another provider.

If a member receives Family Planning services from a non-participating provider, The Plan will reimburse the provider at the Medicaid reimbursement rate, unless another payment rate is negotiated.

Home Health Services
Home health services can be provided on an intermittent or part time basis by a home health aide, LPN, or RN for medically necessary services that can be provided in the place of residence of a recipient. Services included in a home health visit are private duty and personal care services for children twenty one (21) and under, therapy services, medical supplies, and durable medical equipment with limitations. (DME), it does not include homemaker services, Meals on Wheels, companion, social services or a sitter.

All services must be provided by a participating provider. The PCP must notify the Plan of services requiring home healthcare. There are a limited annual amount of visits.

Nursing Facility Services
The Plan shall furnish nursing facility services to enrollees under the age of eighteen (18) years old.

Hysterectomy
Is covered when is non-elective and medically necessary and must meet the following requirements:
- The member or her representative must have been informed verbally and in writing that the hysterectomy will render her incapable of reproduction permanently.
- The member or her representative has signed and been given a copy of the Acknowledgment of Receipt of Hysterectomy Information form (Refer to the Forms Section of the handbook) or an Exception Form to this requirement.
- Hysterectomies are not reimbursable when performed for the sole purpose of rendering a recipient permanently sterile or incapable of reproducing. Hysterectomy procedures must meet specific requirements before payment.

Sterilization
Non-therapeutic sterilization must be documented with a completed Sterilization Consent Form, (Refer to the Forms Section on this Handbook) as per Federal and State regulations. The form may also be downloaded from the AHCA site at http://www.uwmedicine.org/services/gynecology/documents/Surgery%20and%20Anesthesia%20Forms/Sterilization-Consent.pdf, clicking at the Medicaid Provider Reimbursement Handbook.
Sterilization procedures performed in the inpatient hospital, outpatient hospital and ambulatory surgical center settings are for the primary purpose of rendering a recipient (male or female) incapable of reproducing and are voluntary procedures reimbursable by Medicaid.

The following criteria must be met: The recipient must be at least 21 years old at the time of signing the State of Florida Sterilization Consent Form; must be mentally competent and not institutionalized in a correctional, penal, rehabilitation facility or a facility for mental diseases; and a State of Florida Sterilization Consent Form must be correctly completed and signed at least 30 days prior to sterilization, and a copy must be submitted with the physician claim for reimbursement. Abbreviations on the consent form are not acceptable. No other form is acceptable.

The member must wait at least 30 days after signing the consent form to have the operation, except when premature delivery or emergency abdominal surgery takes place at least 72 hours after the consent is obtained. The consent for sterilization cannot be obtained while the plan participant is in the hospital for labor, childbirth, abortion, or under the influence of alcohol or other substances. The consent is effective for 180 days from the date the consent form is signed by the member. If 180 days have passed before the surgery is provided, a new consent from must be signed.

**Peritoneal Dialysis**

According to the United States Renal Data System, the number of patients in the US with End-Stage Renal Disease (ESRD) being managed with chronic hemodialysis far outnumbers the number of patients managed with peritoneal dialysis. Each modality has its own risks and benefits, and many patients may be safely and appropriately be treated with either modality. Hemodialysis is generally much more costly than peritoneal dialysis.

There are multiple factors which contribute to choosing peritoneal versus hemodialysis for an individual patient such as availability, convenience, comorbid medical problems, socioeconomic status, home environment and safety, method of physician reimbursement, and the patient’s ability to tolerate volume shifts. In managing a patient with progressive chronic kidney disease, we recognize that in preparing a patient for dialysis, timing is critical.

The National Kidney Disease Foundation emphasizes that preparation for dialysis usually begins at stage 4 of disease for a variety of reasons. As patients progress to stage 4 kidney disease, a series of assessments and patient education needs to occur in order for them and their caregivers to make informed decisions about further treatment options and adapt to their progressing disease. It also allows for adequate evaluation for kidney transplant when appropriate, while at the same time allowing medical personnel secure appropriate dialysis access and perform necessary assessments and teaching for individuals who chose home peritoneal dialysis or hemodialysis.

The Plan’s Health Services Department and its case and disease managers are aware of all of these issues, and the Plan identifies members with stage 4 kidney disease utilizing laboratory data analysis. Many of these patients have comorbid issues that led to ESRD, including diabetes and hypertension, and are already enrolled in case and disease management. For these patients, we ensure that they are educated on their choices which may include peritoneal dialysis if medically reasonable. Because the efficacy and safety of peritoneal dialysis largely depends on adequate training, a home environment that is suitable for this therapy, and adequate support systems, the disease manager discusses these issues with the patient’s nephrologist and can offer a comprehensive home assessment and home care for education if peritoneal dialysis is felt to be a viable option.

Please keep in mind that peritoneal dialysis is an option for your patients with ESRD.
Section 8. Member Rights and Responsibilities

Overview
This section explains members’ rights and responsibilities, and is included in the Plan’s Member Handbook. Florida law requires healthcare providers and facilities to recognize member rights while they are receiving medical care or services and that the member respect the healthcare provider and facilities’ right to expect certain behavior on the part of the member.

Patient Rights must be posted in the provider’s office for all members to see. Contact a Provider Relations representative for a copy of the Patient Rights and Responsibilities document.

Member’s Rights & Responsibilities
Members and/or legally authorized representation have the right to:

- Be treated with courtesy and respect, and with due consideration of his/her dignity and privacy.
- Receive information on available treatment options and alternatives, presented in a manner appropriate to the enrollee’s condition and ability to understand.
- Participate in decisions regarding his or her healthcare, including the right to refuse treatment.
- Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation.
- Request and receive a copy of his or her medical records, and request that they be amended or corrected.
- Be furnished healthcare services in accordance with federal and state regulations.

The State must ensure that each enrollee is free to exercise his or her rights, and that the exercise of those rights does not adversely affect the way the health plan and its providers or the State agency treat the enrollee.

They also have the right to:

- Receive a prompt and reasonable response to questions and requests.
- Know who is providing medical services and who is responsible for his/her care.
- Know what member support services are available, including whether an interpreter is available if he/she does not speak English.
- Know what rules and regulations apply to his/her conduct.
- Be given, upon request, full information and necessary counseling on the availability of known financial resources for his/her care.
- Receive, upon request, prior to treatment, a reasonable estimate of charges for medical care and receive a copy of a reasonably clear and understandable, itemized bill and, upon request, to have the charges explained for services not covered by the Plan.
- Impartial access to medical treatment or accommodations, regardless of race, national origin, religion, handicap, or source of payment.
- Treatment for any emergency medical condition that will deteriorate from failure to provide treatment.
- Be advised if medical treatment is for purposes of experimental research and be able to give his/her consent or refusal to participate in such experimental research.
- Express grievances regarding any violation of his/her rights, as stated in Florida law, through the grievance procedure of the healthcare provider or healthcare facility which served him/her and to the appropriate state licensing agency.
- Member disclosures and records are treated confidentially, and members are given the opportunity to approve or refuse their release, except when release is required by law.
Members are responsible for:

- Providing to the healthcare provider, to the best of their knowledge, accurate and complete information about present complaints, past illnesses, hospitalizations, medications, and other matters relating to their health.
- Reporting unexpected changes in their condition to the healthcare provider.
- Reporting to the healthcare provider whether they comprehend a contemplated course of action and what is expected of them.
- Following the treatment plan recommended by the healthcare provider.
- Keeping appointments and, when they are unable to do so for any reason, for notifying the healthcare provider or healthcare facility.
- Their actions if they refuse treatment or do not follow the healthcare provider’s instructions.
- Assuring that the financial obligations of their healthcare are fulfilled as promptly as possible.
- Following healthcare facility rules and regulations affecting patient care and conduct.

Services for Translations and the Hearing Impaired

All Plan eligible and potential members whose primary language is not English are entitled to receive interpreter services through the Plan at no cost to the member by calling our Member Service Department at 1-800-887-6888 (Simply) or 1-877-577-9043 (CHA). For the hearing impaired, TTD/TTY is 711 Florida Relay.

Advance Directives

Advance Directives are an individual’s written choice for healthcare. Under Florida State Law, there are two types of directives, which are:

- Durable Power of Attorney for Healthcare
  This Advance Directive names another person to make medical decisions on behalf of the member when they cannot make choices for themselves. It may include plans about specific care a member wants or does not want and include information concerning artificial life support machines and organ donation. This form must be signed, dated and witnessed by a notary public to be valid.

- Directive to Physicians (Living Will)
  This Advance Directive usually states the member requests to die naturally without life-prolonging care and can also include information about specific medical care. This form would be used if the member could not talk and death would occur soon. This directive must be signed, dated and witnessed by two people who know the member well but are not relatives, possible heirs, or healthcare providers.

Written Advance Directives tell the healthcare provider how the members choose to receive medical care in the event they are unable to make end-of-life decisions. Plan providers must honor Advance Directives to the fullest extent permitted under Florida State Law.

Providers must document the presence of an Advance Directive in a prominent location within the member’s medical record. PCPs must discuss Advance Directives with members and provide appropriate medical advice if the members desire guidance or assistance. Under no circumstances may any Plan Provider refuse to treat a member or otherwise discriminate against a member because the member has completed or refuses to complete an Advance Directive.

For members who are no longer able to make decisions and do not have an Advance Directive, the member’s legal guardian or family and provider should confer together to decide upon the best care for the member based on information they know about the member’s end-of-life plans.

Providers are encouraged to review valuable information, educational materials and forms available through the AHCA Website for Advance Directives – The Patient’s Right to Decide at:
Section 9. Preventative Care and Clinical Practice Guidelines

Overview
The Plan utilizes nationally recognized preventative care, evidence-based clinical practice information and clinical practice guidelines/protocols.

This information is made available to Plan providers to ensure fair, consistent, and quality healthcare services and treatment is provided to the members.

Below you will find links to these guidelines. For questions or comments, please contact the Plan Utilization Management Department at 1-877-915-0551 Option 2, or contact your Provider Relations Representative.

<table>
<thead>
<tr>
<th>Clinical Practice Guidelines Reference Guide</th>
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<tbody>
<tr>
<td><strong>Topic</strong></td>
</tr>
<tr>
<td>Asthma (Adult and Pediatric)</td>
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<tr>
<td>Cancer</td>
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<td>Condition</td>
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<td><strong>Diabetes</strong></td>
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<tr>
<td>Topic</td>
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<tr>
<td>Ischemic Heart Disease (IHD)</td>
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### Preventative Services

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<thead>
<tr>
<th>Topic</th>
<th>Website Link</th>
<th>Information Provided</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cancer</td>
<td>Adults and Children: <a href="http://www.ahrq.gov/professionals/clinicians-providers/ehclibrary/cancer/">http://www.ahrq.gov/professionals/clinicians-providers/ehclibrary/cancer/</a></td>
<td>Multiple cancer related topics regarding prevention, screening and counseling</td>
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<tr>
<td>Chronic Obstructive Pulmonary Disease</td>
<td>Adults: <a href="http://www.ahrq.gov/professionals/clinicians-providers/guidelines-recommendations/guide/section2a.html#COPD">http://www.ahrq.gov/professionals/clinicians-providers/guidelines-recommendations/guide/section2a.html#COPD</a></td>
<td>Screening for Chronic Obstructive Pulmonary Disease Using Spirometry</td>
</tr>
<tr>
<td>Category</td>
<td>Adult and Children:</td>
<td>Development and behavior screening information</td>
</tr>
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<td>-----------------------------------------------</td>
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<td>---------------------------------------------------------------------------------------------------------------</td>
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<tr>
<td>Development and Behavior</td>
<td><a href="http://www.uspreventiveservicestaskforce.org/Page/Name/browse-tools-and-resources">http://www.uspreventiveservicestaskforce.org/Page/Name/browse-tools-and-resources</a></td>
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<tr>
<td>Heart and Vascular Diseases</td>
<td>Guidelines on the Treatment of Blood Cholesterol to Reduce Atherosclerotic Cardiovascular Risk in Adults <a href="https://aha.community360.net/Activity/2693405/Detail.aspx">https://aha.community360.net/Activity/2693405/Detail.aspx</a></td>
<td>Multiple heart and vascular related topics regarding prevention, screening and counseling</td>
</tr>
<tr>
<td>Infectious Diseases</td>
<td>Adults: <a href="http://www.idsociety.org/IDSA_Practice_Guidelines/">http://www.idsociety.org/IDSA_Practice_Guidelines/</a></td>
<td>Multiple infectious disease related topics regarding prevention, screening and counseling</td>
</tr>
<tr>
<td>Mental Health Conditions and Substance Abuse</td>
<td>Adults: <a href="http://www.uspreventiveservicestaskforce.org/BrowseRec/Search?s=behavioral+health">http://www.uspreventiveservicestaskforce.org/BrowseRec/Search?s=behavioral+health</a></td>
<td>Multiple mental health and substance abuse related topics regarding screening and counseling</td>
</tr>
<tr>
<td>Metabolic, Nutritional and Endocrine Conditions</td>
<td>Adults: <a href="http://www.uspreventiveservicestaskforce.org/BrowseRec/Search?s=endocrine">http://www.uspreventiveservicestaskforce.org/BrowseRec/Search?s=endocrine</a></td>
<td>Multiple metabolic, nutritional and endocrine related topics regarding prevention, screening and counseling</td>
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<tr>
<td>Musculoskeletal Disorders</td>
<td>Adult and Children: <a href="http://www.uspreventiveservicestaskforce.org/BrowseRec/Search?s=musculoskeletal">http://www.uspreventiveservicestaskforce.org/BrowseRec/Search?s=musculoskeletal</a></td>
<td>Multiple musculoskeletal related disorders topics regarding screening and counseling</td>
</tr>
<tr>
<td>Obstetric and Gynecological Conditions</td>
<td>Adults: <a href="http://www.acog.org/Resources_And_Publications/Practice_Bulletins/Committee_on_Practice_Bulletins_Obstetrics/Thrombocytopenia_in_Pregnancy">http://www.acog.org/Resources_And_Publications/Practice_Bulletins/Committee_on_Practice_Bulletins_Obstetrics/Thrombocytopenia_in_Pregnancy</a></td>
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<tr>
<td>Perinatal Care</td>
<td>Adults, Adolescents and Children: <a href="http://www.uspreventiveservicestaskforce.org/BrowseRec/Search?s=perinatal+care">http://www.uspreventiveservicestaskforce.org/BrowseRec/Search?s=perinatal+care</a></td>
<td>Multiple perinatal care related topics regarding screening</td>
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<td>Children and Adolescents: <a href="http://www.uspreventiveservicestaskforce.org/Page/Name/special-populations">http://www.uspreventiveservicestaskforce.org/Page/Name/special-populations</a></td>
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Section 10. Medical Record Standards

Overview
All Plan physicians are required to maintain a complete electronic or paper medical record for each member, according to approved professional practice standards, as well as state and federal requirements. Records are required to be current, legible, detailed, and organized to allow for effective and confidential member healthcare by all providers.

Requirements
Contracted providers are to have a person designated in charge of medical records whose responsibilities include, but are not limited to:

- The confidentiality, security and physical safety of records, in accordance with HIPAA privacy standards.
- The timely retrieval of individual records upon request.
- Having a unique identification of each member’s record.
- The supervision of the collection, processing, maintenance, storage, retrieval and distribution of records; and
- The maintenance of a predetermined, secured and organized record format.
- Retention of active records and retirement of inactive records.
- Timely entry of data in records.

The provider is responsible for documenting all evaluations, treatment, and services provided to the member. This documentation must include, but is not limited to:

- Family planning services, including discussion of all appropriate methods of contraception, counseling and services to all women and their partners.
- Preventative health services.
- Services for treatment of sexually transmitted diseases (STD’s).
- Ancillary, diagnostic and therapeutic services.
- All services for which a member was referred to a specialist or ancillary provider.
- Health Education and Wellness promotion services available and discussed.

Medical record documentation, at a minimum, must be legible, detailed, and organized in a consistent manner that facilitates continuity of care and maintain the following documentation:

- Member identification: Including name, member identification number, date of birth, sex, and legal guardian, if applicable.
- Medical history summary including:
  - Appropriate and timely diagnosis are based on findings on the initial assessment current medications (both prescribed and over-the-counter), with dosages, dates of initial or refill prescriptions or samples, untoward reactions and allergies to foods and/or drugs (both prescribed and over-the-counter) or documentation that none are known, surgical procedures, past and current medical diagnoses or problems.
- Documentation for the current office visit, which will include, but is not limited to:
- Chief complaint or reason for the current visit.
- Objective findings or observations.
- Consistent with Medical diagnosis or impression, including behavioral health conditions, authorizations and denials are consistent with EOC providers and medically defines services are consistent with state regulations.
- Record of timely consultations.
• Treatment plan, which will include referrals to specialists or other ancillary services; laboratory, radiological or other studies/procedures ordered; all therapies or services administered or prescribed to the member, including dosages and dates of initial or refill prescriptions; disposition, recommendations, instructions to the member, including follow-up time frames for follow-up evaluation/care, evidence of whether there was follow-up and outcome of services documentations of missed and canceled appointment.

• Name and profession of the provider rendering the services (i.e. MD, DO, DDS), including the signature of the provider.

• All entries in the medical record are to be dated and signed by the person who is making the documentation, with the profession (i.e. LPN, RN, PT) noted, if applicable.

• All entries must be legible and maintained in detail.

• All telephone calls from the member/legal guardian are to be documented in the medical record and include:
  - The date/time the call was received and by whom.
  - Fully detailed documentation of any advice, treatment/prescriptions or diagnosis/impression made and by whom, with name/title and signature of the person documenting.

• All member medical records are to include:
  - Documentation of any communication assistance needs that are needed for the delivery of healthcare services (i.e. sign language services for the deaf).
  - A current immunization history.
  - Member’s use of tobacco products or alcohol/substance abuse with documentation when referrals to cessation programs or behavioral services were offered and the member’s decision.
  - Summaries of all emergency care services and hospital discharge summaries with appropriate medical follow-up documented.
  - Documentation of all preventive care (i.e. women's healthcare services, prostate examination, colonoscopy, etc.) that was recommended and ordered for the member (NOTE: If the member refuses the recommended care, this should be documented and the member should sign that he/she refused the recommended service).

• Documentation that the member/legal guardian was provided with written information regarding Advance Directives, including:
  - End-of-life wishes (Do Not Resuscitate).
  - Living Will or Power of Attorney.
  - Whether or not the member/legal guardian has executed and Advance Directive.

  NOTE: Neither the Plan nor any of its providers shall, as a condition of treatment, require the member/legal guardian to execute or waive an Advance Directive.

• Copies of any advance directives executed by the member.

• Documentation in the member’s medical record will clearly indicate diagnostic or therapeutic intervention(s) as part of clinical research (NOTE: This requirement does not hold the Plan responsible for the payment of diagnostic or therapeutic intervention as part of clinical research).

• A release document for each member authorizing the Plan to release medical information for facilitation of medical care.

• A current problem list, including past and current diagnoses, procedures and surgeries, which will be used to provide continuity of care.

• Documentation of health education and wellness promotion services, whether they occurred within the context of a clinical visit or not.

• Providers must retain all the member’s medical records for a minimum of ten (10) years.

• Documentation is to be generated at the time of service or shortly thereafter. Delayed entries within a reasonable time frame (24 to 48 hours) are acceptable for the purpose of clarification, error correction, the addition of information not initially available and if certain unusual circumstance prevented the generation of a note at the time of service.
Medical records must be made available for quality care review studies by Plan reviewers, authorized representatives of the Agency for Healthcare Administration (AHCA), the Department of Health and Human Services (DHHS), Department of Financial Services, Centers for Medicare & Medicaid Services (CMS), Plan member and organizations conducting accreditation audits.

If a member changes his/her PCP, the current PCP is required to provide, without charge and in a timely manner, a copy of the transferring member’s medical record to the new PCP.

In addition to the medical records requirements above, medical records for patients with HIV/AIDS must be maintained according to standards held by, or in association with, the Florida/Caribbean AIDS Education and Training Center (F/C AETC) and/or one of its recognized partners. See the organizational website for more details: [http://www.fcaetc.org/](http://www.fcaetc.org/)

**Medical Records Audits and Compliance**

In order to comply with regulatory and accreditation requirements, our Quality Improvement Department conducts medical records audits in physician offices. The members’ medical records will be reviewed for content and screenings, as applicable.

All providers with an aggregate audit score of 85% or lower are scheduled for their next review in six (6) months or more frequent as determined by their score and deficiencies found.

All providers who scored less than 85% on an audit component directly related to the condition or diagnosis of the enrollee’s medical record reviewed is reviewed every six months or more frequently, until it is determined by the score that deficiencies have been remediated.

Physicians will be given preliminary results at the time of the audit. A final written report will be mailed to the provider within 30 days. A corrective action plan may be required depending on a three-tiered hierarchy:

- **Minimal Deficiencies**- Score is between 85% and 100% no remediation is required.
- **Moderate Deficiencies**- Score is 75% to 84% and a score of 80 to 85% or more in all separate components the provider’s documentation will be reviewed again in six (6) months.
- **Serious Deficiencies**- Score is less 74% and a score of 79% or less in all separate components the provider will be required a corrective action plan.

It is the provider’s responsibility to comply with Corrective Action Plans imposed as the result of any such audit or review.
Section 11. Quality Improvement

Overview
The Plan maintains an active Quality Improvement Program (QIP) that provides structure and processes for our ongoing commitment to continually improve upon the care and services that are offered to our members.

The Quality Improvement Program is designed to assess quality of care and service in a manner that meets or exceeds all acceptable prevailing standards and will initiate improvements in healthcare and service provided to its members. The QIP goals are based upon our ongoing evaluation of programs and services offered; regulatory, contractual and accreditation requirements; and strategic planning initiatives.

Program Goals
The goals of the QIP include but are not limited to:
- Develop, implement and maintain systems and programs that monitor, measure and improve the healthcare outcomes and service levels within identified member populations.
- Ensure access to qualified, competent providers.
- Engage member/legal guardians in the education, managing and improving their current health state.
- Promote a safe, culturally-sensitive delivery of healthcare that promotes appropriate, efficient and effective use of resources and supports the physician-patient relationship.
- Ensure the coordination of and transition of care needs are identified and provided to our members.
- Ensure compliance with standards as required by contract, regulatory statutes and accreditation agencies.
- Encourage and use feedback from stakeholders to improve reporting methods and information availability in relevant, timely manner.
- Utilize a multidisciplinary committee approach to facilitate the success of the QIP goals, improve organizational communication and ensure the participation of contracted community providers in the development/ review of the clinical aspects of programs and services.

The QIP works to achieve these goals through an evaluation process of clinical and service outcomes by measuring the effectiveness of internal processes and ongoing, active improvement interventions. Functional aspects of the QIP that contribute to a high level of clinical and service outcomes include, but are not limited to:
- Care Management and Disease Management Programs.
- Healthy Pregnancy Program; Obstetric and Maternity Program;
- Preventative Care and Clinical Practice Guidelines.
- Measurement of Clinical and Service Quality; HEDIS, CAHPS®, Provider Satisfaction Survey, Member Satisfaction Survey, and key quality metrics.
- Care Management and other Resources for you to assist our members:

  Domestic Violence Hotline- Florida: 1-800-500-1119 (24/7 availability)
  Alcoholic Anonymous – In Dade: 305-461-2425
  Narcotics Anonymous – In Dade: 305-265-9555
  Florida Quit for Life – 1-877-822-6669 to quit smoking
  http://smokefree.gov/ for online resources, information and booklets on how to quit smoking.
  http://www.greatquits.com/ great website for advice on abstinence and pregnancy prevention.

The QIP includes ongoing screening of the members’ medical records to assure compliance with all regulatory and accreditation agency guidelines. In addition, the QIP will also conduct ongoing studies to document compliance with accessibility, availability, efficiency, safety, efficacy, appropriateness, effectiveness, and continuity of patient
care and services delivered by the provider and the Plan itself. As opportunities for improved documentation or patient care are identified, a plan of action will be developed and implemented. Providers may be asked to participate, when possible, in developing the plan of action because collaborative input will help provide a successful workable solution.

The Plan’s QI Department will assess, on an ongoing basis, the minimum guidelines of care required by regulatory agencies and accreditation organizations for medical record review, health screening and high-risk diagnoses; a representative from the Plan’s QI Department, or assigned Plan designee, will contact the provider’s office to schedule an appointment to review the items in the office. Upon completion of the review, the provider will have an exit meeting with the reviewer to have the findings presented to him/her. At that time any deficiencies found during the review will be outlined so as to assist the provider in making any necessary corrections. Additional education will always be provided when deficiencies are identified. A Correction Action Plan may be requested for all identified deficiencies.

Providers Rights Corrective Action, Fair Hearing Plan, and Reporting to the Florida Division of Medical Quality Assurance, Department of Health and the NPDB

Providers have the procedural right to be heard and to appeal the CRC or Peer Review Committee recommendations and actions, including the ones resulting in filing a report to the Florida Division of Medical Quality Assurance, Department of Health and the NPDB.

The Plan conducts an ongoing evaluation of services by providers in the plan’s contracted network to achieve and maintain high standards of professional practice within the discipline. In the event that the prevailing professional standard of care for a given provider is believed not to be that level of care, skill, and treatment which, in light of all relevant surrounding circumstances, is recognized as acceptable and appropriate by reasonably prudent similar healthcare providers in the community, the Plan’s Peer Review Committee will be involved. Peer review may be initiated based on ongoing monitoring of utilization statistics and performance indicators that may indicate quality of care and service issues. Examples include aberrant referral patterns indicating over or underutilization or a trend in member complaints or documented incident reports involving the same provider.

The Peer Review Committee provides fair hearing appeal opportunity for providers and renders judgment in a timely manner and according to the Plan’s policies and procedures. The medical director or a designee chairs the Peer Review Committee. Its membership is drawn from the provider network and includes peers of the provider being reviewed. All peer review activities and data collected are confidential pursuant to Florida State law.

The Plan supplies the providers with a summary of the rights in the hearing in accordance with the Healthcare Quality Improvement Act of 1986, which include:

- Furnishing the physician with written notice of the proposed action, with the time, place and date of any hearing of the proposed.

The right to the hearing may be forfeited if the provider fails, without good cause, to appear in the hearing the provider has the right:

- To representation by an attorney* or other person of the physician’s choice.
- To have a record made of the proceedings, copies of which may be obtained by the physician upon payment of any reasonable charges associated.
- To call, examine and cross-examine witnesses.
- To present evidence determined to be relevant by the Committee.
- To submit a written statement at the close of the hearing.
Upon completion of the hearing, they physician involved has the right to:
- To receive the written recommendation of the Committee, including a statement for the basis of the recommendations (which the Plan will send to the provider within ten (10) days)
- To receive a written decision of the Plan, including a statement for the basis of the decision (which the Plan will send to the provider within thirty (30) days)

* The provider needs to notify the Plan of such representation at least ten (10) working days prior to the scheduled hearing. The Plan may in those cases have legal representation present.

For those cases in which the provider does not agree with the Peer Review Committee’s decision, please see Section 14, Provider Complaints and Disputes, for Second Level Appeals. There is no further appeal for the decision of the second level appeal.

**Satisfaction Surveys**
Simply Healthcare Plans conducts an annual survey to assess provider satisfaction with provider enrollment, communications, education, credentialing, complaints resolution, claims processing, claims reimbursement and utilization management processes. Our Provider Satisfaction Survey tool and methodology are reviewed and approved by the state of Florida prior to administration. The results of this survey are provided to AHCA by July 1st of each calendar year.

The Plan also conducts the Consumer Assessment of Healthcare Providers and Systems (CAHPS) member satisfaction survey. This survey solicits our members’ perceptions about our health plan and our network of providers. The CAHPS member satisfaction survey enables members to rate their providers on several individual and composite measures noted in the chart below:

<table>
<thead>
<tr>
<th>How Well Doctor’s Communicate</th>
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<tbody>
<tr>
<td>Personal Dr. explanation easy to understand</td>
<td></td>
</tr>
<tr>
<td>Personal Dr. listened carefully to you</td>
<td></td>
</tr>
<tr>
<td>Personal Dr. showed respect for what you had to say</td>
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<tr>
<td>Personal Dr. spent enough time with you</td>
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<table>
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<tr>
<th>Getting Care Quickly</th>
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<tbody>
<tr>
<td>Getting care as soon as needed</td>
<td></td>
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<tr>
<td>Getting an appointment as soon as needed</td>
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<table>
<thead>
<tr>
<th>Coordination of Care from Doctor’s Office</th>
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<tbody>
<tr>
<td>Personal doctor informed of specialist care</td>
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<thead>
<tr>
<th>Share Decision Making</th>
<th></th>
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<tbody>
<tr>
<td>Discussed reasons to take medicine</td>
<td></td>
</tr>
<tr>
<td>Discussed reasons not to take a medicine</td>
<td></td>
</tr>
<tr>
<td>Asked preference for medicine</td>
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Section 12. Cultural Competency Program

Overview
The Plan has a comprehensive Cultural Competency Program to ensure that we will deliver culturally competent services that meet the diverse needs of all of its members and to ensure the provision of linguistic access and disability related access to all members including those with limited English proficiency. In addition, the Plan is committed to ensuring our providers fully recognize and care for and provide the culturally diverse needs of the members they serve.

The Cultural Competency Program documents how the individuals and systems within the Plan will effectively provide services to people of all cultures, races, ethnic backgrounds and religions, as well as those members with disabilities, in a manner that recognizes the values of the individuals and preserves the dignity of all.

Cultural competency training is included in all employee and provider training, both upon initially joining the Plan and, at a minimum, annually. This integrated approach was developed so that cultural competency becomes a part of our everyday thinking.

The Plan endorses the view, as promoted by the federal government, that achieving cultural competence will help the Plan to improve services, care and health outcomes for its current members through improved understanding leading to better adherence and satisfaction and to increase market penetration by appealing to potential culturally and linguistically diverse members.

The Plan will review and update, if indicated, its Cultural Competency Program at a minimum of every year to ensure the Program is meeting the needs of the Plan’s members, employees, and the provider network.

Standards
Our Cultural Competency Plan has integrated those standards as recommended by the U. S. Department of Health and Human Services and other agencies. The standards and additional information are available and may be viewed by going to the following website: http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=2&lvlID=15.

The Plan conducts initial and ongoing organizational self-assessments of Culturally and Linguistically Appropriate Services (CLAS) related activities and integrates cultural and linguistic competence-related measures into its internal audits, performance improvement programs, patient satisfaction assessments, conflict and grievance resolution and outcomes-based evaluations.

The standards include but are not limited to the following:

- To ensure that patients receive effective, understandable, and respectful care in a manner compatible with their cultural health beliefs and practices and preferred language.
- To have at all levels of the organization a diverse staff and leadership representative of the demographic characteristics of the service area.
- To ensure that staff at all levels receive ongoing education and training in culturally and linguistically appropriate service delivery.
- To offer and provide language assistance services, including bilingual staff and interpreter services, at no cost to each member with limited English proficiency at all points of contact.
- To provide to members in their preferred language both verbal offers and written notices informing them of their right to receive language assistance services.
- To assure the competence of language assistance provided to limited English proficient members by interpreters and bilingual staff. Family and friends should not be used to provide interpretation services (except on request by the patient).
- To make available easily understood patient-related materials and post signage in the languages of
the commonly encountered groups and/or groups represented in the service area.

- We will strive to develop participatory, collaborative partnerships with communities and utilize a variety of formal and informal mechanisms to facilitate community and patient/consumer involvement in designing and implementing CLAS-related activities.

Program Goals
The overall goals of our Cultural Competency Program (CCP) are:
- Identify members early that have potential cultural or linguistic needs.
- Ensure resources are available to meet language barriers and communication needs.
- Improve communication to members for whom cultural and/or linguistic barriers exist.
- Provide culturally sensitive, appropriate educational materials based on the member’s race, ethnicity and primary language spoken.
- Decrease healthcare disparities in the minority populations where the Plan delivers services.
- Ensure providers and Plan employees are educated and value the diverse cultural and linguistic difference in the organization and populations served care.

Program Components
This CCP is organized around six core areas that represent the foundation for Plan wide cultural competence and the activities associated with each of these areas:

1) Foster Cultural Competence
2) Build Community Partnerships
3) Collect Diversity Data
4) Measure Performance and Evaluate Results
5) Reflect and Respect Diversity
6) Ensure Effective Communication and Language Access

Our Cultural Competency Program includes, but is not limited to data analysis of our employee and provider network diversity, compliance review, our employee and provider training, linguistic services/resources, electronic media services/resources, performance improvement outcomes.

You may request a copy of the Plan’s Cultural Competency Program (CCP) at no cost by calling your representative at Provider Relations. A full copy of the CCP is also available on the Plan’s Provider Website.
Section 13. Credentialing

Overview
The Plan is responsible for all aspects of the credentialing and re-credentialing process for all providers, surgery centers, hospitals, home health agencies, nursing homes, etc. who join or participate in the Plans Network. This process is under the Provider Administration Department and is designed to meet all regulatory and accreditation requirements and standards. In accordance with those standards, members will not be referred or assigned to a provider until the credentialing process has been completed.

We recognize and accept the Council for Affordable Quality Healthcare’s (CAQH) credentialing information and application, or our own practitioner application that includes specific profile elements as required by the State of Florida. We may contract with medical groups/IPA's that have approved credentialing function capabilities as entities with delegated credentialing.

Required Information
As a practitioner requesting initial credentialing or re-credentialing with the Plan, you are required to submit adequate information that will allow us to complete a thorough evaluation which includes your background, experience, education, malpractice cases, sanctions and training; demonstrate the ability to perform as a Plan provider without limitations, including physical and mental health status as permitted by law and other additional information as indicated on applications.

If the application is incomplete in any way, you will receive a request from the Plan, or its delegated entity, to provide the necessary information.

Additional Considerations
We encourage those providers who wish to be participating providers for Clear Health Alliance, and who are not credentialed by the American Academy of HIV Medicine (AAHIVM) or recognized by the Florida/Caribbean AIDS Education and Treatment Centers (AETC) to do so, and refer them accordingly.

While all providers are required to undergo credentialing, we give particular focus to providers serving in the primary care role for our enrollees with HIV/AIDS. We include an Education/Training Attestation for participation as an HIV/AIDS primary care provider as part of the credentialing packet that includes the qualifications described below.

Participation as an HIV/AIDS designated primary care provider requires that the provider attest that they meet the criteria to care for our members in one of the following ways:

1) Be credentialed as an AAHIVM HIV specialist by the American Academy of HIV Medicine
   [www.aahivm.org]
2) Be board certified in the field of infectious disease and, if not certified in the past year
   through the American Board of Medical Specialties, has clinically managed a minimum of
   twenty-five (25) patients in the preceding twelve (12) months as well as successfully
   completed a minimum of ten (10) hours of continuing medical education (CME), with at least
   five (5) hours related to antiretroviral therapy in the past year.
3) Be recognized by the Florida/Caribbean AIDS Education and Training Center as having sufficient
   clinical experience and additional on-going training in HIV/AIDS to be considered a specialist.

Medicaid Background Screening
A satisfactory level II background check is required by law for all treating providers not currently enrolled in
Medicaid’s fee-for-service program, and this screening is a mandatory part of our credentialing process.
Credentialing applicants must submit fingerprints electronically, following the process described on AHCA’s
Background Screening website. The Plan will then verify Medicaid eligibility through the background screening system.

The Plan will not contract with any provider 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.).

Individuals already screened as Medicaid providers, or screened within the past 12 months by another Florida agency or department using the same criteria as AHCA, are not required to submit fingerprints electronically, but must document the results of the previous screening.

Individuals listed in s. 409.907(8) (a), F.S., for whom criminal history background screening cannot be documented must provider fingerprints electronically following the process described on AHCA’s Background Screening website.

Site Reviews
- Site reviews are required for the following provider offices:
  - All Primary Care Physicians (PCP’s), which include Family Practice, General Practice, Pediatrics, and Internal Medicine
  - Women’s Healthcare Providers
  - OB/GYNs
  - High Volume Behavioral Health Providers
- Once the Credentialing Department receives a practitioner’s credentialing application, a Provider Relations representative will schedule an office site visit. The provider must have a review score of 80% or greater to pass the review for the credentialing application process. In the event the provider does not receive a passing score and a corrective action plan is implemented, it is in the best interest of the provider to work with the site reviewer in developing the corrective action plan and correcting any deficiencies so as not to delay the credentialing process.

Credentialing Review Committee (CRC)
- All providers must be credentialed and approved by the CRC prior to their contract becoming effective.
- The Credentialing Review Committee (CRC) voting members are professional peers.
- Once the requesting provider’s credentialing file is complete it is submitted to the CRC for review and decision.
- If the CRC is unable to make a determination based on the available information in the file and requires additional information, the Credentialing Department will request such information on behalf of the CRC.
- On occasion, the CRC may, in its sole discretion, request that an applicant requesting credentialing appear for an interview.
- Our Board of Directors has delegated the authority to approve or deny applicants who apply for credentialing through the CRC.

Verification Process
The Credentialing Department is responsible for verification of the applicant’s information using primary and secondary source verification on items such as medical license, education and training, NPDB, etc., in addition to the credentialing information provided to evaluate the candidate prior to being presented to the CRC.

Re-credentialing
Once a provider is credentialed by the CRC to provide service for the Plan’s members, re-credentialing will
be performed every three (3) years.

The providers will receive a re-credentialing application in a Provider Profile format approximately four (4) months prior to their credentialing expiration date. Only information that has changed since the last credentialing needs to be updated.

Failure of the provider to return the re-credentialing form to the Plan will result in an administrative termination from our Provider Network as a non-compliant provider.

Information will be verified and presented to the CRC for re-credentialing including:
- Qualifications continue to be met in accordance with all State Federal and accreditation guideline.
- Quality performance information (i.e. medical record reviews, member satisfaction surveys, Member Services reports).

In the event a provider’s DEA, medical license and/or liability insurance expires prior to a provider’s next re-credentialing date, the provider will receive a request for the updated information. Failure to provide the requested information with the specified time frame will result in automatic suspension and/or termination from the Plan’s Provider Network.

**Ongoing Monitoring**
The Plan ensures ongoing monitoring with documentation and verification of deemed documents. In the event any issues or discrepancies are found through the monitoring process, the provider will be managed accordingly, including immediate termination if they pose a potential threat to our members, placed on suspension till further notice. Results and actions will be communicated to the provider.

**Medicaid Program**
The Plan is authorized to take whatever steps are necessary to ensure that all our Medicaid Plan Participating providers are recognized by the state Medicaid program, including its choice counseling/enrollment broker contractor(s), as a participating provider of the health plan and that the provider’s submission of encounter data is accepted by the Florida MMIS and/or the state’s encounter data warehouse.

**Provider’s Right to Review**
Providers have the right to review their credentialing file at any time. Please contact your Provider Relations representative if you wish to review your file.

**Provider’s Right to Notify and Correct Information**
In the event the Plan receives information that conflicts with information given by the provider, we will notify the provider, in writing, immediately detailing the information in question.

The provider must submit a written response to the Plan within thirty (30) days of receiving the notification from us, and must explain the discrepancy and correct any erroneous information or provide any proof that he/she may have available.

This response is to be mailed to:

Simply Healthcare Plans  
9250 W. Flagler Street, Suite 600  
Miami, FL 33174-3460  
Attn: Credentialing Coordinator  

If the provider fails to respond within thirty (30) days, the application process will be discontinued and the
provider will not be approved for participation in our Provider Network.

**Provider's Right to be Informed**
Requests for application status update should be made by calling our Provider Relations Department at 1-877- 915-0551 or by regular mail or e-mail; the Provider Relations Department will respond to the request within three working days.

Our Provider Relations Department may share with the provider the status of the application in the credentialing process, however, they will not share with or allow a provider to review references, recommendations or other information that is peer-review protected.

Section 14. Provider Complaints and Disputes
Overview
The Plan’s provider complaint process allows providers the opportunity to express dissatisfaction about the Plan’s policies, procedures, or administrative functions, including proposed actions authorizations, referrals, billing disputes and claims determinations. Additional information requested such as itemized bill requests, submission of corrected claims and submission of coordination of benefits/third party liability information are not considered payment disputes. These are considered correspondence or requests for review and should be addressed to the Claims Department. You may use the Provider Claims Review Form available on the Plan’s website at http://simplyhealthcareplans.com/providers

Definitions
Disputes
The Plan refers to an expression of dissatisfaction concerning a claim as a dispute. A dispute may be filed for the following reasons:
- Untimely claims filing denials
- Contractual payment issues
- Lost or incomplete claim forms or electronic submissions
- Inappropriate or unapproved referrals initiated by providers (e.g., a provider payment dispute may arise if a provider was required to get authorization for a service, did not request the authorization, provided the service and then submitted the claim).
- Retrospective review after a claim denial or partial payment

The Plan’s provider claims dispute process allows providers the opportunity to dispute a claim determination and request a review and redetermination on the initial adverse decision made.

Medicaid members may not be billed for any Medicaid covered services rendered and denied by the Plan.

Complaints
Informal Complaint
The Plan refers to a verbal expression of dissatisfaction not related to claims as an informal complaint. This includes request from a provider to seek a review of a proposed action, service authorization or referral determination

Formal Complaint
The Plan refers to a written expression of dissatisfaction not related to claims as a formal complaint. The provider may seek a review of a proposed action, service authorization or referral determination.

Administrative Appeal
A written expression of dissatisfaction concerning provider sanctions, restrictions, suspensions and/or terminations.

Informal Complaint Process
Providers are encouraged to first communicate any concerns or dissatisfaction about a Plan process or decision verbally through the Provider Relations telephone lines at 1-877-915-0551, Option 4, Monday through Friday between the hours of 8am and 7pm EST, excluding state holidays.

Process for Filing and Submitting a Formal Complaint
Providers may file a formal complaint with the Plan in writing via electronic mail, fax, regular mail, or in person. For provider formal complaints the Plan shall:
• Allow providers forty five (45) days to file a written complaint;
• Within three (3) business days of receipt of a complaint, notify the provider (verbally or in writing) that the complaint has been received and the expected date of resolution;
• Document why a complaint is unresolved after fifteen (15) days of receipt and provide written notice of the status to the provider every fifteen (15) days thereafter; and
• Resolve all complaints within ninety (90) days of receipt and provide written notice of the disposition and the basis of the resolution to the provider within three (3) business days of the resolution.

Formal complaints must be submitted to the Plan via:

Mail: Simply Healthcare Plans
      9250 W. Flagler Street, MS# 200
      Suite 600
      Miami, FL 33174-3460
      Attn: Grievances and Appeals
Fax: 305-408-5880
E-mail: shp-grievance_and_appeals@simplyhealthcareplans.com

Process for Filing and Submitting a Formal Claims Dispute
Providers may file a formal claims dispute with the Plan in writing via electronic mail, fax, regular mail, or in person.

For provider formal claims disputes, the Plan shall:
• Allow providers ninety (90) days to file a written dispute for issues that are about claims;
• Resolve all disputes within sixty (60) days of receipt and provide written notice of the disposition.

A formal claims dispute must be submitted by completing the Plan’s Provider Claims Dispute Form found in Section 24, Forms of this Provider Manual. The form is also available on the Plan’s website at http://www.simplyhealthcareplans.com/providers. The completed form with all supporting documentation, including a copy of the Explanation of Payment (EOP) and a complete explanation of why the payment is being disputed must be sent to:

Mail: Simply Healthcare Plans
      9250 W. Flagler Street, MS# 300
      Suite 600
      Miami, FL 33174-3460
      Attn: Grievances and Appeals
Fax: 305-408-5880

If a provider is dissatisfied with the Plan’s final payment dispute resolution, the provider may appeal the Plan’s decision to the Statewide Provider and Health Plan Claim Dispute Resolution Program (Maximus). Application forms and instructions on how to file claims are available from Maximus directly at 1-866-763-6395, Option 5 and ask for the Florida Provider Appeals Process.

Process for Filing and Submitting an Administrative Appeal
All Plan contracted providers that are imposed sanctions, restrictions, suspended or are terminated for any reason shall have thirty (30) days from the date of receipt of notice of suspension or termination to file an appeal with Plan. The appeal must be submitted in writing to the address below and must be signed by the provider. No additional or separate right of appeal to AHCA, CMS or PLAN is created as a result of the Plan’s act of suspending or terminating a Provider or any Provider Practitioner.
Mail: Simply Healthcare Plans
     9250 W. Flagler Street, MS# 200
     Suite 600
     Miami, FL 33174-3460
     Attn: Grievances and Appeals

Toll Free Phone Number: 1-877-915-0551, Opt. 4
Section 15. Member Grievance and Appeals

Complaints
Any oral or written expression of dissatisfaction by an enrollee submitted to the Managed Care 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 of Managed Care Plan employee, failure to respect the enrollee’s rights, Managed Care Plan administration, claims practices or provision of services that relates to the quality of care rendered by a provider pursuant to the Managed Care Plan’s Contract. A complaint is a subcomponent of the grievance system.

Grievance
Any expression of dissatisfaction about any matter other than an action. Possible subjects for grievances include, but are not limited to, the quality of care, the quality of services provided and aspects of interpersonal relationships such as rudeness of a provider of Managed Care Plan employee or failure to respect the enrollee’s rights.

Appeal
A formal request from an enrollee to seek a review of an action taken by the Managed Care Plan pursuant to 42 CFR 438.400 (b).

Process for Grievance and Appeals
- The Managed Care Plan shall adhere to the following timeframes for filing of grievance and appeals:
  - A grievance may be filed orally or in writing within one (1) year of the occurrence.
  - An Appeal may be filed orally or in writing within thirty (30) days from the date on the notice of action and, except when expedited resolution is required, must be followed with a written notice within ten (10) days of the oral filing. The date of oral notice shall constitute the date of receipt.
  - The Plan will refer all enrollees and/or providers who are filing on behalf of the enrollee (whether participating or non-participating) who are dissatisfied with the Plan or its activities to the Plan’s grievance/appeals coordinator for processing and documentation of the issue.

Standard Timeframes
- A grievance shall be reviewed and a written notice of results sent to the enrollee no later than ninety (90) days from the date the Plan receives it.
- For standard resolution, an appeal shall be heard and notice of results sent to the enrollee no later than forty five (45) days from the date the Managed Care Plan receives it.
- The timeframe for a grievance or appeal may be extended up to fourteen (14) days if:
  - The enrollee asks for an extension, or the Plan documents that additional information is needed and the delay is in the enrollee’s interest;
  - If the timeframe is extended other than at the enrollee’s request, the Plan will notify the enrollee within five (5) business days of the determination, in writing, of the reason for the delay.
- The Plan shall complete the grievance process in time to accommodate an enrollee’s disenrollment effective date, which can be no later than the first day of the second month after the filing of a request for disenrollment.

Expedited Appeals
- The Plan shall have an expedited review process for appeals for use when taking the time for a standard resolution could seriously jeopardize the enrollee’s life or health or ability to attain, maintain
or regain maximum function.

- The Plan shall resolve each expedited appeal and provide notice to the enrollee, as quickly as the enrollee’s health condition requires, within state established timeframes not to exceed three (3) business days after the Plan receives the appeal request, whether the appeal was made orally or in writing.
- The Plan shall ensure that no punitive action is taken against a provider who requests or supports a request for expedited appeal.
- If the Plan denies, the request expedited appeal, it shall immediately transfer the appeal to the timeframe for standard resolution and so notify the enrollee.

**Disposition Notice Requirements**

- The Plan shall provide written notice of disposition of an appeal. In the case of an expedited appeal denial, the Managed Care Plan shall also provide oral notice by close of business on the day of disposition, and written within two (2) days of the disposition.
- Content of notice – The written notice of resolution must include:
  - The results of the resolution process and the date it was completed;
  - If not decided in the enrollee’s favor, information on the right to request a Medicaid Fair Hearing and how to do so; the right to request to receive benefits while the hearing is pending, and how to make the request;
  - If the Plan does not have an independent external review organization for its grievance process, the right to appeal an adverse decision on an appeal to the Subscriber Assistance Program (SAP), including how to initiate such a review.

**Member Information**

The section below is taken from Simply Healthcare’s Enrollee Grievance and Appeal procedure as set forth in the Simply Healthcare Member Handbook. This information is provided to you so that you may assist Simply Healthcare enrollees in this process, should they request your assistance. Please contact your provider contracting representative should you have questions about this process. Simply Healthcare has representatives who handle all enrollee grievances and appeals. A special set of records is kept with the reason, date and results. Simply Healthcare keeps these records in the central office.

**Filing Grievance and Appeal**

If an enrollee has questions or an issue, he or she may call Simply Healthcare Customer Service at 1-800-887-6888 (TTY 711) between 8 a.m. – 7 p.m.

If an enrollee is not happy with the answer he or she receives from customer service, an enrollee can file a grievance/appeal. An enrollee can call customer service to file a complaint, grievance or an appeal. If an enrollee calls about a complaint and we are unable to resolve the complaint by the close of business of the following day, then we request will automatically transferred to the grievance process. If an enrollee would like to file a complaint, grievance or appeal in writing, the enrollee may send us a letter or he or she can get a form from our website or by calling customer service. If an enrollee asks for a form from Simply Healthcare, it will be mailed within three working days. An enrollee can also request help from Simply Healthcare to fill out the form.

All grievance/appeals will be considered. The enrollee can have someone help during the process, whether it is a provider or someone he or she chooses. The enrollee has the right to continue services during the grievance/appeal process. If the enrollee would like his/her services to continue, the enrollee must to submit an appeal within 10 business days after the notice of action is mailed; or within 10 business days after the intended effective date of action, whichever is later. However, if the decision of the Grievance/Appeal Committee is not in the enrollee’s favor, the enrollee may have to pay for those services.
The grievance/appeal must have the following:

- Name, address, telephone number and ID number
- Facts and details of what actions were taken to correct the issue
- What action would resolve the grievance/appeal
- Signature
- Date

**Definitions**

Grievance: The grievance process may take up to 30 days. However, Simply Healthcare will resolve the enrollee’s grievance as quickly as his or her health condition requires. A letter telling the enrollee the outcome of the grievance will go out within 30 days from the date Simply Healthcare receives the request. The enrollee can request a 14-day extension if needed. We can also request an extension if additional information is needed and is in the enrollee’s best interest. Simply Healthcare will send the enrollee a letter telling him or her about the extra time, what additional information is needed and why it is in the enrollee’s best interest.

Appeal: An enrollee must file the appeal either verbally or in writing within 60 calendar days of the receipt of the notice of action. Except when expedited resolution is required, must be followed with a written notice within ten (10) calendar days of the oral filing. The date of the oral notice will be considered the date of receipt. The appeal process may take up to 30 days. However, Simply Healthcare will resolve the appeal as quickly as the health condition requires. A letter telling the enrollee the outcome of the appeal will go out within 30 days from the date Simply Healthcare receives the request. The enrollee can request a 14-day extension if needed. We can also request an extension if additional information is needed and is in the enrollee’s best interest. Simply Healthcare will inform the enrollee by mail of any extra time needed to make a decision, what additional information is needed and why it is in the enrollee’s best interest.

Expedited Process: The enrollee has the right to make an expedited verbal or written appeal. If there is a problem that is putting the enrollee’s life or health in danger, the enrollee or the enrollee’s legal spokesperson can file an “urgent” or “expedited” appeal. These appeals are handled within 72 hours. When making an appeal, the enrollee or enrollee’s legal spokesperson needs to let Simply Healthcare know that this is an “urgent” or “expedited” appeal. An expedited appeal may be made by calling Simply Healthcare at 1-800-887-6888 (TTY 711). If it is determined that it is not an expedited process, it will go through the standard process.

Medicaid Fair Hearing: If an enrollee is not happy with Simply Healthcare’s grievance or appeal decision, he or she can ask for a Medicaid Fair Hearing. Which can be filed within a hundred and twenty days (120) calendar days of receipt of the Simply Healthcare’s notice of resolution. Parties to the Medicaid Fair Hearing include the Plan as well as the enrollee, or that person’s authorized representative.

The addresses and phone numbers for Medicaid Fair Hearings at the local Medicaid Area Offices can be found at:

https://portal.flmms.com/FLPublic/Provider_ContactUs/tabid/38/Default.aspx

They are as follows:
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

The enrollee has the right to continue to receive benefits during a Medicaid Fair Hearing. He or she can
request to continue to receive benefits by calling our customer service department at 1-800-887-6888 (TTY 711) between 8 a.m. and 7 p.m. If the decision is not in the enrollee’s favor, he or she may have to pay for those benefits. The enrollee has the right to review his or her case before and during the appeal process.

Subscriber Assistance Program: If the enrollee is not satisfied with Simply Healthcare Plans appeal or grievance decision, he or she can ask for a review by the Subscriber Assistance Program (SAP). The enrollee has one year from receipt of the decision letter to request this review. If the member has already had a review completed by the Medicaid Fair Hearing, the SAP will not consider the appeal.

To request this review, the enrollee may contact: Agency for Health Care Administration, Agency for Health Care Administration
Subscriber Assistance Program
Building 3, MS #45
2727 Mahan Drive
Tallahassee, Florida 32308
1-850-412-4502,
or toll free 1-888-419-3456.

To send the grievance or appeal request in writing, the enrollee may mail it to the following address:
Simply Healthcare Plans Inc.
9250 W Flagler Street, Suite 600
Miami, FL 33172

Office hours for the grievance and appeals review department are from 8 a.m. and 5 p.m. Eastern time, Monday – Friday. If the enrollee cannot hear or has trouble talking, he or she may call 1-800-887-6888 (TTY 711).

If the enrollee wishes to walk in and file a grievance and appeal, the enrollee may do so at the following address:
Simply Healthcare Medical Plan Inc.
9250 West Flagler Street, Suite 600
Miami, Florida 33174
Office hours Monday – Friday 8 a.m. and 5 p.m.

If the enrollee wishes to contact our customer service department by phone, he or she may call 1-800-887-6888 (TTY 711).

If the enrollee cannot hear or has trouble talking, he or she may call 1-800-887-6888 (TTY 711). Customer service department hours are Monday – Friday, 8 a.m. – 8 p.m. Eastern time.

If the enrollee is calling after-hours, weekends or holidays for an urgent/expedited grievance or appeal, he or she will be asked to leave a voicemail and he or she will receive a callback by the end of the following day by a specialized team to address the expedited grievance or appeal.
Section 16. Claims

Overview
The primary focus of the Claims Department is to process claims in a timely manner. The Claims Department is proactive and works closely with the Provider Operations and Utilization Management Departments in trying to resolve any claims-related issues.

The Plan strives to follow AHCA guidelines for processing claims and payment. These guidelines are contained in the AHCA Provider Handbooks or may be viewed online at:


Claims Submission
Claims are to be submitted to Simply Healthcare Plans with appropriate documentation by mail or filed electronically for CMS-1500 and UB-04 claims. For those members that may be assigned to a delegated medical group/IPA that does its own claims processing, please verify the “Remit To” address on the SHP Member ID Card. Providers billing SHP directly should submit claims to:

Simply Healthcare Plans, Inc. or
Clear Health Alliance
PO BOX 21535
Eagan, MN 55121
Attn: Claims

UPS/FedEx Address:
Simply Healthcare Plans, Inc. or
Clear Health Alliance
c/o Smart Data Solutions
960 Blue Gentian Rd
Eagan, MN 55121

Or via Availity:
Simply Healthcare Plans- Payer ID 00199

Or via Emdeon:
Simply Healthcare Plans- Payer ID 27094

Providers are expected to make a good faith effort when billing the Plan to use the most current coding (ICD-10, CPH, HCPCS, etc.) available, coded to the highest specificity. The following information is to be included on all claims submissions, electronic or paper:

- Member’s name, date of birth, sex and ID number.
- Date(s) of service, place of service(s) and number of days or units, if applicable.
- Provider tax identification and NPI number.
- ICD-10 diagnosis codes by specific service to the highest level of specificity.
- Current CPT, revenue and HCPCS procedure code(s) with modifiers is appropriate.
- Billed charges per service(s) provided and total charges.
- Provider name and address, signature, and phone number.
- Information about other insurance coverage, Workers’ Compensation, accident or auto information, if available.
• Attach a detail description of the service or procedure for claim submitted with unlisted medical or surgical CPT or other revenue codes.
• For resubmissions and corrections of a claim, please submit a new CMS-1500 or UB-40 indicating the correction.

Paper claims must be submitted on the proper claim form, either a CMS-1500 or UB-04 (original forms only- do not make photocopies of blank forms) and must contain the information noted above. We will only process claims that are legible and filed on the appropriate claim form and containing the required data information. Claims filed that are incomplete, inaccurate, or untimely re-submissions may result in the denial of the claim.

Providers can only bill the health plan for any dual eligible members. Providers are advised on monthly cap rosters of dual eligibility and are expected not to send claims to Medicaid Fiscal Agents for reimbursement.

Filing a Claim Electronically
Providers submitting claims electronically should receive an acknowledgement from Emdeon, Availity or their current clearinghouse; if you experience any problems with your transmission please contact your local clearinghouse representative.

Timely Claim Submission
Plan providers will submit claims, as per Provider Contract, promptly to the Plan for covered services rendered to the member.

Plan as Primary payer within six (6) months of service or as per the terms of your contract.

Plan as Secondary payer (if the Plan is not the primary payer under coordination of benefits): within ninety (90) days after final determination by the primary organization.

Unless otherwise provided by law or provided by government sponsored program requirements, any claims that are not submitted to the Plan within these time limits will not be eligible for payment and the provider hereby waives any right to payment theretofore.

Clean Claim
All providers are required to submit clean claims. A clean claim is one that can go through the claims processing without obtaining additional information from the provider who provided the services or from a third party.

Timely Claims Processing and Payment
Clean claims payment will be paid to contracted providers in accordance with the timeframes specified in the contractual payment arrangement between the provider and the Plan. Payment is subject to the minimum standards as set forth by AHCA.

Claims for Emergency Services
The Plan shall not deny claims for the provision of emergency services and care submitted by a nonparticipating provider solely based on the period between the date of service and the date of clean claim submission, unless that period exceeds three hundred and sixty five (365) days.

Reimbursement for services provided to an enrollee by a non-participating provider shall be the lesser of:
• The non-participating provider’s charges
• The usual and customary provider charges for similar services in the community where the services were provided
• The amount mutually agreed to by the Plan and the non-participating provider within sixty (60) calendar days after the non-participating provider submits a claim; or
• The Florida Medicaid reimbursement rate established for the hospital or provider.

Florida Medicaid will reimburse one emergency room visit, per recipient, per day unless additional claims differ significantly in diagnosis or services provided.

Coordination of Benefits
Coordination of Benefits (COB) is the process used to process healthcare payments when a member has coverage with more than one insurer. When it is identified that a member has coverage with more than one insurer:
• Providers should first submit a claim to identified payers who have primary responsibility for payment of a claim before submitting a claim to the plan.
• Medicaid is considered payer of last resort.
• When the plan is the secondary payer, the provider must submit the claim to the plan with in ninety (90) days of the final determination by the primary payer (primary EOB date).
• The plan shall reimburse in accordance with the AHCA coordination of benefits payment guidelines.
• When filing a claim to the Plan, you must include a copy of the other insurance’s EOB with the claim.
• If the Plan is the secondary insurance, the Plan will pay the member’s responsibility after the primary insurance carrier has paid, not to exceed the Plan’s contracted allowable rate.
• The Plan may request a refund for COB claims paid in error for up to thirty (30) months from the original payment date.

Third Party Liability
Subrogation: The Plan will pay claims for covered services when probable third party liability has not been established or third party benefits are not available to pay a claim. The Plan will attempt to recover any third party resources available to members and shall maintain records pertaining to third party liability collections on behalf of members for audit and review.

Coordination of benefits: will be administered in accordance with applicable statutes and regulations.

Retroactive Eligibility Changes
A member’s eligibility with a health plan may change retroactively if the individual’s policy or benefit contract has been terminated, or the Plan receives information that the patient is no longer a member of the Plan, or if the eligibility information we received turned out to be untrue.

A claim adjustment may be necessary if you have had claims in which the members have had retroactive eligibility changes. The Explanation of Payment (EOP) or Provider Remittance Advice (PRA) will show the reason for the claim adjustment.

Encounter Submissions
In accordance with Agency for Health Care Administration, Encounter data collection and submission is required from all Plans for all services including expanded benefits, rendered to its enrollees (excluding services paid directly by the Agency on a fee-for-service basis). The Managed Care Plan shall submit encounter data that meets established Agency data quality standards as defined herein. These standards are defined by the Agency to ensure receipt of complete and accurate data for program administration and are closely monitored and enforced. The Agency for Health Care Administration (AHCA) requires 100 percent encounter submissions:
• 95 percent must pass through the state’s system
• Providers included on any health plan encounter transaction must be an active, registered provider with Florida Medicaid for the date service
• Providers must have a Florida Medicaid ID with Florida Medicaid
• Fee-for-service and capitated providers included

Encounters and claims identify members who have received services:
• Decreases the need for medical record review during HEDIS
• Will be critical for future world of Medicaid Risk Adjustment
• Helps identify members receiving preventive screenings

Encounter claims must be filed within 7 days of adjudication. Sanctions for noncompliance can include liquidated damages and even enrollment freezes. All Plan Delegated Entities must refer to their respective Delegated Contracts for Encounter Submission guidelines.
The encounter data submission standards required to support encounter data collection and submission are defined by the Agency for Health Care Administration (AHCA) in the Florida Medicaid Companion Guides, Pharmacy Payer Specifications and in this section. In addition, the Agency will post encounter data reporting requirements on the following websites:
  • http://portal.flmmis.com/FLPublic/Provider_EDI/Provider_EDI_CompanionGuides/tabId/62/Default.aspx
  • http://portal.flmmis.com/FLPublic/Provider_Pharmacy/tabId/52/Default.aspx

Providers who do not currently have a Florida Medicaid ID, can register through the Plan, apply directly to Medicaid via the online enrollment wizard for Limited Enrollment, or can apply directly to Medicaid via the online enrollment wizard for Full Enrollment. Provider may also register by completing the Florida Medicaid Provider Registration Form found on the Florida Medicaid Web Portal at:
http://portal.flmmis.com/FLPublic/Portals/0/StaticContent/Public/Managed%20Care/Treat%20Prov%20Reg%20Rev%20050615.pdf
Instructions for completing the Florida Medicaid Provider Registration Guide can be found at:
http://portal.flmmis.com/FLPublic/Portals/0/StaticContent/Public/Managed%20Care/Registration%20Guide%20rev%20051115%20FINAL.pdf
Section 17. Information on Fraud and Abuse

Overview
The Plan has policies and procedures towards the prevention, detection, reduction, correction and reporting of healthcare fraud, waste and abuse in compliance with all state and federal program integrity requirements.

The Plan’s Special Investigations Unit Manager oversees all the activities of our SIU program and reports any possible violations to the proper agencies. If you suspect a violation or a Plan member tells you of a possible violation please contact our Fraud Hotline via telephone at 1-877-253-9251 via fax to 786-441-4625; via email to SIU@simplyhealthcareplans.com or SIU@clearhealthalliance.com. For direct reporting of suspected fraud, waste or abuse, please use one of the following avenues below:

- Agency for Healthcare Administration Hotline: 1-888-419-3456
- Florida Attorney General's Office: 1-866-966-7226
- The Florida Medicaid Program Integrity Office: 1-850-412-4600
- Complaint Form: https://apps.ahca.myflorida.com/inspectorgeneral/fraud_complaintform.aspx

The Plan instructs and expects all employees, associates and providers to comply with all applicable laws and regulations and has procedures to report violations and suspected violations on the part of any employee, associate, person or entity providing care or services to our members.

Examples of violations include bribery, false claims, conspiracy to commit fraud, theft or embezzlement, false statements, mail fraud, healthcare fraud, obstruction of a federal healthcare fraud investigation, money laundering, failure to provide medically necessary services, marketing schemes, prescription forging or altering, physician illegal remuneration schemes, compensation for prescription drug switching, prescribing drugs that are not medically necessary, theft of the prescriber’s DEA number or prescription pad, identity theft, or members’ fraud with medications.

The Plan is obligated to report any suspected cases of healthcare fraud or abuse to regulatory agencies. The Plan may also consider reporting suspected cases of healthcare fraud to other government authorities such as the Office of Attorney General, Office of Inspector General or the Department of Justice.

In addition, the Agency for Healthcare Administration (AHCA), Office of the Inspector General (OIG), Office of Attorney General, Bureau of Medicaid Program Integrity audits and investigates providers suspected of overbilling or defrauding the Florida Medicaid Program, recovers overpayments, issues administrative sanctions, and refers cases of suspected fraud for criminal investigation to the Medicaid Fraud Control Unit. Program Integrity may also originate an investigation due to a complaint being filed.

Federal regulations require mandatory Compliance and Fraud and Abuse training to be completed by First Tier, Downstream and Related Entities (FDRs) as well as their employees, within ninety (90) days of hire/contracting and annually, thereafter.

Records of the training must be maintained for a period of ten (10) years with copies available to the SHP Compliance Officer. These records must include the following as the Plan, AHCA, CMS or agents of AHCA or CMS may request such records to verify that training occurred.

1) Materials used for classroom training; Date(s) training was provided
2) Methods of training provided or online training modules
3) Training sign-in logs or employee attestations, or electronic certifications from the employees completing the training.
If you or your employees have not taken the Compliance and or Fraud and Abuse training, please log onto our website under Medicaid, then click on the drop down menu, click on Providers for the training materials.

Please contact your representatives for additional instructions as needed. As stated above, it is your responsibility and part of your contractual obligation to comply with all federal and state healthcare program requirements for your continued participation with the Plan. You must maintain record of completion. During a Plan and or CMS/AHCA review, you will be asked to provide evidence of completion for our files. This material should be readily available and at the Plan’s request.

It is important that you review certain federal regulations:

1. The False Claims Act
   The Plan has prepared its compliance programs so that its policies and procedures are consistent with the Federal Civil False Claims Act, which prohibits knowingly presenting (or causing to be presented) to the federal government a false or fraudulent claim for payment or approval. The Act also prohibits knowingly making or using (or causing to be made or used) a false record or statement to get a false or fraudulent claim paid or approved by the federal government or its agents.

   When submitting claims data you must certify that the claims data is true and accurate to the best of your knowledge and belief. In addition, parties have a continuing obligation to disclose to the government any new information indicating the falsity of the original statement. Since the Plan maintains ultimate responsibility for adhering to all terms and conditions of its contract with state and federal programs, the Plan shall monitor its subcontractors for compliance with all applicable regulations.

2. The Anti-Kickback Statute
   Section 1128B(b) of the Social Security Act (42 U.S.C. 1320a-7b(b)) provides criminal penalties for individuals or entities that knowingly and willfully offer, pay, solicit, or receive remuneration in order to induce or reward business payable (or reimbursable) under the Medicare or other Federal healthcare programs. In addition to applicable criminal sanctions, an individual or entity may be excluded from participation in the Medicare and other Federal healthcare programs and subject to civil monetary penalties. For purposes of the anti-kickback statute, “remuneration” includes the transfer of anything of value, directly or indirectly, overtly or covertly, in cash or in kind. The Plan has policies and procedures employed to ensure that illegal remuneration is not permitted and shall specify follow-up procedures if they uncover unlawful remuneration schemes.

3. The Health Insurance Portability and Accountability Act (HIPAA)
   HIPAA was enacted, among other things, for the purpose of improving the efficiency and effectiveness of health information systems through the establishment of standards and requirements for the electronic transmission of certain health information. As a result, there are standards for certain electronic transactions, minimum security requirements, and minimum privacy protections for individually identifiable health information that is held by covered entities (i.e., protected health information); national identifiers under HIPAA for providers, plans and employers. Covered entities include health plans, healthcare clearinghouses and certain healthcare providers (namely those that conduct covered transactions).

   The Office for Civil Rights (OCR) is the Departmental component responsible for implementing and enforcing the privacy regulations. The Centers for Medicare and Medicaid Services (CMS) is the Departmental component responsible for implementing and enforcing the other HIPAA regulations.

**How to Report Fraud or Abuse**
Suspected fraud and/or abuse may be reported by phone and online. To report suspected fraud and/or abuse in Florida Medicaid, call the Consumer Complaint Hotline toll-free at 1-888-419-3456, or complete a
Medicaid Fraud and Abuse Complaint Form, which is available online at:

**Reward Program**
If you report suspected fraud and your report results in a fine, penalty, or forfeiture of property from a doctor or other healthcare provider, you may be eligible for a reward through the Attorney General's Fraud Rewards Program (toll-free 1-866-966-7226 or 1-850-412-3990). The reward may be up to 25 percent 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.

**HIPAA (Health Insurance Portability and Accountability Act of 1996) Privacy Rule**
We anticipate that you may have questions about whether the HIPAA (Health Insurance Portability and Accountability Act of 1996) Privacy Rule permits you to disclose your patients’ (our members’) medical information to us for these activities without written authorization from your patients.

Section 164.506(c)(4) of the Privacy Rule explicitly permits you to make this type of disclosure to Simply Healthcare Plans without a written authorization.

Additionally, the Office of Civil Rights (the federal agency tasked with enforcing the Privacy Rule) has also made this point clear. It wrote in its December 3, 2002, Guidance on the Privacy Rule that: “A covered entity may disclose protected health information to another covered entity for certain healthcare operation activities of the entity that receives the information if each entity either has or had a relationship with the individual who is the subject of the information and the protected health information pertains to the relationship, and the disclosure is for a quality related healthcare operations activity.”

**Breach Reporting**
Breach: The impermissible acquisition, access, use, or disclosure of Protected Health Information (PHI), which compromises the security and or privacy of such information, except where an unauthorized person, to whom such information is disclosed, would not reasonably have been able to retain such information.

It is the policy of the Plans to assure that all patient/member Protected Health Information (PHI), including electronic PHI, remains secure, confidential, and that it is only disclosed with proper authorization. Protected Health Information is individuals’ past, present, and future health information.

Types of PHI:
- Name
- Address
- Birth date
- Social security number
- Phone number
- Plan ID number
- Medical record number
- Admission/discharge dates
- Encounter dates, etc.
- Medicare/Medicaid ID numbers

Breaches could result from improper disposal of PHI, theft, loss, hacking, and because of other or unknown reasons. Contracted entities shall comply with all HIPAA privacy and security regulations and report HIPAA violations (breaches), to the Plans using the Plans’ HIPAA Breach Report Form, within 24 hours of discovery. (See the attached HIPAA Breach Report Form).
Section 18. Recommended Immunization Schedules for Persons Aged 0 through 18 Years

UNITED STATES, 2012

This schedule includes recommendations in effect as of December 23, 2011. Any dose not administered at the recommended age should be administered at a subsequent visit, when indicated and feasible. The use of a combination vaccine generally is preferred over separate injections of its equivalent component vaccines. Vaccination providers should consult the relevant Advisory Committee on Immunization Practices (ACIP) statement for detailed recommendations, available online at http://www.cdc.gov/vaccines/pubs/acip-list.htm. Clinically significant adverse events that follow vaccination should be reported to the Vaccine Adverse Event Reporting System (VAERS) online (http://www.vaers.hhs.gov) or by telephone (800-822-7967).

- Advisory Committee on Immunization Practices
  http://www.cdc.gov/vaccines/acip/index.html

- American Academy of Pediatrics
  http://www.aap.org

- American College of Obstetricians and Gynecologists
  http://www.acog.org

- U.S. Department of Health and Human Services Centers for Disease Control and Prevention
Immunization for Release of Medical Information

Primary Care Physician request release of Enrollee’s medical record, when medically necessary.

To Simply Healthcare Plans Care, Inc.

I,________________________________________ authorize/ do not authorize

(Member Name) (Circle one)

________________________________________

(Primary Care Provider)

To release an initial summary and progress notes on my health condition to my behavioral healthcare, substance abuse treatment, or other medical or clinical information. I also know that this authorization allows setting up a continuing plan of care and information to be released to my behavioral healthcare provider and to Simply Healthcare Plans or its designee as may be needed to administer my healthcare coverage.

I understand that this consent shall remain in effect for one year or throughout this course of treatment, whichever is longer. I also understand that I may cancel this authorization at any time by written notice to the above named treatment provider and Simply Healthcare Plans, Inc.

SIGNATURE: ______________________________ DATE: ______________________________

(If minor, signature of parents or guardian)

WITNESS: ______________________________ DATE: ______________________________
Section 19. Infection Control and Prevention Plan

Overview
Infection prevention and control is the goal of Simply Healthcare Plans. All infection control policies and this plan are written for the protection of health plan members, personnel, providers, and visitors. Simply Healthcare Plans has developed this infection prevention and control program based on principals established through various nationally recognized organizations in infection control that include Centers for Disease Control (CDC), The Association for Professionals in Infection Control and Epidemiology (APIC), and The Healthcare Infection Control Practices Advisory Committee (HICPAC). The program is under the leadership of the Chief Medical Officer who reports to the Board of Directors. The Board and the Chief Medical Officer have appointed a Medical Director with a Master’s in Public Health to serve as the Infection Control Lead for Simply Healthcare Plans. This individual is supported by the health plan Chief Medical Officer, Medical Directors and the administrators and managers of the various provider offices to ensure appropriate education, monitoring, and surveillance of the prevention and control of infections. It is noted that the infection prevention and control processes are integrated into the Plan’s QI Program.

The objectives of the infection control plan are as follows:
- To prevent, identify, minimize and manage infections and communicable diseases.
- To establish and implement the policies and procedures related to the control of infections at provider offices.
- To provide a mechanism to prevent cross-contamination of members/patients.
- To provide the Plan with pertinent information, counsel, and advice in relation to infection control.
- This shall include evaluation of new equipment and procedures for cleaning, decontaminating, and sterilizing, if appropriate.
- To ensure cooperation between the health plan and the physician offices in reflecting the occurrence of any infections.
- To establish and implement the surveillance system for evaluating and reporting infections in members, staff, and physicians.
- To delegate authority to institute any appropriate control measures or studies when there is a reasonable danger to any member or staff/physicians.
- To maintain active participation of staff through orientation and in-services and other activities and to ensure staff are knowledgeable of their respective roles and responsibilities in the prevention and control of infections.

Process
1) Prevention
This is most appropriately accomplished through orientation and training of staff in the physician offices and the implementation of policies and procedures as follows:
- Appointment of an infection control qualified healthcare professional who, in addition to holding Medical Doctor Degree, holds a Master’s degree in Public Health.
- Initial training during orientation (within 30 days of hire) and annually thereafter of all staff, allied health professional, and physicians as a component of the provider network training on OSHA standards and infection control practices.
- Provider offices are expected to adhere to the infection prevention and control policies and procedures of the health plan at all times.
- The physician network is expected to evaluate the disinfecting agents used by contracted services to ensure that they are appropriate and effective.
- Member education on an on-going basis related to infections.
- Monitoring of employee illness trends.
- Use of Personnel Protective Equipment (PPE), as appropriate (gloves).
2) Have a sharps prevention program in place (see below). Control hand washing procedures will be in place and provider offices will be trained in the techniques at new provider orientation.
   - Policies related to hand-washing will be adopted and provider offices will be educated during orientation.
   - Should any provider office in the network perform minor procedures using equipment that requires cleaning, high definition level cleaning or sterilization practices will be in place. Monitoring processes will be expected to be conducted.
   - Controls related to the disposal of biohazardous waste and storage in appropriate containers.
   - Monitoring the compliance with asepsis policies and procedures as outlined in OSHA standards.
   - Adherence to cleaning standards of patient care areas prior to use, between patients, and at the end of each day. Such cleaning will include the wiping down of all patient related equipment, the exam table, counters, and surfaces using approved disinfecting wipes.
   - Monitoring of employee illnesses.
   - Environmental controls that include restriction of persons in patient care areas if identified as having a communicable disease.
   - The Provider Manual of Simply Healthcare Plans will contain information on OSHA requirements, sharps injury protection, and hand-washing protocols.

3) Identification
   Identification is accomplished through a number of surveillance and monitoring processes as follows:
   - Members are to be instructed by their providers to contact them in the event that symptoms of infection are identified such as from a site where blood was drawn.
   - Provider office employee illness monitoring is conducted for trends.
   - Awareness of community issues that may include outbreaks of communicable diseases.

4) Reporting
   Reporting is an important component of the Infection Prevention Control Plan. Steps of reporting would include the following:
   - Reporting to local public health authorities as required by law and regulation (see Policy on Reporting of Reportable Conditions).
   - Reporting of infections through completion of an adverse incident report.
   - Reporting of office employee related exposures through the adverse incident reporting process.

**Sharp Prevention Program**
The Plan has a specific provider network program in place that ensures safety and the prevention of infections or contamination through its Sharps Prevention Program. The program includes the following parameters:

- Orientation of all provider office staff and the providers on the program within thirty (30) days of contracting. Articles on infection control may be provided in the newsletters on a periodic basis.
- The placement of sharp containers that are puncture proof throughout the provider offices in appropriate areas to be secure from tampering.
- Requirement for disposal of all intact needles and syringes in these sharp containers.
- Adherence to strict protocols on the safe use of needles related to re-capping that includes no bending or breaking of the needles from the syringes.
- Replacement of sharp containers when they are 2/3 full (to the line).
- Appropriate handling and disposal of the full containers using a recognized disposer contractor.
Section 20. Safety and Health Program

Introduction
The Plan’s Safety and Health Program follows the Occupational Safety and Health Administration (OSHA) Safety and Health Program Management Guidelines and has incorporated CMS safety initiatives to ensure safe care for its members.

Our Safety and Health Program contains 4 basic program elements:
- Management leadership with employee and provider network involvement
- Worksite analysis and provider office safety
- Hazard prevention and control
- Training

Under each element are numerous sub-elements. This program contains descriptions of how the program elements and sub-elements are designed and implemented. Specific documents resulting from program implementation will need to be kept in an organized fashion.

Management Leadership and Employee Involvement
The Plan commits the necessary resources of staff, money, and time to ensure that all persons working or visiting are protected from injury and illness hazards. In addition, management visibly leads in the design, implementation, and continuous improvement of the organization’s safety and health activities. The Board of Directors has ultimate responsibility for the Safety and Health Program and reviews and approves the program based on input and recommendation by the Compliance Officer, Quality Management Steering Committee, and the QI Department. The Compliance Officer ensures that all employees and providers are trained on this program and is designated as the Safety Officer.

Periodic evaluations of the overall Safety and Health Program are conducted to include evaluation of any required corrective action plans and the attainment of goals as appropriate.

The leadership and management of the Plan ensures that all employees have clearly written safety and health responsibilities included within their job description, with appropriate authority to carry out those responsibilities. The Plan ensures that all providers maintain a program of safety in treatment locations.

The Plan ensures that at least several avenues exist for employee involvement in safety and health decision-making and problem-solving. These avenues may include serving on committees or ad-hoc groups, acting as safety observers, assisting in training other employees, analyzing hazards inherent in the workplace and devising methods and practices that protect against such hazards, and planning activities to heighten safety and health awareness. Management encourages involvement and expects safety protocols are followed by the provider network that ensure safety care and conditions for the members.

Provider Office Safety Requirements and Assessments
The Plan supports a safe environment for its members. Providers are requested to maintain a safe work environment and to know that they may be inspected by the Plan’s provider relations staff on a periodic basis. The following outlines requirements for a safe environment that must be maintained:
- Implementation of processes for the management of identified hazards, potential threats, near misses, and other applicable safety concerns.
- Process for reporting of adverse incidents to the Plan’s provider relations and/or Compliance Officer in accordance with state requirements.
- Process in place to ensure a reduction and avoidance of medication errors.
- Implementation of a program that ensures the prevention of falls and injuries of patients, staff, and
visitors.

- Implementation of a process of monitoring medications and equipment/supplies that may be subjected to a recall to ensure that the recalled item(s) is returned and as appropriate, patients are contacted.

All employees are trained to recognize hazards and to report any hazard they find to the Safety Officer so that the hazard can be corrected as soon as possible. All employee reports of hazards should be documented as an adverse incident report. Any near miss, first aid incident, or accident is investigated by the Risk Manager/Safety Officer. All investigations will be subjected to a root cause analysis to determine required interventions.

As part of the annual safety and health program evaluation, the site owner, a manager, and an employee review all near misses, first aid incidents, and entries on the OSHA 200 Log, as well as employee reports of hazards, to determine if any pattern exists that can be addressed. The results of this analysis are considered in setting the goal, objectives, and action plans for the next year.

Provider offices are responsible to train staff in infection control and prevention as well at the time of hire and annually thereafter.

Patient records are to be maintained in compliance with medical record documentation standards and records are to have a means of identification that is unique.

Each provider office is required to maintain an Emergency Preparedness Plan to include evacuation protocols and conduct drills at least quarterly (must include at least 1 CPR drill). Simply Healthcare Plans has an Emergency Plan for all potential emergencies, including fire, explosion, accident, severe weather, loss of power and/or water, and violence from an outside source.

Provider offices are required to ensure on-going monitoring for expired medications that may be maintained either in medication cabinets, refrigerators, or sample medication rooms.

**Hazard Prevention and Control**

The Plan ensures that the Program is followed to protect persons at its administrative offices and provider network sites. Identified hazards will be eliminated when economically feasible. Provider network offices are expected to use barriers that protect persons from hazards that may include machine guards and Personal Protective Equipment (PPE). Provider network offices will be expected to have sharps safety protocols and medical emergency procedures that ensure safety in the care delivery areas. The Plan ensures that the organization and its premises properly maintained to ensure safety and health. If maintenance needs exceed the capability of the worksite employees, contract employees are hired to do the work and are screened and supervised to ensure they work according to the organizations safety and health procedures.

All employees, including all levels of management, are held accountable for obeying the Plan’s safety and health rules. The following 3-step disciplinary process will be applied to everyone by the appropriate level of supervisor for any safety related infractions:

- Oral warning;
- Written reprimand;
- Dismissal.

Visitors, who violate safety and health rules and procedures, will be escorted from the premises.

Persons needing emergency care are transported by ambulance to the hospital.

**Recalls**

As part of the processes to ensure safety, provider offices are required to have a process in place to
determine if any medications, equipment, or supplies have been subjected to a recall. Should the provider office be notified of a recall, the following processes will be performed:

- Staff in the office will be notified of the recalled item.
- Recalled item will be returned in accordance with instructions from the manufacturer.
- Investigation to determine if the recalled item(s) had been prescribed or used with a patient.
- Contact with the affected patient.
- Documentation of response to the recalled item(s) to include disposition of the returned item.

**Training**

The Plan believes that employee and provider network involvement in the Safety and Health Program can only be successful when sufficient training is provide that ensures an understanding what their safety and health responsibilities and opportunities are and how to fulfill them. All new employees will receive training on the Safety and Health Program at the time of initial orientation and annually thereafter. The provider network will be provided information on safety and health expectations at the time of initial contracting and periodically thereafter through the Provider Manual, communications, and newsletters.
Section 21. Highlights of Practitioner Services Coverage and Limitations

The provider type Physicians, ARNP, PA, RNFA and AA were consolidated into a single Practitioner Services and Limitation Handbook.

Coverage and Limitations
Mobile Units-Providers that are affiliated with LCME or COCA may be reimbursed.

Supervision- Services provided by an ARNP or a PA under the personal supervision of a physician may be billed by the physician instead of the ARNP or PA. Teaching physicians who seek reimbursement for oversight of patient care by a resident must personally supervise all services performed by the resident.

Exception- Deliveries, Psychiatric services, Child Health Check-Up screenings. ARNP or PA must bill using their own Medicaid ID number. RNFA must adhere to the supervision guidelines set by the Board of Nursing. All services provided by a RNFA must be under direct supervision of the physician. The AA must adhere to the supervision guidelines in Chapter 458 and 459, F.S and requires- on-site, personal supervision by an anesthesiologist in the office or suite where the procedure is being performed. Florida statute require that the anesthesiologist directly supervise services provided by an AA. The supervising anesthesiologist may bill as the rendering provider. If the provider chooses to bill the claim with the AA as the rendering provider, the supervising anesthesiologist may bill for supervision of the AA by billing the anesthesia code with a QK modifier. An anesthesiologist may supervise a max of four CRNAs or AAs at one time. Medicaid reimburses the anesthesiologist 20% of the anesthesia fee for supervising the CRNA or AA. Medicaid does not reimburses for supervision of procedure outside 00100-01999 anesthesia range. Medicaid does not reimburses anesthesiology supervision of CRNAs performing MAC or moderate sedation. Non-Invasive radiological studies do not require direct physician supervision to be reimbursed by Medicaid, but do require indirect supervision. Invasive radiological studies require personal supervision to be reimbursed by Medicaid.

Telemedicine Services- Only physicians can provide and receive reimbursement for telemedicine services. A physician, ARNP, or PA may initiate a consultation from the spoke site. The referring physician must be present during the consultation as well as the recipient. None of the following interactions are Medicaid reimbursable:

- Telephone conversations
- Video cell phone conversations
- E-mail messages
- Telecommunication with recipient other than spoke (location of the Medicaid recipient)
- Medicaid does not reimburse for the costs or fees of any of the equipment's necessary to provider services.

Documentation required:

- A brief explanation of why services were not provided face to face.
- Assessment and a signed statement form from the recipient, indicating their choice to receive services through telemedicine.
- Only codes reimbursed 99241 through 99255 with modifier GT.
- Services are limited to the hospital outpatient setting, inpatient setting, and physician office.

Recap
If an AA, ARNP, PA OR RNFA is employed by or contracts with a physician who can enroll as a Medicaid provider, the physician must enroll as a group provider and the AA, ARNP, PA or RNFA must enroll as an individual treating provider within the group. An individual treating provider, who is a member of a group, must be enrolled and obtain an individual Medicaid provider ID number before performing services for Medicaid recipients. It is the responsibility of the individual treating provider to notify the
Medicaid fiscal agent of all group practices with which is affiliated. Medicaid requires that the provider retain all business records on all services provided to a Medicaid recipient. In order to qualify as a basis for reimbursement, the records must be signed and dated at the time of services. Rubber-stamped signatures must be initialed. The records must be accessible, legible, and comprehensible. Medicaid payments for services that lack required documentation or appropriate signatures will be recouped.
**Section 22. Healthy Behaviors**

The Plan offer several Healthy Behaviors programs to encourage members to develop and maintain healthy lifestyles. In addition to the program information provided in this section, you may contact your Provider Relations representative for further details.

**Alcohol and Drug Abuse**

Healthy Behaviors Rewards Program

The Alcohol and Drug Abuse Healthy Behaviors Rewards Program (HBRP) is a one year program of treatment and rewards for success for Plan members who want to achieve sobriety.

The purpose of the Alcohol and Drug Abuse HBRP is to:

- Routinely screen all Plan members during regular PCP visits for risk of alcohol and/or substance abuse.
- Refer Plan members who screen positive for alcohol and/or substance abuse to the Beacon Health Options based Encompass Program where they will be encouraged to take steps toward sobriety and provided with support through the process.
- Assure that Plan members have the opportunity to work with a Beacon Health Options case manager to develop a strategy for achieving sobriety.
- Assure that Plan members have the medical and psychological support they need to achieve sobriety.
- Offer incentives to Plan members for attending Alcoholics Anonymous and Narcotics Anonymous meetings.

**How it Works**

<table>
<thead>
<tr>
<th>Intervention/ Milestone</th>
<th>Incentive Type*</th>
<th>Incentive Value *</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Make commitment to program</td>
<td>Point-based mail order rewards</td>
<td>5 points</td>
<td>Member and case manager sign Promise Form and submit to the Healthy Behaviors Reward Program (HBRP). Member can participate in the Alcohol or Drug Abuse HBRP only one time within a 12 month period.</td>
</tr>
<tr>
<td>1 Day Sobriety</td>
<td>Point-based mail order rewards</td>
<td>9 points</td>
<td>Member presents appropriate chip as evidence of compliance with attendance in AA/NA Reward contingent on Case Manager and member signature on compliance verification form and submission to the HBRP.</td>
</tr>
<tr>
<td>30 day Sobriety</td>
<td>Point-based mail order rewards</td>
<td>9 points</td>
<td>Member presents appropriate chip as evidence of compliance with attendance in AA/NA Reward contingent on Case Manager and member signature on compliance verification form and submission to the HBRP.</td>
</tr>
<tr>
<td>90 day Sobriety</td>
<td>Point-based mail order rewards</td>
<td>9 points</td>
<td>Member presents appropriate chip as evidence of compliance with attendance in AA/NA Reward contingent on Case Manager and member signature on compliance verification form and submission to the HBRP.</td>
</tr>
<tr>
<td>180 day Sobriety</td>
<td>Point-based mail order rewards</td>
<td>9 points</td>
<td>Member presents appropriate chip as evidence of compliance with attendance in AA/NA Reward contingent on Case Manager and member signature on compliance verification form and submission to the HBRP.</td>
</tr>
<tr>
<td>365 day Sobriety</td>
<td>Point-based mail order rewards</td>
<td>9 points</td>
<td>Member presents appropriate chip as evidence of compliance with attendance in AA/NA Reward contingent on Case Manager and member signature on compliance verification form and submission to the HBRP.</td>
</tr>
</tbody>
</table>

All Plan PCPs, case managers, and hospital-based concurrent nurse reviewers will receive training with regard to how to screen for alcohol and substance abuse and how to interpret results in terms of which members should be referred to the Alcohol and Drug Abuse HBRP. Alcohol and substance abuse screening should be conducted during routine PCP visits, case manager home visits or phone consultations, or during a hospital stay. To refer members identified at risk, a special referral form will be completed by the screener and sent or faxed to: (1) Beacon Health Options to initiate alcohol and substance abuse services and (2) the HBRP so that we can invite the member to participate in the incentive program.

When the HBRP receives a referral, an invitation to participate in the Alcohol and Drug Abuse HBRP, a program description, and a Promise Form (with pre-addressed, postage-paid envelope) will be mailed to the identified member. The purpose of the Promise Form is to engage the member in the contemplation phase of change. The member and the assigned Beacon Health Options case manager or counselor will sign the Promise Form. It is the member’s responsibility to return the Promise Form to the HBRP. A pre-addressed, postage-paid envelope is provided.

Once a member enrolls in the HBRP, they have the opportunity to earn points with which they will be able to purchase a variety of personal or household items. Each point earned has the value of $1. Maximum number of points is 50. Five points are awarded when the member returns the Promise Form. The table above shows how a Plan member who is enrolled in the Alcohol and Drug Abuse HBRP can accumulate points.

**Maternity**
Healthy Behaviors Rewards Program
The Maternity Healthy Behaviors Rewards Program (HBRP) continues during the entire prenatal period from the first trimester into the postpartum visit that occurs between three and eight weeks following delivery (per Medical Guidelines and HEDIS specifications).

The purpose of the Maternity HBRP is to:
- Identify pregnant Plan members early in their pregnancy.
- Promote a healthy pregnancy and delivery for the member and the baby.
- Encourage pregnant members to see the OB at least three times in each of the three pregnancy trimesters.
- Follow the member in the initial postpartum period (three to eight weeks).
- Encourage the member to take advantage of the free dental cleaning available to them through the Plan benefits during their pregnancy.
- Proactively identify potential risk of prenatal and/or postpartum complications with appropriate referral and intervention.

**How it Works**
Pregnant Plan members are identified through claims/encounters, inpatient admissions, emergency room utilization, the AHCA Special Needs Report, and laboratory data. Additionally, members may be identified through internal referrals (e.g., through the Utilization Management and Member Services Departments), PCP or specialist referrals, and member self-referral. Enrollment in the Maternity Case Management Program is automatic for all members who are identified as pregnant.

Once a member is identified as pregnant and enrolled in the Maternity Case Management Program, an invitation to participate in the Maternity HBRP, a program description, and a Promise Form (with pre...
addressed, postage-paid envelope) will be mailed to the identified member. The purpose of the Promise Form is to engage the member in the contemplation phase of change. The member will sign the Promise Form and return it to the HBRP. A pre-addressed, postage-paid envelope is provided.

When a member enrolls in the HBRP, they have the opportunity to earn points with which they will be able to purchase a variety of personal or household items. Each point earned has the value of $1. Maximum number of points is 50. Five points are awarded when the member returns the Promise Form. The table below shows how a Plan member who is enrolled in the Maternity HBRP can accumulate points.

<table>
<thead>
<tr>
<th>Intervention/Milestone</th>
<th>Incentive Type*</th>
<th>Incentive Value *</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Make commitment to program</td>
<td>Point-based mail order rewards</td>
<td>5 points</td>
<td>Member signs Promise Form and submits to the Healthy Behaviors Reward Program (HBRP)</td>
</tr>
<tr>
<td>Complete 1&lt;sup&gt;st&lt;/sup&gt; trimester expected visits to assure a healthy delivery.</td>
<td>Point-based mail order rewards</td>
<td>8 points</td>
<td>Attendance at three 1&lt;sup&gt;st&lt;/sup&gt; trimester visits. Incentive contingent on PCP /OB attestation and progress note documentation submitted to the Plan and/or claims data.</td>
</tr>
<tr>
<td>Complete 2&lt;sup&gt;nd&lt;/sup&gt; trimester expected visits to assure a healthy delivery.</td>
<td>Point-based mail order rewards</td>
<td>8 points</td>
<td>Attendance at three 2&lt;sup&gt;nd&lt;/sup&gt; trimester visits. Reward contingent on PCP/OB attestation and progress note documentation submitted to the Plan and/or claims data.</td>
</tr>
<tr>
<td>Complete 3&lt;sup&gt;rd&lt;/sup&gt; trimester expected visits to assure a healthy delivery.</td>
<td>Point-based mail order rewards</td>
<td>8 points</td>
<td>Attendance at all 3&lt;sup&gt;rd&lt;/sup&gt; trimester visits recommended by OB. Incentive contingent on PCP/OB attestation and progress note documentation submitted to the Plan and/or claims data.</td>
</tr>
<tr>
<td>Attend one dental cleaning during the pregnancy.</td>
<td>Point-based mail order rewards</td>
<td>8 points</td>
<td>Attendance at one dental cleaning. Incentive contingent on PCP/OB attestation and progress note documentation submitted to the Plan and/or claims data.</td>
</tr>
<tr>
<td>Attend postpartum visit to confirm no complications and plan for future birth control, if appropriate.</td>
<td>Point-based mail order rewards</td>
<td>13 points</td>
<td>Attendance at one postpartum visit within 21-56 days of delivery. Incentive contingent on PCP/OB attestation and progress note documentation submitted to the Plan and/or claims data.</td>
</tr>
</tbody>
</table>

**Quit Smoking**

Healthy Behaviors Rewards Program

The Quit Smoking Healthy Behaviors Rewards Program (HBRP) is a one-year program based on the evidence-based, physician-authored clinical decision support resource Up To Date (www.uptodate.com), which is associated with proven outcomes. The program hinges on an aggressive, systematic outreach and registration plan; is strengthened by a targeted, evidence-based approach to individual counseling/health coaching; and is bolstered by strong linkages with existing community resources. In addition, the program enables enrollees to gain access to the pharmaceutical support they need to improve their chances of quitting successfully.

The purpose of the Quit Smoking HBRP is to:

- Identify members who smoke or otherwise use tobacco products.
- Introduce a dialogue regarding risks and the benefits of quitting.
- Assure that members who want to quit smoking and using tobacco products have support that maximizes the probability of successful quitting.
- Offer incentives for meeting important milestones.
How it Works

- Enrollees are identified and offered the option to register in the Plan’s Quit Smoking Healthy Behaviors Rewards Program via several routes. Members identified as a smoker during the Health Risk Assessment will be offered information about the Quit Smoking HBRP and how to register. Providers are encouraged to refer their patients to the program by mailing, emailing, or faxing a special referral form. Plan providers will receive a copy of the U.S. Department of Health and Human Services Quick Reference Guide for clinicians, Treating Tobacco Use and Dependence, in order to assist in the identification and referral of tobacco users to the Stop Smoking HBRP.

- When the HBRP receives an internal or provider-initiated referral, an invitation to participate in the Quit Smoking HBRP, a program description, and a Promise Form (with pre-addressed, postage-paid envelope) will be mailed to the identified member. The purpose of the Promise Form is to engage the member in the contemplation phase of change. Regardless of how the member was referred, they are required to obtain their PCP’s signature on the Promise Form. It is the member’s responsibility to return the Promise Form to the HBRP. A pre-addressed, postage-paid envelope is provided.

- Once a member enrolls in the HBRP, they have the opportunity to earn points with which they will be able to purchase a variety of personal or household items. Each point earned has the value of $1. Maximum number of points is 50. Five points are awarded when the member returns the Promise Form. The table below shows how a Plan member who is registered in the Quit Smoking HBRP can accumulate points.

<table>
<thead>
<tr>
<th>Intervention/Milestone</th>
<th>Incentive Type*</th>
<th>Incentive Value*</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Make commitment to program</td>
<td>Point-based mail order rewards</td>
<td>5 points</td>
<td>Member and PCP sign Promise Form and submit to the Healthy Behaviors Reward Program (HBRP). Member can participate in the Quit Smoking HBRP only one time within a 12 month period.</td>
</tr>
<tr>
<td>Member completes smoking and tobacco use cessation program selected from a pre-approved list</td>
<td>Point-based mail order rewards</td>
<td>15 points</td>
<td>Completion of approved smoking/tobacco cessation program. Reward contingent on member submitting attendance certificate to the HBRP.</td>
</tr>
<tr>
<td>Member demonstrates learned skills and commitment by remaining tobacco free for one month</td>
<td>Point-based mail order rewards</td>
<td>10 points</td>
<td>Member is one month tobacco free. Reward contingent on member submitting personal and PCP attestation that member did not smoke for one month.</td>
</tr>
<tr>
<td>Member remains tobacco free for three months</td>
<td>Point-based mail order rewards</td>
<td>20 points</td>
<td>Member is three months tobacco free. Reward contingent on member submitting personal and PCP attestation that member did not smoke for three months.</td>
</tr>
</tbody>
</table>

Weight Loss
Healthy Behaviors Rewards Program

The Weight Loss Healthy Behaviors Rewards Program (HBRP) is a one-year program that targets Plan members who have a BMI of 30 or higher. The program will include consultation with a nutritionist, participation in both weight management and exercise programs, maintaining a food and exercise log. Participation in this program also requires that the member work with the PCP to develop a weight loss Plan.
The purpose of the Weight Loss HBRP is to:
- Identify members who are obese, very obese, or morbidly obese.
- Introduce a dialogue regarding the risks and benefits of improved nutrition, weight management, and regular exercise.
- Assure that members who want to lose weight have support that maximizes the probability of success.
- Offer incentives for meeting important milestones over a six month period.

How it Works
Members are identified and offered the option to register in the Plan's Weight Loss Healthy Behaviors Rewards Program via several routes. PCPs can refer their patients with a BMI of 30 or higher to the program by mailing, emailing, or faxing a special referral form. There is a similar internal referral process for Plan case managers or concurrent review nurses who identify members who meet the criterion. Members may also self- refer by calling the toll free HBRP telephone line or sending an email request for information.

When the HBRP receives an internal or provider-initiated referral or a self-referral, an invitation to participate in the Weight Loss HBRP, a program description, and a Promise Form (with pre-addressed, postage-paid envelope) will be mailed to the identified member. The purpose of the Promise Form is to engage the member in the contemplation phase of change. Regardless of how the member was referred, they are required to obtain their PCP's signature on the Promise Form. It is the member's responsibility to return the Promise Form to the HBRP. A pre-addressed, postage-paid envelope is provided.

Once a member enrolls in the HBRP, they have the opportunity to earn points with which they will be able to purchase a variety of personal or household items. Each point earned has the value of $1. Maximum number of points is 50. Five points are awarded when the member returns the Promise Form. The table below shows how a Plan member who is registered in the Weight Loss HBRP can accumulate points.

<table>
<thead>
<tr>
<th>Intervention/ Milestone</th>
<th>Incentive Type*</th>
<th>Incentive Value *</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Make commitment to program and talk to PCP about Plan of Care.</td>
<td>Point-based mail order rewards</td>
<td>5 points</td>
<td>Member and PCP sign Promise Form and submit to the Healthy Behaviors Reward Program (HBRP). Member can participate in the Weight Loss HBRP only one time within a 12 month period.</td>
</tr>
<tr>
<td>Member attends initial nutrition support session with a nutritionist and follow-up visit within two weeks.</td>
<td>Point-based mail order rewards</td>
<td>10 points</td>
<td>Member must attend an initial visit and follow up visit approximately two weeks later with a nutritionist. PCP will need to make a referral.</td>
</tr>
<tr>
<td>At one month after beginning their weight loss Plan of Care, the member demonstrates active participation in weight loss by keeping a daily food diary, an exercise log, and a diary of stress prevention/remediation</td>
<td>Point-based mail order rewards</td>
<td>15 points</td>
<td>Member and PCP attest to maintenance of the log/diary and loss of at least 4 pounds during initial month after implementation of weight loss Plan of Care.</td>
</tr>
<tr>
<td>Intervention/ Milestone</td>
<td>Incentive Type*</td>
<td>Incentive Value *</td>
<td>Description</td>
</tr>
<tr>
<td>---------------------------------------------------------------------------------------</td>
<td>-----------------</td>
<td>-------------------</td>
<td>-------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>strategies used and member loses at least 4 pounds.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Member maintains weight loss at six months after beginning weight loss Plan of Care.</td>
<td>Point-based mail order rewards</td>
<td>20 points</td>
<td>Member and PCP attest that member has maintained weight loss of at least four pounds over the six months since member began their weight loss Plan of Care.</td>
</tr>
</tbody>
</table>

**Well Child Visits**

Healthy Behaviors Rewards Program

The Well Child Visits Healthy Behaviors Rewards Program (HBRP) is a one year program that focuses on critical elements of the CHCUP. The program differs slightly, based on the age of the child, with one set of milestones for members between 0 and 23 months of age and another set of milestones for members ages 2 through 20 years. The purpose of the Well Child Visits HBRP is to encourage parents and guardians to participate in critical Well Child Health Check-Up (CHCUP) components.

For children ages 0 to 23 months of age these include:

- Seeing the doctor six times for well child visits before the member turns 15 months.
- Seeing the doctor for all recommended immunizations in the first 15 months.
- Seeing the doctor for a lead screening blood test between 13 and 23 months.

For children ages 2 through years of age these include:

- Seeing the doctor for one well child visit within 12 months of date of Well Child Visits HBRP enrollment.
- Seeing the dentist for one preventive dental visit within 12 months of date of Well Child Visits HBRP enrollment.
- Getting all immunizations recommended for the member’s age, including an annual flu shot, within 12 months of date of Well Child Visits HBRP enrollment.

**How it Works**

Parents/guardians of all members between 0 and 20 years of age will be provided with information about the Well Child Visit HBRP. Effective with implementation, currently enrolled Plan members who meet the age criterion (birth through 20 years of age) will receive information about the Well Child Visit HBRP. These members will be identified through a report generated from the Plan’s enrollment database. Thereafter, registration in the Well Child Visit HBRP will be offered as new members enroll in the Plan. Currently, all new enrollees receive two enrollment packages from the Plan: (1) a membership card and (2) member handbook and provider directory mailing. Information about the Well Child Visit HBRP will be included in the member package for all new enrollees in the targeted age range, as identified by initial enrollment data received monthly from AHCA.

Once a member enrolls in the HBRP, they have the opportunity to earn points with which they will be able to purchase a variety of personal or household items. Each point earned has the value of $1. Maximum number of points is 50. Five points are awarded when the member returns the Promise Form. The table below shows how a Plan member who is enrolled in the Well Child Visit HBRP can accumulate points.
<table>
<thead>
<tr>
<th>Intervention/Milestone</th>
<th>Incentive Type*</th>
<th>Incentive Value *</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Members all ages</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Make commitment to program</td>
<td>Point-based mail order rewards</td>
<td>5 points</td>
<td>Parents/guardians and doctor sign Promise Form and submit to the Healthy Behaviors Reward Program (HBRP). There must be a separate letter signed for each child</td>
</tr>
<tr>
<td><strong>Members 0-23 months at time of Well Child Visit HBRP Registration</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>At least six well child visits</td>
<td>Point-based mail order rewards</td>
<td>15 points</td>
<td>Child must have six well child visits, that occur before the member turns 15 months of age</td>
</tr>
<tr>
<td>Member receives all shots recommended in the first 15 months of life</td>
<td>Point-based mail order rewards</td>
<td>15 points</td>
<td>Pediatrician/PCP must confirm that member received all shots recommended for the first 15 months of life.</td>
</tr>
<tr>
<td>Member receives lead screening blood test</td>
<td>Point-based mail order rewards</td>
<td>15 points</td>
<td>Test should be done when child is between 13 and 15 months of age.</td>
</tr>
<tr>
<td><strong>Members 2-20 years at time of Well Child Visit HBRP Registration</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>One well child visit</td>
<td>Point-based mail order rewards</td>
<td>15 points</td>
<td>Pediatrician/PCP must confirm that member had one complete well child visit. Visit must occur within 12 months of date of program registration.</td>
</tr>
<tr>
<td>One preventive dental visit</td>
<td>Point-based mail order rewards</td>
<td>15 points</td>
<td>Dentist must confirm that member had preventive dental visit. Visit must occur within 12 months of date of program registration.</td>
</tr>
<tr>
<td>Member receives all shots based on age, including annual flu shot</td>
<td>Point-based mail order rewards</td>
<td>15 points</td>
<td>Pediatrician/PCP must confirm that member had all shots recommended for his/her age; pharmacist can confirm flu shot. Shots must occur within 12 months of date of program registration.</td>
</tr>
</tbody>
</table>
Section 23. Simply and Clear Health Alliance Quality Measurement Standards

Simply and Clear Health Alliance contracts with a NCQA/HEDIS Certified Software vendor which produces eligible population, analyzes compliance/non-compliance, and report rates for the following measures as established in the current MMA Contract Requirements:

<table>
<thead>
<tr>
<th>Measure Indicator</th>
<th>Measure- Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>AWC</td>
<td>Adolescent Well-Care Visits</td>
</tr>
<tr>
<td>AAP</td>
<td>Adults’ Access to Preventive/Ambulatory Health Services</td>
</tr>
<tr>
<td>ADV</td>
<td>Annual Dental Visits</td>
</tr>
<tr>
<td>AMM</td>
<td>Antidepressant Medication Management</td>
</tr>
<tr>
<td>ABA</td>
<td>Adult BMI Assessment</td>
</tr>
<tr>
<td>BCS</td>
<td>Breast Cancer Screening</td>
</tr>
<tr>
<td>CCS</td>
<td>Cervical Cancer Screening</td>
</tr>
<tr>
<td>CIS</td>
<td>Childhood Immunization Status - Combo 2 and 3</td>
</tr>
<tr>
<td>CDC</td>
<td>Comprehensive Diabetes Care</td>
</tr>
</tbody>
</table>
| CDC               | • Hemoglobin A1c (HbA1c) Testing  
|                   | • HbA1c poor control  
|                   | • HbA1c control (<8%)  
|                   | • Eye Exam (retinal) performed  
<p>|                   | •• Medical attention for nephropathy |
| CBP               | Controlling High Blood Pressure |
| ADD               | Follow-up Care of Children Prescribed ADHD Medication |
| IMA               | Immunizations for Adolescents |
| CHL               | Chlamydia Screening in Women |
| PPC               | Prenatal and Postpartum Care |
| MMA               | Medication Management for People with Asthma |
| W15               | Well-Child Visits in the First 15 Months of Life |
| W34               | Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life |
| CAP               | Children and Adolescents’ Access to Primary Care Practitioners |
| IET               | Initiation and Engagement of Alcohol and Other Drug Dependence Treatment |
| AMB               | Ambulatory Care |
| LSC               | Lead Screening in Children |
| MPM               | Annual Monitoring for Patients on Persistent Medications |
| FPC               | Frequency of Ongoing Prenatal Care |
| SAA               | Adherence to Antipsychotic Medications for Individuals With Schizophrenia |
| APM               | Metabolic Monitoring for Children and Adolescents on Antipsychotics |
| APC               | Use of Multiple Concurrent Antipsychotics in Children and Adolescents |</p>
<table>
<thead>
<tr>
<th>HEDIS &amp; Agency-Defined</th>
<th>Agency-Defined</th>
</tr>
</thead>
<tbody>
<tr>
<td>FHM  Follow-up after Hospitalization for Mental-Illness</td>
<td>RER Mental Health Readmission Rate</td>
</tr>
<tr>
<td></td>
<td>TRT Transportation Timeliness</td>
</tr>
<tr>
<td></td>
<td>Tra Transportation Availability</td>
</tr>
<tr>
<td></td>
<td>HAART Highly Active Anti-Retroviral Treatment</td>
</tr>
<tr>
<td></td>
<td>HIVV HIV-Related Outpatient Medical Visits</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Child Health Check-Up Report (CMS-416)</strong></td>
<td></td>
</tr>
<tr>
<td>TDENT Dental Treatment Services</td>
<td></td>
</tr>
<tr>
<td>SEA Sealants</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Child Health Check-Up Report (CMS-416)</strong></td>
<td></td>
</tr>
<tr>
<td>PDENT Preventative Dental Services</td>
<td></td>
</tr>
<tr>
<td>SEAL Dental Sealants for 6-9 Year Old Children at Elevated Caries Risk</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Child Core Set</strong></td>
<td></td>
</tr>
<tr>
<td>HPV HPV Vaccine for Female Adolescents</td>
<td></td>
</tr>
<tr>
<td>WCC Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Adult Core Set</strong></td>
<td></td>
</tr>
<tr>
<td>ANT Antenatal Steroids</td>
<td></td>
</tr>
<tr>
<td>PCR Plan All-Cause Readmissions</td>
<td></td>
</tr>
<tr>
<td>VLS HIV Viral Load Suppression</td>
<td></td>
</tr>
<tr>
<td>MSC Medical Assistance with Smoking and Tobacco Use Cessation</td>
<td></td>
</tr>
</tbody>
</table>
Section 24. Care Coordination/Case and Disease Management Process

Overview
Case Management (CM) process is a comprehensive one that incorporates the coordination of social, medical and behavioral health services among the plan’s resources, contract providers, non-contracted providers, state and community agencies.

Disease Management (DM) is a system of coordinated healthcare 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. The disease management initiatives include, but are not limited to, Asthma, HIV/AIDS, Diabetes, Congestive Heart Failure, Oncology, and Hypertension. The Plan may develop and implement additional disease management programs for its members as needed.

The risk assessment process and interventions implemented rely on evidenced based standardized clinical practice guidelines (per the U.S. Department of Health and Human Services (DHHS) and contain additional requirements and/or specification within the distinct case/disease management program descriptions as relevant for each disease or condition state. Program descriptions describe how the program fulfills the principles and functions of each of the Accreditation Association for Ambulatory Health Care, Inc (AAAHC) and National Committee for Quality Assurance’s (NCQA) Disease Management Standards and Guidelines categories. In addition, each DM Program Description describes (1) how members are identified for eligibility; (2) how they are stratified by severity and risk level; and (3) the interventions for each stratification and risk level. The descriptions follow the AAAHC and NCQA most recent Disease Management Standards and Guidelines, the latter may be accessed online at http://www.ncqa.org/programs/accreditation/disease-management-dm.

Case and disease managers address the acuity level and service needs of each participating program enrollee through the use of the Agency Approved health risk assessment tool which includes very specific questions related to the severity of disease, co-morbid conditions, medications taken, compliance with care, utilization patterns, available support services, and socioeconomic factors.

Upon enrollment, new Plan members are provided with a written Health Risk Assessment (HRA) to be completed and returned in a stamped, pre-addressed return envelope. A second attempt to obtain the HRA is made by Member Service Representatives during the Welcome Call. Members who are unreachable are sent an Unable to Contact (UTC) letter requesting updated contact information and a return call in order to complete the HRA telephonically. Those members who do not return the HRA, receive an additional four (4) to six (6) contact attempts during the second to third month from enrollment through Interactive Voice Recognition (IVR) HRA calls. All attempts are documented accordingly. Additional HRA attempts are made through the Case/Disease Manager during direct attempts to engage for identified program needs. The completed HRAs are scored and automatically stratified by risk level based on an algorithm created by the Plan’s Medical staff to ensure consistency in determining low, moderate, or high risk level when entered into the care management system. A Case/Disease Manager may adjust the overall risk level higher or lower (e.g., upgrade risk level from low to moderate) based on additional information gathered through disease specific assessments or other sources as applicable and as justified in the documentation. In addition, identified health conditions, diseases, symptoms and other concerns will trigger referral for case/disease management programs or information/assistance as applicable. Based on HRA responses referrals are triggered and reviewed by the case/disease management team for program invitation, assignment and/or direct follow-up with the member.
Assessment results guide the development of an Individualized Plan of Care (ICP) for program participants and corresponding interventions are designed to improve compliance to PCP treatment regimen, prevent acute exacerbations, and improve self-management and health outcomes.

The ICP will be completed in collaboration with the member, legal guardian, or other legally authorized individual as appropriate and may include, but is not limited to, the following based on member assessed needs:

- Identified problems based on discussion with member/caregiver, HRA findings, and additional assessments (as applicable);
- Interventions to mitigate problems, improve self-management and/or decrease health risks including, but not limited to, the following as applicable:
  - Education based on the member assessment of health risks and chronic conditions;
  - Monitoring of adherence to treatment regimen;
  - Co-morbid conditions and the monitoring of other health related conditions and lifestyle issues;
  - Symptom management including addressing needs such as working with the member on health goals;
  - Emotional issues of the caregiver
  - Behavioral management issues of the member;
  - Effective communication with providers through care coordination of appointments, primary-specialist care, transportation, and other assistance as needed to facilitate care for member;
  - Medication management, including the review of medications that a member is currently taking to avoid adverse effects or interactions from contra-indicated medications, and;
  - Referrals to formal/informal resources, including community based supports.
- Identified barriers, if any, to care or member participation in goals (CMs/DMs will also conduct a Member Cultural Assessment as needed if during the course of care planning potential cultural or sensory barriers are identified.
- Established and measurable goals/objectives and outcomes, as well as, sufficient information to determine if goals/outcomes are met. The level of intervention for each risk category is explained below.

All care plans are individualized with different types of interventions and intensity of service provision based on member severity and/or risk level and as indicated in evidence-based clinical guidelines. Empowering members to self-manage is a key component to the care coordination provided. Members will be encouraged to actively participate in reaching the care plan goals. Motivational Interviewing or other techniques and education shall be utilized to improve the participant’s ability to overcame barriers and adhere to treatment regimens as appropriate. To ensure enhanced communication and coordination of care with PCP and/or specialist providers for members who are at moderate or high risk, the CM/DM will send a copy of the care plan for review and feedback. Feedback obtained will be adjusted on the care plan and CM/DM will communicate with PCP and/or specialist office any changes.

The Plan has developed a resource listing by region of available community supports covering a wide range of topics (e.g., health, economic needs, shelter, etc.) to meet our members’ community support needs as identified and in keeping with findings from annual membership studies. Department staff will be trained at least annually regarding local community-based resources and facilitating member referrals to those entities and will be provided a reference file of information regarding potential supports and contacts available. The resource listing shall be updated periodically by an assigned care coordinator or other designee. In addition, CMs/DMs and
members have access to Healthwise®, a library of evidence-based educational materials and resources (note: only AHCA approved materials will be sent to members).

Our care coordination/case management staff is highly educated and has extensive experience in working with people living with multiple medical conditions. They are reflective of the population served and are assigned to members based on a number of factors, including but not limited to, language preferences (English/Spanish/Creole) and staff expertise as it relates to the member’s condition, age socioeconomic needs and cultural factors (including sexual orientation). Caseloads are balanced among the staff to ensure that moderate and high risk members are evenly distributed.

Case Managers collaborate with local service organizations such as Ryan White and Project AIDS Care (PAC) Waiver agencies for members with HIV/AIDIS or other community based organizations that may assist enrollees with special needs for additional supportive care (not covered by Medicaid) such as food bank, legal or housing assistance, support groups/psychosocial counseling, clinical trials, and outpatient substance abuse-related programs geared towards the issues/concerns of our members.

In addition, members stratified as high risk may receive home visits to provide a comprehensive review of the services and supports that the members need. These members also are presented in Interdisciplinary Care Team (ICT) meetings to review services and members’ progress with the input of their PCP/Specialty Care Providers are addressed and to discuss the member’s progress. Based on the member’s risk category, this communication and coordination may occur more frequently.
Section 25. Marketing

Marketing in the Health Care Setting
Simply Healthcare Plans shall not conduct marketing activities in health care settings except in common areas. Common areas where marketing activities are allowed include areas such as hospital or nursing home cafeterias, community or recreational rooms, and conference rooms. If a pharmacy counter area is located within a retail store, common areas would include the space outside of where patients wait for services or interact with pharmacy providers and obtain medications.

Simply Healthcare Plans shall not conduct marketing in areas where patients primarily intend to receive health care services or are waiting to receive health care services. These restricted areas generally include, but are not limited to, waiting rooms, exam rooms, hospital patient rooms, dialysis center treatment areas (where patients interact with their clinical team and receive treatment), and pharmacy counter areas (where patients interact with pharmacy providers and obtain medications). The prohibition against conducting marketing activities in health care settings extends to activities planned in health care settings outside of normal business hours. Simply Healthcare Plans shall only schedule personal/individual marketing appointments with potential enrollees residing in long-term care facilities (including nursing facilities and assisted living facilities) upon request by the potential enrollee.

Provider-Based Marketing Activities
Providers are permitted to make available and/or distribute Managed Care Plan marketing materials as long as the provider and/or the facility distributes or makes available marketing materials for all Managed Care Plans with which the provider participates. The Agency does not expect providers to proactively contact all Managed Care Plans; rather, if a provider agrees to make available and/or distribute Managed Care Plan marketing materials it should do so knowing it must accept future requests from other Managed Care Plans with which it participates. Providers are also permitted to display posters or other materials in common areas such as the provider’s waiting room. Additionally, long-term care facilities are permitted to provide materials in admission packets announcing all Managed Care Plan contractual relationships.

Providers can assist a potential enrollee in an objective assessment of his/her needs and potential options to meet those needs, the provider may do so. Providers may engage in discussions with potential enrollees should a potential enrollee seek advice. However, the provider shall remain neutral when assisting with enrollment decisions.

Providers may distribute printed information provided by the Managed Care Plan to their patients comparing the benefits of all of the different Managed Care Plans with which the providers contract. The Managed Care Plan shall ensure that:

- Materials do not “rank order” or highlight specific Managed Care Plans and include only objective information.
- Such materials have the concurrence of all Managed Care Plans involved in the comparison and are approved by the Agency prior to distribution.

Provider Affiliation Information
Providers may announce new or continuing affiliations with the Managed Care Plan through general advertising (e.g., radio, television, websites).

- Providers may make new affiliation announcements within the first thirty (30) days of the new provider contract.
- Providers may make one announcement to patients of a new affiliation that names only the Managed Care Plan when such announcement is conveyed through direct mail, email, or phone.
• Additional direct mail and/or email communications from providers to their patients regarding affiliations must include a list of all Managed Care Plans with which the provider contracts.
• Any affiliation communication materials that include Managed Care Plan specific information (e.g., benefits, formularies) must be prior approved by the Agency.

Providers **may not:**
• Offer marketing/appointment forms.
• Make phone calls or direct, urge or attempt to persuade potential enrollees to enroll in the Managed Care Plan based on financial or any other interests of the provider.
• Mail marketing materials on behalf of the Managed Care Plan.
• Offer anything of value to induce potential enrollees to select them as their provider.
• Offer inducements to persuade potential enrollees to enroll in the Managed Care Plan.
• Accept compensation directly or indirectly from the Managed Care Plan for marketing activities.
• Distribute marketing materials within an exam room setting.
• Furnish to the Managed Care Plan lists of their Medicaid patients or the membership of any Managed Care Plan.

Providers **may:**
• Provide the names of the Managed Care Plans with which they participate.
• Make available and/or distribute Managed Care Plan marketing materials outside of an exam room.
• Refer their patients to other sources of information, such as the Managed Care Plan, the enrollment broker or the local Medicaid Area Office.
• Share information with patients from the Agency’s website or CMS’ website.
• Conduct health screening as a marketing activity
Section 26. Forms

1. Claims Review Form
2. Referral and Authorization Form
3. Quick Authorization Form
4. Beacon Health Options Case Management Referral Form
5. OB Assessment Form
6. Pregnancy Notification Form
7. Case Management Referral Form
8. State of Florida Acknowledgment of Receipt of Hysterectomy Information
9. State of Florida Exception to Hysterectomy Acknowledgement Requirement Form
10. Newborn/Unborn Activation Form- AHCA Form 5240-006
11. Abortion Certification Form
12. Incident Report Form
13. Sterilization Consent Form- English
14. Sterilization Consent Form- Spanish
15. Florida Department of Health, Practitioner Disease Report Form
16. HIPAA Breach Report Form
Provider Claims Review Form  
(Use a separate form for each patient)

**PROVIDER INFORMATION**

<table>
<thead>
<tr>
<th>Provider Name:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider Tax ID</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Contact Name:</th>
<th>Signature:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Telephone:</td>
<td>Fax:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Address:</th>
<th>City:</th>
<th>State:</th>
<th>Zip:</th>
</tr>
</thead>
</table>

**PROVIDER TYPE**

- ☐ Professional
- ☐ Institutional
- ☐ Skilled Nursing Facility
- ☐ Assisted Living Facility
- ☐ DME
- ☐ Home Health
- ☐ Ambulance
- ☐ Other (please specify)

**CLAIM INFORMATION**

<table>
<thead>
<tr>
<th>Enrollee Name:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Enrollee ID:</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Claim Number(s):</th>
<th>Enrollee Date of Birth:</th>
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<table>
<thead>
<tr>
<th>Date of Service From</th>
<th>Date of Service To</th>
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</thead>
</table>

<table>
<thead>
<tr>
<th>Disputed Amount:</th>
<th></th>
</tr>
</thead>
</table>

**REASON**

- ☐ No Authorization on File
- ☐ Coordination of Benefits
- ☐ Timely Filing
- ☐ Exceeds Authorization
- ☐ Payment Determination
- ☐ Contract Dispute
- ☐ Authorization Denial or Reduced Payment
- ☐ Request for Additional Information
- ☐ Other (please specify)

**DESCRIPTION OF DISPUTE**

<table>
<thead>
<tr>
<th>SUPPORTING DOCUMENTATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Authorization</td>
</tr>
<tr>
<td>☐ Medical Records</td>
</tr>
<tr>
<td>☐ Original Claim Form</td>
</tr>
</tbody>
</table>
Provider Claims Review Form  
(Use a separate form for each patient)

Date: 

**PROVIDER INFORMATION**

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<tr>
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**PROVIDER TYPE**

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- [ ] Institutional  
- [ ] Skilled Nursing Facility  
- [ ] Assisted Living Facility  
- [ ] DME  
- [ ] Home Health  
- [ ] Ambulance  
- [ ] Other (please specify)  

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</thead>
<tbody>
<tr>
<td>Enrollee ID:</td>
<td>Authorization Number:</td>
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<tr>
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<tr>
<td>Date of Service To</td>
<td></td>
</tr>
<tr>
<td>Disputed Amount:</td>
<td></td>
</tr>
</tbody>
</table>

**REASON**

- [ ] No Authorization on File  
- [ ] Coordination of Benefits  
- [ ] Timely Filing  
- [ ] Exceeds Authorization  
- [ ] Payment Determination  
- [ ] Contract Dispute  
- [ ] Authorization Denial or Reduced Payment  
- [ ] Request for Additional Information  
- [ ] Other (please specify)  

**DESCRIPTION OF DISPUTE**


**SUPPORTING DOCUMENTATION**

- [ ] Authorization  
- [ ] Explanation of Benefits (EOB)  
- [ ] Copy of Primary Insurer's Remittance advise  
- [ ] Medical Records  
- [ ] Medical Equipment Invoice  
- [ ] Proof of Timely Filing  
- [ ] Original Claim Form  
- [ ] Itemized Bill  
- [ ] Other (please specify)
Request for Services Requiring Prior Authorization

**MEDICARE ONLY**
Please Fax ALL Requests for DME/HH/INFUSION Services Directly to 844-215-4265

| Member Name: ____________________________ | Referred to: ____________________________ |
|________________________________________|________________________________________|
| Plan Name (Circle One): Simply** Better Clear Health | Specialty: ____________________________ |
| Health Plan ID #: ________________________ | Referred to: Provider ID #: ____________________________ |
| Member DOB: ______/_____/______ Phone: (____) - | Referred to Fax #: ____________________________ |
| PCP Name: ____________________________ Phone: (____) - | Diagnostic (ICD-): ____________________________ |
| PCP ID #: ____________________________ Phone: (____) - | CPT Codes: ____________________________ |
| Referring Physician Name: ____________________________ | Reason for Referral: ____________________________ |
| Contact Person: ____________________________ | ____________________________ |
| Referring Physician Telephone: (____) | ____________________________ |
| Referring Physician Fax Number: (____) | ____________________________ |

Request Type: □ Standard □ Expedited/Urgent* 

By checking this box I certify that applying the standard review time frame may seriously jeopardize the member’s life, health, or ability to regain maximum function. You may call our Pre-Certification department and advise the request is Expedited/Urgent at 1-877-915-0551, option 2

**IMPORTANT NOTE** An Expedited/Urgent request for a determination is a request in which waiting for a decision under the Standard time frame could place the member’s life, health, or ability to regain maximum function in serious jeopardy.

Is this request related to an accident? □ YES □ NO

Does this member have other insurance coverage? □ YES □ NO

□ MVA □ LONG TERM CARE MANAGED CARE □ Worker’s Compensation □ Medicaid □ Other

INSURANCE (specify): ____________________________

The following services require PRE-AUTHORIZATION—Please submit supporting clinical documentation to determine medical necessity, TO INCLUDE RECENT OFFICE VISITS, DIAGNOSIS CODES AND ANY PERTINENT RECENT X-RAY OR LAB REPORTS.

<table>
<thead>
<tr>
<th>Inpatient Services</th>
<th>Outpatient Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Hospital Admissions</td>
<td>□ PET Scan</td>
</tr>
<tr>
<td>□ Birthing Centers</td>
<td>□ MRA</td>
</tr>
<tr>
<td>□ Observation</td>
<td>□ MRI</td>
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<tr>
<td>□ Observation</td>
<td>□ Physical Therapy</td>
</tr>
<tr>
<td>□ Observation</td>
<td>□ Sleep Study</td>
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<tr>
<td>□ Observation</td>
<td>□ Wound Care</td>
</tr>
<tr>
<td>□ Observation</td>
<td>□ Total OB Care</td>
</tr>
<tr>
<td>□ Observation</td>
<td>□ SPEECH, OCCUPATIONAL OR RESPIRATORY Therapies (ST/OT/RT):</td>
</tr>
<tr>
<td>□ Observation</td>
<td>□ Chemotherapy</td>
</tr>
<tr>
<td>□ Observation</td>
<td>□ Radiation Therapy</td>
</tr>
</tbody>
</table>
| □ Observation | □ Medicaid

Durable Medical Equipment (DME), Home Health, ARD Infusion Services

**Medicare ONLY**

**Please fax ALL requests for Durable Medical Equipment (DME), HOME HEALTH (HH), AND INFUSION SERVICES DIRECTLY TO 844-215-4265**

***PRIOR AUTHORIZATION IS NOT A GUARANTEE OF PAYMENT***

PRIVACY NOTICE: This communication, including attachments, may include confidential and/or proprietary information, and may be used only by the person or entity to whom it is addressed. If the reader of this fax is not the intended recipient or his or her authorized agent, the reader is hereby notified that any dissemination, distribution or copying of this fax and attachments is prohibited. If you have received this fax in error, please notify the sender by calling the above number and destroy this message and attachments immediately. July 2015.

GM 4-28-16

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QAF-NO AUTHORIZATION REQUIRED FORM (MEDIACD)

For participating Primary Care Providers only to refer to a participating specialist or diagnostic center for the codes listed below. Do not use for Hospitals, ASCs or for Preventive care visits/diagnostics.

***VALID FOR 90 DAYS***

For questions, please call 1-877-915-0551, Prompt 2

<table>
<thead>
<tr>
<th>Diagnosis Code(s) (required):</th>
<th>Provider Signature (required):</th>
</tr>
</thead>
</table>

| SPECIALIST OFFICE VISITS | 
| "MUST HAVE CONSULTATION" |
| Levels 1 & 2 require supporting medical documentation with the claim. |
| New: 99211 - 99219 |
| Established: 99211 - 99215 |
| New or Established: 99245 |

| ALLERGY AND PPD | 
| Scratch Test: 95044 |
| Intradermal Test: 95074 |
| Patch Test: 95044 |
| Allergy Injections: 90515, 95117, 95165 |

| CARDIOLOGY TESTS | 
| Doppler Echo Exam: 93520, 93531 |
| Doppler Color Flow: 93535 |
| Echo Heart: 93530-93538 |
| 24-Hr Holter Monitor: 94224 |
| Pacemaker Interrogation: 92298 |
| AICD Interrogation: 92299 |
| Stress Test, non-invasive: 93531 |
| Stress Echo: 93531 |

| PULMONARY FUNCTION | 
| Spirometry: 94010, 94060 |
| Vitral Capacity: 94110 |
| Lung Volume, Gas: 94277 |
| Ean or Pulse Czometry: 94700 |
| Neral Therapy: 94040, 94060 |
| Carbon Monooxide: 94279 |

| INJECTIONS | 
| betaneethanol: J0932 |
| Ceftriaxone Sodium, 250 mg: J0566 |
| Dexamethasone: J1100 |
| Meprobamate: J1091, J1090, J1090 |
| 20 mg, 45 mg, 90 mg: J0970 |
| Fenchelization: 90100 units: J0569 |
| Shambazol: J0391 |
| Pentosteone: J0391 |
| Therapeutic, prophylactic, or diagnostic injection: J0392 |

| NEUROLOGY | 
| EMS: 95610, 95610 |
| Muscle test one limb: 95612 |
| Muscle test 2 limbs: 95613 |
| Muscle test 3 limbs: 95613 |
| Muscle test 4 limbs: 95614 |
| Muscle test larynx: 95615 |
| Muscle test hemidiaphragm: 95616 |
| Muscle test cranial n.i.: 95617 |
| Muscle test cranial nii: 95618 |
| Nerve Conduction: 95910 - 95911 |

| DERMATOLOGY | 
| Drainage Skin Abscess: 10100 - 10100 |
| Excision - Debridement: 11000 - 11000 |
| Biopsy Skin Lesion: 11100 - 11100 |
| Shaving Dermal Lesion: 11200 - 11200 |
| Excision Benign Lesion: 11400 - 11400 |
| Excision Malignant Lesion: 11500 - 11500 |
| Excision Malignant Lesion: 11600 - 11600 |
| Wound Closure: 12000 - 12000 |
| Destruction of Lesion: 12000 - 12000 |
| Destruction: 12000 - 12000 |
| Malignant Lesion: 12000 - 12000 |
| Nail Biopsy: 11705 |

| GYNECOLOGY | 
| Well Woman Exam Initial visit: 90394 - 90397 |
| Well Woman Exam: 90394 - 90397 |
| Vaginal Irrigation: 57100 |
| Pap Smear: 57100 |
| Colposcopy without biopsy: 51600 |
| Colposcopy with biopsy: 51600 |
| Cone Biopsy: 57520 |
| Endometrial Biopsy: 57010 |
| Pregnancy Test: 92100 |
| Wound Mount Stain, O&F prep: 92100 |
| IUD Device: J3000 |
| Device & IUD Device: J3000 |
| IUD Insertion/Removal: 95300 |
| Contraceptive Implant - Intrauterine: J2077 |

| X-RAY/DIAGNOSTICS | 
| Head and Neck: 70358 - 70359 |
| Neck Soft Tissue: 70260 |
| Brain: 70310 |
| Rib: 70250 |
| Sternum: 70310 |
| Spine: 70260 |
| Pelvis: 70270 |
| Upper Extremity: 70290 |
| Lower Extremity: 70300 |
| Urography: 74000 |
| Urography: 74800 |

| CT SCANS | 
| Head or Brain: 70400-70401 |
| Diaphragm, Posterior: 70400-70401 |
| Liver, Portal Vein: 70400-70401 |
| Pancreas: 70400-70401 |
| Renal: 70400-70401 |
| Urogenital: 70400-70401 |

| X-RAY/DIAGNOSTICS | 
| Head and Neck: 70358 - 70359 |
| Neck Soft Tissue: 70260 |
| Brain: 70310 |
| Rib: 70250 |
| Sternum: 70310 |
| Spine: 70260 |
| Pelvis: 70270 |
| Upper Extremity: 70290 |
| Lower Extremity: 70300 |
| Urography: 74800 |
| Urography: 74800 |

| ULTRASOUNDS | 
| Renal: 70400-70401 |
| Common: 70400-70401 |
| Abdominal: 70400-70401 |
| Testicular Ultrasound: 70400-70401 |
| Breast: 70400-70401 |
| Transabdominal: 70400-70401 |

| SPECIALTY SERVICES | 
| "Refers to contract network provider if listed with an asterisk" |

| AUDDIOLOGY | 
| "Hear US: AUA 731-737, Select Option 1" |

| AUDDIOLOGY - OFFICE PROREDURES | 
| 72150 - 72151 |
| 72150 - 72151 |
| 72150 - 72151 |
| 72150 - 72151 |

| DIABETIC SUPPLIES | 
| "Neighborhood Diabetes (800) 979-9999" |

| OPTOMETRY | 
| "Florida Eye Care: (877) 481-2224, Opt" |

| OPTMDIOLDOLOGY | 
| "Premier Eye: (877) 721-1099" |

| DENTAL - ADULTS | 
| "DentalCare: (877) 636-0646" |

| BEHAVIORAL HEALTH | 
| "PsychCare: (800) 321-0547" |

| TRANSPORTATION | 
| "For inquiries, refer to the back of the member's ID card for information."

Send claims to: Simply Healthcare Plans, Inc./CHA, Attn: Claims, P.O. Box 25165, Eagan, MN 55111, Electronic Submission #B2048 (EMDEON). Claims are paid by Medicaid Guidelines and/or contract requirements.

Simply QAF-November 2013 Revised 2/22/2016

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Beacon Case Management Referral Form

Date of Referral: __________________________ Member Name: __________________________
Member ID #: __________________________ Member Date of Birth: __________________________
Member Phone #: __________________________ Health Plan Name: __________________________

Referral Source (name):

<table>
<thead>
<tr>
<th>Referral Source Role</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Plan</td>
<td>PCP</td>
<td>Agency</td>
</tr>
<tr>
<td>Provider/Practitioner</td>
<td>Family/Caregiver</td>
<td>Other:</td>
</tr>
</tbody>
</table>

Referral Contact #: __________________________ Referral Contact Fax #: __________________________

Relationship to Member: __________________________ Alternate Contact #: __________________________

If a Center Referral, Specify Center Location:

- [ ] Care Coordination (up to 3 months follow-up)
  Member with: Medication non-compliance; Lack of social support; No Outpatient services in place; Not compliant with Outpatient services in place; Need for community resources.

- [ ] Intensive Case Management (up to 6 months or more follow-up)
  Member with: Rapid Hospital admissions (within 60 days); Frequent ER visits; Recent suicide attempt; Co-morbid medical condition with Behavioral Health and/or Substance Abuse Disorder that could result in exacerbation of fragile medical status.

If member only needs referrals for Behavioral Health Specialists and/or Benefits Information, please have them call our Member Services line at 1-800-221-5487.

Referral Track (if any):

- [ ] Jail Diversion
- [ ] Substance Abuse
- [ ] Post Partum Depression
- [ ] High ER Utilizer
- [ ] Co-Morbid Medical/Behavioral
- [ ] Dual Diagnosis
- [ ] Special Needs
- [ ] Smoking Cessation
- [ ] Weight Management
- [ ] Other: __________________________

Referral Reason:

Agency Involvement (if any):

- [ ] AHCA
- [ ] Court
- [ ] Child Protective Services
- [ ] Corrections
- [ ] DCF
- [ ] Other: __________________________

Frequency of Feedback: As referral source, I am requesting the following frequency of communication regarding the identified member:

- [ ] Weekly
- [ ] Monthly
- [ ] Other: __________________________

For weekly or more frequent visits, please provide clinical justification:

NOTE: Feedback is contingent on member consent and frequency should reflect the urgency of the referral.

Any Additional Information:

Please send completed forms to Beacon Health Strategies, LLC at Beacon_CMI@beaconhealthoptions.com or 306-722-3018.
Pregnancy Notification Form to be completed by PCP
Please complete and fax to (877) 577-0117 or (786) 441-4607 within 2 working days of the visit

<table>
<thead>
<tr>
<th>MEMBER’S DEMOGRAPHIC INFORMATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Last Name</td>
</tr>
<tr>
<td>Member ID #</td>
</tr>
<tr>
<td>Address</td>
</tr>
<tr>
<td>Phone</td>
</tr>
</tbody>
</table>

MEDICAL INFORMATION REGARDING OB RISKS (Please check all that apply):

CURRENT PREGNANCY:
- [ ] Diabetes
- [ ] Hypertension
- [ ] Smoking
- [ ] Multiple Pregnancy
- [ ] Immunosuppressed
- [ ] ETOH or Drugs
- [ ] HIV Testing?
- [ ] Other __________

MEDICAL/SOCIAL PROBLEMS:
- [ ] Asthma
- [ ] Heart Disease
- [ ] Renal Disease
- [ ] Neurologic Illness
- [ ] Domestic Violence
- [ ] Anemia
- [ ] STD’s
- [ ] WIC Referral Done?
- [ ] Healthy Start Referral Done?

Comments or Other Pertinent Information:
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Revised 12/2016
Pregnancy Notification Form to be completed by PCP
Please complete and fax to (877) 577-0117 or (786) 441-4607 within 2 working days of the visit

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<tbody>
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<td>Diabetes</td>
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<td>ETCH or Drugs</td>
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<tbody>
<tr>
<td>Asthma</td>
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<tr>
<td>Anemia</td>
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<tr>
<td>HIV Referral Done?</td>
</tr>
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</table>

Comments or Other Pertinent Information:
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Revised 12/2016
# Case and Disease Management Referral Form

**PLEASE FAX TO (877) 577-0117**

**Date:**

**Referred Type:** Routine  High-Risk  
**LOB:** Simply Medicaid  Simply Medicare  Better Health  Clear Health  

<table>
<thead>
<tr>
<th>Member's Name:</th>
<th>ID #:</th>
<th>DOB:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home Phone #:</td>
<td>Other Phone #:</td>
<td></td>
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<tr>
<td>Member's Address:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>City</td>
<td>Zip Code</td>
<td></td>
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<tr>
<td>Caregiver:</td>
<td>Phone #:</td>
<td></td>
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<tr>
<td>(Name/relationship)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Referring Provider Name:</td>
<td>Phone #:</td>
<td></td>
</tr>
<tr>
<td>PCP</td>
<td>Specialist</td>
<td>Fax #:</td>
</tr>
</tbody>
</table>

### Diagnosis:

<table>
<thead>
<tr>
<th>Referral reason or program:</th>
<th>High-Risk OB</th>
<th>Normal Pregnancy</th>
<th>High Blood Lead Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>Readmissions</td>
<td>Complex Case</td>
<td>Oncology</td>
<td>Chronic Diseases</td>
</tr>
<tr>
<td>Diabetes</td>
<td>CHF</td>
<td>Transition of Care</td>
<td>Asthma</td>
</tr>
<tr>
<td>Weight Management</td>
<td>Other</td>
<td></td>
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</tbody>
</table>

### Additional Information (i.e. reason for referral and brief history of admissions or other pertinent information):
STATE OF FLORIDA
HYSTERECTOMY
ACKNOWLEDGEMENT FORM

Acknowledgement of Receipt of Hysterectomy Information

PART I - PHYSICIAN’S STATEMENT (To be completed by the physician’s office)

______________________________  __________________________
Physician’s Name (Print)        Provider Identification Number

I understand the Florida Medicaid program will not reimburse for a hysterectomy service unless it is performed in accordance with the federal requirements as specified in Title 42, Code of Federal Regulations, Section 441, Subpart F. The hysterectomy to be performed is not solely for the purpose of rendering the below named recipient permanently incapable of reproducing, nor is the hysterectomy for medical purposes which by themselves do not mandate a hysterectomy. The non-elective hysterectomy is therefore being performed for the following medical reasons (include any applicable diagnosis):

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

______________________________  __________________________
Physician’s Signature          Date

PART II - RECIPIENT’S STATEMENT (To be completed by the Florida Medicaid recipient)

______________________________  __________________________
Recipient Name (Print)          Florida Medicaid Identification Number

I was told verbally, and in writing, that I will not be able to have children after this surgery.

______________________________  __________________________
Recipient’s Signature           Date

Interpreter’s Signature (If necessary)  Date

NOTE: A copy of this form must be attached to any and all Medicaid claims submitted by providers involved in the performance of the procedure.

HAF-5000 (JUN 2016), incorporated by reference in Rule 59G-1.045, F.A.C.
Unborn Activation Form

For use by providers to activate a newborn’s Medicaid Identification (ID) Number when they have been determined eligible by the Florida Department of Children and Families. Complete all information and print clearly. FAX completed form to the Florida Medicaid Fiscal Agent at 1-877-231-2170.

MOTHER

MEDICAID ID NUMBER: __________________________
FIRST NAME: __________________________
LAST NAME: __________________________

NEWBORN

MEDICAID ID NUMBER: __________________________
FIRST NAME: __________________________
LAST NAME: __________________________

SEX (M OR F): __________

PROVIDER

MEDICAID ID NUMBER: __________________________
PROVIDER NAME: __________________________
ADDRESS: __________________________
TELEPHONE NUMBER: __________________________
CONTACT NAME: __________________________

Fiscal Agent Use Only

Mom Eligible ______
HMO Enrolled ______
If yes, attach screen.

Fiscal Agent Use Only

Date Entered on FMMIS __________________
Operator ID __________________

The Florida Medicaid fiscal agent will activate the newborn’s Florida Medicaid ID number within two working days of receipt, unless:

• The mother is not eligible for Florida Medicaid at the time of the baby’s birth.
• The mother is eligible under the PEPW or Family Planning Waiver benefit categories.
• The Unborn Activation Form is incomplete.

AHCA Form 5240-006, (JUN 2016), incorporated by reference in Rule 59G-1.045, F.A.C.
State of Florida
Abortion
Certification Form

SECTION I

1. Recipient’s Name:__________________________________________________________

2. Address:______________________________________________________________

3. Medicaid Identification Number__________________________________________

SECTION II

4. On the basis of my professional judgement, I have performed an abortion on the above named recipient for the following reason:

☐ The woman suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused or arising from the pregnancy itself that would place the woman in danger of death unless an abortion is performed.

☐ Based on all the information available to me, I concluded that this pregnancy was the result of an act of rape.

☐ Based on all the information available to me, I concluded that this pregnancy was the result of an act of incest.

I have documented in the recipient’s medical record the reason for performing the abortion; and I understand that Medicaid reimbursement to me for this abortion is subject to recoupment if medical record documentation does not reflect the reason for the abortion as checked above.

5. ___________________________ 6. ___________________________
   Physician’s Name               Physician’s Signature

7. ___________________________ 8. ___________________________
   Physician’s Provider Number    Date of Signature

AHCA MedServ Form 011, (JUN 2016), incorporated by reference in Rule 59G-1.045, F.A.C
CONSENT FOR STERILIZATION

NOTICE: YOUR DECISION AT ANY TIME NOT TO BE STERILIZED WILL NOT RESULT IN THE WITHDRAWAL OR WITHHOLDING OF ANY BENEFITS PROVIDED BY PROGRAMS OR PROJECTS RECEIVING FEDERAL FUNDS.

■ CONSENT TO STERILIZATION ■

I have asked for and received information about sterilization from __________________________. When I first asked __________________________ for the information, I was told that the decision to be sterilized is completely up to me. I was told that I could decide not to be sterilized. If I decide not to be sterilized, my decision will not affect my right to future care or treatment. I will not lose any help or benefits from programs receiving Federal funds, such as Temporary Assistance for Needy Families (TANF) or Medicaid that I am now getting or for which I may become eligible.

I UNDERSTAND THAT THE STERILIZATION MUST BE CONSIDERED PERMANENT AND NOT REVERSIBLE. I HAVE DECIDED THAT I DO NOT WANT TO BECOME PREGNANT, BEAR CHILDREN OR FATHER CHILDREN.

I was told about those temporary methods of birth control that are available and could be provided to me which will allow me to bear or father a child in the future. I have rejected these alternatives and chosen to be sterilized.

I understand that I will be sterilized by an operation known as a __________________________. The discomforts, risks, and benefits associated with the operation have been explained to me. All my questions have been answered to my satisfaction.

I understand that the operation will not be done until at least 30 days after I sign this form. I understand that I can change my mind at any time and that my decision at any time not to be sterilized will not result in the withholding of any benefits or medical services provided by federally funded programs.

I am at least 21 years of age and was born on: __________________________. I, __________________________, hereby consent of my own free will to be sterilized by __________________________. My consent expires 180 days from the date of my signature below.

I also consent to the release of this form and other medical records about the operation to:

Representatives of the Department of Health and Human Services,
Employees of programs or projects funded by the Department
but only for determining if Federal laws were observed.

I have received a copy of this form.

__________________________  __________________________
Signature of Person Obtaining Consent  Date

Facility

Address

Physicians Statement

Shortly before I performed a sterilization operation upon:

__________________________  __________________________
Name of Individual  Date of Sterilization

I explained to him/her the nature of the sterilization operation __________________________, the fact that it is __________________________ intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent. I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or any benefits provided by Federal funds.

To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appears to understand the nature and consequences of the procedure.

__________________________  __________________________
Signature of Person Obtaining Consent  Date

Facility

Address

Physician’s Statement

If an interpreter is provided to assist the individual to be sterilized: I have translated the information and advice presented orally to the individual to be sterilized by the person obtaining this consent. I have also read him/her the consent form in language and explained its contents to him/her. To the best of my knowledge and belief he/she understood this explanation.

__________________________  __________________________
Interpreter’s Signature  Date

HHS-887 (10/12), incorporated by reference in Rule 59G-1045, F.A.C.
PAPERWORK REDUCTION ACT STATEMENT

A Federal agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays the currently valid OMB control number. Public reporting burden for this collection of information will vary; however, we estimate an average of one hour per response, including for reviewing instructions, gathering and maintaining the necessary data, and disclosing the information. Send any comment regarding the burden estimate or any other aspect of this collection of information to the OMB Reports Clearance Officer, ASTP/Budget Room 503 HH Building, 200 Independence Avenue, SW, Washington, DC 20201.

Respondents should be informed that the collection of information requested on this form is authorized by 42 CFR part 50, subpart B, relating to the sterilization of persons in federally assisted public health programs. The purpose of requesting this information is to ensure that individuals requesting sterilization receive information regarding the risks, benefits and consequences, and to assure the voluntary and informed consent of all persons undergoing sterilization procedures in federally assisted public health programs. Although not required, respondents are requested to supply information on their race and ethnicity. Failure to provide the other information requested on this consent form, and to sign this consent form, may result in an inability to receive sterilization procedures funded through federally assisted public health programs.

All information as to personal facts and circumstances obtained through this form will be held confidential, and not disclosed without the individual’s consent, pursuant to any applicable confidentiality regulations. [43 FR 52105, Nov. 8, 1978, as amended at 58 FR 13393, June 17, 1993; 66 FR 12308, Mar. 14, 2003]

HHS-087 (10/12), incorporated by reference in Rule 56G-1.045, F.A.C.
CONSENTIMIENTO PARA LA ESTERILIZACIÓN

NOTA: LA DECISIÓN DE NO ESTERILIZARSE QUE USTED PUEDE TOMAR EN CUALQUIER MOMENTO, NO CAUSA EL RETIRO O LA RETENCIÓN DE NINGÚN BENEFICIO QUE LE SEA PROPORCIONADO POR PROGRAMAS O PROYECTOS QUE RECIBEN FONDOS FEDERALES.

■ CONSENTIMIENTO PARA ESTERILIZACIÓN ■

Yo he solicitado y he recibido información de:

(médico o clínica)

sobre la esterilización. Cuando inicialmente solicité esta información, me dijeron que la decisión de ser esterilizada/o es completamente mía. Me dijeron que yo podía decidir no ser esterilizada/o. Si decidí no esterilizarme, mi decisión no afectará a mi derecho a recibir tratamiento o cuidados médicos en el futuro. No perderé ninguna asistencia o beneficios de programas patrocinados con fondos federales, tales como A.F. D. C. o Medicaid, que recibo actualmente o para los cuales será elegible.

ENTIENDO QUE LA ESTERILIZACIÓN SE CONSIDERA UNA OPERACIÓN PERMANENTE E IRREVERSIBLE. Yo HE DECIDIDO QUE NO QUIERO QUEMIAR EMBARAZADA, NO QUIERO TENER HIJOS O NO QUIERO PROCREAR HIJOS.

Me informaron que me pueden proporcionar otros métodos de anticoncepción disponibles que son temporales y que permitirán que pueda tener o procrear hijos en el futuro. He rechazado estas opciones y he decidido ser esterilizada/o.

Entiendo que seré esterilizada/o por medio de una operación conocida como:

Me han explicado las molestias, los riesgos y los beneficios asociados con la operación. Han respondido satisfactoriamente a todas mis preguntas.

Entiendo que la operación no se realizará hasta pasado 30 días, como mínimo, a partir de la fecha en la que firme esta forma. Entiendo que puedo cambiar de opinión en cualquier momento y que mi decisión en cualquier momento de no ser esterilizada/o no resultará en la retirada de beneficios o servicios médicos proporcionados a través de programas que reciben fondos federales.

Tengo por lo menos 21 años y naci el:

(día, mes, año)

Yo:

por medio de la presente doy mi consentimiento de mi libre voluntad para ser esterilizada/o por:

(médico)

por el método llamado:

Mi consentimiento vence 180 días a partir de la fecha en la que firme este documento.

Además, doy mi consentimiento para que se presente esta Forma y otros expedientes médicos sobre la operación a:

Representantes del Departamento de Salud y Servicios Sociales, o Empleados de programas o proyectos financiados por ese Departamento, pero sólo para que puedan determinar si se han cumplido las leyes federales.

He recibido una copia de esta Forma.

(firma)

fecha:

(día, mes, año)

Se ruega proporcione la siguiente información, aunque no es obligatorio hacerlo: (Definición de raza y origen étnico)

Origen étnico:

□ Indígena americana o indígena de Alaska
□ No hispano o latino
□ Afroamericano
□ Raza (marque según aplique):
□ Asiático
□ Natural de Hawai o otras islas del Pacífico
□ Blanco

■ DECLARACIÓN DEL INTERPRETE ■

Si se han proporcionado los servicios de un intérprete para asistir a la persona que será esterilizada:

He traducido la información y los consejos que verbalmente se le han presentado a la persona que será esterilizada/o por el individuo que ha obtenido este consentimiento. También le he leído a éll/e la Forma de consentimiento en idioma,

y le he explicado el contenido de esta forma. A mi mejor saber y entender, éll/e ha entendido esta explicación.

(firma del intérprete)

fecha:

■ DECLARACIÓN DE LA PERSONA QUE OBTIENE CONSENTIMIENTO ■

Antes de que:

(nombre persona)

firmara la Forma de Consentimiento para la Esterilización, la ha explicado a ella/el los detalles de la operación:

para la esterilización, el hecho de que el resultado de este procedimiento es final e irreversible, y las molestias, los riesgos y los beneficios asociados con este procedimiento.

He aconsejado a la persona que será esterilizada o hay disponibles otros métodos de anticoncepción que son temporales. Le he explicado que la esterilización es diferente porque es permanente.

Le he explicado a la persona que será esterilizada que puede retirar su consentimiento en cualquier momento y que ella/el no perderá ningún servicio de salud o beneficio proporcionado con el patrocinio de fondos federales.

A mi mejor saber y entender, la persona que será esterilizada tiene por lo menos 21 años de edad y parece ser mentalmente competente. Ella/el ha solicitado con conocimiento de causa y por libre voluntad ser esterilizada/o y parece entender la naturaleza del procedimiento y sus consecuencias.

(firma de la persona que obtiene el consentimiento)

(fecha)

(lugar)

■ DECLARACIÓN DEL MÉDICO ■

Previo a realizar la operación para la esterilización:

(nombre persona esterilizada)

en:

(nombre de la opción)

Le explicó a ella/el los detalles de esta operación para la esterilización:

(espécifico tipo de operación), del hecho de que es un procedimiento con un resultado final e irreversible, y las molestias, los riesgos y los beneficios asociados con esta operación.

Le aconsejó a la persona que será esterilizada que hay disponibles otros métodos de anticoncepción que son temporales. Le explicó que la esterilización es diferente porque es permanente.

Le informé a la persona que será esterilizada que podía retirar su consentimiento en cualquier momento y que ella/el no perdería ningún servicio de salud o beneficio proporcionado con el patrocinio de fondos federales.

A mi mejor saber y entender, la persona que será esterilizada tiene por lo menos 21 años de edad y parece ser mentalmente competente. Ella/el solicitó con conocimiento de causa y por libre voluntad ser esterilizada/o y parece entender el procedimiento y las consecuencias de este procedimiento.

(Instrucciones para uso alternativo de párrafos finales): Utilice el párrafo 1 que se presenta a continuación, excepto para casos de parto prematuro y cirugía abdominal de emergencia cuando se ha realizado la esterilización a menos de 90 días después de la fecha en la que la persona firmó la Forma de Consentimiento para la Esterilización. Para esos casos, utilice el párrafo 2 que se presenta más adelante. Taché con una X el párrafo que no se aplique.

(1) Han transcurrido por lo menos 30 días entre la fecha en que la persona firmó esta Forma de Consentimiento y la fecha en la que realizó la esterilización.

(2) La operación para la esterilización se realizó a menos de 30 días, pero a más de 72 horas, después de la fecha en la que la persona firmó la Forma de Consentimiento debido a las siguientes circunstancias (marque la casilla apropiada y escriba la información requerida):

□ Parto prematuro
□ Cirugía abdominal de urgencia (Describa las circunstancias):

(firma del médico)

fecha:

HHS-687-1 (11/2006)
DECLARACIÓN SOBRE LEY DE REDUCCIÓN DE TRÁMITES

Una agencia federal no debe llevar a cabo o patrocinar la recolección de información, y el público no está obligado a responder a la misma o a facilitar la información, a no ser que dicha solicitud de información presente un número de control válido de la OMB. La carga horaria para el público que completa esta forma variará; sin embargo, se ha estimado un promedio de una hora por cada respuesta, cálculo que incluye el tiempo para revisar las instrucciones, buscar y presentar los datos exigidos y completar la forma. Para enviar sus comentarios sobre la carga horaria estimada o cualquier otro aspecto de la información requerida, escriba a OS Reports Clearance Officer, ASBTF/Budget Room 503 HHH Building, 200 Independence Avenue, S.W., Washington, D.C. 20201.

Se debe informar al público que responde a esta forma que la recolección de información solicitada en la misma se autoriza en virtud de 42 CAR parte 50, subparte B, que tiene que ver con la esterilización de personas en programas de salud pública que son financiados por el gobierno federal. El propósito de la recolección de esta información es asegurar que las personas que solicitan la esterilización sean informadas sobre los riesgos, los beneficios y las consecuencias de esta operación, y para asegurar el consentimiento voluntario e informado de todas las personas que se someten al procedimiento de esterilización en programas de salud pública que reciben asistencia federal. Se pide a las personas que llenen la forma que incluyan datos sobre su raza y grupo étnico, aunque esta información no es requerida. Toda la demás información solicitada en esta forma de consentimiento es requerida. Si la persona que llena la forma no proporciona la información requerida o si no firma esta forma de consentimiento, podría resultar en que no recibiera el procedimiento de esterilización financiado por un programa de salud pública patrocinado con fondos federales.

Toda la información de datos y circunstancias personales obtenidas por medio de esta Forma son confidenciales y no se divulgarán sin el consentimiento de la persona, en conformidad con todos los reglamentos aplicables de confidencialidad.
# PROVIDER INCIDENT REPORT FORM

**Section 1 Provider/Vendor/Facility Information**

- PROVIDER NAME: ________________________________
- PHONE NO. & EXTENSION: ________________________
- OFFICE OR GROUP NAME (IF APPLICABLE): ________
- STREET ADDRESS/SUITE #: ______________________
- CITY: ___________ COUNTY: ___________ ST: _______ ZIP: _______
- PROVIDER PLAN ID #: __________________________
- OFFICE CONTACT PERSON: ______________________
- PHONE NO./EXT: ______________________________
- RISK MANAGER NAME: __________________________
- PHONE NUMBER/EXTENSION: ____________________
- RISK MANAGER E-MAIL: _________________________
- FAX #: _____________________________________

**Section 2 Member Information**

- LOB: [ ] Medicare [ ] Medicaid
- MEMBER NAME: ________________________________
- MEMBER ID: _________________________________
- SEX: _______ DATE OF BIRTH: _________________
- MEMBER ADDRESS: ____________________________
- MEMBER PH #: ________________________________
- GUARDIAN: __________________________________
- HOSPITAL/FACILITY: __________________________
- HOSPITAL ADDRESS: __________________________
- DATE OF ADMISSION: __________________________
- ADMITTING DIAGNOSIS: _______________________  
  ICD-10 CODE: __________ INCIDENT DATE/TIME: _______
- CURRENT DIAGNOSIS: _________________________  
  ICD-10 CODE: __________ (After event/incident, and if still at facility) 
  DATE OF DISCHARGE: __________  DISCHARGE DIAGNOSIS: __________  
  ICD-10 CODE: __________

**Section 3 Incident Information**

- [ ] Pharmacy [ ] Laboratory
- [ ] Physician Office [ ] Ambulatory Surgical Center
- [ ] Hospital-IP [ ] Assisted Living Facility
- [ ] Hospital-OP [ ] SNF
- [ ] Emergency Room [ ] Transportation
- [ ] Home Health [ ] DME
- [ ] Nursing Home [ ] Behavior Health/Facility
- [ ] Outpatient Facility [ ] Other

**RELATED HEALTH CARE PROVIDER:**

- [ ] Enrollee death
- [ ] Enrollee brain damage
- [ ] Enrollee spinal damage
- [ ] Permanent disfigurement
- [ ] Fracture or dislocation of bones or joints
- [ ] Any condition requiring definitive or specialized medical attention, which is not consistent with or expected to be a consequence of service provision. It could occur as a result of service provision to which the patient has not given his informed consent, or occur as the result of any other action or lack thereof on the part of the staff of the provider.

**ADVERSE INCIDENT BEING REPORTED:**

- [ ] Enrollee death
- [ ] Enrollee brain damage
- [ ] Enrollee spinal damage
- [ ] Permanent disfigurement
- [ ] Fracture or dislocation of bones or joints
- [ ] Any condition requiring definitive or specialized medical attention, which is not consistent with or expected to be a consequence of service provision. It could occur as a result of service provision to which the patient has not given his informed consent, or occur as the result of any other action or lack thereof on the part of the staff of the provider.

**ADVERSE INCIDENT INJURY:**

- [ ] Any condition resulting in transfer of the patient within or outside the facility to a unit providing a more acute level of care
- [ ] Any condition that extends the enrollee's length of stay
- [ ] Any condition that results in a limitation of neurological, physical, or sensory function, which continues after discharge from the facility

**ADVERSE INCIDENT CAUSE:**

- [ ] Other:

---

*DO NOT PHOTOCOPY*
Section 3 – Incident Information (Continued)

Past Medical History/Diagnoses:


Detailed Incident Description:


Note the names of all personnel and the capacity in which they were involved with this incident:


Action(s) Taken by Facility/Vendor/Provider to Mitigate the Incident:


ICD 10 CM Codes: (TO BE COMPLETED BY RN or PROVIDER ONLY) if applicable

<table>
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<tr>
<th>Surgical, diagnostic or treatment procedure performed at time of incident (ICD 10 Codes):</th>
<th>Accident, event, circumstances, or specific agent that caused the injury or event (ICD 10 E-Codes):</th>
<th>Resulting Injury (ICD 10 Codes):</th>
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Full Name of Individual Completing Form: ____________________________________________

Signature: ____________________________

Title: ____________________________

Date: ____________________________

DO NOT PHOTOCOPY
## Section 4 Analysis and Corrective Action
(To be completed by Plan-RM Staff)

### Analysis (apparent cause) of this incident:

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### Describe CAP (corrective action plan) Including timeframes for CAP implementation:

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### Incident Resolved? If unresolved, explain how it will be resolved:

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**Signature of Plan Risk Manager**

**Date**

---

**PROVIDER/FACILITY/VENDOR:** Please complete Sections 1, 2, and 3 of this incident form and submit it to

RiskManagement@simplyhealthcareplans.com via a HIPAA secured e-mail or

FAX to 786-441-8218 within 24 hours of discovery of the incident.

You may also contact Deborah L. Polynice, Licensed Healthcare Risk Manager at 786.264.0786

---

DO NOT PHOTOCOPY
HIPAA BREACH REPORT FORM

PERSONAL AND CONFIDENTIAL

Date Breach Reported to /Received at Plan (Date of Discovery):
Date Breach Occurred (PHI accessed/transmitted/Disclosed) to unauthorized individual):

SECTION 1: Information for Person Reporting Breach

Name of person reporting Breach: ____________________________ Phone No. ____________________________
Member ID# (If applicable) ____________________________ Plan Provider ID# (If applicable): ____________________________
Complete Address: ____________________________ Apt/Suite #: ____________________________
City: ____________________________ State: ____________________________ ZIP Code: ____________________________
The person reporting the breach: ☐ A Member ☐ Parent of Member ☐ Spouse of Member
☐ Designated Member Representative ☐ A Subcontractor/Business Associate ☐ A Non-Par Provider
☐ Other Non-Related Individual that Received the PHI/ Breached Information
☐ Other (explain): ____________________________________________

If individual reporting breach received mail for a Plan member, was the mail opened? ☐ YES ☐ NO
If yes, please complete this form using the information viewed in the mailing.
If no, complete this form, as best as possible, using the information available on the envelope.

SECTION 2: Demographics of the Member Whose PHI Was Disclosed by the Breach

Member No. 1
Line of Business: ☐ Medicare ☐ Medicaid
Name of person affected by Breach: ____________________________ Member ID#: ____________________________
Complete Address: ____________________________ Apt/Suite #: ____________________________
City: ____________________________ State: ____________________________ ZIP Code: ____________________________

Did the breach include PHI for other Plan members? ☐ YES ☐ NO
If yes, please enter their information in Section 7 of this form.

Section 3: Member’s Personal Health Information That Was Accessed or Disclosed

☐ Name ☐ Address ☐ Phone Number ☐ Gender ☐ Date of Birth ☐ SSN ☐ Member Plan ID#
☐ Medicare# ☐ Medicaid # ☐ Other Insurance Information ☐ Diagnosis Code/Information ☐ Plan Name
☐ Procedure Code/Treatment Received ☐ Name of Providers ☐ Dates of Treatment/Service
☐ Other: ____________________________________________
HIPAA BREACH REPORT FORM

PERSONAL AND CONFIDENTIAL

Section 4: Method of Breached PHI

- Stolen Cell Phone
- Stolen Desktop Computer
- Stolen Laptop
- Stolen Tablet
- E-mail
- Phone
- Public Conversation
- Fax
- Copier
- Mail
- SFTP/FTP Site

Section 5: Format of PHI Disclosed

- Claim Form
- Explanation of Benefit
- Authorizations Letter
- Member ID Card
- Case Management/Disease Management Member Letter
- QM Member Letter
- Provider Termination Letter to Member
- Claim Letter
- New Member Mailing
- E-mail
- Disenrollment/Reinstatement/Member Letter
- Enrollment Verification Letter
- Other (Explain):

Section 6: Other Information

Who has viewed the information?

If disposed, how were it disposed of?  □ Trashcan (Intact as received)  □ Trashcan (Shredded into pieces)

□ Returned to Plan via mail/Post Office  □ Shredded

May the Plan send a representative to pick up the information?  □ YES  □ NO

If yes, when is best date and time for pick up?

Address for pick up?  Apt/Suite#: ____________

If no, can you please return the information back to the Plan?  □ YES  □ NO

If yes, when will it be returned?

How will it be returned?  □ Mail  □ In Person

If no, can the information be shredded and safely disposed of?  □ YES  □ NO

Section 6: Information on Person Completing This Form

Name:  Title:  Dept:

Phone Number:  Location:  □ Flagler  □ Tampa  □ Other

Signature:  Date:
HIPAA BREACH REPORT FORM

PERSONAL AND CONFIDENTIAL

SECTION 7: ADDITIONAL MEMBERS AFFECTED BY THE BREACH

<table>
<thead>
<tr>
<th>Member #2:</th>
<th>Member #3</th>
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<tbody>
<tr>
<td>Plan:</td>
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<tr>
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<td>Name of person affected by breach:</td>
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ADDITIONAL COMMENTS/REMARKS/SUMMARY:

Please complete this HIPAA Breach Report Form in its entirety, and submit it to the Plan via a HIPAA secure fax at (305) 408-5880.

This form must be submitted to the Plan within 24 hours from the date/time or discovery of the breach.

Revised: 09/2016